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EUR-HUMAN

Work package 6, Task 6.1

Deliverable 6.1

Report about the results of the assessment of the local situation and resources available

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Medical University of Vienna team:

Elisabeth Sophie Mayrhuber

Elena Jirovsky

Kathryn Hoffmann

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List of Contributors

Elisabeth Sophie Mayrhuber MUW
Elena Jirovsky MUW
Kathryn Hoffmann MUW (WP6 leader)
Christos Lionis UoC (scientific coordinator EUR-HUMAN)
Agapi Angelaki UoC
Enkeleint Aggelos Mechili UoC

Authors of local reports:

Austria:
Elisabeth Sophie Mayrhuber
Elena Jirovsky
Kathryn Hoffmann

Croatia:
Helena Bakic
Lena Pehar
Nikolina Stankovic
Dean Ajdukovic

Greece:
Christos Lionis
Agapi Angelaki
Chrysanthi Tatsi
Kyriakos Maltezis
Enkeleint Aggelos Mechili

Hungary:
Imre Rurik
László R. Kolozsvári

Italy:
Maria José Caldes
Nicole Mascia
Guilia Borgoili
Laura Delli Paoli

Slovenia:
Danica Rotar Pavlic
Mateja Žagar
Alem Maksuti
Eva Vičič
Erika Zelko

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Consortium partners EUR-HUMAN:

University of Crete (Coordinator) (UoC)
Radboud University Medical centre (Radboudumc)
University of Liverpool (UoL)
Netherlands Institute for Health Services Research (NIVEL)
Faculty of Humanities and Social Sciences, Zagreb (FFZG)
Medizinische Universität Wien (MUW)
Univerza V Ljubljani (UL)
European Forum for Primary Care (EFPC)
Local Health Authority Toscana Centro (AUSLTC)
Arq Psychotrauma Expert Group (ARQ)
University of Debrecen (UoD)

Executive summary

The EUR-HUMAN project, aims to identify, design, assess and implement measures and interventions to improve primary health care delivery for refugees and other migrants. Deliverable 6.1 reports on the results of the assessment of the local situation and resources available in terms of refugee facilities, primary health care for refugees, initial health assessment, interpreters and cultural mediators, challenges and barriers for primary health care providers and health care skills amongst refugees.

Each intervention site country (Greece, Italy, Croatia, Slovenia, Hungary, and Austria) compiled a structured national report on the local country specific challenges and resource situation. In order to ensure that all relevant aspects for the assessment and identification of existing capacities were covered, three methods were proposed to be combined: 1) a narrative literature review, 2) (semi-) structured interviews with local primary health care providers or stakeholders involved in refugee care provision or organisation, and 3) participant observation. All six intervention partners applied all three suggested methods and gathered data independently between April 1st and 30th and submitted their national reports to MUW until May 15th 2016.

Specific challenges were identified on different levels, one of the biggest challenges was found to permeate the systemic level. The extremely dynamic nature and complexity of the refugee crisis and the continuous changes that were undertaken with regards to it, pose a huge challenge to the intervention countries in terms of health care provision for refugees and other migrants. After the high influx of refugees via the Balkan route the situation changed quite substantially after the EU-Turkey deal came. This shift had different implications for intervention site countries and poses challenges for countries to respond to it. Findings also showed that challenges emerged due to varying capacities of facilities for refugees, frequently centres and camps were e.g. converted, re-named, opened and closed during the high influx of refugees 2015.

On an organizational level the greatest challenge in all intervention countries appeared to be the lack of staff and resources. Particularly the lack of multidisciplinary teams, including GPs, pediatricians, nurses, psychologists, social workers, cultural mediators, pediatricians and midwifes was found extremely problematic and challenging in terms of adequate health care provision. The term cultural mediator specifically refers to interpreters who are not only translating but also function as cultural mediators. Furthermore we found that clear pathways for (primary) health care for refugees are missing in many intervention site countries. For instance, there is no standardized initial health assessment in place in the intervention countries and documentation and monitoring structures are often unsuitable or missing. The lack of specific guidelines for vulnerable refugees, such as pregnant women, unaccompanied minors, refugees and migrants subjected to torture and violence, was also identified as challenging for health care provision. Another crucial organizational challenge that was specified was related to the coordination of different organizations, which provided (primary) health care services. Especially in settings e.g. Greece, where a clear division of competences and responsibilities is difficult to establish and many different organizations are engaged, the situation of challenged the health care provision for refugees.

On the level of primary health care providers, challenges and barriers existed particularly with respect to lack of information and knowledge on specific refugee care provision, risk factors, country specific illnesses, mental health support and recognizing and treating post-traumatic stress disorders. Linked to that findings showed that cultural barriers also posed a challenge to provision of care e.g. different

understandings of illness, treatment, privacy and taboos lead to ethical dilemmas and finally also hampered the work of health providers on the ground. Knowledge on country specific idioms of distress, as well as different illness concepts was noted as insufficient. At the same time legal questions on work permission, insurance and ethical aspects were issues important in the context of refugee care. Another aspect was the lack of a standardized format for medical documentation, or the difficult access to medical data records of refugees or asylum seekers, that was mentioned as a barrier in terms of providing health care and especially continuity of care. For GPs who provided long-term care for asylum seekers, the lack of remuneration for additional efforts as well as the lack of translation services available was also identified as challenging and problematic.

Lastly, the summary report found that there was hardly any information on health care skills of refugees. In most intervention site countries data on (primary) health care professionals who are refugees was difficult to obtain or did not exist at all, because it has never been collected. Findings showed that in some cases voluntary assistance and help of refugees who were health care workers was reported, however, they mostly acted as interpreters. In Austria, documentation on refugee health workers is increasingly established though an informal network of Arab speaking health professionals, and negotiations take place to engage people earlier into the workforce, potentially before their official validation of foreign studies and degrees is finished. Based on the findings, it is recommended that this unused potential should be formally recognized and built upon.

This deliverable 6.1 can be considered as assistance for the intervention countries of the EUR-HUMAN project. In brief, to be able to tackle the multifaceted challenges regarding primary health care for refugees and other migrants, integrated, person-centered, multi-professional interventions are needed which are adaptable to the special needs as well as cultural and ethical challenges of the local sites.

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Introduction, aims and objectives

In 2015 the flow of migrants, and especially refugees, entering Europe considerably increased. The high numbers of refugees arriving at the Greek islands and Italy shores, and travelling from there through South – Eastern Europe towards countries of their destination in Northern-Europe, led to the introduction of the term *'international refugee crisis'*. Many European countries are since then developing policies and plans to better define their role in supporting refugees entering Europe.

The EUR-HUMAN project, running from January to December 2016, aims to identify, design, assess and implement measures and interventions to improve primary health care delivery for refugees and other migrants with a focus on vulnerable groups. The objective is to provide good and affordable comprehensive, person-centred and integrated care for all ages and all ailments, taking into account the trans-cultural setting and the needs, wishes and expectations of the newly arriving refugees, and to ensure a service delivery equitable to that of the local population. Related to this, the aim of WP 6, task 6.1 was to assess the local situation and resources available to be able start from the local needs when developing trainings and interventions to improve the situation.

Title of WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

WP 6, task 6.1:

Identification and assessment of existing capacity of local organisations regarding primary care for refugees and other migrants and of refugees and other migrants who have themselves worked in primary care.

Specific objective of WP 6, task 6.1

Specific objective for task 6.1: to identify and assess the capacity, local situation, and needs of staff in Community-oriented Primary Care centres as well as other existing primary care settings (in six countries) regarding primary health care for refugees in order to improve the primary health care delivery for newly arrived refugees and other migrants with a focus on vulnerable groups.

In order to reach the specific objective each intervention site country (Greece, Italy, Croatia, Slovenia, Hungary, and Austria) provided input regarding their national as well as implementation site situation by writing a structured national report. The summary report described the situation as it was in April and May 2016, however, in some countries as e.g. in Greece the situation is not the same at the current date (29th June 2016). Thus, the provided information in the summary report relates to the situation as it was in April and May 2016, unless specified otherwise when updated data could be included during finalisation of the summary report. All national reports provided input to this deliverable 6.1.

Deliverable 6.1

Report about the results of the assessment of local resources available.

Timeline

Timeline	Tasks	**Responsible EUR-HUMAN partner**
1. April – 30. April	Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and other migrants and of refugees and other migrants who have themselves worked in medical care through: • Literature review (obligatory) • Semi-structured interviews • Participatory observation (for details please see methods section below)	**UoC, UoD, UL, FFZG, MUW, AUSL11**
1. May – 15. May	Writing and sending the national reports (=complete the blank sections of this template) to MUW	**UoC, UoD, UL, FFZG, MUW, AUSL11**
16. May – 05. June	Preliminary summary report of deliverable 6.1 for WP4 (expert meeting) to RUMC and UoC	**MUW**
10. June - 30. June	Synthesis and finalization of the summary report **(Deliverable 6.1)**	**MUW**

Methods

Design

The identification and assessment of the existing situation and the local primary health care resources available in six EU countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria) was conducted by answering to the following questions:

- Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?
    - If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)
- Main countries where refugees and other migrants come from in your country?
- What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?
- How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)
- How is Primary Health Care provided in your country in general?
- Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?
- Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
- How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
- Primary health care staff situation (numbers, capacity, payment, safety, …)?
- Biggest challenges and barriers for primary health care providers?
- Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum? In what way are these resources documented and used already?

In order to be able to answer these questions three different methods were proposed to be combined: 1) narrative literature review/search of grey and scientific literature and reports, 2) (semi-) structured interviews with local primary health care providers treating refugees and other migrants and stakeholders involved in the organisation of primary health care for refugees and 3) participant observations in refugee camps and centres. According to the timeline, the intervention countries applied these methods between April 1st to April 30th 2016 and wrote and sent their national reports to MUW until May 15th 2016.

As defined in the final template for the national report for deliverable 6.1 (see A1. Final template for national report for deliverable 6.1) the narrative literature review was the minimum methodological criterion which had to be conducted for the national report. However, it was recommended to combine all of the following methods for the national report.

- **Narrative literature review/search of local grey[1] and scientific literature and reports** (existing documents on the local/national primary care capacity situation which include our questions raised above). Narrative means to describe and discuss the state of the existing literature of a specific topic or theme from a theoretical and contextual point of view. A narrative review consists of critical analysis of the grey and scientific literature published.[2] It does not describe the methodological approach that would permit reproduction of data nor does it answer to specific quantitative research questions. Nevertheless, a narrative review provides readers with up-to-date knowledge about a specific topic or theme. Examples for grey literature are reports by NGOs, governments, national, regional and international organisations, websites, publications in non-reviewed, non-indexed journals and quality newspaper articles.

- **(Semi-) structured interviews** with local primary health care providers treating refugees and other migrants and stakeholders involved in the organization of primary health care for refugees (~ 6-10 persons). The interviews could be face-to-face, as telephone-interviews, or skype interviews. It was voluntary to audiotape and transcribe the interviews for analysing the content, taking memory notes was also an option. It was also possible to send the question per email to certain persons and receive answers via email. The analysis should have been conducted with the aim to be able to answer the questions raised (the detailed interview guideline can be found in A1. Final template for national report for deliverable 6.1).

- **Participatory observations in refugee camps and centres**: Participatory observation is a technique of field research, commonly used in anthropology or sociology, by which one or more investigators (participant observers) study the life of a group by sharing in its activities and observing and documenting the incidences occurring, the behaviour of individuals and the group, as well as the interactions between individuals. In the context of primary health care, for instance, this allows the researcher to better understand the challenges and issues in clinical practice by observing the interactions between patients and health care workers.

[1]Luxembourg Convention on Grey Literature. Perspectives on the Design and Transfer of Scientific and Technical Information. Third Conference on Grey Literature. [http://www.greynet.org/]. Dobbins M, Robeson P: A Methodology for Searching the Grey Literature for Effectiveness Evidence Syntheses related to Public Health. The Public Health Agency of Canada; 2006.

[2] Cook DJ et al. Ann Intern Med 1997;126:376-380

Data generation and analysis

The six EU countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria) generated data independently and submitted their national reports to MUW until May 15th 2016. All three suggested methods were applied by the respective intervention site partners. In order to ensure that all relevant aspects for the assessment and identification of existing capacities were covered, MUW provided a template on how to write the national report including an (adaptable) interview guideline (see: A1. Final template for national report for deliverable 6.1). The template was based on required information and developed with input of all EUR-HUMAN partners.

Table 1: Applied methods per country

Country	Literature search	Interviews	No.	Participant observation	No.	Explanatory note
Greece	✓	✓	8	✓	1	Greece: observations at hotspot of Moria
Italy	✓	✓	6	✓	1	Italy: observations at facility for asylum seekers and refugees with severe pathologies
Croatia	✓	✓	9	✓	2	Croatia: two observations at Porin Reception Centre
Slovenia	✓	✓	22	✓	2	Slovenia: observations at transit centre and an accommodation centre
Hungary	✓	✓	8	✓	*	Hungary: observations from WP2
Austria	✓	✓	8	✓	3	Austria: observations at three different long-term refugee camps

In addition, the six EUR-HUMAN intervention partners also included results from earlier studies, protocols from presentations and meetings, and results from already finished WPs in order to complete the questions raised in their national reports.

The (semi-) structured stakeholder interviews were conducted with the following representatives as listed in Table 2.

Table 2: List of conducted (semi-) structured interviews

Country	No.	Stakeholder/ Representative
Greece 8 Interviews	1	The Greek part of Médiciens Sans Frontières/Doctors Without Borders (MSF)
	2	The Greek part of Médiciens du Monde (MDM)
	3	The Greek Red Cross
	4	Praksis NGO
	5	Metadrasi NGO
	6	International Organization of Migration (IOM)
	7	United Nations High Commissioner for Refugees (UNHCR)
	8	The National Health Operations Centre (EKEPY) of the Hellenic Ministry of Health
Italy 6 Interviews	6	Six Health workers were interviewed of the Tuscan Local Health Unity (ASLTC) who deal with migrants and refugees in different ways and contexts; persons with different qualifications: GPs, obstetricians, paediatricians, public health doctors

Croatia 9 Interviews	1	Croatian Red Cross employee working in Kutina/Porin - psychologist
	2	Croatian Red Cross employee working in Kutina/Porin - social worker
	3	Croatian Red Cross employee working in Kutina/Porin - occupational therapist
	4	Volunteer coordinator - Centre for Peace Studies
	5	Volunteer - Centre for Peace Studies
	6	Psychologist - Society for Psychological Assistance
	7	Psychologist - Society for Psychological Assistance
	8	GP
	9	GP
Slovenia 22 Interviews	12	Interviews with health workers at Schengen border
	1	Volunteer at reception centre Vrhnika
	2	Nurse from Brežice
	3	Doctor from emergency medical aid
	4	Head GP of medical care in Vrhnika
	5	Coordinator for health care of migrants from Ministry of Health (Rigonci & Dobova)
	6	Medical technician from Brežice
	7	Head GP of health care of migrants in Brežice
	8	Nurse from Brežice
	9	Medical technician from Brežice
	10	GP from Logatec Health Centre
Hungary 8 Interviews	8	Eight local primary health care providers were interviewed, who treat refugees and other migrants in community shelters or in refugee camps
Austria 8 Interviews	1	GP, who also worked in transit centres
	2	GP, who also worked in transit centres
	3	GP, who also worked in transit centres
	4	Stakeholder, Asylkoordination
	5	Dentist from Syria, who also worked in transit centres
	6	Stakeholder, Austrian Red Cross federal representative for emergency rescue
	7	Refugee camp manager
	8	Refugee camp manager

All intervention site partners analysed their gathered data themselves and filled out the template. Several researchers were involved who co-authored the respective country reports and independently analysed at least part of the data.

MUW then completed the thematic analysis of all country reports, assembled it for the summary report and provides main findings and implications in this Deliverable 6.1.

Due to the different citation format and the huge amount of references in the respective national reports, the citations and references are not listed each individually in this summary report but all references per country are listed below in the section: “References” and can be checked in detail in the respective national reports.

Ethical approval

No specific ethical approval was necessary for the expert interviews; however several countries applied for ethical approval for the methods used in WP6 task 6.1 together with the methods used in WP2 of the EUR-HUMAN project. In Table 3 the countries and ethical approval numbers are listed.

Table 3: Overview of ethical approvals

Country	Approval	Ethic committee	Date/ File number
Greece	Approval	2nd health region of Piaeus and Aegean. Approval from the governor of 2nd health region	Protocol number: 7496, date 22-02-2016
Italy	No approval necessary	-	-
Croatia	No approval necessary	-	-
Slovenia	Approval	National Ethic Committee	24-03-2016
Hungary	No approval necessary	-	-
Austria	Approval	Ethics committee of the Medical University of Vienna	Austria: EK-No: 2181/2015

Results

Overall number of refugees and other migrants

As described in Deliverable 2.1, the flow of migrants and especially refugees entering Europe considerably increased in 2015. The majority of refugees arrive at the Greek islands or Italian shores (hotspots), until March 2016 they continued to travel from there through Croatia, Slovenia, Hungary to Austria or other countries of final destination in Northern Europe. This route was referred to as the "Western Balkan route" (Fact sheet: The Refugee/ Migration Crisis and Greece, April 2016).

European countries were challenged with different scenarios during 2015 until March 2016, while counties with sea borders (Greece and Italy) face a huge challenge of first point of entry hotspots; other countries remained primarily transit countries for refugees and migrants or became firstly host countries for asylum seekers. Croatia for example, reported that although it remained a transit country, the number of people applying to for asylum increased after the introduction of more restrictive measures for the control of refugees and migrant influx in mid-February (Croatian national report 6.1). After the EU-Turkey agreement came into effect and the west borders of Greece (Greece-FYROM borders) were closed, many refugees and immigrants got "stacked" in Greece. Due to this agreement, approximately 48,000 refugees and migrants who arrived before 20th March, which is the date on which the agreement came into effect, continued to be stranded in Greece with reduced options for onward travel (Greek national report 6.1).

Table 4: Number of refugees entering the country and number of asylum applications

	Refugees entering the country 2015	entering until March 2016	Asylum applications 2015	Asylum applications until March 2016
Greece	862.138	151.656	13.197	2641 (Jan+Feb)
Italy	153.842	23.179*	83.970	22.596
Croatia	558.242	100.487	152	379
Slovenia	360.213	98.068	385	340**
Hungary	~ above 500.000		177.130	7.185
Austria	730.000	114.124	88.151	14.328
* until April 13th 2016				
** incl. persons accommodated in deportation centres				

As Table 4 explicitly shows, all six EUR-HUMAN intervention site countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria) recorded high numbers of refugees entering the country between 2015 until March 2016. While the various specific challenges in terms of primary health care for refugees and other migrants may vary in the different countries, the principal selection of the six intervention countries is once more underscored by the given numbers. It should be mentioned that the refugees entering Croatia, Slovenia, Hungary and Austria are largely coming from Greece and Italy.

The numbers in Table 4 were directly taken from the respective national reports sent to MUW, which rely on different sources, and final numbers on transit refugees as well as on asylum applications may differ according to these sources. Thus, Table 4 has an overview purpose as numbers cannot be compared one-to-one and should be treated with caution.

During 2015, **Greece** received 85% of refugees and migrants who wished to reach Europe and became the first entry point for 862.138 refugees and migrants for this explicit reason. Most of these people crossed the border via the "Balkan transit route" until the EU-Turkey agreement was reached and EU-borders were closed. The Greek national report estimates that the number of asylum seekers in Greece will raise due to the deal, as refugees can apply for asylum at Greek authorities, in order to avoid deportation to Turkey (Greek national report 6.1).

Italy is the second most important first entry point to Europe with established hotspots counting 153.842 refugees and migrants to have entered in 2015. Many of those persons continued traveling, however 83.970 persons applied for asylum in Italy until the end of 2015. According to the latest data from the Italian Ministry of Interior there are a total of 111.081 refugees and asylum seekers in Italy as of April 29th 2016 (Italian national report 6.1).

With the closing of the "Balkan transit route" the situation also changed substantially in the transit countries as well as in host countries. Before the EU-Turkey deal the majority of refugees who entered Slovenia or Croatia for example, did not apply for asylum but transited further. In Slovenia there exists the possibility that a person who does not apply for asylum can apply for a 6-month permit of retention in Slovenia, they are entitled to accommodation and basic care in accommodation centre (Slovenian national report 6.1). As with the closure of borders, the Croatian national report indicated that all new refugees and migrants who come to Croatia are mainly readmission cases, from other EU countries. The Dublin regulation and the challenges that rise from it are furthermore mentioned. The possibility of large numbers of asylum seekers to be continuously transferred back to Croatia from other EU countries is assumed to be hardly manageable under the system in its current state (Croatian national

report 6.1). Hungary, for example, erected a fence on the Serbian-Hungarian border and stopped the movement of refugees and migrants through the country. The Hungarian national report describes that people who crossed the border legally were transported to open refugee facilities, but most persons did not stay at Hungarian camps. In order to close predictable alternative routes, Hungary plans to also erect a fence between Hungary and Rumania (Hungarian national report 6.1). It is noted that the Austrian authorities started controlling the border between Hungary and Austria and did not allow the crossing of persons without official documents (Hungarian national report 6.1).

In terms of number of asylum applications in each country, it is relevant to note that the provided numbers do not reflect how many asylum seekers actually reside in a specific intervention site country. It was reported that e.g. in Hungary the number of asylum applications are much higher compared to the number of persons who are actually residing in the country (Hungarian national report 6.1). The dynamic situation poses specific challenges for the intervention site countries as well as for other countries of destination, where persons will not be admitted to an asylum procedure but have to potentially reside without any recognized status or option for international protection.

Refugee facilities

There exist different refugee facilities in the six intervention site countries, in line with Deliverable 2.1 this summary report classifies:

1) **HOTSPOTS,** or **HOTSPOT CENTRES** in Greece and Italy, and **TRANSIT CENTRES** in other countries – both places intended for short periods of stay
2) **INTERMEDIATE** short-stay centres for registration and/or application
3) **LONG-TERM** refugee centres, where persons reside who applied for asylum and are in the asylum process

Lastly, we also added deportation centres for persons who are not admitted to an asylum application in the country that they applied for asylum (Dublin III) or for persons who received a negative asylum decision.

4) **DEPORTATION CENTRES**, where persons reside who are not entitled to remain in the country.

It is relevant to note that this classification serves mainly to gain an overview of the different refugee facilities in the respective intervention site countries. However, in certain settings this classification falls short to precisely classify a facility under the scheme as centres were re-classified or converted during the high influx of refugees in 2015 and until March 2016 (e.g. from intermediate to long-term centres).

Table 5: Different refugee facilities per country

		HOTSPOT CENTRES (Greece, Italy), TRANSIT CENTRES	INTERMEDIATE (registration/ application)	LONG-TERM (during asylum procedure)	DEPORTATION
Greece (last data: 29.6.2016)		5 hotspots/reception centres: Eastern Aegean islands of Samos, Lesvos (Moria), Chios, Kos, Leors (now these became pre-departure-detention centres)	46 hosting centres: whereof 13 in Athens hosting around 14.870 persons, 5 in central Greece hosting 2172 persons, 1 in south Greece hosting 248 persons, 27centres in north Greece hosting 24.768 persons; the 4 unofficial camps were [all closed], additionally to the state centres there are 4745 persons hosted in UNHCR facilities, around 150 are out hosting centres		see hotspots section
	Capacity	(see Figure 1)	(see Figure 1)	Capacity of accommodation centres: 33.910 (30.000 new accommodation places will be created shortly)	see hotspots section
	Time period	all new arrivals are held while their case is assessed, Syrian refugees often leave immediately, others stay between 3 days and 1 week (WP2)	in reception centres for over 6 months, not intended	immigrants/refugees are hosted in relocation camps until a decision for asylum or for relocation in an EU country comes out	see hotspots section
Italy		6 hotspots in Lampedusa, Porto Empedocle, Pozzallo, Trapani, Augusta, Taranto	14 CARA, CPSA, CDA, Regional Hubs and 1657 temporary reception centres (CAS) established 2014 to face emergencies when there is no places at CARA, CPSA, CDA, Regional Hubs or in the SPRAR	SPRAR Project facilities (Protection System for Asylum Seekers and Refugees) (e.g. Villa Pepi and Villa Immacolata WP2)	5 CIE (Centres for identification and expulsion) in Rome, Turin, Bari, Caltanissetta, Trapani
	Capacity	Capacity: 2.100	Capacity CARA, CPSA,CDA: 9.504 Capacity CAS: 37.028	Total amount of asylum seekers in SPRAR: 20.596	N/A
	Time period	72 hours	time necessary to apply for international protection	until asylum decision is made (in theory)	N/A
Croatia		around 8 transit/temporary reception centres: in Tovarnik, Čepin, Beli Manastir, Zagreb - Dugave, Zagreb - Velesajam, Ježevo, Sisak, Opatovac, Slavonski Brod [all closed]	Reception Centre for Asylum Seekers Kutina and Porin (Zagreb)		Detention centre for Irregular Migrants Ježevo
	Capacity	Capacity Opatovac: 4000 Capacity Slavonski Brod: 5000	Capacity Kutina: 100 Capacity Porin: 600		Capacity: 100
	Time period	36 to 48 hours	N/A (all refugees who applied for asylum in Croatia were accommodated there; refugees who did not apply for asylum but were considered vulnerable groups were also accommodated in a closed section of Porin)		total maximum of 18 months

Slovenia		Transit Zone: Šentilj accommodation centre/reception centres Transit centre: Dobova Temporary accommodation centre Vrhnika [closed]		Accommodation places: 2 in Ljublijana 1 in Logatec Youth Crisis Centre: 10	Centre for Foreigners Postojna
	Capacity	Capacity Šentilj: 4152 Capacity Dobova: 4000		overall capacity: N/A (current occupancy) Ljubljana AH LI: 203 (187) Kotnikova (part of AH LI): 90 (65) Logatec (part of AH LI): 220 (29) Private houses or flats: N/A (11)	Postojna: 50 (occupancy: 38)
	Time period	only a few hours		until asylum decision is made	N/A
Hungary		Transit Zones: Röszke, Tompa, Letenye, Beremend	Permanent reception centres: Bicske, Vámosszabadi, Debrencen [closed] Temporary reception centre: Nagyfa, Körmend, Szentgotthárd Community Shelter: Balassagyarmat For unaccompanied children: Fót, and Hódmezővásárhely		Closed-off reception centres: Békéscsaba, Nyírbátor, Kiskunhalas; Győr
	Capacity	N/A	Capacity Bicske: 439 Capacity Vámosszabadi: 216 Debrencen: [closed] Capacity Nagyfa: 300 Capacity Körmend: 300-500 Capacity Szentgotthárd: N/A Capacity Balassagyarmat: 111 Capacity Fót: N/A Capacity Hódmezővásárhely: N/A	There are no numbers of how many asylum seekers are currently located in Hungarian refugee centres	N/A
	Time period	some hours, maximum days	Permanent reception centres & temporary reception centre: stay for the time of asylum process, can leave before Community Shelter: maximum stay of 2 months For unaccompanied children: N/A		maximum stay is 12 months
Austria		Transit centre: there existed over 80 emergency shelters along the transit routes [all closed]	Initial reception centres: Traiskirchen, Thalham Five federal refugee centres Seven distribution centres	Refugee camps	One specific detention centre Vordernberg for asylum seekers
	Capacity	capacity depended on the emergency shelter, detailed number is not available	Initial reception centres: Capacity Traiskirchen: 1500 Capacity Thalham: 150 Distribution centres: Capacity Bad Kreuzen: 180 Capacity distribution centre Vienna: 150 Capacity Traiskrichen East: 180 Capacity Gaisberg: 160	~ 85.000 (but reports show that the capacity is not sufficient)	specific detention centre Vordernberg: 200-220

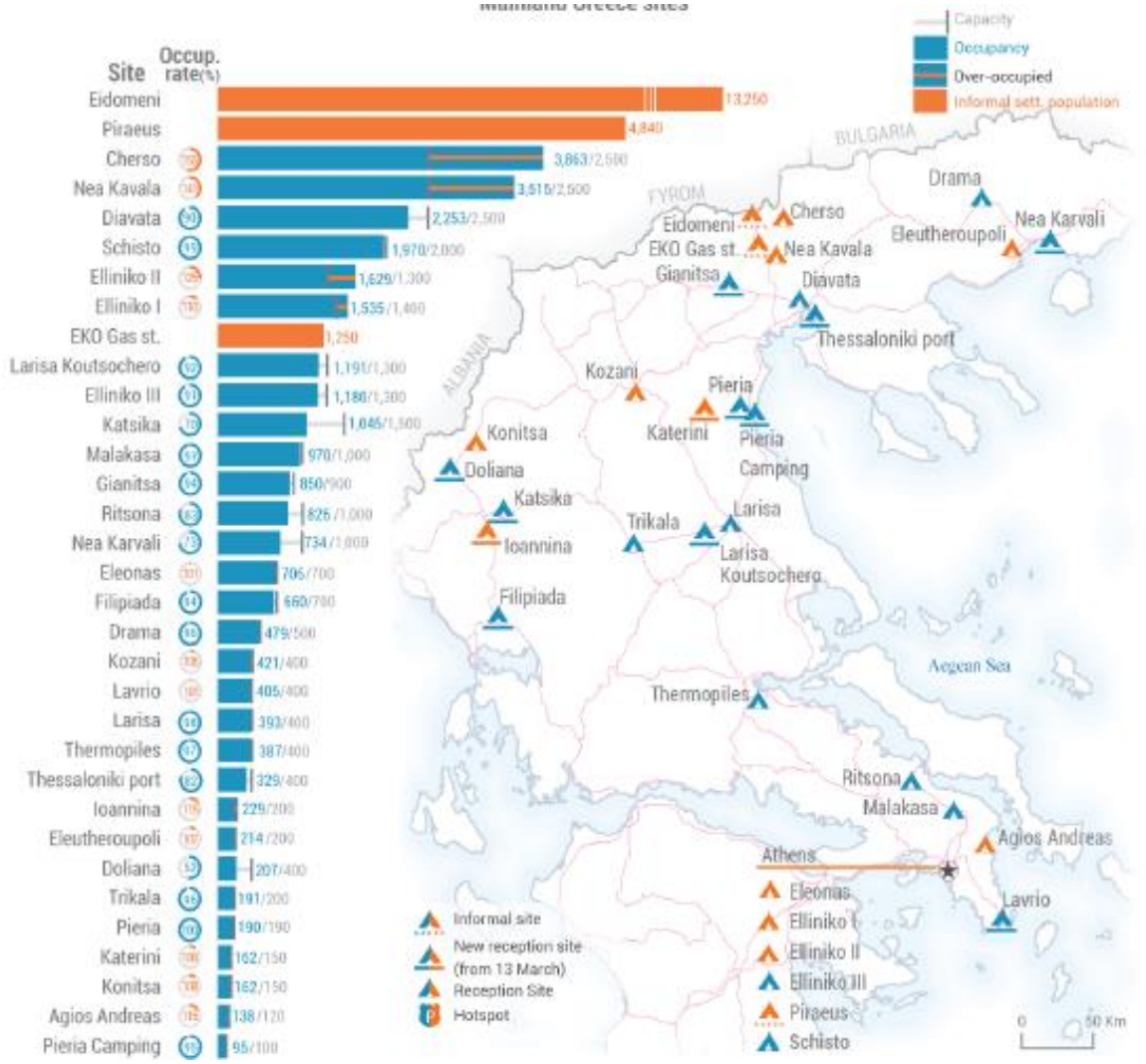
			Capacity Innsbruck: 200 Capacity Fehring: 150 Capacity Ossiach: 200		
	Time period	several hours, one day for up to three days	distribution centres: 48 hours but often refugees also remain there longer; persons who are assumed not be eligible for an asylum application in Austria are brought to the initial reception centre	Asylum seekers stay in the refugee camps until the asylum procedure is finished	Stay is as long as it takes for the person to get deported

Persons, who arrive in **Greece** after the EU-Turkey agreement, which came into effect on March 18th 2016, are accommodated in the 5 hotspots on the Greek islands. The lack of personnel in asylum procedures is the most significant obstacle for the procedure to be finished within the agreed 6-months' time frame (Greek National Report 6.1).

In terms of refugee facilities there exist at the moment 5 hotspots (in fact the 5th is the island of Kos due to island residents' reactions is unofficially out of order) Figure 5 shows the situation of relocation camps/hosting centres as of May 2016 (see: Figure 1), even newer data is provided below. In Lesvos island also, except the hotspot of Moria, which is the first created in Greece, there exists the hosting centre of Kara Tepe mainly for Syrian families. Refugees and immigrants can apply for asylum during their arrival at the hotspot, when they get recorded or at any time when they reach the mainland. They can also apply for asylum (after EU-Turkey agreement) even at the moment when they are on a boat being deported to Turkey.

By the shutting down of the main "Balkan migration route" to Western Europe, more than 42.000 refugees/migrants remain temporarily stranded across Greece, with an increasing trend. Latest data from Greece showed, that as of 29th June 2016, around 14.870 persons are hosted in 13 centres in Athens, 2172 persons are hosted in 5 centres in central Greece, 248 persons were hosted in one centre in south Greece, and 24.768 persons were hosted in 27 centres in north Greece. The unofficial camps were closed already. In addition to the formal state centres, there are different facilities from UNHCR hosting 4745 persons and around 1500 hosted in out hosting centres. At the Greek mainland, the majority of these centres have reached or have gone over their full capacity. Additionally, dilatory asylum procedures keep people stranded in reception centres for over six months, and as a conclusion of that, they will increasingly require integration assistance, education, and longer-term health interventions. In addition to reception facilities, over 30 accommodation centres are in operation throughout Greece as of April 2016, with a total capacity of 33.910 places, while 30.000 new accommodation places will be created shortly. In terms of long-term facilities it is relevant to note that until the EU-Turkey deal, Greece was a country not considered as final destination for refugees and migrants, so there are few long-term facilities or a mechanism to integrate these populations (Greek national report 6.1).

Figure 1: Cities capacity vs. occupancy in Greek hotspots and reception centres (UNHCR 2016)



In **Italy** a refugee plan is in place organized on three main levels, first a hotspot system provides for first reception services, first aid, identification and photo signalling. Persons are supposed to stay at hotspots between 48 and 71 hours, the 6 hotspots in the south are listed above in Table 5. The second level of reception is represented by government centres – CARA (Reception Centre for Asylum Seekers), CPSA (First Aid and Reception Centre), CDA (Reception Centre) – and Regional Hubs that are covering widespread the Italian territory. After their arrival in the South of Italy, migrants and asylum seekers are distributed throughout the Italian territory according to the capacity of the different structures in the Regions. In the government centres, migrants can apply for international protection and wait for the conclusion of procedures by the Commission or the competent territorial section.

There exist also temporary reception centres (CAS), established in 2014, according to Ministry of the Interior Circular no. 104, on January 8th 2014. According to their definition, they should be temporary reception centres, established to face emergencies and exceptional situations when there are no places available in the second level and in the SPRAR project (third level see below). De facto, they are used for ordinary reception and, according to the data available the majority of asylum seekers arriving

to Italy are placed in this type of centres. Situations of overcrowding in the second level of reception have been denounced by several NGOs.

The third level of reception is represented by the SPRAR project (Protection System for Asylum Seekers and Refugees). The SPRAR project is managed by the Ministry of Interior and by Italian local authorities (ANCI), including third sector organizations and network. The SPRAR project deals with refugees and asylum seekers waiting for the granting of international protection and aims at providing for 'integrated hospitality'. Refugees and asylum seekers receive not only board and lodging, but also social support activities, aimed at an effective integration in the territory and access to local services, including health and social assistance. The SPRAR project provides also for Italian language courses, training to facilitate employment and measures taken to have access to housing, enrolment of children in school and legal support. Theoretically, the person should stay at the second level centre for the time necessary to apply for asylum or protection. Then, the person should participate to the SPRAR project. Actually, due to the lack of places in the SPRAR, persons keep staying in the second level even after the application. Thus, in theory, every asylum seeker should run through the three levels. They should stay in the hotspots no longer than 72 hours. Equally, they should stay in the second level of reception only for the time necessary to apply for international protection. After the application, they should be involved in the SPRAR project, in order to start a pathway of integration. The Italian national report indicates that the actually situation is very different, as asylum seekers stay in the second level reception centres for months. Thus, although temporary reception centres (CAS) were settled to be extraordinary, they are actually used for ordinary reception. Available places in the SPRAR project are scarce and the waiting lists are long, this results in persons waiting for available places while they remain staying in the second level of reception.

CIE (Centres for identification and expulsion) are detention centres for irregular migrants in Italy (persons without legal documents to entry Italy, persons who haven't applied for international protection or who received a negative asylum decision), waiting to be expelled (Italian national report 6.1).

For **Croatia** the massive influx of refugees and migrants travelling across the "Balkan migrant route" was reported to have begun on September 16th 2015. Refugees crossing the Croatian border were transferred by buses and trains organised by the Croatian Ministry of Interior to several temporary reception centres in Tovarnik, Čepin, Beli Manastir, Zagreb - Dugave, Zagreb - Velesajam, Ježevo and Sisak. In these temporary and provisional facilities the persons were registered and Croatian Red Cross staff provided humanitarian assistance. After registration, the persons were transported by bus and train directly to Slovenian or Hungarian border. As the influx of refugees and migrants continued to grow, the Croatian Government opened a large reception centre in the village of Opatovaci in eastern Croatia on September 21st. All centres established during the first few days have been completely vacated as migrants left for Hungary and Slovenia and all people entering the border since September 21st were transferred to the Reception Centre Opatovac. In order to provide adequate conditions for a large number of refugees and migrants during winter months, the Government opened a Winter Reception and Transit Centre in Slavonski Brod on November 3rd. During September and December 2015 several reception centres were opened, closed and re-opened again, for a detailed description see: Croatian national report 6.1.

After the Balkan migrant route was officially closed on March 30th, Croatian authorities closed the Winter Reception Transit Centre Slavonski Brod on April 15th and the remaining 320 refugees and

migrants were transferred to existing long-term accommodation facilities for foreigners in Croatia. At that time these persons were presented with an official ban from leaving the centre and could only apply for asylum in Croatia or leave the European Economic Area voluntarily. Individuals who applied for asylum in Croatia were moved either to Reception Centre for Asylum Seekers Kutina (mostly vulnerable groups of asylum seekers) or to the Reception Centre for Asylum Seekers Porin in Zagreb (single men and other categories of asylum seekers). The "permanent" Reception Centre for Asylum Seekers Kutina provides long term accommodation for vulnerable groups of asylum seekers such as unaccompanied minors, families, pregnant women, persons with disabilities and persons suffering from mental disorders. This is an open type of facility so that the residents can go outside whenever they want but they have to be back by 10pm. If they want to leave the centre for a longer period of time they have to get permission from the administrator of the facility. At the moment of writing this report there were 54 individuals at Kutina, mostly particularly vulnerable individuals. The second Reception Centre for Asylum Seekers is Porin, initially intended to accommodate single male asylum seekers, in a leased part of the former railways hotel Porin located in Zagreb's neighbourhood of Dugave. Porin also functions as registration centre where asylum seekers provide their fingerprints, submit their asylum applications and receive their seeker's identity card. Just like in Kutina, the residents of the centre are free to go outside and are entitled to similar conditions. They also receive primary health care on the location. The centre currently accommodates 221 persons in total, including 169 asylum seekers and 42 family members who did not apply for asylum and are located in the separate part of the centre.

Individuals who did not apply for asylum in Croatia, were mostly directly moved to Detention Centre for Irregular Migrants Ježevo, except for those pertaining to vulnerable groups such as families who were transferred to a separate part of the Reception Centre Porin. The Croatian national report notes that, many persons who applied for asylum in Croatia after the EU-Turkey deal did not remain on Croatian territory but left the country within a short period of time. As of the closure of the borders, all new refugees and migrants that come to Croatia mainly due to readmission from other EU countries are situated in one of the long-term accommodation facilities (Croatian national report 6.1).

In **Slovenia** reception centres are places were the immigrants enter (or leave) Slovenia, they are registered and afterwards sent with trains or busses to the border, or they are sent to accommodation places. Accommodation places are facilities where immigrants stay a longer period (some hours to days) before the leave the country, or they apply for asylum. Šentilj, denominates an accommodation centre and an emergency makeshift railway platform, set up for the arriving migrants to get off the train in the immediate vicinity of the overburdened Šentilj accommodation centre. The accommodation centre in Šentilj, the point of exit from Slovenia with the heaviest refugee traffic, had up to 7000 people passing through it each day. According Slovenian national report, all the people accommodated in Šentilj were well taken care of. Some 160 to 200 people were caring for the transit refugees at the centre each day, not counting members of the police. The refugee reception procedure is conducted by the police with the support of the Armed Forces and at least one Arabic, Kurdish and Iraqi interpreter was assisting at all times. The tents were heated and had wooden floors. In addition to a total of 2,000 beds, refugees could also make use of shower facilities. A regular routine had been established at the transit centre, where refugees were provided with all the necessary care, and once the tents were vacated, they were thoroughly cleaned. Food was also provided. It was reported that during the day, regular medical teams, each comprising a physician and two nurses, assisted by volunteers, whose ranks include paediatricians and infectious disease specialists were working at the

centre. Together, they were able to examine around 100 to 150 people in eight hours. Since most patients could be treated on site, transportation to hospitals was reported to be not required and the overall situation was described as manageable.

At Dobova transit centre all refugees and other migrants first underwent a security check directly at the Dobova railway station and also received medical assistance. Then, they boarded the Slovenian train and were transferred to accommodations centres, where they underwent the registration procedure, with a view to simplifying and speeding up the registration of migrants, some technical improvements have been introduced, such as e-application, which enables fast entry of personal data into the police records. The procedure also included the taking of fingerprints and photographs. The number of registration points was reported to have been increased. The camp of Dobova was the major and only camp at the border to Croatia. It was close to the train station where the trains from Croatia arrived and the refugees were transferred to the authority of the Slovenian government. Recently, the camp was enlarged with new tents for food distribution and sanitation, and the floor was concreted to avoid mud and flood. On November 19th 2015 about 2000 refugees were expected to transit through the Dobova transit centre. When the refugees arrived at Dobova station, they were separated in two groups in order for the police to proceed with the registration. The first one was going to the accommodation camp Livarna in Dobova, while the other group remained at the train station. Registration included identity controls and issuing of "permission to remain" on the Slovenian territory. After registration, refugees were transferred to other accommodation camps in Slovenia (mainly Šentilj, or they were taken by train through Jesenice to Austria). The general situation in the camp was reported as good, there was also food distribution and the Red Cross set up a restoring-families-link wifi hotspot signal, for detailed description see: Slovenian national report 6.1. An overall lack of interpreters and doctors was reported for Dobova, at certain times there was just one doctor and one interpreter for Arabic available per shift. As a result of that the medical tent was saturated with requests. It was observed that many refugees did not have time to see a doctor before leaving the camp again. Furthermore interpreters were not able to assist the medical staff with interpreting as they were constantly needed at the registration.

Refugees who apply for international protection or asylum in Slovenia are generally transported to receiving asylum homes, where there are health controls, and the entire procedure for obtaining asylum is carried out. Slovenia has 3 asylum homes/centres (2 in Ljubljana, 1 in Logatec) and one national Centre for foreigners in Postojna. A total of 342 refugees and other migrants were accommodated in these centres as of April 28th 2016 and not all of them applied for asylum in Slovenia. There were 10 young people accommodated at a Youth Crisis Centre.

In autumn 2015 refugees and other migrants were staying in accommodation centres operated in the municipalities of Ankaran, Celje, Gornja Radgona, Lenart, Lendava, Logatec, Ljubljana, Maribor, Šentilj and Vrhnika (Slovenian national report 6.1).

In **Hungary** the transit zones were the legal open points of entry into the country, there refugees were registered, and could apply for asylum. In the Hungarian report it was described that, refugees only stayed in transit zones only for a short period (hours, max. days), containers were made available there, before they continued their way to one of the centres or to other counties of destination. Registered transit zone in Hungary were at: Röszke, Tompa, Letenye, Beremend. According to the latest official data and terminology, there are now 3 main types of reception facilities: Open reception centres, closed asylum reception centres and Community shelters. In open reception centres persons can leave

the centre whenever they want, in closed reception centres they cannot as they are mainly for detained asylum-seekers and for the majority who are people waiting for their deportation and community shelters (semi-open camps), in which a maximum stay of 2 months is possible. Open reception centres operate in Hungary (with a maximum capacity) and are located in Bicske (439) and in Vámosszabadi (216). Nagyfa (300) is the newest reception centre, which opened on January 12th 2015, initially meant as a temporary facility but since September 2015 being used as a regular reception centre. The centre consist of heated containers. Nagyfa is located inside the territory of a penitentiary institution and it is far away from the nearest settlement. Refugees who are accommodated in open camps have to register, and they can apply for asylum. While it is an open camp, they can leave the camp and some of them really leave before the end of the asylum process. Closed asylum reception centres operate in Békéscsaba, Nyírbátor and Kiskunhalas and they can be left only upon permission. The biggest reception centre in Debrecen was closed in October 2015 and one new open centre was opened in Körmend. There were approximately 200 people in Körmend in May 2016, however, it has a capacity of approximately 300-500 people. The Community Shelter in Balassagyarmat (111), co-operates with different societies, NGOs, charity, international, partner, local governmental and law enforcement organizations. Asylum seekers can leave the camp during the day but must return before 10pm. Among others cooperating organisations in the community shelter are the Hungarian Red Cross and the Menedék NGO (Association for help of migrants, in the field legal assistance with the Hungarian Helsinki Committee). The community shelter works for asylum seekers, persons tolerated to stay, persons in immigration procedure and foreigners who have exceeded 12 months in immigration detention, and now also receive beneficiaries of international protection. Generally, asylum seekers can also request to stay in private accommodation at their own cost, however in that case, they are then not entitled to most of the material reception conditions.

These centres are managed by the BÁH, the reception centres operate financially under the direction of the Director-General as an independent department and perform their professional tasks under the supervision of the Refugee Affairs Directorate of the BÁH. Thus, only one central body is responsible for the financial operation and the professional duties of the reception centres. Nevertheless, NGOs who work in the field of asylum cooperate with the refugee authority in providing supplementary services for asylum applicants. The BÁH coordinates the activities carried out in the reception centres. Refugees and migrants applying for asylum at the border zones are kept inside the transit zones, unless they are exempted from the border procedure, whereby they are transferred either to the asylum detention centre or are directed to go to the open reception centres. Where the detention grounds do not apply, they are given a train or bus ticket and are taken to the closest station so as to travel to the designated reception centre. Those asking for asylum at the airport can stay in a small facility (maximum capacity of 8 persons) within the airport transit area up to 8 days (Hungarian national report 6.1).

In **Austria** a differentiation is made between facilities intended for refugees who seek asylum in Austria (federal refugee centres, initial reception centres, distribution centres, refugee camps) and temporary facilities for transit refugees (emergency shelters, transit centres). Additionally there are also detention centres, for persons who receive a negative asylum decision and are obliged to return to their country of origin. From a procedural point of view the asylum procedure is a multi-stage process, at the beginning at the initial registration (at an initial reception centre or a distribution centre or at a BFA site) the person gets a procedure card (*Verfahrenskarte*, a green coloured card). After the person

is admitted to the asylum procedure he/she gets a white card, an asylum application card, which is a residence permit for the length of the asylum proceeding.

In terms of refugee facilities, as of May 2016, there exist five federal refugee centres in Austria (*Bundesbetreuungsstellen*), whereof two are located in Lower Austria Traiskirchen (Bundesbetreuungsstelle Ost) and Reichenau an der Rax (Bundesbetreuungsstelle Süd), and two in Upper Austria Thalham in Str. Georgen in Attergau (Bundesbetreuungsstelle West) and Bad Kreuzen (Bundesbetreuungsstelle Nord), and in Vienna Alsergrund (Bundesbetreuungsstelle Mitte). Two of these federal refugee centres also function as initial reception centres (*Erstaufnahmeeinrichungen*), and additionally, there is an initial reception centre at the international airport Vienna Schwechat, which is directly run by the Federal office for Immigration and asylum (.BFA), an authority directly reporting to the MoI and the final authority conducting first instance asylum procedures. Until summer 2015 the initial reception centres were responsible for the registration procedures for refugees who want to seek asylum in Austria. Refugees stayed there for the time that was required for checking if a person is admitted to asylum procedures in Austria (Dublin III). An asylum application can also be submitted at any police department or police officer and the first inquiry takes place. In the admissibility procedure an examination takes place to find out whether a person is admitted to the asylum process in Austria (Dublin III).

In summer 2015, with the increasing number of refugees coming to or transiting through Austria, seven so called distribution centres were established in several Austrian federal states, in order to disburden the two overcrowded initial reception centres Traiskirchen East and Thalham West. Not all of these distribution centres were newly established, some existed already as federal refugee centres and were converted into distribution centres. The distribution centres are set up by the federal government at the following locations: Bad Kreuzen (Upper Austria), Vienna Alsergrund/Nussdorferstraße (in charge of Burgenland and Vienna), Traiskirchen East (Lower Austria), Gaisberg (Salzburg), Innsbruck (in charge of Tyrol and Vorarlberg), Fehring (Styria), and Ossiach (Carinthia). Through the adoption of a new law Fremdenrechtsänderungsgesetz 2015 (BGBI. I Nr. 70/2015) asylum seekers do not need to be initially registered in one of the two initial reception centres, but can directly be brought to any of the distribution centre, where the first registration, first inquiry and the initial health assessment takes place. After the admissibility procedure, which should in principle only take 2 days, but can in fact take up to several weeks, the refugee either enters the basic welfare support scheme and is brought to a permanent refugee camp, or, if it is decided that Austria is not competent to examine the application of asylum, the person is transported to the initial reception centre Traiskirchen or Thalham, and is brought back to the country where he/she was first registered (Dublin III). The MoI reports that currently (May 2016) asylum seekers are only transferred to one of the initial reception centres if it is expected that another EU country is responsible for the asylum proceedings (Dublin III) or if the person is identified or presumed to be an unaccompanied minor.

In addition to general federal refugee centres there are also UMR federal refugee centres (specific focus on unaccompanied minor refugees), these are also supervised by the MoI.

Asylum seekers (except they are identified as or assumed to be unaccompanied minors), who are admitted to the asylum procedure in Austria, ought to be directly transferred from a facility by the federal government (distribution centre) to one of around 700 different refugee facilities in one of the nine provinces. These refugee camps can be organized or private accommodations, and persons are entitled to financial and social support based on the Basic Welfare Support Agreement 2004. As of

January 2015 there were about 85.000 asylum seekers in the basic welfare support scheme housed in various different forms of refugee camps. The report emphasised, that the capital city Vienna accepted a much higher quota of asylum seekers in refugee camps than the other provinces, and as of April 5th 2016 a total of 21.100 were located in Vienna. But by now every province has created refugee camps for asylum seekers and primary health care providers in all these provinces became provider for refugees (Austrian national report 6.1). For a detailed description of refugee facilities for unaccompanied minor refugees as well as refugee facilities set up as transit centres and emergency shelters please see: Austrian national report 6.1.

Primary health care in general

Before examining how primary health care is provided for refugees, primary health care systems in the six different countries are described in brief.

In **Greece**, primary health care is delivered through a combination of publically funded state health services, by general practitioners (GPs), who work at the private sector, and specialists. The choice of the provider is free but there are some charges. People can arrange an appointment at PEDY (Institution of Primary Health Care Provision in Greece) but there are long waiting times, which is considered as a main problem. The public service is delivered through Regional Health Care Centres, Health Care Centres in rural and remote areas (which are accessible 24 hours a day, 7 days a week) and public hospitals. Private GPs and specialists provide their services on a fee-for-service basis. Since the beginning of the financial crisis, Greece has been trying to improve national health care services with a focus on strengthening PHC services but the results remain poor. The creation of a National Organization for Healthcare Provision (EOPYY), the development of the electronic prescribing system and the creation of a Primary Healthcare Network in an effort to meet the needs of the population and ensure the efficient use of public resources were some of the Greek government efforts in order to improve primary health care services in the country.

In **Italy**, primary health care is provided by the State according to principles of universalism, equality and equity. The National Health Service (Servizio Sanitario Nazionale) is organized at a local level, where Local Health Services and Hospitals provide for health assistance. In the last 20 years, Italian Regions have gained significant autonomy in the field of health assistance and Primary Health Care is now one of the Regions' main tasks. Italian Regions have to formulate policies, draw operational tools in order to implement and supervise policies, set priorities and develop strategies. In Italy, primary health care providers are GPs. Primary Health Care centres exist all across the country and every person has a reference GP. Local Health Units (ASL) are part of the National Health Service and consist of hospitals, social districts and prevention departments. Depending on the territory, every ASL could consist of hospitals, health districts, continuity care assistance, family planning centres, mental health services, paediatricians, specialist exams, pathological dependencies.

In **Croatia** the health care system is organized by the Ministry of Health, it is based on the principle of social health insurance by which citizens are required to participate in the expenses for basic health care services with an exception for certain categories of insured persons. The main financing body is the Croatian Health Insurance Fund, which provides universal health coverage to the whole population,

defines basic health services and prices covered under the mandatory, as well as voluntary health insurance. Basic health insurance is mandatory for everyone in Croatia, including temporary residents. The primary care physicians are usually patients' first point of contact and each insured citizen has to register with a general practice doctor, a paediatrician, a gynaecologist and a dentist of their choice. If necessary, primary health care physicians refer the patient for further treatment to secondary or tertiary specialist health care facilities. Secondary health care includes specialist-consultative healthcare, hospital health care in general and specialized hospitals and health resorts. Tertiary health care refers to most complex forms of health care in specialised clinical centres and national health institutes. Mental health services are mainly provided within institutions such as general and university clinical hospitals as well as specialist psychiatric hospitals. Local county governments own most of the public primary and secondary health care facilities while the state owns and controls tertiary health care facilities.

Health care in **Slovenia** is funded by a mix of public and private spending. The public sector is the primary source of health care funding. On average across EU countries, three-quarters of all health care spending was publicly funded in 2012. Slovenia's health system is funded by compulsory health insurance for everyone meeting statutory requirements, by state revenues, voluntary health insurance, and out-of-pocket spending. The delivery of PC is organized in health care centres and health stations and independent contractors, so called concessionaires. Health care personnel involved in PC include family practitioners (FPs)/ general practitioners (GPs), primary gynaecologists, and paediatricians, specialists in occupational medicine, and nurses with diploma in model practices. There are pomologists in some health centres. FPs in Slovenia act as "gatekeepers," controlling access to secondary services. Patients must choose their own personal FPs, who is responsible for providing PC for their patients, including emergency care 24 hours a day provided by physicians working in rotation outside regular office hours. This requirement has had a great impact on both the quality and cost of health care. Most first-patient contacts are made by FPs, and continued good access is of the utmost importance. There are 7,153 physicians registered with the Medical Chamber of Slovenia. At the primary level, there are 1,057 FPs working at health centres and around 343 FPs in the form of independent contractors. The Health Insurance Institute of Slovenia (HIIS) concluded contracts with 1,784 providers: 224 public institutions and 1,560 concession-holders in 2011. The number of contractors fell by six in 2011 compared with 2010.

Primary care in **Hungary** is financially regulated by the government and services are provided by a one doctor (GP) one nurse system. Based on single handed private practices there are about 6800 primary care physicians working in Hungary, whereof around half are providers for the adult population, around a quarter are providers for children, and one quarter of providers care for mixed populations (from new-borns to elderly). There are no group practices in the countries, and the financing is mostly based on capitations with other elements and small incentives. Thus, GPs mostly working as private enterprisers contracted with local municipalities for services and with the National Health Insurance Fund (NHIF) for financing.

The **Austrian** health care system provides universal coverage for a wide range of benefits, there is a free choice of providers, unrestricted access to all care levels such as general practitioners, specialist physicians and hospitals. The health care system is by constitution a federal responsibility and

overseen by the Federal Ministry of Health assisted by a range of national institutions. The implementation of health insurance has been delegated to social security institutions brought together in a national Federation of Austrian Social Security Institution (HVSV). In 2011 almost the entire population (99,9%) had health insurance coverage, membership of a specific scheme is determined by place of residence and/or occupation and social insurance contributions are determined at federal level by parliament; there are also private health insurance funds made use of by a small part of the population. A clear distinction of the three level of professional health care into primary, secondary and tertiary health care in Austria is lacking. From a patient point of view it is remarkable that the free choice of provider incorporates that besides only a few exceptions (e.g. radiology or labour medicine) a person can seek out to extra- as well as intramural working specialists directly and without medical referral at the primary care level. Thus, in Austria primary health care physicians are not always patients' first point of contact. In a nutshell the Austrian system is marked by coexisting decentralization, relatively weak regulation and little budget control with limited "gatekeeping".

Primary health care provision for refugees

In this chapter overall primary health care provision for refugees in the respective countries is addressed. However the main focus is given to primary health care provision in special refugee centres since the national reports also focus on the provision of primary health care in special centres (e.g. the Greek national report focuses on PHC provision in Moria, the Austrian national report focuses on PHC provision in long-term facilities).

Several authorities are involved in refugee (health) care in **Greece**, including ministries, regional and municipal authorities, port authorities, Greek coast guard and police, primary health care services (PEDY), hospitals, tertiary health services, the Greek army, national and international non-government organizations (NGO's), NATO and Frontex. At the Greek hotspots primary health care is provided mainly by national and international NGOs, such as Praxis, Médecins Sans Frontières/Doctors Without Borders (MSF), Médecins du Monde (MDM), the Greek Red Cross, KEELPNO, who provide humanitarian support in the field. The UNHCR is responsible for coordinating all NGO activities and the EKEPY is the coordination authority on all provided health care services to refugees in Greece. Refugees in need of medical assistance are mainly escorted to Médecins Sans Frontières / Doctors without Borders (MSF), Médecins du Monde (MDM), Women and Health Alliance International (WAHA), Greek Red Cross and PRAKSIS facilities at the hotspots and refugees camp. They can escort them to the hospital (emergency department which provides also primary health care services). In general, refugees and immigrants are not referred to PEDY due to its lack of facilities and personnel. KEELPNO (Hellenic centre for control and prevention of diseases), provides health services too, usually through mobile units.

MDM provides health care services (including mental health care services) to all refugees and immigrants who arrive in Greece and are in need, as they informed us during an interview we had conducted with their coordinator, in Moria's (Lesvos) hotspot. The health care professionals of MDM consist of a multidisciplinary team of general practitioner (GP), cardiologist, orthopedist, otolaryngologist, nurse, psychologist and social worker. An exact number of health care personnel could not be obtained from the interviewed stakeholder as it highly depended on the migrant influx.

In general the personnel of MDM at the hotspot of Moria included six or seven physicians, two nurses and two interpreters (Arabic and Farsi). MDM also launched a program entitled "strengthening of first reception mobile units in areas with huge refugees/immigrant influx", providing psychological support to refugees and immigrants reaching Lesvos shores. It is reported that MDM provided services to 168.955 refugees/immigrants/asylum seekers in 2015, and the number of visits to MDM services in Lesvos reached 34.254 visits.

MSF provides medical care, shelter, water, sanitation and hygiene promotion services (watsan), and distributing relief items to refugees and migrants arriving in the Dodecanese Islands as well as in Lesbos, Samos and Agathonisi, in Athens and at the Eidomeni's border crossing to FYROM. They provide medical care, in mobile clinics, at the island of Kos and other nearby islands. Since June 2015, in Lesvos they have provided health care services, in mobile clinics, distribute hygiene kits and improve water and sanitation facilities in the camps at Kara Tepe and Moria. In Eidomeni medical care is provided through mobile clinics to people, who are trying to cross the borders to reach FYROM. In collaboration with other NGOs, they set up a short stay camp and installed water and sanitation facilities along the border. In Athens, MSF provides medical care, psychosocial support and legal assistance to refugees, who have been tortured. MSF teams in Greece, are providing first aid, medical and psychological support, shelter, water, sanitation and essential relief items at reception centres and transit camps. MSF teams provide also medical health care services to refugees and migrants in Moria camp and at the port of Mytilini. It is reported that MSF psychologists have assisted 149 people through individual sessions and have conducted 133 group sessions with 589 participants in Lesvos island. Also the Greek Red Cross is active in Lesvos, they provide health services, first aid, nursing services and psychological support. Additionally they engage in informative actions and education programs for volunteers. In Moria as of 26th June 2016, there are 3 clinics that provide PHC. MDM provides services from 10:00-23:00 with doctors, nurses, psychologists, social workers and translators (Farsi and Arabic). One center works from 10:00-16:00. The Dutch organization BRF provides services with a doctor from 23:00-9:00. At Karatepe centre the NGO Human Appeal provides services 24/7 with a doctor, a nurse and a translator. MDM and MsF provide also services 8 hours per day.

It is recognizable that various organizations are providing primary health care at the Greek hotspots, for a very detailed record of health care provision at different sites please see: Greek national report 6.1.

Table 6: Primary health care staff situation in different centres in Greece

Centre	Staff	Problems
Moria hotspot	MDM provides services from 10:00-23:00 with doctors, nurses, psychologists, social workers and translators (Farsi and Arabic). One center works from 10:00-16:00. The Dutch organization Boat Refugee Foundation (BRF) provides services with a doctor from 23:00-9:00.	There is sewerage network but the sewage tank overflow.

Karatepe	NGO Human Appeal provide services 24/7 with a doctor, a nurse and a translator. MDM and MsF provide also services 8 hours per day.	
Samos (+hotspot)	Organizations: -Greek army is responsible for coordinating all NGOs activities and provides on call services during weekend and late at night. -Medin provides its healthcare services for 8 hours (9:00-17:00) from Monday to Friday. The healthcare professionals of Medin are consisted of a team:2 physicians, 2 nurses, 1 psycologist and 1 sociologist. -KEELPNO and Hellenic Red Cross (HRC) provide nursing/physician coverage for 8 hour per day (9:00-17:00) from Wednesday to Sunday. - Medicaments are provided by several NGO's -There is 1 bus available by police authority for regular occurrences (such as pregnancy, accompanied minors, etc.). For emergency issues there is 1 EKAB ambulance available. The healthcare services offices are located 3 containers (1 HRC, 1 Medin, 1 KEELPNO).	
Chios(+hotspot)	-Greek Army provides nursing/physician coverage for 8 hour per day (7:00-15:00). -HRC in collaboration with Spanish Red Cross provide nursing/physician coverage (1 physician and 3 nurses) for 7 hours (10:00-17:00) per day (except Friday). -Praksis provides nursing/physician coverage (1 physician and 1 nurse) for 8 hours per day. -WAHA International provides nursing/physician coverage for 5 hours per day (17:00-22:00) and for emergency issues during the night provides on call services. -Praksis, Greek Army and HRC provide medicaments. -There is 1 ambulance available by NGO for regular occurrences. For emergency issues there is 1 EKAB ambulance available.	There are complaints about the food supplies, which are under the coordination of UNHCR.

	-MDM provides its services to unofficial camps of Souda and DHPETHE for 8 hours per day (9:00-15:00) and WAHA International provides nursing/physician coverage for 5 hours per day (17:00-22:00) and for emergency issues during the night provides on call services.	
Schisto	-Greek Army provides nursing/physician (2 physicians and 3 nurses) coverage (1 clinic for adults and 1 for children) for 5 hours per day (8:00-13:00) and Greek Air Force provides nursing/physician (1 physician and 1 nurse) coverage for 3 hours per day (17:00-20:00). -MDM provides a mobile unit only Tuesday and Friday (1 pediatrician). -There is 1 available ambulance by Greek Air Force for emergency conditions.	There is great issue with septik tank. It is recommended a connection with the central sewer.
Elaionas	-KEELPNO and WAHA International provide nursing/physician coverage. -MSF provides its services (2 emerge containers with a dentist office) for 7 hours per day (13:00-20:00) in collaboration with 2 cultural mediators (Arabic-Farsi).	
Elliniko	-KEELPNO and several NGO's provide nursing/physician coverage under the coordination of EKEPY and KEELPNO. -The medicaments are provided by several NGO's.	-Lack of security guards during the night. -Lack of personal hygiene facilities for refugees and for the personnel too.
Baseball field	-MDM provide nursing/physician coverage in collaboration with 2 cultural mediators (Arabic and Farsi) for 4 hours per day (10:00-14:00). -WAHA international provides nursing/physician coverage in collaboration with mission team Aigaleo for 7hours per day (16:00-23:00).	
Hockey field	-KEELPNO provides nursing/physician coverage for 4 hours per day (9:00-13:00). -MDM provides nursing/physician coverage (1 physician and 2 nurses) in collaboration with 2 cultural mediators (Arabic and Farsi) for 7 hours per day (10:00-14:00 and 16:00-19:00) -Solidarity dentist of Elliniko provides its services 2 times per week.	

Arrival area	-FAIR PLANET, Metropolitan Social Solidarity clinic of Elliniko provide physician coverage for 4 hours per day (10:00-14:00) -MDM provides nursing/physician coverage in collaboration with cultural mediators for 4 hours per day (16:00-20:00). -Metropolitan Social Solidarity Pharmacy and Pharmacists du Monde (PDM), provide medicaments. -Social Solidarity clinic and pharmacy of Athens provides nursing/physician coverage (such as otolaryngologist, dentist, hematoogist, nurse, etc.) for morning and afternoon shift in collaboration with the NGO's, which mentioned above. -KIFA offered an ultrasound and a precision scale.	-PDM needs an extra place in order to establish a proper pharmacy (cabinets, fridge, etc.), which will be accessible to other refugee camps (such as Baseball and Hockey field). -Piraeus Dental Association is requested to establish a dental unit (with the support of volunteers) at the same area (due to the maintain needs).
Ag.Andreas	-Greek Army provides 24-hour nursing/physician coverage (3 physicians and 3 nurses) in collaboration with Greek Navy.	
Malakasa	-MDM provides nursing/physician coverage (gynecologist, pediatrician and midwife) in collaboration with cultural mediators for 4 hours per day (10:00-16:00). -MSF provide psychosocial services for 6 hours per day (12:00-18:00). -There are available 1 EKAB ambulance (for emergency issues) and 1 bus for regular occurrences.	
Lavrio (Agrotiki bank camp)	-Greek Navy provides physician coverage 24 hours per day. -There is 1 bus available for regular occurrences offered by Municipality of Lavrio.	
Lavrio (asylum seekers camp)	-National authority (since 1999, next to PHC unit of Lavrio) provides nursing/physician coverage (physician and administrative personnel for 4 hours per day and nurse for 24 hours per day) five days per week.	
Piraeus Port	-2nd Regional Health Directorate, EKAB, AEMY, GRC, KEELPNO, Athens Medical Association, Piraeus Dental Association, The smile of the child, other NGO'S and	

	individual volunteers provide nursing/physician coverage. -Medical materials are provided by MDM and MSF. -All provided healthcare services are under the coordination of EKEPY and AEMY. -KEELPNO and GRC provide mobile units and a vehicle for internal transport among the gates for 6 hours per day (17:00-23:00).	
Skaramanga	-Greek Army provides nursing/physician coverage (1 Physiatrist, 1 nurse for 24 hours per day and 1 endocrinologist for morning shift). -Mobile unit provides nursing/physician coverage (1 physician/paediatrician, 2 nurses and 1 cultural mediators) for 5 hours per day (9:00-14:00). -KEELPNO provides physician coverage (1 paediatrician) for 5 hours per day (9:00-14:00). -Soon 2 containers will be transformed to a dental clinic and a pharmacy.	There is a great need for mosquitocide
Merchant Marine Academy	Greek Army provides nursing/physician and pharmaceutical coverage (1 physician and 1 nurse) for 8 hours per day (7:00-15:00).	
Ristona	Greek Army, Greek Air Force in collaboration with GRC, French and Spanish Red Cross provide a mobile unit (1 GP and nurse) for 5 and half hours per day (10:00-14:30 and 16:00-19:00). -There are available 1 EKAB ambulance (for emergency issues) and 1 bus for regular occurrences.	-Lack of containers -Lack of fire precaution
Fthiotida-Thermopyles	-Lamia Medical Association provides voluntary physician coverage. -There are available 1 EKAB ambulance (for emergency issues) and 1 vehicle for regular occurrences offered by Prefecture of Central Greece.	
Larisa-Koutsochero	-GRC provides nursing/physician coverage sporadically (not proper conditions) -5th Regional Health Directorate provides 1 mobile unit (not proper conditions).	-Lack of containers -Lack of protection against snakes.

	-MDM provides a mobile unit (1 physician, 1 nurse and 2 cultural mediators).	
Oinofyta-Boeotia	-Greek Army provides accommodation in an old factory. -ADVENTIST provides nursing/physician and pharmaceutical coverage 24 hours per day. -There is drinking water available.	There is a great need for mosquitocide.
Volos	-Greek Army provides accommodation (in old car factor) and nursing/physician and pharmaceutical coverage (1 army physician, 3 paediatricians for 3 times per week, 1 dentist, 1 cardiologist and 1 volunteer physician from the hospital).	
Andravida	-Greek Army provides a GP (every Tuesday). -PHC unit provides a GP (every Thursday). -Amaliada Medical Association provides physician coverage (1 paediatrician 2 times per week and midwife/gynaecologist every Friday).	
Diavata	-Greek Army, EKEPY, GRC, WAHA International, MDM, Praksis, Protecta, social clinic, PHC unit Diavata, Salonica pharmaceutical Association provide and nursing/physician and pharmaceutical coverage.	-Lack of ambulance. -Lack of cultural mediators during the night shift.
Thessaloniki (port)	-EKEPY, Thessaloniki Port Authority, MDM, WAHA International, GRC,Medical Associations, Social clinic and individual volunteers provide nursing/physician and pharmaceutical coverage under the coordination of EKEPY.	
Lagadikia (Army camp UNHCR)	-MDM provides nursing/physician coverage (1 paediatrician 3 times per week, 1 gynaecologist once a week, 2 nurses and cultural mediators) for 8 hours per day (8:00-16:00) under the coordination of UNHCR and Greek Army.	There is a great need for mosquitocide.
Oraiokastro (Thessaloniki)	-MDM provides nursing/physician coverage 5 days per week (morning and evening shift).	There is great issue with septik tank. It is recommended a connection with the central sewer.
Sindos (Karamnlis building-Thessaloniki)	-Sam Global Response provides nursing/physician coverage for 8 hours per day.	Lack of drinking water.

Sindos (Frakapor-Thessaloniki)	-Sam Global Response provides nursing/physician coverage for 8 hours per day (9:00-15:00).	Lack of drinking water.
Kalochori (Iliadi-Thessaloniki)	-Sam Global Response provides nursing/physician coverage for 8 hours per day (9:00-15:00).	There is a great need for mosquitocide.
Kordelio	-GRC in collaboration with Finish and German Red Cross provides nursing/physician coverage for 10 hours per day (9:00-17:00).	
Vagiochori (Thessaloniki)	-Greek Army provides nursing/physician coverage (in 2 tents)	
Derveni (Alexil-Thessaloniki)	-WAHA International provides nursing/physician coverage for 8 hours per day.	
Sinatex (Kavalari-Thessaloniki)	-Humedica provides nursing/physician coverage for 8 hours per day.	
Herso (Kilkis)	-Greek Army and International Red Cross (IRC) provide nursing/physician coverage for 24 hours per day (18:00-8:00 Greek Army and 8:00-18:00 IRC) -Kilkis Medical Association provides nursing/physician coverage (1 paediatrician and 1 nurse every afternoon- volunteers). -Kilkis Pharmaceutical Association provides medicaments.	Lack of containers
Polycastro	-Greek Army and IRC provide nursing/physician coverage (in 3 tents) for 24 hours per day (8:00-17:00 IRC and 17:00-8:00 Greek Army) -There is 1 bus available for regular occurrences.	
Drama	-Municipality of Drama, Medical District, Drama Medical Association and GRC provide nursing/physician coverage in 4 different clinic (1 for males, 1 for females, 1 for children and there is a pharmacy) (1 paediatrician and 1 pathologist for 3 hours per day during the morning, 1 dermatologist on some mornings during the week, 1 gynaecologist once a week). -There is 1 ultrasound available. -Drama Pharmaceutical Association provides medicaments.	
Chalkero (Kavala)	-Greek Army provides accommodation.	

	-MDM provides nursing/physician coverage (2 physicians and 2 nurses) for 6 hours per day (10:00-13:00 and 17:00-20:00) from Monday to Friday. - Medical district of Kavalas provides 1 mobile unit and 2 pharmacists.	
Konitsa	-PHC unit of Konitsa provides nursing/physician coverage (personnel of 8 people). - There is 1 ambulance available.	
Pieria (Hercules field)	- Katerini Medical Association provides physician coverage (physician and paediatrician -volunteers) for 3 times per week. -Katerini Pharmaceutical Association and Prefecture of Central Macedonia provide medicaments. - There is 1 vehicle available for regular occurrences.	
Pieria (Nireas camping)	-PHC unit and hospital provide nursing/physician coverage. -The regular occurrences are handled by volunteers. -This camp will be shut down soon.	
Petra (Olympos)	-ADRA provides nursing/physician coverage (1 physician and 2 nurses) for 16 hours per day and 1 vehicle for regular occurrences.	There is a great issue with scabies.
Filipiada (Preveza)	- Greek Army, 6th Medical District, PHC units (Kalentini, Preveza, Thesprotiko, Filipiada), Social clinic of Preveza and Arta Medical Association provide nursing/physician coverage. - There is 1 EKAB ambulance available.	
Doliana	-Greek Army provides nursing/physician coverage (2 army physicians 24 hours per day, 1 GP, 1 nurse and 1 midwife once a week). -There is 1 EKAB ambulance available.	
Tsepelovo (Ioannina)	-Greek Army provides physician coverage (1 physician) for some hours every Monday and Wednesday.	
Katsika (Ioannina)	-Greek army, GRC, PHC unit (Voutsara) and hospital provide nursing/physician coverage (2 army physicians for 24 hours per day, GPs from PHC unit and Hospital, paediatrician from hospital, gynaecologists and midwife from hospital).	There is great issue with septik tank. It is recommended a connection with the central sewer.

	- Medicaments are provided by hospitals and social pharmacy.	
Giannitsa	-Greek army and volunteers from Pella Medical Association provide physician coverage (1 army physician and volunteers). -WAHA International provides nursing coverage (1 nurse and 1 cultural mediator) for 8 and half hours per day (9:30-18:00). - Medicaments are provided by Pella Pharmaceutical association.	Lack of protection against snakes.
Veria (Army camp Armatolou Kokkinou Imathias)	-Greek army and volunteers from Veria Medical Association provide physician coverage (1 army physician for 3-4 hours during the morning shift and 1 dentist, 1 pathologist, 1female gynaecologist and 1 ophthalmologist- volunteers). -Medicaments are provided by Veria Pharmaceutical Association.	
Aleksandia (Imathias)	-Greek Army provides physician coverage (1 army physiatrist and 1 surgeon) for morning shift. -Saint Elisabeth University of Slovakia provides nursing/physician coverage. -Medicaments are provided by Veria Pharmaceutical Association.	There is a great need for mosquitocide.
Kordogianni field (Vasilika)	-Greek army and Social clinic of Thermi provide limited nursing/physician coverage.	

In **Italy** NGOs and third sector organizations also have a key role in providing primary health care for refugees and migrants. A first health screening is provided to every refugee or migrant arriving to Italy at the hotspots in the first hours after arrival. Italian hotspots are strictly regulated, staff is highly trained and it is reported that it is highly difficult to get a permission to enter. After arrival at the hotspots refugees and asylum seekers are allocated among the Italian regions to reception centres, in which there is no primary health care staff supplied. Thus, there is no special health assistance for

refugees and asylum seekers and primary health care is officially supplied by the Local Health Services at that point.

Italian legislation allows access to healthcare for all, differentially regulated among the different legal statuses. Migrants from non-EU countries and without legal documents can access Italian healthcare through the STP code (Temporarily Present Foreigner), which guarantees access to healthcare for the period preceding the asylum request or the obtaining of documents and papers. STP code guarantees first aid and emergencies, and every health service considered essential for people health and wellbeing. STP code is valid for 6 months and it is renewable. After international protection is granted or the documents are obtained, persons are registered in the National Health Service (SSN), and they are assigned to a general practitioner (GP). It is reported that de facto, NGOs and third sector organizations play a crucial role in the collaboration with Local Health Units for the provision of health assistance to asylum seekers hosted in centres. Since primary health care is provided at a local level, the involvement of NGOs and local organizations is extremely variable depending on the territory. The Italian intervention site partners emphasized in their national report that interviewed health and social workers from the Tuscan Local Health Units expressed the necessity to improve their skills dealing with migrants. Based on that finding the possibility to organize the Italian training in the Region of Tuscany, especially in the ASLTC (Central Tuscany Local Health Unit) is assessed.

Primary health care in the **Croatian** temporary reception centres, that were operating at some point during the refugee and migrant crisis but are now closed, was provided by several international and civil society organizations and NGOs. The Croatian Ministry of Interior appointed the Headquarters for Crisis Coordination to coordinate all activities related to the arrival of refugees and migrants in Croatia and Croatian Red Cross (CRC) to coordinate all other organisations involved in providing care for refugees and migrants in temporary reception centres and border crossings. Amongst other organisations the State Commodity Reserves, the UNHCR and the United Nations Children's Fund (UNICEF), the Caritas Croatia, the Zagreb Islamic Community Mesihat, Magna NGO and the IOM were operating in different fields of refugee care. Furthermore the Jesuit refugee Service and local NGOs such as the Centre for Peace Studies, and the Society for Psychological Assistance provided support at these sites, which are mostly closed now. The Winter Reception Centre Slavonski Brod a well organised system for providing humanitarian response and health care for refugees and migrants in transit was established. It included 20 organisations and around 320 volunteers and staff members. National health system employees (physicians, nurses and medical technicians) organised by the Croatian Ministry of Health provided immediate medical services with the support of CRC and Magna. In the case of a more serious medical problem medical staff transported the patients to a nearby hospital in Slavonski Brod with a dedicated ambulance vehicle. Interpreters from various organisations assisted medical personnel during medical interventions in the centre and local hospitals. UNICEF, Save the Children International and Magna were responsible for providing specialised care for children and babies in child friendly spaces and mother-baby areas. UNHCR had a permanent presence in the centre in order to identify people with specific needs or at risk and to refer them to other organisations and services if needed and also provided the majority of non-food necessities. CRC and other NGOs (ADRA Croatia, Volunteer Centre Osijek, Volunteer Centre Slavonski Brod, Intereuropean Human Aid Association, JRS, Caritas Croatia, Union of Baptist Churches in Croatia, Samaritan's Purse, CPS, SPA) provided food, water, blankets, raincoats, hygienic kits, specific children supplies and psychosocial support. Considering that the transit centres in Croatia are now closed and that some of the staff now works in one of the two Reception Centres for Asylum Seekers in Kutina and Zagreb, in the remaining part of the report we will focus on these, currently active centres.

Primary health care in both currently active reception centres for asylum seekers is provided by a nurse who is a full-time employee of the Ministry of Interior, a general physician (GP) from the local medical health centre (also has a contract with the Ministry of the Interior) and several NGO workers in the helping professions. Nurses in the centres are usually present for eight hours a day, but at the moment they are both on a maternity leave and they have not yet been replaced. The medical nurses are in charge of basic medical care including monitoring and administering medication, measuring temperature and blood pressure. The GP in Reception Centre Kutina comes when the centre employees call him (usually 2-3 times a week), having a contract with a local pharmacy a prescription is officially stamped by the centre and JRS or CRC workers can pick up the necessary medication at the pharmacy free of charge, as the costs are covered by the Croatian Health Insurance Fund. The GP at the Reception Centre Porin provides medical examinations 2 times a week for 4 hours and is also on call for emergency cases. Within the GP office at the Porin centre typical medicines (also funded by the Croatian Health Insurance Fund) are available and the GP is also responsible that necessary medication is in-stock. When needed, the GPs refer patients with chronic diseases, acute mental disorders and pregnant women to specialist treatment in community health clinics or hospitals. JRC or CRC personnel accompanied by an interpreter (if available) transport them to the hospital and, when possible, cover the costs of specialized medical examinations and treatments, which are not provided by the national insurance. Although no paediatricians or other children's health specialists are present in the centre, the GPs refer children to appropriate specialist in the community health clinic or hospital. If a medical intervention is needed outside the doctor's working hours and the nurse alone is not able to help, asylum seekers are transported to the nearby hospital and provided with emergency medical help. SPA also sees the asylum seekers in need of psychological therapy and counselling in their offices in the centre of the city for free. CRC employees and volunteers as well as psychologists from SPA provide psychosocial support and counselling. Given that asylum seekers are not entitled to dental care, but only tooth extraction, two dentists with private practices in Zagreb provide free dental services to asylum seekers from Porin and Kutina. There is also a general practitioner who works in a county health centre but, as she is not allowed to receive asylum seekers there, they usually meet outside of working hours and a gynaecologist who provides free services mostly to non-pregnant women in her private practice. Unfortunately, primary medical providers who, unlike health personnel working in the reception centres, do not have a contract with the Ministry of Interior are not allowed by the law to provide services to refugees and migrants. However, volunteers in reception centres usually find a way to contact and organise appointments with several external health care providers who volunteer to give free medical examinations and treatments of asylum seekers.

In addition to the nurse and the GP, one social worker and one occupational therapist from CRC are also working full time in every reception centre and the CRC psychologist comes on a weekly basis. Finally, SPA teams visit the centres every week to provide counselling and psychosocial support mostly consists of psychologists and interpreters who are specially trained to interpret psychological counselling. According to the GPs working in these centres, the level of medical care currently provided is sufficient considering the number and the severity of health problems of asylum seekers. Besides the medical staff, CRC and JRS have contracts with the Ministry of Interior in both centres which allow them to employ full-time staff working on distribution of necessities and medicines, interpretation, transportation of people to medical examinations and treatments outside of the centre, organisation of medical records and the provision of psychosocial support. In addition, staff and volunteers from the CPS and SPA, although they're not full-time employees, often provide psychological assistance and

organise various activities with asylum seekers (workshops, language courses, recreational activities, etc.).

In **Slovenia** medical care is provided by medical teams in reception and accommodation centres, which has been organised in cooperation with the health centres from individual regions. The coordination on the ground is in the hands of the respective health centre closest to the reception centres; if necessary, other health centres in the vicinity are set in motion. Representatives of the Slovenian and Hungarian Caritas, volunteer health professionals and Doctors Without Borders are also engaged in providing medical care to the migrants on the ground. The head of a reception centre informs the nearest health centre about the arrival of the migrants. If it is not possible to assemble a medical team of professionals on regular duty or volunteer doctors, such a team is sent to the reception centre by the head of the emergency medical service. All persons who are assessed to urgently need medical help are examined. If there is a suspicion of any contagious disease among the migrants, the Slovenian Epidemiological Service of the National Public Health Institute is activated. Migrants from the reception centres who are in need of emergency treatment in a healthcare institution are accompanied there by the medical staff. The health care workers attend to the reception centres always when a new contingent of refugees was arriving and stayed there around 2 to 8 hours. In terms of health care providers on the ground, it is reported that personnel was present according the number of migrants at the accommodation centres. When it was very busy health care providers were available 24 hours a day in Šentilj and Dobova, in Gornja Radgona and Lendava around 4 hours per day and later only on call if they were needed. In Logatec and Vrhnika health care providers are only available on call. If the staff was on-call duty they managed the work additionally to their usual workload, but at the facilities where there existed attendance times/the hours were fixed staff worked every day at the fixed hours and were extra paid for their work in the receptions or accommodations canters. In terms of adequacy of health services the report included contrary views of interviewed persons, *"the camp as a whole functioned perfectly"* (HW6) versus *"in the camp health care was not adequately provided"* (HW2). In Deliverable 2.1 it was also reported that the local health care workers cooperated with the Slovenian Red Cross, Caritas Slovenia, Civil Protection Services, Administration for Civil Protection and Disaster Relief, and foreign organizations and offices (Deliverable 2.1).

Table 7: Primary health care staff situation in selected centres

Centre	Staff	Hours of health care providers presence
Dobova [transit, closed]	GP and nurse, paramedics, Red Cross workers, interpreters	24 hours
Vrhnika [transit, closed]	GP, nurse, paediatrician, psychologist, interpreters	24 hours and on-call combination
Ljubljana [AH LI]	GP, nurse, emergency medicine, psychologist, interpreters	24 hours and on-call combination
Šentilj [transit, closed]	GP and nurse, paramedics, Mobile Czech Republic Military Hospital, Red Cross workers, interpreters	24 hours

Gornja Radgona [accommodation centre, closed]	GP and nurse, paramedics, paediatrician, Red Cross workers, interpreters	4 hours every day
Lendava [accommodation centre, closed]	GP and nurse, paramedics, Red Cross workers, interpreters	2-4 hours at the arrival time of refugees and every day on-call if there were people at the centre
Postojna [Centre for Foreigners]	GP and nurse, paramedics, interpreters	24 hours and on-call combination
Logatec [part of AH LI]	GP and nurse, paramedics, social workers, interpreters	24 hours and on-call combination

In **Hungary** health services at the official camps are provided by doctors employed or contracted with the BÁH, the Office of Immigration and Nationality. Nurses and medical assistants work in these camps as well, and in some NGOs provide specialists such as paediatricians, gynaecologists and psychiatrists. According to the results of the Hungarian report continuous access to medical care was provided in all refugee facilities. In the permanent reception centre Bicske and Vámosszabadi a nurse was present for 10 hours a day, responsible for triaging the cases and informing the GPs or paediatricians, who also perform surgeries according to the needs at approximately 4 to 8 hours per day (sometimes shifts were longer). It is reported that in the centres access to urgent-emergency medical care 24/7 was available every day through the nearby location in the next village or city, if this was required.

The report highlights the high turnover of inhabitants of the refugee camps, which follow an "open-policy" and point to the health care provision challenges in this context. It is described that persons who wanted to move to Western EU countries left Hungary while the remaining camp inhabitants applied for asylum or temporary permit for staying in Hungary. In terms of transit zones a quick general health assessment was conducted at the transit zones and as soon they are in the centre they receive the same medical care as the Hungarian population (Hungarian national report 6.1).

As soon as a person applies for asylum in **Austria** and is admitted to the asylum procedure, the person is insured in the common health insurance system and is entitled to receive health care equally to Austrian citizens. At the initial reception centres and distribution centres, which are the intermediate facilities where refugees/asylum seekers are transferred to initially, operated by the Ministry of Interior, an initial health assessment is mandatory within 72 hours and primary health care is provided. The ORS service GmbH is commissioned by the MoI to conduct the initial medical assessment and is also responsible for the provision of primary health care in these facilities. The ORS Service GmbH officially provides primary health care in these federal facilities, but based on contractual provisions regarding confidentiality the company is not obligated to reveal the specific contractual content. In terms of UMFs, the federal reception facility east in Traiskirchen provides a 24 hours a day supervisor to whom she/he can refer with any questions or problems for each UMR, and a special practice to be applied to UMFs below the age of 14[3], as they are taken care of additionally by selected women who

[3] For unaccompanied minor refugees who are underage, thus under 14 years old, there are special provisions in the Basic Welfare Support Scheme 2004.

function as so-called remuneration mothers. The 24-hours care, psychological care and day-structuring measures, etc. were also reported in a response to the parliamentary question PA 7312/J dated January 26th 2016, where the MoI identifies all federal refugee centres (both UMF federal refugee centres and normal federal refugee centres) to be operated by ORS Service GmbH. Based on a care-giving contract and a "comprehensive care concept" for unaccompanied minor refugees the ORS Service GmbH is responsible for provision (1), however, details of what is included in the "comprehensive care concept" are again unclear and not accessible to the public. With regards to the situation in Traiskirchen and especially in the case of UMFs the ORS Service GmbH is caught in crossfire of criticism, for a detailed analysis also with regard to primary health care staff in federal facilities please see: Austrian national report 6.1.

After the asylum seeker is admitted to the procedure, he/she is transferred to a long-term facility of operated by the provinces, herein referred to as refugee camp. In these refugee camps there are no provisions on additional health care and primary health care is provided within the conventional health care provision system. In some larger refugee camps additional medical service is available on-call or regularly, but largely asylum seekers have access to the conventional system. Depending on the respective Austrian province asylum seekers might receive e-cards (which is the personal electronic smart card with which one can access the health care system, indicating name and social security number) or e-card alternatives with which physicians and GPs can be visited.

With regards to transit centres (which do not exist anymore, as of 2016/06/21), health care was first and foremost provided by NGOs (Austrian Red Cross, Medical Aid for Refugees, Samariterbund, and other NGOs with the medical personnel capacity), there were also a huge amount of primary health care professionals working as volunteers involved in assisting the NGO personnel, later they were formally integrated in the NGO structure. For a more detailed report on primary health care provision in transit centres and emergency shelters please see: Austrian national report 6.1.

Initial health assessment

The initial health assessment is conducted differently in the respective implementation site countries; Table 7 was created for providing an overview.

Table 8: Initial health assessment per country

	Initial health assessment	Protocol	obligatory	voluntary	Documentation	Level of execution
Greece	no: currently there is no health assessment especially for asylum seekers in place in Moria	according to Greek legislation, all Greek authorities can request a health examination (within the official asylum procedure) from the asylum seeker in order to keep proceed with their asylum application (according to Ministry of citizens protection, 2010 basic information for asylum seekers in Greece	when authorities thing an initial health examination is necessary it contains e.g. vaccination for communicable disease control (not specified which vaccinations), tuberculosis or x-ray		no information available	according to NGO representatives assessment, there is no health assessment for refugees who apply for asylum at the present
Italy	yes: a first health screening is provided in the hotspots	no information, only that health workers express necessity of specific guidelines for asylum seekers and refugees in case of vulnerable migrants	no information available		no information available	no information available
Croatia	yes: when admitted to asylum process no: when transit	no special protocol for initial health screening	initial check-up: clinical interview, taking blood pressure and pulse, mouth and throat inspection, examinations of lung and heart functions using a stethoscope		asylum seekers carry medical records (in Croatian) with them	estimated level is good, all in Kutina, Porin and Slavonski Brod have had initial health screening
Slovenia	no: there is no initial health assessment for persons who applied for asylum	no information available	no information available		no information available	no information available
Hungary	yes: a first quick general health assessment at transit zones, and another health assessment in the centres	there are special operational plans, regulated by the National Public Health and Medical Officer Services	the health assessment in the centre includes blood test, skin-inspection, chest x-ray, screening for infectious diseases, physical examination, other investigations if necessary		documentation is paper and computer based	no information available
Austria	yes: when admitted to asylum process* no: when transit	guideline by Ministry of Health, pursuant to Article 6(1)(4) of the Basic Welfare Support Agreement - Article 15a B-VG	x-ray of the lung/ TC screening	vaccination recommendations (MEA-MUM-RUB(-VAR), DIP-TET-IPV, MEN)**	no information available	estimated level is very low, many asylum seekers were never assessed, currently in the process of conducting all remaining initial health assessment

*when a person initially entered the country as refugee and not through a visa

**according to three-letter code vaccine nomenclature in line with EU legislative framework

For **Greece**: the health providers at Moria's hotspot reported that currently there is no health assessment, especially for asylum seekers. This was due to the fact that until the EU-Turkey deal, Greece was also, a transit country where refugees arrive and leave after a couple of days. In general, according to the Greek legislation, all Greek authorities can request from the asylum seekers, to conduct health examinations (within the official asylum procedure) in order to keep proceed with their asylum application. When authorities think that an initial health examination is necessary (e.g. such as vaccination for communicable disease control, mainly Tuberculosis or x-ray) this is conducted according to the Ministry of Citizens Protection, 2010 basic information for asylum seekers in Greece. MDM has established a referral system with the hospital in Lesvos and Chios, whilst MSF operates a small clinic in the abandoned Captain Elias hotel in Kos and are scaling up to manage mobile clinics in Kara Tepe in Lesvos.

According to the MDM doctors, usually pregnant women are directly recommended to visit the hospital. Their usual practice is to recommend people in need to hospitals and secondary health care services. However, the head of the emergency department of Lesvos hospital mentioned that most of these recommended cases could be easily managed and delegated at the hotspot or at PEDY.

According to both MDM and MSF interviews, there is no health assessment for those refugees who apply for asylum at the present. The MDM official informed us that their health personnel has recognized the needs of the current situation and have made efforts to use the known and most common methods and guidelines in PHC for triage. The MSF field worker informed us that only a rudimentary triage procedure is being conducted in the sites of Piraeus, Elliniko and Victoria square.

The MDM NGO has an official agreement with KEPY and Lesvos hospital, in order to refer refugees and immigrants there. At Piraeus port, KEPY is firstly informed, in case a refugee/migrant should be transferred to the hospital, in order to have the authorization of the referral and afterwards the person in need could be escorted and transferred to the hospital.

A first health screening is provided in the hotspots in **Italy**, mainly to identify infectious diseases and to assess children's age (wrist x-ray). The procedure of wrist x-ray in order to assess children age has been extremely criticized by NGOs present in the hotspots. The screening is carried out by health workers from the Local Health Unit.

Once migrants and asylum seekers are provided with the STP code, they can access to health assistance trough 'normal' channel: first aid, hospitals and Local Health Units. In this context, there are no special procedures dedicated to asylum seekers and refugees.

Health workers we interviewed did manifest the necessity of specific guidelines for asylum seekers and refugees in case of vulnerable migrants (pregnant women, unaccompanied children, migrants subjected to torture and violence). According to this, special procedures and guidelines could be useful in order to assess mental health.

In the **Croatian** national report it is stated, that according to the general practitioner from Reception centre Kutina, all asylum seekers have gone through an initial health screening during their stay in Winter Reception Centre Slavonski Brod and they carry their medical records (in Croatian) with them. Because of this, the doctor in Kutina doesn't carry out a thorough medical examination of asylum seekers once they arrive at the centre, but only inquires whether they have some kind of a medical problem or take any medication. The general practitioner from Reception Centre Porin claims that all

refugees and migrants in Porin, not only asylum seekers, are offered to take an initial check-up. Although there is no special protocol for initial health screening of asylum seekers, these check-ups usually include a clinical interview about the health status and possible complaints, taking blood pressure and pulse, mouth and throat inspection and examinations of lung and hearth functions using a stethoscope. He also mentioned that the asylum seekers have had initial health assessment while staying in Slavonski Brod. However, there is neither an initial assessment nor a screening for mental health issues. Also, no recommendations for triage are formalized specifically for asylum seekers.

In the **Slovenian** national report one quote is given:

> *"There is no initial health assessment for persons who applied for asylum" (Interview ATS from Slovenian national report 6.1)*

In **Hungary** there is firstly a quick general health assessment in the transit zones, then another health assessment in the centres, for all migrants/refugees/asylum seekers. The health assessment includes more tests in the centres (blood test, X-ray, screening for infectious diseases, other investigations if necessary). The documentation is paper and computer based.

> *"They receive the same medical care, as the Hungarian population; there are also special operational plans, regulated by the National Public Health and Medical Officer Service. The care starts when they get off the bus-there is general health assessment, test for infectious diseases e.g., screening for parasites, x-ray, general health check-dehydration, malnutrition of if there is a need for hospital admission." (Interview from Hungarian national report 6.1)*

Described in the Local Report Hungary for WP2 a medical screening is performed before the official admission into a camp, it contains skin-inspection, chest x-ray, physical examination and others depending from the findings (WP2 Local Report Hungary).

Persons who seek asylum in **Austria** and are admitted to the asylum process and who entered Austria as refugees[4] an initial health assessment is obligatory. It is a standardized assessment procedure which is supposed to take within 72 hours after the registration process, in German it is called: *Medizinische Untersuchung bei der Erstaufnahme* translated as initial health assessment (3). According to the guidelines provided by the MoH an operational plan is followed and includes a self-anamnesis, an x-ray of the lung (obligatory) and a (voluntary) vaccination (MEA-MUM-RUB(-VAR), DIP-TET-IPV, MEN). As the federal facilities in Austria are operated by ORS Service GmbH, they are responsible for the initial health examination as well as the provision of primary health care in these facilities, commissioned by the MoI and the MoH. Interviewed stakeholder reported that as of March 2016 there is a huge backlog with the initial health assessment, as the ORS Service GmbH is several months behind. It was also reported that only a few persons were actually vaccinated and only the x-ray was extensively conducted. From mid-March 2016 onwards the Austrian Red Cross was assigned to additionally conduct initial health assessments, asylum seekers who were already accommodated in permanent refugee camps were then subsequently assessed. In terms of documentation of the assessment we found that no coherent documentation was available, especially primary health care providers are facing a challenge when they later treat asylum seekers. Generally it was reported that

[4] For persons who entered Austria through a Visa (e.g. student visa, working visa, etc.) and only after entering Austria applied for asylum there is no initial health assessment required.

initial health assessment was given priority in initial reception centres and a triage system in order to detect acute disease was not in place.

Interpreters and cultural mediators

Based on the empirical data from WP2 a lack of interpreters was observed in Moria hotspot in **Greece**. Furthermore a lack of interpreters and especially interpreters who speak Farsi was reported at the hotspot. In principle each organisation or NGO has their own interpreter(s) for Arabic and Farsi. However, there appeared a lack of coordination among the organizations (NGOs) and their interpreters. The Greek researchers were informed by the authorities (EKEPY) that the biggest issue was with interpreters from Afghanistan (Farsi) who were available in a very limited number. The hospital of Lesvos since February 2016 had four interpreters working in shifts, mostly in the emergency department. MSF, MDM and PRAKSIS representatives informed us that their organizations have interpreters but the number and the capacity and the lack of medical terms and knowledge (especially Farsi language) embedded them from achieving the level of medical services they intent to provide to the refugees and migrants. All of stakeholders stated that there is a lack of interpreters in the different hosting/detention places.

> *"There are a lot, but do not have the capacity to do the job. Around 150 interpreters are capable to do this […]" (MDM official)*

As of April 2016, persons from refugees/migrant communities (mainly in Piraeus and Eidomeni centres) are used as interpreters, whether or not they possess the appropriate knowledge or capacity. These "interpreters" work as volunteers (mainly refugees/migrant from Syria and sometimes from Afghanistan) and are used due to the absence of official interpreters in these places.

In **Italy** interpreters and cultural mediators are provided in the hotspots and first reception centres depending on the capacity of the place. The provision of interpreters and cultural mediators is managed at a local level, by local institutions and organizations. Regarding the presence of interpreters and cultural mediators in the Local Health Units, hospitals and first aid services, this is extremely variable depending on the territory.

On average, the interviewed health workers were satisfied by the effectiveness of the interpretation service. For example, the Careggi Hospital (one of the main hospitals in Florence) has 4 languages present in the service: Chinese, Arab, Romanian and Albanian. Interpreters and cultural mediators are not available 24 hours a day but only in limited time slots, mainly in the morning. There is also a service of telephone mediation, called Help Voice. Health workers mainly facing with urgencies (e.g., first aid, women giving birth, urgent necessity of informed consent) judged the service of cultural mediation insufficient.

In **Croatia** there are enough interpreters from different organisations available in the two reception centres Kutina and Zagreb. Especially during medical examinations an interpreter is always present, unless an asylum seeker speaks English well and can communicate on their own. According to the CRC social worker whom we interviewed, around 30 interpreters are available in Reception Centre Porin alone. Croatian Ministry of Interior provides official interpreters for various languages free of charge but only during the asylum application procedure or other legal issues. However, CRC and JRS both have unofficial interpreters in their teams who regularly visit the centres Porin and Kutina, although

these are mostly people who are fluent in the required languages but not trained for interpretation. CRC has 6 interpreters (3 for Arabic, 1 for Urdu, Pashto and Farsi) and JRS employs 5 native speakers of Arabic and Farsi who have been granted asylum in Croatia few years ago (before the European migrant crisis started) and are now helping in interpretation and communication with the medical staff. SPA provides 8 interpreters for various languages who are specially trained for interpretation during psychological counselling.

The **Slovenian** national report details the initial problem of the lack of interpreters, it is stated that by and by interpreters were present in more places. However, these were not always in the appropriate number they were needed and often refugees with good English skills stepped, as the following quotes confirm:

> *"[…] the young or minor were able to speak English much better than the older, including for example persons of 25 plus. So minors they also helped with the interpretation. The main problem was the communication" (Interview Logatec)*

> *"In a case if a refugee does not speak English or speak very badly, and you are in situation that currently you do not have an interpreter available. It's really challenging because you do not know what and how to help him. (Interview Dobova)*

> *"In the refugee camps the availability of interpreters and mediators was very scarce at the very beginning. With time, when things were more organized it was better. UNHCR, the Organization for Refugees United Nations High Commissioner for Refugees provided interpreters. They provide a lot of interpreters. In principle, they were primarily planned to help in police operations and people seeking asylum, to inform them. But they were also constantly available for health care. When there were large numbers of refugees - refugees themselves helped us if they were able to speak English. At the beginning there was definitely a shortage of interpreters." (Interview Dobova)*

In **Hungary** the centre/camps staff is usually supported by interpreters who are available in all centres and camps for certain times when it is required. Generally interpreters are not available all the times, one health care worker explains:

> *"There are native language interpreters, we (the doctors and nurses) also speak basic Farsi, Arabic, etc. or English if they speak English." (Interview from Hungarian National Report 6.1)*

In **Austria** a person who applies for asylum has a right to an asylum proceeding in a language understandable to him/her and interpreted by an official interpreter under oath during the asylum process, where inquiries on personal circumstances, travel to Austria, and reasons for flight, are made by the Federal Office for Immigration and Asylum. In detail, first the fingerprints and interview is made at the police, an interpreter should be present, then at the Federal Office for Immigration and Asylum an admission procedure is undertaken, inquiries on travel route, etc., an interpreter is present, after admission is granted the asylum procedure takes place, the interview on the reason for fleeing the home country, and again an interpreter is present.

In the different other settings described above, outside of the interrogation for the asylum process, interpreters or cultural mediators were solely available on a voluntary and sometimes sporadic basis and the organisation in charge organised these services as voluntary work (for more details see below

section: challenges for primary health care providers). The self-anamnesis document which is to be filled out by the asylum seeker at the initial health assessment was reported to be available in various languages, certainly in Arabic, Farsi and English.

In emergency shelters/ transit centres a lot of volunteers, who had themselves migratory background worked as interpreters and helped out with their bilingual skills.

> *"Arabic from Tunisia is something completely different than Arabic from Iraq or from Syria and if sometimes then even little dialects came it was certainly a huge challenge [for the people who volunteered as interpreters]. I would say for acute symptoms it is not even necessary because we had really good pictograms" (Interview 2, GP)*

In cooperation with the Red Cross, the Caritas and the Medical Aid for Refugees initiative pictograms were developed and used[5]. Generally the GPs and other health care providers can use video or telephone interpretation systems. Salzburg is the first province who offers from March 2016 onwards telephone interpretation systems for resident doctors/GPs the province co-finances this with the Medial Association Salzburg. This 6 months pilot project is exceptional in Austria as in all the other provinces the expenses have to be covered by the GPs themselves. There is neither a refunding for purchase of the device nor for the actual interpretation service in all other provinces in Austria. The application of video interpretation systems are still in their infancy in the Austrian health care system, also in hospitals video interpretation tends to be the exception rather than the rule. In the federal government detention centre Vordernberg in Styria video interpretation is available since October 2014, on the website it reads:

> *"[…] the introduction of video interpretation in the ambulance of the AHZ Vordernberg was a very good decision. The medical care of our clients is very important to us in our facility and through the quick availability and the linguistic diversity the provision of care is ensured" (http://www.videodolmetschen.com/portfolio/anhaltezentrum-vordernberg-steiermark-oesterreich).*

The conclusions are that there were overall not enough interpreters available in the different refugee facilities in the intervention countries during the high influx of refugees in 2015 and up to the present point. As a result we saw that lay persons with language skills were engaged as interpreters or for interpretation.

Challenges and barriers for primary health care providers

There were specific challenges and barriers for primary health care providers identified in the six intervention site countries.

The **Greek** national report identifies the lack of providing medical services and psychosocial support for refugees and migrants as one of the biggest challenges, as services are mostly provided by national and international NGOs. It is reported that in 9 out of the 24 refugee camps at the Greek mainland health care facilities were non-existent and/or not available within less than 5 km distance, e.g. in

[5] see: http://buerobauer.com/projekte/first-aid-kit/

Elliniko I, II and III, in Ristona, in Nea Kavala, in Cheerso, in Giannitsa, in Eleftheroupoli and in Drama. Another important issue mentioned is that the Ministry of Health does not provide psychosocial programs in any of the hosting centres. Furthermore only 17 out of the 24 refugee camps have asylum services and only 5 out of the 24 camps provide food distribution. Additional difficulties were identified by the interviewed stakeholders specifically but not exclusively for the hotspot Moria and subsumed in the following Table 8.

Table 9: Challenges and barriers for primary health care providers identified in the Greek national report 6.1

Key issue	Explanation, specification
Lack of leadership	All the national and international authorities who are located in the hotspot of Moria have different responsibilities and each one believes that he is responsible for the hotspot
Lack of commitment	The coordination organization UNHCR does not have permanent personnel on the spot and this fact makes the implementation for the agreed decisions made by the weekly assembly of NGOs difficult
Lack of PEDY involvement	Primary Health Care (PHC) in Greece is not present to support the attempts of the authorities which are located in this hotspot
Lack of political stability and information	The majority of refugees have a great desire to move on from Greece to their final destination (to finish their trip and to find a safe place to live), so they don't pay attention to the provided health care services in the hotspot of Moria
Lack of personnel at KEPY first reception and inadequate facility	KEPY has an interdisciplinary team to take care of children, but as the head of KEPY explained the facility resembles more to a prison, it is inappropriate for children who suffered a lot in their countries and during the trip. Secondly the facility lacks a pediatrician
Lack of psychosocial programs in the detention and hosting centres	The medical services and psychosocial support services are not provided by the MoH for refugees and migrants
Safety of health care providers	The safety is threatened because it is difficult to explain to refugees that they have to respect queues because someone else has priority because of a more serious problem
Absence of institutional framework	The absence of an institutional framework at hotspots and hosting centres poses a huge challenge
Lack of qualified personnel	A crucial problem is the difficulty in recruiting a well-trained multidisciplinary team to address the humanitarian crisis, because a significant number of physicians and nurses have emigrated from Greece do different central and north European countries in order to find jobs
Lack of space	The lack of space in mobile units is identified as a challenge
Lack of medical stock	Especially on the islands there are limited amounts of medicines available
Lack of cultural mediators	Due to the absence of qualified interpreters there are linguistic barriers
Referrals to hospitals	Referrals to and returns from hospitals are problematic due to the usual lack of transport possiblities via hospital ambulances

Cronic disease management	Furthermore the difficulties in chronic disease management are mentioned
Lack of integrated care	The lack of integrated care was identified by interviewed representatives

The **Italian** national report portrays the challenges and barriers for health care providers as follows.

Table 10: Challenges and barriers for primary health care providers identified in the Italian national report 6.1

Key issues	Explanation, specification
Language barriers	According to the interviewed health workers, the biggest challenge was the language barrier and the lack of sufficient cultural mediation
Use of first aid	It is reported that the bad use of first aid services is problematic
Lack of guidelines	The lack of specific guidelines for vulnerable refugees and migrants (such as pregnant women, unaccompanied minors, refugees and migrants subjected to torture and violence) was mentioned, as well as the lack of specific guidelines for mental health
Management of severe pathologies	The management of severe pathologies is an additional challenge that health care providers face

In the **Croatian** national report both interviewed GPs working in the reception centres Kutina and Porin respectively assess the available health care in the centres as sufficient. In terms of challenges and barriers several key issues were identified, as listed in the figure below.

Table 11: Challenges and barriers for primary health care providers identified in the Croatian national report 6.1

Key issues	Explanation, specification
Lack of personnel	As the greatest difficulty was the absence of the two medical nurses in the reception centres identified, both were on maternity leave and have not been replaced
Medical data record	The medical data on the asylum seeker is not entered into an official, national data base. The CRC keeps some kind of medical record but for GPs it is difficult to access. Thereby the work of GPs is made more complicated as it is difficult to access health records of refugees; thereby also the establishment of continuity of care is prevented
(Mis-) Understanding of GP role	Asylum seekers often expect GPs to help them understand their legal situation, future perspectives, and opportunities, while doctors have no knowledge on that
Lack of mental health care services	Highly distressed, apathetic or tense individuals in the centres require help that is outside of a GP's or a nurse's working domain; additional mental health services are needed but they are not covered by the national health insurance
Restricted access to reception centres	There are external health care providers who would like to provide health care for asylum seekers in centres free of charge, however, access to the reception centre is restricted by law

The **Slovenian** national report identified four problem areas: 1) communication (language barriers), 2) refugees' social deprivation and traumatic occurrences, 3) negative attitudes among health workers and refugees, and 4) cultural differences.

Table 12: Challenges and barriers for primary health care providers identified in the Slovenian national report 6.1

Key issues	Explanation, specification
Language barriers	Communication problems were identified as the biggest and most common challenge, also previous data showed that it is the biggest obstacle for comprehensive health service provision for refugees; Making a diagnosis is identified as difficult and challenging; Health workers are therefore in permanent stress due to incomplete communication with the patient and possible wrong diagnosis or misidentification treatment;
Lack of interpreters	Therewith related was the absence of formal interpreters mentioned, it was reported that the present interpreters were mostly volunteers and the medical team had no interpreter, some interviewees explained they rely on google translate
Refugees social deprivation and traumatic occurences	Due to the refugees experiences in their countries of origin (surviving war zones and war situations) they acted suspicious and introverted towards health workers; the need for psychological (moral) support, understanding and a sense of security and acceptance was identified
Negative attitutes	With the previous issue related, was the fact that negative attitudes existed among health workers and refugees. E.g. refugees rejected hospitalization because they did not want to be separated from their peers, or refused detailed medical examination because of fear.
Cultural differences	The report links the negative attitudes to cultural differences and different cultural heritage of people; different understandings of illness, treatment, privacy and family ties; through different importance and meanings of those issues ethical dilemmas emerged and finally also hampered the work of health workers on the ground

The **Hungarian** report stresses that the overall primary care capacity situation in Hungary is insufficient to manage a higher amount of patients, with different origin, having quite different cultural backgrounds, and a high linguistic diversity. Barriers and specific challenges are concretely outlined in Table 12.

Table 13: Challenges and barriers for primary health care providers identified in the Hungarian national report 6.1

Key issues	Explanation, specification

Lack of resources	The capacity of Hungarian primary care is reported to be insufficient to manage a higher amount of patients with different origin, different cultural backgrounds and high linguistic diversity; but also the lack of financial resources and lack of organisation was highlighted as challenging for provision of health care
Language barrier	High linguistic communication barriers were identified as huge challenges for health care providers and they would need more support for developing communcation skills with people having differen languages
Lack of knowledge	Primary health care providers would need more support and information about never seen morbidities
Cultural barriers	The report suggest that most of the refugees never received any treatment from primary care in their country, and some do not cooperate and do not understand why these investigations are needed

The **Austrian** national report identifies three different levels on which specific challenges and barriers for primary health care providers exist, [1] first at the level of emergency shelters/transit centres, [2] secondly at the triage level and first assessment at entry point level, and [3] third at the first contract level with the primary health care system, which is the level of long-term primary health care.

Table 14: Challenges and barriers for primary health care providers identified in the Austrian national report 6.1

Key issues	**Explanations, specifications**
Logistical challenges	It was noted that the provision and availability of all kinds of drugs, material and medical equippment in emergency shelters was challenging
Challenge of provision of adequate care	The very short time frame was identified as a barrier for providing adequate care, disease monitoring and treatment was difficult if persons were only accommodated shortly [1]; in cases when impatient care was needed but persons wanted to continue their travel hospitalisation could not be enforced [1], also the cooperation with border authorities were sometimes hindering provision of adequate care [1]
Documentation of disease cases	The lack of a standardized format to document patients was noted [1], also GPs identified the lack of passing-on documentation as challenging and hindering [3]
Inadequate accommodation/ sanitation	Inadequate accommodation/ sanitation was identified as a barrier for health care providers, e.g. danger of overmedication when lack of water/tea [1]
Lack of psychological support	Difficulty to provide psychological support in short-time settings [1], the lack of a psychiatric-neurological service as well as psychological crisis internvention which is available 24 hours was identified for the second level [2], and underfunded mental health support in long-term care, e.g. limited therapy places and even further limited therapy places with interpretation services [3]

Unclear legal working status of health workers	The legal working status of health care providers in emergency settings was noted, questions of insurance were raised [1], additionally the question of refusal of patients by GPs was noted without interpretation [3]
Overload of personnel	Work overload and the necessity of burn-out prevention for health care workers was pointed to as the work in emergency settings since all work was done additionally to the day-to-day work [1], at the second level reports also show an under-staffed situation and high workloads were noted [2]
Lack of specialist	Women- and children's specialists were absent at the second level as well as dental acute-care was absent [2]
Lack of triage	Repors show that initial health assessment was prioritized over provision of primary health care to vulnerable persons, such as pregnant women, children, old or disabled persons and no triage system in order to detect acute diseases, which have to be treated as a matter of priority was in place at the second level [2]
Hesitant health seeking behaviour	Refugees are hesitant to seek health care at the second level, not only because of the long waiting hours, but because of fear of consequences e.g. that it has a negative effect on their asylum procedure [2]
Difficulty of referral	Difficult to transfer asylum seekers to specialists, or hospitals, in many cases the refrerrals are informally organised [2]
Access to apparatuses	The cooperation with hospitals was sometimes difficult and also the access to necessary medical devices or laboratories was sometimes difficult, e.g. roentgen, blood count, etc. [2]
Lack of remuneration	As the biggest challenge for primary health care providers at the thrid level was the difficulty in remuneration identified [3]
Language barrier	There is no free interpretation services available for primary health care providers and especially in terms of first anamnesis and explanation of diagnosis and treatment the physician face a huge communcation barrier [3]
Culture related communication differences	It is reported that it is very challenging for the GP e.g. to interpret traumatising experiences of patients as well as cultural differences in non-verbal communication [3]
Lack of information	For GPs it is often unclear and undocumented what medical assessment occurred before the first contact with the conventional primary health care system, e.g. vaccination, or a general patient record also hospitalization [3]
Lack of information material for refugees	Interviewed persons pointed to the lack of infos for refugees on health services within the Austrian health care system, also in terms of vaccination, etc. [3]
Lack of information material for health care workers	GPs and other health care workers note that it would decrease barriers if they had easy access to information on country of origin, flight conditions, nutrition habits, taboos, etc. from refugees or asylum seekers [3]
Lack of knowledge	GPs or other health care providers at the third level might lack the knowledge on post-traumatic stress disorders, psycho-trauma and similar conditions [3]
Financial barriers	Refugees who are in the asylum process might not be able to procure costs which are not covered by the insurance, e.g. transportation costs, costs for ultasound [3]

Refugees who worked in (primary) medical care and have applied for asylum

In the majority of the national reports from the intervention country we found hardly any evidence about refugees who worked in (primary) health care and have now applied for asylum or were already granted asylum or subsidiary protection.

In **Greece**, no evidence to address this issue was found in literature also in existing national reports from NGOs operating in Greece no information on this topic was available. According to the Greek Ministry of Migration, 3.362 persons (of various specialties) will be hired in order to address this issue. Regarding the interviews, MDM and MSF stakeholders, PRAKSIS and Metadrasi reported that there are some refugees/migrants who informed them, that they were health personnel in their origin country and who wanted to assist them. However, all the volunteers, apart from two, could not provide any evidence to support this claim, which embed the refugees from joining the already existing medical teams of NGOs.

> "*There must be around 20 persons mainly from Syria at Piraeus port with a background in health services, but we are not sure […]" (MDM official)*

Both MDM official and MSF field worker, agreed that that does not exist any record procedure about profession in the country of origin.

According to the interviewed stakeholders in **Croatia**, no primary medical care staff has been identified among the asylum seekers in the reception centres. What was reported that a Syrian dentist assisted in the Reception Centre Porin, he consults the GP in the centre when the patients suffer from acute dental conditions.

No data was available for **Italy** on that issue. Yet, all interviewed health workers emphasized that migrants with health care experience could present an important resource, while also difficulties to in involve them were also raised.

No data was available for **Slovenia** on that issue. Several quotes suggest that stakeholders referred to persons who helped out as interpreters and had a medical background.

No data was available for **Hungary** on that issue. One stakeholder explained that some of the refugees worked as health care workers before but they could not be involved in the care of refugees.

In **Austria** 112 persons were registered to have worked in a medical profession and were granted asylum or subsidiary protection as of March 2016, whereof 83 live in Vienna. For persons who are still in the asylum process there was an informal network of Arab speaking health care professions established by a Syrian dentist who works in Vienna for 15 years. The network includes persons from Syria, Iraq, Egypt and Libya, the communication is in Arabic and the main purpose is the increased information exchange and event organisation. The group includes 180 contacts, registered with number, email address, time of arrival in Austria, level of German and date which they plan to take the Nostrification (the validation of foreign studies and degrees).

Up to the present date, the health care professionals had the possibility to work as non-medical assistants in refugee camps, however, without treating patients they often fulfilled merely acted as interpreters. Furthermore a few of these professionals could do an unpaid traineeship (*Hospitanz*) at hospitals and from the next asylum novella onwards it should be provided that they can also engage in occupations as they are possible within clinical traineeships (*Famulaturen*). Many asylum seekers

who worked as (primary) health care workers suffer especially from the long waiting period where they are not allowed to work and are afraid to be out of training once they are allowed to work again.

Discussion of main findings and implications for further Work Packages

Based on the findings it becomes clear that the situation in the respective intervention site countries is highly complex and very dynamic. Main findings and specific challenges were observed on different levels and implications will be discussed in the following.

Systemic level

One of the biggest challenge is assumed to be to respond to the challenges that emerge on a systemic level. The extremely dynamic nature of the refugee crisis and the continuous changes that are undertaken with regards to it, pose a huge challenge to the intervention countries in terms of health care provision for refugees and other migrants. As reported in the findings, after the high influx of refugees via the Balkan route the situation changed quite substantially, after the route was closed and one or more alternative routes were taken. The shift of "illegal" routes, however, had different implications for the different intervention site countries. Political decisions are inter-related in this context, and with the closing of borders by some countries combined with the coming into force of the EU-Turkey deal dramatic systemic challenges arose. During the peak of the refugee crisis, it was also found that frequently centres and camps were converted, re-named, opened and closed. Furthermore the capacity of facilities varied according to (new) legislative guidelines but also depended on classification of a facility. The overall question is, which systemic orientation the institutions, states and organizations establish the respond to the challenges that arise from the refugee crisis.

Organizational level

On the organizational level it appeared that the greatest challenge in all intervention countries, where data were collected, was the lack of staff and resources. Particularly the lack of multidisciplinary teams in the (primary) health care of refugees was noted, but also particularly the lack of certain specialists such as pediatricians and mental health professionals. Multidisciplinary teams ideally consist of general practitioners, nurses, psychologists, social workers, cultural mediators, pediatricians and midwifes. They are considered optimal for providing comprehensive person-centred and integrated care for all ages and alignments, and have the capacity to take into account the trans-cultural setting and needs, wishes and expectations of refugees. The term cultural mediators in this context specifically refers to interpreters who are not only translating but also function as cultural mediators and are e.g. trained in asylum specific and health specific translation (see: e.g. UNHCR Trainings program).

Secondly, we found that clear pathways for (primary) health care for refugees are missing in many intervention site countries. Findings showed that treatment pathways, as well as structures in health care for refugees were to some extent lacking and often unclear responsibilities challenged the health care provision for refugees. For instance, it was reported that there is no standardized initial health assessment in intervention countries and documentation and monitoring structures are often missing. Furthermore the lack of specific guidelines for vulnerable refugees, such as pregnant women, unaccompanied minors, refugees and migrants subjected to torture and violence, was identified as challenging for health care provision.

Thirdly, a crucial problem and challenge on the organizational level was the coordination of different organizations that provided (primary) health care services. In Greece e.g. this was a particular big issue, despite the improvement of the situation in June 2016 compared to previous months, the considerable coordination effort that is needed considering this enormous challenge was recognized.

Provider level

On the level of primary health care provider we found several challenges and barriers for health care provision for refugees, as listed in the chapter on Challenges and barriers for primary health care providers, we could resume that the following challenges and barriers exist at the provider level.

First of all, results showed that a lack of information and knowledge regarding flight specific diseases and risk factors and regarding country of origin specific illnesses, by providers. The lack of mental health support for refugees who may suffer from post-traumatic stress disorders, or other mental health problems were identified by primary health care providers. Linked to that some providers explained that the cultural barriers posed a challenge to provision of care, e.g. different understandings of illness, treatment, privacy and taboos lead to ethical dilemmas and finally also hampered the work of health providers on the ground. Knowledge on country specific idioms of distress, as well as different illness concepts was noted as insufficient. At the same time we found that legal questions on work permission, insurance and ethical aspects were issues important in this context. Another aspect was the lack of standardized format for documentation, or the difficult access to medical data records of refugees or asylum seekers, that was mentioned as a barrier in terms of providing health care and especially continuity of care. For GPs in particular the lack of remuneration was a huge challenge as well as the lack of translation services available.

Potential remains unused

In terms of refugees and other migrants who have themselves worked in (primary) health care and have now applied for asylum we found that these resources are hardly documented and the considerable potential remains unused. Data on refugees or asylum seekers who worked as primary health care providers was in most of the intervention site countries difficult to obtain or did not exist at all because the data was never collected. In most countries no data was available on that issue, in some cases voluntary assistance and help was reported, however, refugees mostly acted as interpreters. In Austria, where documentation on refugee health workers is increasingly established though an informal network of Arab speaking health professionals, negotiations take place to engage individuals earlier in the workforce, before their official validation of foreign studies and degrees is finished. Based on the findings, it is recommended that this unused potential should be formally recognized and used.

The summary report identified specific challenges on different levels that were emphasized in the national reports, and were highly relevant in the respective local national contexts. This deliverable 6.1 can be considered as assistance for intervention countries. In brief, to be able to tackle the multifaceted challenges regarding primary health care for refugees and other migrants, integrated, person-centred, multi-professional interventions are needed which are adaptable to the special needs as well as cultural and ethical challenges of the local sites.

With regards to the continuity of the project this deliverable 6.1 indicates the situation in the respective intervention countries in terms of refugee care, primary health care system, human resource situation of primary health care providers, challenges and barriers of primary health care proiders and limitations. Thereby it serves as a basis to understand the local conditions and settings in order to carry out tasks 6.8 – 6.13, and be able to ultimately aim to implement interventions to improve primary health care deliverable for refugees and other migrants. The EUR-HUMAN objective thereby is to provide good and affordable comprehensive person-centred and integrated care for all ages and all alignments, taking into account the local situations and conditions.

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List of abbreviations

Table 7: List of abbreviations

AH LJ	Slovenia: Asylum home Ljubljana
ASL	Italy: Local Health Units
BÁH	Hungary: The Office of Immigration and Nationality/ Bevándorlási és Állampolgársági Hivatal
BFA	Austria: Federal Office for Immigrations and Asylum/ Bundesamt für Fremdenwesen und Asyl
CARA	Italy: Reception Centre for Asylum Seeker
CAS	Italy: Extraordinary and temporary reception centres
CDA	Italy: Reception Centre
CIE	Italy: Centres for Identification and Expulsion
CPSA	Italy: First Aid and Reception Centre
CRC	Croatian Red Cross
EKEPY	Greece: The National Health Operations Centre
EOPYY	Greece: National Organization for Healthcare Provision
FP	Family practitioner
GP	General practitioner
HIIS	Slovenia: Health Insurance Institute of Slovenia
HVSV	Austria: National Federation of Austrian Social Security Institution
IOM	International Organisation of Migration
JRS	Croatia: Jesuit Refugee Service
MDM	Greece: Médecins du Monde
MoH	Ministry of Health
MoI	Ministry of Interior
MSF	Médecins Sans Frontières
NGO	Non-governmental organisation
NHIF	Hungary: National Health Insurance Fund

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Annex

A1. Final template for national report for deliverable 6.1

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (COUNTRY) – Version 07/04/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1
Name of authors

Co-funded by
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of the European Union

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Introduction

The national reports will provide input to Deliverable 6.1: Summary report about the local resources available (deliverable 6.1 month 6 – preliminary results in month 5). Deliverable 6.1 is part of the WP 6 with the aim to enhance the capacity building of the primary care workforce through the assessment of the existing situation and the development of an online curriculum for local primary care professionals and refugees who are primary care professionals. For the summary report MUW is responsible with the support and input of the intervention site countries (Greece, Italy, Croatia, Slovenia, Hungary and Austria).

Task 6.1

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and other migrants and of refugees and other migrants who have themselves worked in medical care.

Specific objective for task 6.1

To enhance the capacity building for staff in Community Oriented Primary Care centres as well as other existing primary care settings with regard to refugee care.
What we need to know from each intervention country to be able to complete the task, deliverable, and aim:

The situation should be described like it is at the moment (e.g. March/April 2016).

- Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?
    - If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)
- Main countries where refugees and other migrants come from in your country?
- What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?
- How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)
- How is Primary Health Care provided in your country in general?
- Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?
- Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
- How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
- Primary health care staff situation (numbers, capacity, payment, safety, …)?
- Biggest challenges and barriers for primary health care providers?
- Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum? In what way are these resources documented and used already?

Timeline

1. April – 30. April	Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and other migrants and of refugees and other migrants who have themselves worked in medical care through:	**All intervention countries (UoC, UoD, UL, FFZG, MUW, AUSL11)**

	• Literature review (obligatory) • Semi-structured interviews • Participatory observation (for details please see methods section below)	
1. May – 15. May	Writing and sending the national reports (=complete the blank section of this template) to MUW	**All intervention countries (UoC, UoD, UL, FFZG, MUW, AUSL11)**
16. May – 05. June	Preliminary summary report of deliverable 6.1 for WP4 (expert meeting) to RUMC and UoC	**MUW**
10. June - 30. June	Synthesis and finalization of the summary report **(Deliverable 6.1)**	**MUW**

Methods

The literature search is the minimum criterion in the context of limited resources. However, it would be optimal to combine all of the following methods for the national report. At the end of this section is space for you to describe the methods selected and conducted:

- **Narrative literature review/search of local grey[6] and scientific literature and reports** (existing documents on the local/national primary care capacity situation which include our questions raised above). Narrative means to describe and discuss the state of the existing literature of a specific topic or theme from a theoretical and contextual point of view. A narrative review consists of critical analysis of the grey and scientific literature published.[7] It does not describe the methodological approach that would permit reproduction of data nor does it answer to specific quantitative research questions. Nevertheless, a narrative review provides readers with up-to-date knowledge about a specific topic or theme. Examples for grey literature are reports by NGOs, governments, national, regional and international organisations, websites, publications in non-reviewed, non-indexed journals and quality newspaper articles.

- **(Semi-)structured interviews** with local primary health care providers treating refugees and other migrants and stakeholders involved in the organization of primary health care for refugees (~ 6-10 persons).
  Possible interview guideline (depending on the position of the provider/stakeholder interviewed), please adapt the questions accordingly:
  - Thank you for your participation in this interview. We would like to talk to you specifically about health care for refugees. Could you first, please, give us an overview of what you are doing and on the relevant concerns in your field of work?
  - What kind of refugee centre do you work in/ does your organisation administrate (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum)?
    - If applicable: How many refugees visited your organization/PHC unit per day/per month? (If possible gender and age information)

[6]Luxembourg Convention on Grey Literature. Perspectives on the Design and Transfer of Scientific and Technical Information. Third Conference on Grey Literature. [http://www.greynet.org/]. Dobbins M, Robeson P: A Methodology for Searching the Grey Literature for Effectiveness Evidence Syntheses related to Public Health. The Public Health Agency of Canada; 2006.

[7] Cook DJ et al. Ann Intern Med 1997;126:376-380

- Who – if anyone – is providing primary health care in these different centres/camps/shelters (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)?
- Which are the main countries where refugees and other migrants come from?
- Are there any differences in the health needs of refugees from different countries of origin? How are these health needs documented/solved/dealt with?
- How is the primary health care staff in the different centres composed of (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)? Which responsibilities? Are there special operational plans for them?
- How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
- What is the situation of the primary health care staff in the centres/camps/shelters?
- If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?
- Is there a sort of initial health assessment for persons who applied for asylum? Do objective criteria or recommendations for triage and referral exist?
- What are the biggest challenges and barriers for primary health care providers?
- Do you have an idea of the number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your centres? In what way are these resources documented and used already?

The interviews can be face-to-face, as telephone-interviews, or skype interviews. It is voluntary if you audiotape and transcribe the interviews for analysing the content or if you take memory notes. It is also possible to send the question per email to certain persons and receive answers via email. The analysis should be conducted with the aim to be able to answer the questions raised.

- **Participatory observations in refugee camps and centres** (like for example the report from Dean from the Croatian transit centre): Participatory observation is a technique of field research, commonly used in anthropology or sociology, by which one or more investigators (participant observers) study the life of a group by sharing in its activities and observing and documenting the incidences occurring, the behavior of individuals and the group, as well as the interactions between individuals. In the context of primary health care, for instance, this allows the researcher to better understand the challenges and issues in clinical practice by observing the interactions between patients and health care workers.

Please, describe the method(s) used in your country for this report in detail:

Use as much space as necessary…

Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)? ○ **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Main countries where refugees and other migrants come from?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
How is Primary Health Care provided in your country in general?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible**

(2) Web based report/article: Title, Link **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Primary health care staff situation (numbers, capacity, payment, safety, …)? **If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?**
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**

How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Biggest challenges and barriers for primary health care providers?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?
Answer: use as much space as necessary (1, 2, 3, 4) **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

Use as much space as necessary

Thank you very much!

Best regards,

The Viennese EUR-HUMAN team!

A2. Country Report Greece

EUR-HUMAN

WP6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (Greece) – Version 18/05/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Christos Lionis

Agapi Angelaki

Chrysanthi Tatsi

Kyriakos Maltezis

Enkeleint Aggelos Mechili

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Disclaimer

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Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?

- ***If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)***

Greece is the country that receives 95% of refugees and migrants, who wish to reach Europe[1] and during 2015, it was the country that became the first entry point of 862,138 refugees and migrants for this explicit reason.[2,3] During the first three months of 2016 (1/1/2016 - 1/4/2016) 151,656 people[4,5] had crossed the Mediterranean Sea and arrived in Greece, mainly via the ports of Mytilene (Lesvos), Samos, Chios, Kos and Leros. The average daily arrivals during March (2016) in Greece were 856 people and during February 1,931 people respectively (see appendix table 1 and 2). Until the 6th of April 2016 the average arrivals in Greece were 229 persons per day. On 8 March 2016- the date where the former Yugoslav Republic of Macedonia (FYROM) closed the border from Greece- leaving over 46,000 refugees and migrants stranded in mainland of Greece (until 11 April). [6]

During 2015 the number of arrivals reached its peak in October 2015 when in Greece arrived 211.663 persons. In general, during 2015 it is estimated that around 2.362 refugees and immigrants arrived in Greece per day. In Lesvos during 2015 arrived 500.018 in total (1370 per day). 59% of total refugees and immigrants arrivals are estimated to have reached Lesvos in 2015. The estimated departures per day to the mainland were 1753. During 2016 (January-March 2016) in Lesvos arrived 86.432 immigrants and refugees (59% of total). As about Chios, the island during 2015 was reached by 123.279 persons (14% compared to total) and the estimated departures to mainland were 1375 per day.

The most of these people crossed the border via the called "*Balkan transit route*" and reached central European countries. After the EU-Turkey agreement come into effect and the western borders of Greece (Greece-FYROM borders) closed, many refugees and immigrants get "stacked" in

the country. Due to this agreement, approximately 48,000 refugees and migrants who arrived before 20 March (date that come into effect the deal) and continue to be stranded in Greece with reduced options for onward travel.

The situation in Greece indeed demonstrated that large numbers of potential applicants for asylum arriving in an irregular manner by sea can lead to severe difficulties in the registration foreseen by the new legislation.[7] In Greece during 2015, 13.197 asylum application were applied when in 2014 were 9432 (an increase of 40%). From them, only 625 were approved. The most of asylum applicants in 2015 were from Syria (3.495), Afghanistan (1708), Pakistan (1617) and Albania (1003). During January and February 2016, 1171 and 1470 asylum applications were done.[8,9] After the EU-Turkey agreement[10], Greek authorities recorded an estimated 2.870 people who expressed interest in applying for asylum. The authorities confirmed that these people will not be sent back until their claim is assessed, a procedure that is bound to last at least two weeks. Within the next months, is estimated that the number of asylum seekers in Greece will raise due to the EU-Turkey deal. Refugees and immigrants could apply to the Greek authorities to seek asylum, in order avoid to be deported to Turkey. That was also the main reason EU commission, EASO and FRONTEX agreed to deploy officers to help with asylum procedures.[3,11]

References:

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2. Medicins Sans Frontiers (MSM). Obstacle Course to Europe. A policy-made humanitarian crisis at EU borders. December 2015. Available at: https://www.doctorswithoutborders.org/sites/usa/files/msf_obstacle_course_to_europe_report2.pdf (15/3/2016)
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7. FRONTEX. Risk analysis for 2016. Available at: http://frontex.europa.eu/assets/Publications/Risk_Analysis/Annula_Risk_Analysis_2016.pdf (12/4/2016)
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Main countries where refugees and other migrants come from?

The main countries of origin of refugees and migrants, who arrived in Greece, are the following: Syria, Afghanistan and Iraq (see appendix table 1). In 2015, 56% of the total arrivals in Greece were from Syria, 24% from Afghanistan, 10% from Iraq, 3% from Pakistan, 1% from Somalia and 6% from other countries. From the total number of arrivals, 55% were male, 17% female and 28% children. Until the 16th of March almost half of refugees (50.5%) came from Syria, 25.3% came from Afghanistan and 14.7% from Iraq. However, 3% and 4% reach Greece shores from Iran and Pakistan, respectively. The remaining refugees (approximately 2.5%) arrived from Morocco, Bangladesh, Egypt and other countries of North Africa.[1,2]

References:

1. UNHCR. Nationality of arrivals to Greece, Italy and Spain. January-December 2015. Available at: http://data.unhcr.org/mediterranean/country.php?id=83 (28/1/2016)
2. UNHCR. Refugees/Migrants Emergency Response – Mediterranean. Available at: http://data.unhcr.org/mediterranean/country.php?id=83 (17/4/2016)

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

Currently, in Greece exists 5 hotspot (in fact the 5th in the island of Kos due to island residents' reactions is unofficially out of order) and 24 relocation camps/hosting centres plus four unofficial camps (see figure 1); In Lesvos island also, except the hotspot of Moria, which is the first created in Greece exists the hosting centre of Kara Tepe mainly for Syrian families.[1-3] Refugees and immigrants can apply for asylum during their arrival at the hotspot (when they get recorded or at any time when they reach the mainland). They can also apply for asylum (after EU-Turkey deal) even at the moment when they are in the boat deported to Turkey.[4]

References:

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4. Discussion with IOM representative during the meeting with stakeholders in Lesvos (Mytilene).

How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)

Following the full closure of borders between Greece and FYROM (until then to the Greece-FYROM border only some refugees were allowed to pass), known as "*Balkan transit route*" on the 8th of March, the EU-Turkey agreement came into effect at midnight on the 20th of March. Any new arrivals to Greece after this date, regardless of nationality and need for international protection, are subject to possible deportation back to Turkey after a fast-tracked asylum process. With Turkey reclassified as a "*third safe country*" migrants and refugees can still claim asylum in Greece, but applications could likely be declared as "inadmissible". As a result of this event, Greek hotspots had overnight become pre-departure - detention facilities where all new arrivals are held while their case is assessed.

In Greece exists also 24 official relocation camps, of which the most of them are abandoned military camps (see appendix table 2); Except the official hotspots and hosting centres/hosting camps/ relocation camps there are at least four "*unofficial*" hosting centers /unofficial camps in Greece; The first was in Piraeus port, the second at National Road to FYROM borders, the third at Eidomeni close

to the Greece-FYROM borders and the fourth at Victoria square in Athens. As a conclusion, by the shutting down of the main *"Balkan migration route"* to Western Europe, up to 52.352 migrants remain temporarily (5.984 on the islands, 2.542 in Central Greece, 14.506 in Attica, 28.980 in Northern Greece and 340 in Southern Greece) stranded across Greece, with an increasing trend.[1] Refugees and migrants are hosted in a total of 33 relocation centers and "informal" sites on the mainland and 5 hotspots which now became detention centers on the islands. Reception centres are the 5 hotspots which became detention centres after the EU-Turkey deal. Relocation camps are centres in the mainland in which immigrants/refuges are hosted. They are hosted in these centres until a decision for asylum or for relocation in an EU county comes out. In the mainland, the majority of these centers have reached or have gone over their full capacity. Additionally, dilatory asylum procedures keep people stranded in reception centers for over six months, and as a conclusion of that, they will increasingly require integration assistance, education, and longer-term health interventions.[2]

Capacity

In addition to reception facilities, over 30 accommodation centers are in operation throughout Greece in April, with a total capacity of 33.910 places, while 30.000 new accommodation places will be created shortly. In this context, Greek authorities are making efforts to relocate all refugees/migrants from unofficial camps to organized accommodation facilities that guarantee decent living conditions.[1] As about long-term facilities, until EU-Turkey deal Greece was a country which was not the final destination of refugees and migrants, so does not have long-term facilities or a mechanism to integrate these populations. Persons that arrives in Greece after the EU-Turkey deal are accommodated in the 5 hotspos in the Greek islands. They have to wait in these facilities about their asylum decision. It was agreed that the decision should come out in less than six month. As about the refugees/migrants in the mainland they are accommodated in the hosting centres. Officially in less than six month a decision should be taken. The lack of personnel in asylum procedures is the most significant obstacle the procedure to be finished so quickly.

Humanitarian organisations have major concerns about the human right protection of thousands of refugees and migrants who are now in overcrowded detention facilities on the Greek islands and may soon be returned to Turkey. The system for assessing asylum applications in the Greek islands and mainland seems to be understaffed and inadequate. The two major characteristics of refugees and migrants that are likely to have the greatest impact on the level of protection that refugees and

migrants receive from European states and their access to services, irrespective of their specific needs and vulnerabilities are arrival date and nationality.[3-6]

References:

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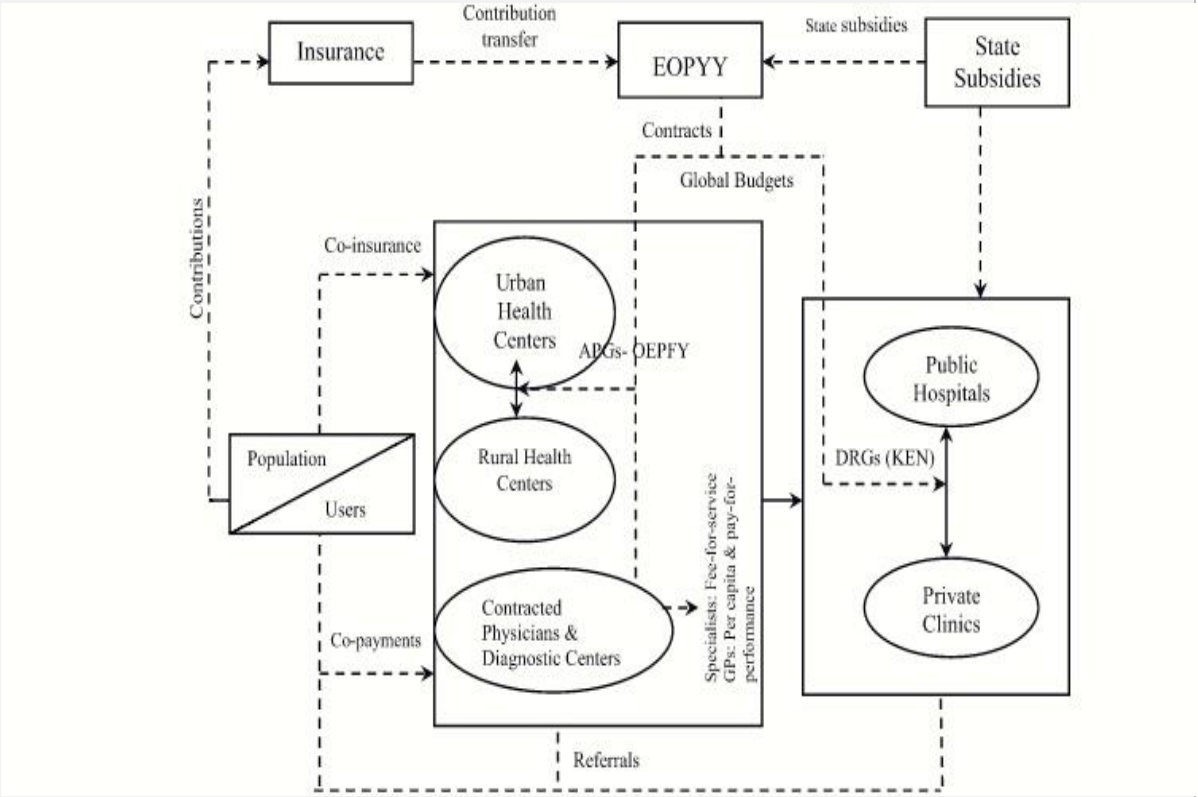
3. Relief web. Refugee/Migrant crisis in Europe. Situation update, Greece: March 2016. Available at: http://reliefweb.int/report/greece/refugeemigrant-crisis-europe-situation-update-greece-march-2016
4. Discussion with Police representative during the meeting with stakeholders in Lesvos (Mytilene).
5. Discussion with MDM representative during the meeting with stakeholders in Lesvos (Mytilene).
6. Discussion with EKEPY head during the meeting with stakeholders in Lesvos (Mytilene).

How is Primary Health Care provided in your country in general?

In Greece, PHC is delivered through a combination of publically funded state health services, by general practitioners (GPs), who work at the private sector and specialists. The choice of the provider is free but there are some charges. On the other side people can arrange an appointment at PEDY (Institution of Primary Health Care Provision in Greece) but the existence of long waiting times is the main problem.[1,2] The public service is delivered through Regional Health Care Centers, Health Care Centers in rural and remote areas (which are accessible 24 hours a day, 7 days a week) and public hospitals. Private GPs and specialists provide their services on a fee-for-service basis.[1] Since the beginning of financial crisis, Greece has been trying to improve national health care services with a focus on strengthening PHC services but still the results are poor.[3] The creation of National Organization for Healthcare Provision (EOPYY), the development of the electronic prescribing system and the creation of a Primary Healthcare Network in an effort to meet the needs of the population and ensure the efficient use of public resources were some of the Greek government efforts in order to improve primary health care services.[3,4]

The following figure presents the structure of the Greek National Healthcare System.

Figure 1.Flows of proposed Health Provision and Financing in Greece.



Source: Polyzos et al.[2]

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Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

In addressing refugee/migrant issue several authorities were involved, including ministries, regional and municipal authorities, port authorities, Greek coast guard and police, primary health care services (PEDY), hospitals, tertiary health services, Greek army, national and international non-government organizations (NGO's), NATO and Frontex.[1]

In general, primary health care services are provided mainly by several national and international NGOs which provide humanitarian support in the field such as: Praxis, Médecins Sans Frontières/Doctors Without Borders (MSF), Médecins du Monde (MDM), the Greek Red Cross, KEELPNO. The UNHCR is responsible for coordinating all NGOs activities. The EKEPY is the coordinator authority on all provided health care services to refugees. Refugees with need of medical assistance are mainly escorted to Médecins Sans Frontières / Doctors without Borders (MSF), Médecins du Monde (MDM), Women and Health Alliance International (WAHA), Greek Red Cross and PRAKSIS facilities at the hotspots and refugees camps, especially in Piraeus port, Elaionas and Elliniko. They can escort them to the hospital (emergency department which provides also primary health care services). In general, refugees and immigrants are not referred to PEDY due to its lack of facilities and personnel.[2] KEELPNO (Hellenic center for control and prevention of diseases), provides health services too with mobile units usually.[2]

MDM provides health care services (including mental) to all refugees and immigrants that arrived in Greece and are in need as they informed us during an interview we had conducted with their coordinator, in Moria's (Lesvos) hotspot. The health care professionals of MDM consist of a multidisciplinary team of general practitioner (GP), cardiologist, orthopedist, otolaryngologist, nurse, psychologist and social worker. They could not provide us with an e exact number of their personnel as they informed us that depends on the migrant influx. In general at the hotspot of Moria

the personnel of MDM included six or seven physicians, two nurses and two interpreters (Arabic and Farsi).[2]

MDM launched the program entitled "strengthen of first receptions mobile units in area with huge refugees/immigrants influx". This program provides primary health care services and psychosocial support to refugees and immigrants reaching Lesvos shores. At Kara Tepe center in Lesvos, they provide primary health care services and pharmaceutical services. At hotspot of Chios island, MDM have also, established a unit providing primary health care services at the island's hotspot. They provide primary health care services, pharmaceutical services and psychosocial support at the different refugees and migrant hosting centers in Attica (Elaionas, Elliniko, Faliro and Galatsi). Finally, they also provide the same services at Eidomeni. During 2015, MDM provided services to 168.955 refugees/immigrants/asylum seekers. The number of visits to MDM services in Lesvos reached 34.254, 6.610 visits in Chios, 11.710 visits in Eidomeni, 2.551 visits in Attica and 95 visits in Tilos.[3]

MSF provides medical care, shelter, water, sanitation and hygiene promotion services (watsan), and distributing relief items to refugees and migrants arriving in the **Dodecanese Islands** as well as in **Lesbos, Samos and Agathonisi,** in **Athens** and at the **Eidomeni's border crossing** to FYROM. They provide medical care, in mobile clinics, at the island of Kos and other nearby islands. Since June 2015, in Lesvos they have provided health care services, in mobile clinics, distribute hygiene kits and improve water and sanitation facilities in the camps at Kara Tepe and Moria. I**n Eidomeni** medical care **is** provided through mobile clinics to people, who are trying to cross the borders to reach FYROM. In collaboration with other NGOs, they set up a short stay camp and installed water and sanitation facilities along the border. **In Athens**, MSF provides medical care, psychosocial support and legal assistance to refugees, who have been tortured.[4] MSF teams in Greece, are providing first aid, medical and psychological support, shelter, water, sanitation and essential relief items at reception centres and transit camps.

In Kos island, MSF runs a medical clinic which includes access to a psychologist. In Leros, MSF is providing shelter and hygiene facilities to host the people brought to the island for registration from the neighbouring military island of Farmakonissi, conducting medical activities and distributing NFI's and water. The MSF team has been conducting vulnerability screenings in order to identify the most vulnerable groups like pregnant women, minors, but also people without access to health services,

providing medical consultations and mental health support. Since the beginning of January 2016, MSF medical teams have conducted a total of 919 medical consultations in Kos island and 1.971 medical consultations in Leros. MSF psychologists have, in the same time, conducted 48 mental health counselling sessions and 265 group sessions with 1,370 participants. MSF teams provide medical health care to refugees and migrants in Moria camp and at the port of Mytilini. There have been treating several pathologies related to the winter conditions, such as respiratory tract infections as well as injuries associated with the journey. Since the beginning of January, MSF medical teams have conducted 8372 medical consultations. MSF psychologists have assisted 149 people through individual sessions and have conducted 133 groups sessions with 589 participants in Lesvos island. MSF is running a medical clinic that carried out over 4.000 medical consultations the first two weeks of March. The main pathologies treated are respiratory tract infections and gastroenteritis, all linked to the hygienic and shelter conditions and the cold weather. Since January 2016, MSF medical teams have treated an increasing number of patients for injuries consistent with violent behaviour from FYROM police and army. Between the 1rst and the 12th of March 2016, MSF medical teams conducted 3.865 medical consultations between Eidomeni Transit Camp and the called «Gas Station camp». The main morbidities are respiratory tract infections (associated with inadequate shelter - 54%) and gastrointestinal pathologies (associated with inadequate access to hygiene facilities - 12%). Since beginning of January 2016 and until the date of report, MSF psychologists have conducted 149 individuals sessions and 174 group sessions with a total of 2.016 participants. An MSF team provided first aid to refugees once they arrived in Samos. In Vathy (Samos) MSF is performing medical and mental health activities and during weekends, they also run a mobile clinic next to the screening center in the north of Vathy town. Medical services also, have been provided to Agathonisi and Korinthos. At Eleonas Hospitality Centre in Athens, MSF is still providing outpatient medical consultations. The medical team is consistied of one medical doctor, one nurse, one Arabic translator and one Farsi translator. They are present every day including weekends.[5]

According a MSF worker in Athens in port of Peiraeus port (mainly to Gate E1 where around 4500 refugees/migrants were hosted) their organization provided 24/7 health services. Their team is included by a doctor, a nurse and a cultural mediator (one arabic and one farsi). During the last period (since March 2016) there have been efforts to also include a psychologist to the team.[6]

PRAKSIS NGO provide medical services in Piraeus, Elaionas and Elliniko. Prior to this allocation of health services, PRAKSIS provided health services to the following islands: Samos, Leros and Kos. Since October 2015, in collaboration with the International Medical Corps, Praksis, PRAKSIS has launched the programm of Medical Mobile Units. Since October 2015, in collaboration with with World Jewish Relief provided of the refugees/migrants in Northern Greece. The NGO Praksis provides its services in Piraeus for 8 hours per day to an average of 60 refugees per day, while in islands was 6 hours per day to an average of 40 refugees per day, respectively. Every mobile unit of Praksis is consisted of a multidisciplinary team; a General Practitioner (GP), a nurse, a social scientist, a cultural mediator and a driver. At Eleonas detention center in Athens, Praksis provides daily (16:00-20:00 local time) psychosocial support.[7]

The representative of NGO PRAKSIS informed us about the following collaborations with other NGOs and local/national authorities in order to provide PHC to these specific areas:[7]

Samos: MSF, PRAKSIS, WAHA, Greek Red Cross

Kos: MSF, PRAKSIS

Leros: MSF, PRAKSIS

Piraeus: MSF, PRAKSIS, Greek Red Cross, MDM, KEELPNO, Athens Medical Association, 2nd Healthcare Region of Piraeus and Aegean islands.

KEPY (the First Reception System) that was originally designed by the Greek authorities, involved a team of professionals (a legal advisor, doctor, nurse, psychologist, social worker) to welcome all refugees in purpose-built, high standard reception facilities prior to any contact with the police authorities.[8]

Metadrasi NGO provides the following services: interpretation, protection to unaccompanied minors and humanitarian aid in every hotspot and refugee camp all over the Greece. Since 31/12/2015 and up until today (April 2016), Metadrasi has been provided its services, to 110 unaccompanied minors (accommodation, psychological support, escorting to healthcare services).[9]

Greek Red Cross provides services to refugees/immigrants, as well. With emergency response units in Samos, Chios and Eidomeni through the Emergency Appeal Programme of International Organizations of Red Cross and Crescent Greek Red Cross provides health services. They provide health services at Cherso, Nea Kavala, Piraeus port, Skaramanga, Lesvos, Relocation center at

Diavata and at detention centers in Chios and Samos. Red Cross provides first aid services, nursing services and psychosocial support. Informative actions are made too (creation and leaflets distributions, health treatment to control diseases and epidemics). Education programs for volunteers and humanitarian aid are also provided. In a weekly basis, 2.397 refugees/migrants are served by the ten Red Cross health units, while 3.325 refugees/migrants received psychosocial support services. In addition, 1.565 refugees/immigrants received hygiene promotion interventions.[10]

Both the representatives of PRAKSIS and Metadrasi mentioned that one of the crucial health issues of the refugees, is the injuries and the hardships of the journey.[7,9]

There has been a significant variation in the demographics data of the Piraeus camp population over the last six months (second half of 2015).[6,8] At the end of 2014 the majority of new arrivals were 18 – 35 year olds. During the second half of 2015, MDM recorded the new arrivals of refugees/migrants including a larger number of neonates and elderly people. According to these records, chronic diseases seem to have an increase within the refugees/migrants population, including mainly hypertension, diabetes mellitus and renal failure. MDM has reported that 5 - 7% of the affected population have disabilities (through conflict-related wounds).[8] Red Cross officials informed us that they had launched on (November 2015) an electronic record system (Open Data Kit) to record and manage refugees/immigrants health needs.[10]

According to the interview with an MDM official, they collaborate with KEPY, PRAKSIS, METADRASI and other organizations that provide health services at the different detention and hosting centers.[11]

EKEPY has records of PHC professionals and refugee healthcare services, but unfortunately they are not available for sharing at this point.[12]

References:

1. Ministry of Economy, Growth and Tourism. Impacts of refugees' influx in Aegean islands. September 2015 (in Greek)
2. Discussion with MDM representative during the meeting with stakeholders in Lesvos (Mytilene).

3. MDM. Annual action report. Available at: http://mdmgreece.gr/app/uploads/2016/03/Annual-Report-A_SmallSize.pdf (15/4/2016) in Greek
4. MSF. Our programs in Greece. Available at: https://www.msf.gr/en/programmes-in-Greece (15/4/2016) in Greek
5. MSF. EU migration crisis update –March 2016. Available at: http://www.msf.org/article/eu-migration-crisis-update-march-2016 (12/4/2016)
6. Discussion with MSF field worker by phone.
7. Interview with Praksis representative (central offices Athens).
8. Save the Children. Multi-sector needs assessment of migrants and refugees in Greece. Available at: http://www.savethechildren.de/fileadmin/Berichte_Reports/Greece_Assessment_Report_Save_the_Children.pdf (16/4/2016)
9. Interview with Metadrasi representative (central offices Athens).
10. Communication with Greek Red Cross authorities.
11. Discussion with MDM official by phone.
12. Representative of EKEPY (central offices MoH Athens)

Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?

The health care professionals of MDM in Moria's hotspot are consisted of a team of a nurse, a general practitioner (GP), a cardiologist, an orthopedist, an otolaryngologist, a psychologist and a social worker. Health care providers usually come from different parts of Greece to take turns in providing support and services. In general, at the hotspot of Moria's they had 6-7 doctors, 2 nurses and 2 interpreters (Arabic and Farsi).[1]

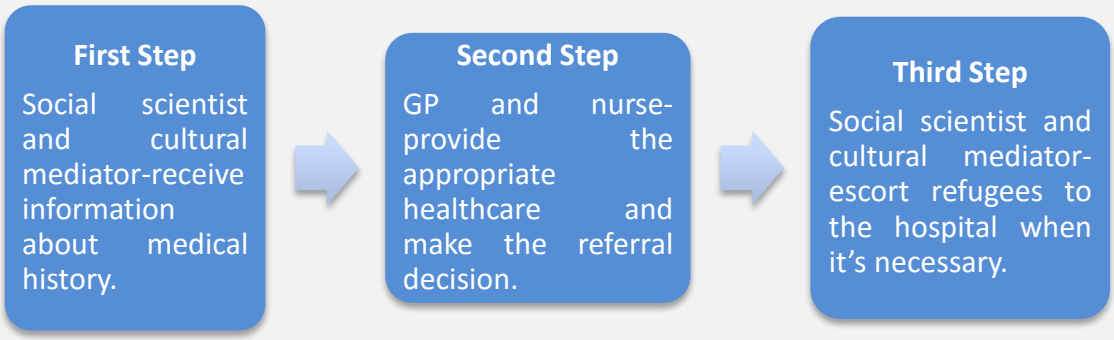
There is limited primary health care coverage across migrant and refugee sites. Migrants and refugees do not get a health screening as standard on arrival at formal and informal camps. MDM manage clinics in the Detention Centres of Moria (Lesvos) and Mersinidi (Chios).[2]

There are mobile clinics of MSF, at the island of Kos, Leros, Samos, Eleonas and Eidomeni (see above). The medical teams are consistied of one medical doctor, one nurse, one Arabic translator and one Farsi translator.[3]

Regarding PRAKSIS, the multidisciplinary team of the mobile unit is not made up of volunteers and it consists of the following personnel: two GPs, two nurses, one social worker, one psychologist, one administrative staff, one information officer, one driver and one cultural mediator. So, the overall number of the professionals would be between 20-24 persons.[4]

The figure 2 below, presents the healthcare process that PHC professionals, who provide services to refugees through PRAKSIS.[4]

Figure 2. Process of PHC professionals (PRAKSIS)



Source: Representative of PRAKSIS (central offices Athens)

During the interview with the MSF field worker, we were informed that their team at Piraeus port is consisted by a doctor, a nurse and two interpreters. Psychologists are usually volunteeres.[5] In the interview with the MDM stakeholder, it was stated that their mobile teams are consisted mainly by doctors, nurses, social workers (included here psychologistes), interpreteres and administrative staff.[6]

According interviews with MDM and MSF personnel, the MDM teams in the mainland are consisted of a doctor, a nurse, a psychosocial worker, a mediator and administrative staff. Regarding the MSF, their team is composed of a doctor, a nurse and a mediator. Currently, they are trying to include a psychologist too.[5,6]

Regarding the Greek Red Cross, their team is consisted of GPs, pathologists, pediatricians, nurses, social workers and volunteers.[7]

References:

1. Discussion with MDM representative during the meeting with stakeholders in Lesvos (Mytilene).
2. Save the Children. Multi-sector needs assessment of migrants and refugees in Greece. Available at: http://www.savethechildren.de/fileadmin/Berichte_Reports/Greece_Assessment_Report_Save_the_Children.pdf (16/4/2016)
3. MSF. EU migration crisis update –March 2016. Available at: http://www.msf.org/article/eu-migration-crisis-update-march-2016 (12/4/2016)
4. Interview with Praksis representative(central offices Athens)
5. Discussion with MSF field worker by phone.
6. Discussion with MDM official by phone.
7. Communication with Greek Red Cross authorities.

Primary health care staff situation (numbers, capacity, payment, safety, …)?
If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

The interviewed stakeholders (Praksis, Metadrasi and EKEPY) informed us that PHC services to refugees are provided by national, international NGO's, medical associations and national healthcare system.[1-3] Apart from Praksis organization that informed us that the number of PHC professionals were around 24, all the other organizations could not provide us an exact personnel number.

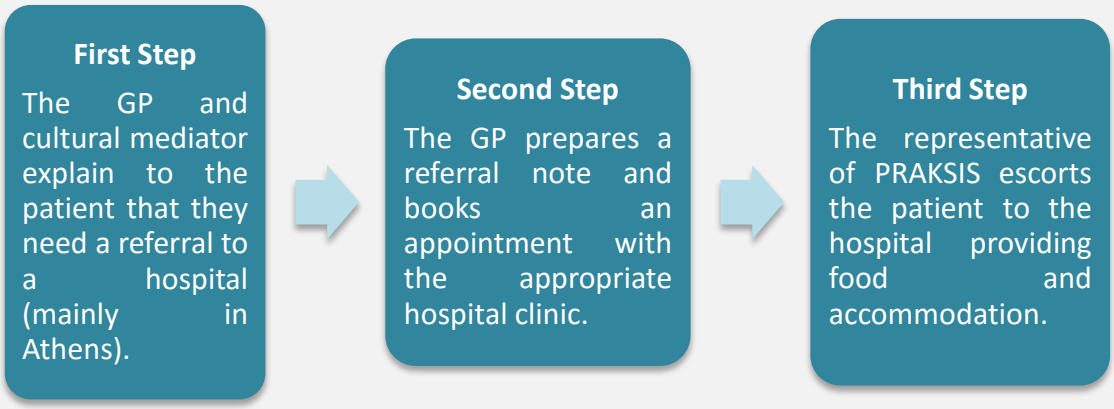
References:

1. Interview with Praksis representative (central offices Athens).
2. Interview with Metadrasi representative (central offices Athens).
3. Representative of EKEPY (central offices MoH Athens).

Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
As we have discussed with the health providers at Moria's hotspot, currently there is no health assessment, especially for asylum seekers. This was due to the fact that until the EU-Turkey deal, Greece was also, a transit country where refugees arrive and leave after a couple of days. In general, according to the Greek legislation, all Greek authorities can request from the asylum seekers, to conduct health examinations (within the official asylum procedure) in order to keep proceed with their asylum application.[1] When the authorities think that this is necessary (e.g. such as vaccination for communicable disease control (mainly Tuberculosis) or x-ray, according to the Ministry of citizens protection. 2010 Basic Information for asylum seekers in Greece. (Available at: http://www.minocp.gov.gr/images/stories//2011/BASIC_INFO_FINAL_22072011_LR.pdf) Refugees and migrants in the most of the hosting and detention centres (17 almost) can apply for asylum in Greece (see table 4).[2] MDM has established a referral system with the hospital in Lesvos and Chios, whilst MSF operates a small clinic in the abandoned Captain Elias hotel in Kos and are scaling up to manage mobile clinics in Kara Tepe in Lesvos.[3] According to the MDM doctors, usually pregnant women are directly recommended to visit the hospital. Their usual practice, is to recommend people in need to hospitals and secondary health care services. However, the head of the emergency department of Lesvos hospital informed us that most of these recommended cases could be easily managed and delegated at the hotspot or at PEDY.[4,5] According to both MDM and MSF interviews, there is no health assessment for those refugees who apply for asylum at the present. The MDM official informed us that their health personnel has recognized the needs of the current situation and have made efforts to use the known and most common methods and guidelines in PHC for triage. The MSF field worker informed us that only a rudimentary triage procedure is being conducted in the sites of Piraeus, Elliniko and Victoria square.[6,7] The MDM NGO has an official agreement with KEPY and Lesvos hospital, in order to refer refugees and immigrants there. At Piraeus port, KEPY is firstly informed, in case a refugee/migrant should be transferred to the hospital, in order to have the authorization of the referral and afterwards the person in need could be escorted and transferred to the hospital. [6,7]

The following figure describes the referral process of PHC professionals of PRAKSIS. [8]

Figure 3. The referral process of PRAKSIS.



Source: Representative of PRAKSIS (central offices Athens)

References:

1. N.A. Who can made an asylum application? Available at: http://www.helleniclawyer.eu/2016/03/basic-information-for-people-seeking.html (14/4/2016)
2. UNHCR. Site profiles – Greece. Available at: http://rrse-smi.maps.arcgis.com/apps/MapJournal/index.html?appid=dc0cf99f05f44858b886c824f3a5633d#map
3. Save the Children. Multi-sector needs assessment of migrants and refugees in Greece. Available at: http://www.savethechildren.de/fileadmin/Berichte_Reports/Greece_Assessment_Report_Save_the_Children.pdf (16/4/2016)
4. Discussion with MDM representative during the meeting with stakeholders in Lesvos (Mytilene).
5. Discussion with stakeholders in Lesvos (Mytilene).
6. Discussion with MSF field worker by phone.

7. Discussion with MDM official by phone.
8. Interview with Praksis representative (central offices Athens).

How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?

In general, based on the empirical data during the data collection within the framework of WP2 in Morias's hotspot, exists an absence of interpreters. There was also, a lack of interpreters at the hotspot, and especially with interpreters speaking Farsi. Each organization (NGO) has their own interpreter(s) (that spoke mainly Arabic and Farsi). However is seems to be a lack of coordination among the organizations (NGOs) and their interpreters. We were informed by the authorities (EKEPY) that the biggest issue was with interpreters from Afghanistan (Farsi) who were in a very limited number. The hospital of Lesvos since February 2016 had four interpreters working in shifts, mostly in the emergency department.[1] MSF, MDM and PRAKSIS representatives informed us that their organizations have interpreters but the number and the capacity and the lack of medical terms and knowledge (especially Farsi language) embedded them from achieving the level of medical services they intent to provide to the refugees and migrants. [2-4] All of stakeholders stated that there is a lack of interpreters in the different hosting/detention places. [2-4]

"*There are a lot, but do not have the capacity to do the job. Around 150 interpreters are capable to do this…*" (MDM official).

At present (April 2016) are used persons from refugees/migrant communities (mainly in Piraeus and Eidomeni centres) but without the appropriate knowledge and capacity. These "interpreters" are volunteers (mainly refugees/migrant from Syria and sometimes from Afghanistan) and are used due to the absence of interpreters in these places.[2,3]

References:

1. Discussion with stakeholders in Lesvos (Mytilene).
2. Discussion with MSF field worker by phone.
3. Discussion with MDM official by phone.
4. Interview with PRAKSIS representative (central offices Athens)

Biggest challenges and barriers for primary health care providers?

As far as the medical services and psychosocial support for refugees and migrants, it seems to be a lack of providing these services, since these are mostly provided by national and international NGO's (see appendix table 2). Also in 9 (of 24) refugees camps health care facilities are nonexistent or available within less than 5 Km (see appendix table 3). For instance, at Elliniko, Ritsona, Nea Kavala

and other hosting centres in the mainland health facilities are nonexistent, not available or more than 5km away from the centre. Another important issue is that Ministry of Health does not provide psychosocial programs in any of the hosting centres. According to table 4 (see appendix table 4), 17 out of 24 refugee camps have asylum services, while only 5 of them provide food distributions. Also, the representatives of stakeholders mentioned the following difficulties:

-There is more than one national authority responsible at the refugees' camps and hotspots, so these areas do not have a director.

-The coordination of UNHCR has a lot of problems, because the personnel of this organization is not permanent and there is no commitment about the implementation of the approved decisions by the majority of NGOs (MDM, MSF, Red Cross, IOM, etc.).

-The national authorities provided services until 23:00 every day and certain hours during the weekend.

-There are no referrals to the Greek National Primary Health Care Network (PEDY), most of the refugees/migrants refer to national hospitals.

-The majority of the refugees/migrants aims to continue their journey and are seeking out health care services only when they have to face a serious health issue (injuries/diseases of their children or a health problem which makes them unable to continue).

-MSF field worker mentioned that the most important issues for health care providers were safety, maintain the balance between different cultural groups, the difficulties in explaining them to respect the queues and that someone else probably has a more serious problem than them. MDM official reported all the above issues and also mentioned that except the hotspots, there is an absence of an "institutional" framework at hotspots and hosting cetres.[3,4]

-The representative of PRAKSIS mentioned that a crucial problem they faced, is the recruitment of a well-trained multidisciplinary team to address this humanitarian crisis, because a significant number of physicians and nurses had also emigrated from Greece in different Center and North European countries in order to find a job.[5]

-Lack of space in mobile units.[5]

-Limited amounts of medicines especially in islands.[5]

-Difficulties in chronic disease management.[5]

-No integrated care. [6]

-Lack of cultural mediators. [6]

Regarding the Red Cross, they mentioned that a significant problem at present (April 2016, especially at Piraeus and Eidomeni hosting centres) is the safety of health personnel. Another important problem is the management of chronic diseases because these persons usually are not educated for their health problem (health literacy). In addition, the Red Cross stakeholders mentioned that the referrals of refugees to hospitals and their return are a crucial problem due to the usual lack of transportation via hospital ambulances. Finally, they informed us about linguistic barriers also, due to the absence of qualified interpreters.[7]

References:

1. Greek Reporter. Greece Completes Refugee Hotspots Amid Citizen Reactions. Available at: http://greece.greekreporter.com/2016/02/17/greece-completes-refugee-hotspots-amid-citizen-reactions/#sthash.Jo409nZi.dpuf (17/2/2016)
2. UNHCR. Site profiles – Greece. Available at: http://rrse-smi.maps.arcgis.com/apps/MapJournal/index.html?appid=dc0cf99f05f44858b886c824f3a5633d#map
3. Discussion with MSF field worker by phone.
4. Discussion with MDM official by phone.
5. Interview with PRAKSIS representative (central offices Athens).
6. Representative of EKEPY (central offices MoH Athens).
7. Communication with Greek Red Cross authorities.

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

During this search, we found no evidence in the literature to address this issue. The existing national reports and from NGOs oparating in Greece was searched but there were no information. According to Greek Ministry of Migration, 3.362 persons (of various specialties) will be hired in order to address this issue.[1] Regarding the interviews, MDM and MSF stakeholders, PRAKSIS and Metadrasi reported that there are some refuggees/migrants who informing them, that they were health personnel in their origin country and that wanted to assist them. However, all the volunteers, apart from two,

could not provide any evidence to support this claim, which embed the refugees from joining the already existing medical teams of NGOs.

"*There must be around 20 persons mainly from Syria at Piraeus port with a background in health services, but we are not sure…*" (MDM official).

Both MDM official and MSF field worker, agreed that that does not exist any record procedure about profession in the country of origin.[1,2,3,4]

References:

1. Ethnos. 3,362 contracts for Refugee Hosting Centres. Available at: http://www.ethnos.gr/ergasia/arthro/3_362_symbaseis_gia_to_kentro_filoksenias_prosfygon-64343621/ (17/2/2016)
2. Discussion with MSF field worker by phone.
3. Discussion with MDM official by phone.
4. Interview with PRAKSIS representative (central offices Athens)
5. Interview with Metadrasi representative (central offices Athens)

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

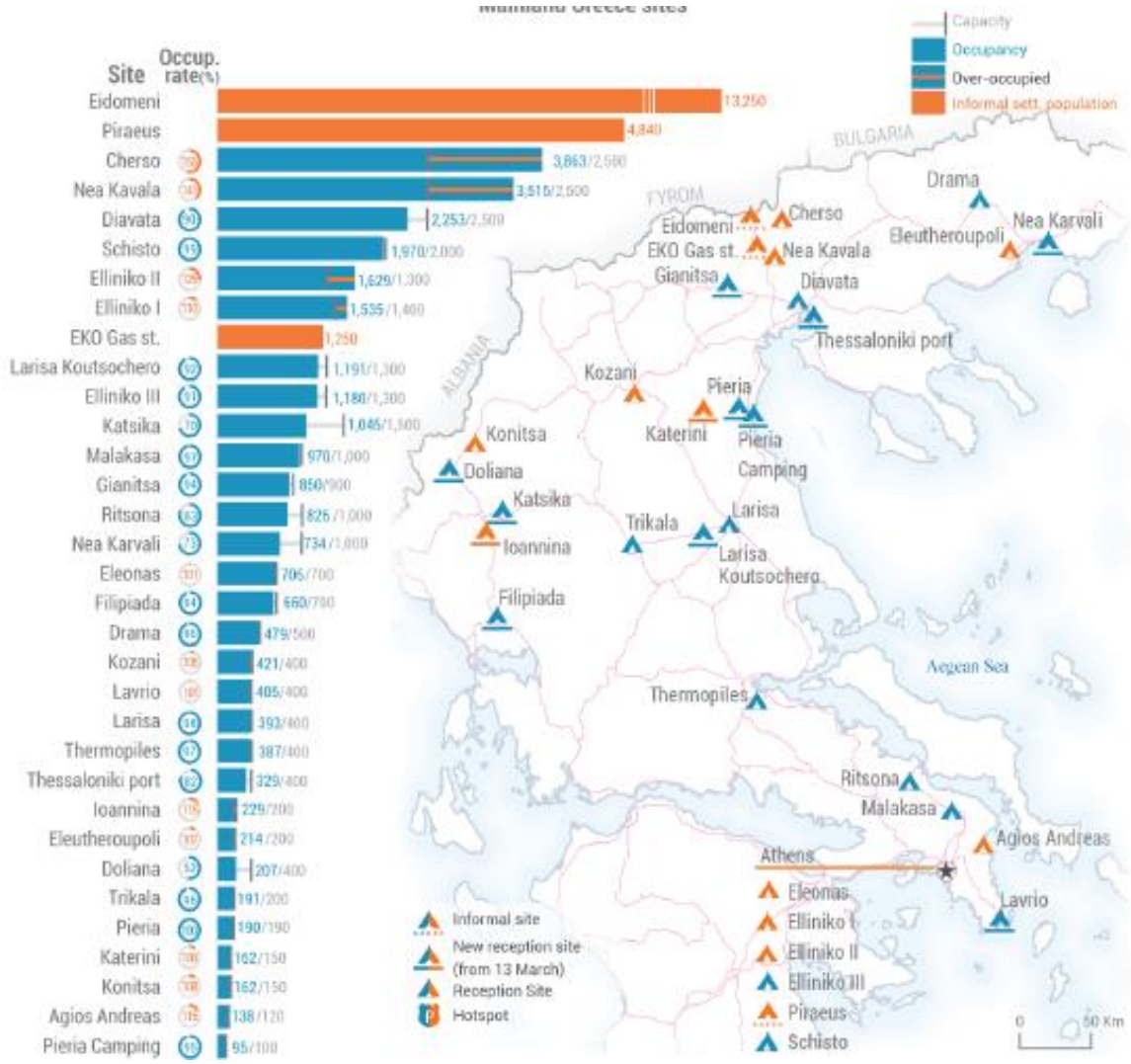
Use as much space as necessary

Table 2. Key issues

Key issue	Explanation	Possible solutions and additional issues
Lack of leadership	All the National and International authorities who are located in the hotspot of Moria have different responsibilities and each one believes that is responsible for the hotspot.	It will be useful for the Greek policy makers to decide which national authority must rule the hotspot. This issue is fundamental for the implementation of our project.
Lack of commitment	The coordinator organization (UNHCR) doesn't have permanent personnel and this fact makes the implementation of the agreed decisions made by the weekly assembly of NGO's difficult.	It is important for UNHCR to provide a stable environment and to encourage and support the role of the NGO's in the hotspot of Moria. Since the NGO's are our stakeholders we need their collaboration and of course the coordination by UNHCR, which will affect our project.

Lack of PEDY involvement	Primary Health Care (PHC) in Greece is not present to support the attempts of the authorities which are located in this hotspot.	The Greek policy makers should realize that the immigration crisis is a crucial issue with multidisciplinary approach. The role of PHC should be leading in health care services of these vulnerable population. So, our project gives us the opportunity to highlight the involvement of PHC in immigration crisis.
Lack of political stability and information	The majority of refugees have a great desire to move from Greece and to arrive in their final destination (to finish their trip and to find a safe place to live), so they don't pay attention to the provided health care services in the hotspot of Moria.	Since the political field about the immigration crisis is still open, this situation has a great impact in our project.
Lack of personnel at first reception (KEPY). KEPY first reception is primarily responsible for unaccompanied minors	KEPY has an interdisciplinary team to take care the children, but "the facilities here is like prison, which is something inappropriate for children who suffer a lot in their countries and during the trip" told us the head of KEPY. Secondly, I do not have a pediatrician her.	Improving the facilities of KEPY, hiring a pediatrician.
Lack of psychosocial program in the detention and hosting centers.	The medical services and psychosocial support for refugees and migrants are no provided services from MoH	More services provided by MoH

Figure 1. Cites capacity vs occupancy in Greek hotspots and reception centres



UNHCR 2016

Appendix

Table1. Data about refugees arrivals in Greece

Data about refugees and immigrants in Greece	Numbers/percentages
Total arrivals in Greece (2015)	862,138
Total arrivals in Greece (1/1/2016-1/4/2016)	151,659 (67,415 on January, 57,066 on February and 26,623 on March)
Average daily arrivals during February 2016	1,931
Average daily arrivals during March 2016	859
Average daily arrivals during April 2016 (until April the 6th)	229
Total asylum applications during January	1,171
Total asylum applications during February	1,470
Top 3 nationalities of arrivals in Greece during January (2016)	45% Syria, 28% Afghanistan, 18% Iraq
Top 3 nationalities of arrivals in Greece during February (2016)	52% Syria, 25% Afghanistan, 16% Iraq
Total arrivals on Lesvos island (1/1/2016-5/3/2016)	76,856
% arrivals on Lesvos compared to total (2015)	60%
% arrivals on Lesvos compared to total (2016)	59%
Average daily arrivals on Lesvos during February 2016	1,058
Average daily arrivals on Lesvos during March 2016	718
Estimated residual population staying on the island	3,550
Top 3 nationalities of arrivals on Lesvos during January (2016)	44% Syria, 27% Afghanistan, 19% Iraq
Top 3 nationalities of arrivals on Lesvos during February (2016)	38% Syria, 25% Afghanistan, 26% Iraq
Total number of hotspots in Greece	5 (Eastern Aegean islands of Samos, Lesvos, Chios, Kos and Leros)
Total number of relocation camps	24

Source: UNHCR[1]

Table 2. Arrivals and departures in 2015

Island	Total number of arrivals in 2015	Estimated departures to mainland	Number of arrivals until April 2016	Estimated departures to mainland	% of total arrivals
Lesvos	500.018	1753	152.476	7	59
Chios	123.279	1375	31.494	0	14
Samos	104.366	403	9.491	0	7

Source: UNHCR[1]

Table 3. Health facilities in Greek mainland refugee camps

Area	Distance to nearest health facility: Available or less than 5km away	Ministry of Health (MoH) Psychosocial programs available	Other Psychosocial programs available	24x7 referral service in place
Elliniko I (Hochey Stadium)	No	No	Yes	Yes
Elliniko II (West/Olympic Arrivals)	No	No	No	Yes
Elliniko III (Baseball Stadium)	No	No	No	Yes
Eleonas	Yes	No	Yes	Yes
Schisto	Yes	No	No	Yes
Ristona	No	No	Unknown	Unknown
Larisa-Koutsochero	Yes	No	No	Yes
Trikala (Frourio)	Yes	No	Yes	Yes
Magnisia (Aerinou)	Yes	No	No	Yes
Fthiotida(Thermopiles)	Yes	No	No	Yes
Doliana	Yes	No	No	Yes
Diavata	Yes	No	Yes	Yes
Nea Kavala	No	No	Yes	Yes
Cherso	No	No	Yes	Yes
Kozani(Leykovrisi Stadium)	Yes	No	Yes	Yes
Filipiada	Yes	No	No	Yes
Katsika Ioanninon	Yes	No	Yes	Yes
Giannitsa	No	No	No	Yes
Veria (Armatolou Kokkinou)	Yes	No	No	Unknown
Konitsa	Yes	No	Yes	Yes
Nea Karvali	Yes	No	No	Yes
Eleftheroupoli	No	No	No	No
Drama	No	No	No	No
Andravida	Yes	No	No	Yes

Source: UNHCR[2]

Table 4. Asylum Procedures and food distributions in Greek mainland refugee camps.

Area	Asylum Procedures	Food distributions
Elliniko I (Hockey Stadium)	Yes	Yes
Elliniko II (West/Olympic Arrivals)	Yes	Yes
Elliniko III (Baseball Stadium)	Yes	No
Eleonas	Yes	Yes
Schisto	Yes	Yes
Ristona	Yes	Yes
Larisa-Koutsochero	Yes	No
Fthiotida(Thermopiles)	No	No

Doliana	Yes	No
Diavata	Yes	No
Nea Kavala	Yes	No
Cherso	Yes	No
Kozani(Leykovrisi Stadium)	No	No
Filipiada	No	No
Katsika Ioanninon	No	No
Giannitsa	Yes	No
Veria (Armatolou Kokkinou)	Yes	No
Konitsa	No	No
Nea Karvali	Yes	No
Eleftheroupoli	Yes	No
Drama	Yes	No
Andravida	No	No
Eidomeni	Yes	Yes
Victoria Square	No	No

Source: UNHCR[2]

Thank you very much!

Best regards,

The UoC team

A3. Country Report Italy

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (ITALY) – Version 13/05/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Authors: Maria José Caldes, Nicole Mascia, Giulia Borgioli, Laura Delli Paoli

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Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)? ○ **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**
In Italy, in 2015, arrived 153.842 migrants. This is the monthly distribution of the migrants arrivals: January 3.528; February 4.354; March 2.283; April 16.063; May 21.235; June 22.891; July 23.186; August 22.609; September 15.922; October 8.916; November 3.218; December 9.637. In 2016 (up to April 13th), arrived 23.170 migrants. This is the monthly distribution of the arrivals: January 5.273; February 3.827. Number of arrivals distributed per week is not available. As for the number of asylum applications, these are the data available. Total amount of applications in 2015: 83.970. Total amount of applications in 2016: 22.596. Distribution month by month: January 7.505; February 7.693; March 7.398 References: (1) UNHCR, Sea arrivals to Italy, http://unhcr.it/risorse/statistiche/sea-arrivals-to-italy (2) Italian Ministry of the Interior, http://www.interno.gov.it/it/sala-stampa/dati-e-statistiche/trend-arrivi-dei-migranti-sulle-coste-italiane ; http://www.interno.gov.it/it/sala-stampa/dati-e-statistiche/i-numeri-dellasilo (3) IOM, http://doe.iom.int/docs/WEEKLY%20Flows%20Compilation%20No%2013%207%20April%202016.pdf ; http://migration.iom.int/europe
Main countries where refugees and other migrants come from?
Main countries of origin of people who arrived in Italy in 2015 (from January 1st to December 31st): Eritrea 39.162; Nigeria 22.237; Somalia 12.433; Sudan 8.932; Gambia 8.454; Syria 7.448; Senegal

5.981; Mali 5.826; Bangladesh 5.040; Morocco 4.647; Ghana 4.431; Ivory Coast 3.772; Ethiopia 2.631; Guinea 2.629; Egypt 2.610; Pakistan 1.982; Occupied Palestinian Territories 1.673; Iraq 996; Tunisia 880; Cameroon 662; Libya 563; Burkina Faso 470; Guinea Bissau 456; Benin 396; Togo 360; Algeria 343; Sierra Leone 250; Comoros 192; Chad 174; Congo 154; Niger 154; Liberia 137; Iran 119; Afghanistan 117; Other (26 countries) 393; Unidentified 7.138. TOTAL: 153.842

Main countries of origin for 2016 (from January 1st to February 29th): Nigeria 17,2%; Gambia 12,8%; Guinea 9,6%; Senegal 9,3%; Morocco 9,2%, Mali 7,5%; Ivory Coast 6,3%; Somali 5,2%; Sudan 2,4%; Eritrea 2,3%; Ethiopia 2,1%; Algeria 1,9%; Cameroon 1,8%; Ghana 1,6%; Other 6,2%; Unidentified 4,6%[8].

References:

(1) UNHCR, http://data.unhcr.org/mediterranean/country.php?id=105

(2) La Repubblica, Flussi migratori: 12 mesi di sbarchi in Italia, January 7th 2016, http://www.repubblica.it/solidarieta/immigrazione/2016/01/07/news/flussi_migratori_12_mesi_di_sbarchi_in_europa-130787694

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

The Italian refugee plan is organized in three main levels.
The hotspots system provides for first reception service, first aid, identification and photo signalling. First aid in the hotspots is provided by health workers of the Local Health Units and by health workers from other organizations and NGOs (e.g., Italian Red Cross, MSF) People should stay in the hotspots between 48 and 72 hours. In Italy, there are 6 hotspots in the South (5 in Sicily and 1 in Apulia): Lampedusa, Porto Empedocle, Pozzallo, Trapani, Augusta e Taranto.
The second level of reception is represented by government centres – CARA (Reception Centre for Asylum Seekers), CPSA (First Aid and Reception Centre), CDA (Reception Centre) – and Regional Hubs that are covering widespread the Italian territory. After their arrival in the South of Italy, migrants and asylum seekers are distributed throughout the Italian territory according to the capacity of the different structures in the Regions. In the government centres, migrants can apply for international protection and wait for the conclusion of procedures by the Commission or the competent territorial section. Theoretically, the person should stay at the second level centre for the time necessary to apply for asylum or protection. Then, the person should participate to the SPRAR project. Actually, due to the lack of places in the SPRAR, persons keep staying in the second level even after the application.
The third level of reception is represented by the SPRAR project (Protection System for Asylum Seekers and Refugees). The SPRAR project is managed by the Ministry of Interior and by Italian local authorities (ANCI), including third sector organizations and network. The SPRAR project deals with refugees and asylum seekers waiting for the granting of international protection and aims at providing for 'integrated hospitality'. Refugees and asylum seekers receive not only board and

[8] Since the data is recent, it was not possible to find the total amount of migrants from each country but only a percentage.

lodging, but also social support activities, aimed at an effective integration in the territory and access to local services, including health and social assistance. The SPRAR project provides also for Italian language courses, training to facilitate employment and measures taken to have access to housing, enrolment of children in school and legal support. In theory, every asylum seeker should run through the three levels. They should stay in the hotspots no longer than 72 hours. Equally, they should stay in the second level of reception only for the time necessary to apply for international protection. After the application, they should be involved in the SPRAR project, in order to start a pathway of integration.
Actually, the situation is very different. Asylum seekers stay in the second level reception centres for months: temporary reception centres (CAS) settled to be extraordinary are actually used for ordinary reception.
Available places in the SPRAR project are not enough. There are waiting lists and the persons waiting for available places keep staying in the second level of reception.

According to the latest data from the Ministry of Interior (last update April 29th 2016), refugees and asylum seekers in Italy are 111.081.

Data available on reception centres date back to February 2015.
Number of government centres for primary reception (CARA/CPSA/CDA): 14
Number of CAS (extraordinary and temporary reception centres): 1657
CAS (temporary reception centres) have been established in 2014, according to Ministry of the Interior Circular no. 104, January 8th 2014. According to their definition, they should be temporary reception centres, established to face emergencies and exceptional situations when there are no places available in the second level and in the SPRAR project. De facto, they are used for ordinary reception and, according to the data available, the majority of asylum seekers arriving to Italy are placed in this type of centres.

Are there detention centres for persons who are not admitted to the asylum process (Dublin III) or persons who receive a negative asylum decision?

CIE (Centers for identification and expulsion) are detention centres for irregular migrants (persons without legal documents to entry Italy, persons who haven't applied for international protection or who received a negative asylum decision), waiting to be expelled. At the moment, there are 5 detection centres in Italy: Rome, Turin, Bari, Caltanissetta and Trapani.

References:

(1) Italian Ministry of the Interior, http://www.interno.gov.it/it/sala-stampa/dati-e-statistiche/presenze-dei-migranti-nelle-strutture-accoglienza-italia ; http://www.interno.gov.it/sites/default/files/dati_statistici_marzo_2015.pdf ; http://www2.immigrazione.regione.toscana.it/?q=norma&css=1&urn=urn:nir:ministero.interno:accordo:2014-07-09

(2) SPRAR, http://www.sprar.it/index.php?option=com_k2&view=itemlist&layout=category&task=category&id=19&Itemid=667
How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)
Total capacity of the 6 Italian hotspots: 2.100 Total amount of migrants in CAS (temporary reception centres): 37.028 Total amount of migrants in CARA/CDA/CPSA: 9.504 Total amount of refugees and asylum seekers in the SPRAR project: 20.596 Exact data are not available. As already mentioned, reception centres settled to be extraordinary are used in the ordinary reception. Many situations of overcrowding in the second level of reception have been denounced by the NGOs. Available places in the SPRAR project are not enough. References: (1) Italian Ministry of the Interior, http://www.interno.gov.it/sites/default/files/dati_statistici_marzo_2015.pdf ; http://www.meltingpot.org/IMG/pdf/roadmap-2015.pdf ; http://www.meltingpot.org/IMG/pdf/2015_ministero_interno_14106_6-_10_accoglienza.pdf
How is Primary Health Care provided in your country in general?
In Italy, Primary Health Care is provided by the State according to principles of universalism, equality and equity. Article 32 of the Italian Constitution states that "the Italian Republic protects right to health as a fundamental individual right and an interest of the community, and safeguards free access to health assistance for needy people". The National Health Service (Servizio Sanitario Nazionale) is organized at a local level, where Local Health Services and Hospitals provide for health assistance. In the last 20 years, Italian Regions have gained significant autonomy in the field of health assistance and Primary Health Care is now one of the Regions' main tasks. Italian Regions have to formulate policies, draw operational tools in order to implement and supervise policies, set priorities and develop strategies. In Italy, Primary Health Care providers are GPs. There are Primary Health Care centres and every person has a reference GP. Local Health Units (ASL) are part of the National Health Service and consist of hospitals, social district and prevention department. Depending on the territory, every ASL could consist of hospitals, health districts, continuity care

assistance, family planning centres, mental health services, pediatricians, specialist exams, pathological dependencies.
Italian legislation allows access to healthcare for all, differentially regulated among the different legal statuses. Migrants from non-EU countries and without legal documents can access Italian healthcare through the STP code (Temporarily Present Foreigner), which guarantees access to healthcare for the period preceding the asylum request or the obtaining of documents and papers. STP code guarantees first aid and emergencies, and every health service considered essential for people health and wellbeing. STP code is valid for 6 months and it is renewable. After the international protection is granted or the documents are obtained, they are registered in the National Health Service (SSN), and they are assigned to a general practitioner (GP).

References:

(1) Italian Ministry of Health, http://www.salute.gov.it/portale/salute/p1_4.jsp?lingua=italiano&area=Il_Ssn ; http://www.salute.gov.it/portale/salute/p1_5.jsp?lingua=italiano&id=187&area=Servizi_al_cittadino_e_al_paziente

(2) Region of Tuscany, http://www2.immigrazione.regione.toscana.it/sites/default/files/circolare%20RT%2015%20gennaio%202016.pdf ; http://www.immigrazione.regione.toscana.it/lenya/paesi/live/contenuti/percorsoguidatoaiprocedimenti/attribuzionetesserinostp.html?sigla=FI&p=Firenze#accesso

Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

No Primary Health Care staff is supplied in the reception centres for migrants, refugees and asylum seekers. A first health screening is provided in the hotspots, at the arrival. The first health screening is provided to every migrant arriving to Italy in the hotspots, in the first hours after their arrival.
Officially, Primary Health Care is supplied by the Local Health Services, since migrants are provided with the STP code and, after the granting of international protection, they are assigned to a General Practitioner. *De facto*, NGOs and third sector organizations have a key role in the collaboration with Local Health Units for the provision of health assistance to people hosted in the centres. Since Primary Health Care is provided at a local level, the involvement of NGOs and local organizations is extremely variable depending on the territory.

References:

1) Medici Senza Frontiere, http://www.medicisenzafrontiere.it/notizie/news/rapporto-pozzallo-condizioni-inaccettabili-servono-risposte-urgenti-e-strutturate ; http://archivio.medicisenzafrontiere.it/pdf/Rapporto_CPI_CPSA_Pozzallo_final.pdf

2) MEDU, http://www.mediciperidirittiumani.org/pdf/MEDU_Rapporto_CAS_26_aprile_FINALE.pdf ; http://www.mediciperidirittiumani.org/rapporto-cara-mineo-modello-accoglienza-incompatibile-dignita-persona
Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
No Primary Health Care staff is provided in the centres for migrants, refugees and asylum seekers.
Primary health care staff situation (numbers, capacity, payment, safety, …)? **If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?**
As already said, no Primary Health Care staff is provided. Primary Health Care is supplied by the Local Health Units, trough the STP code. After the first screening in the hotspots, migrants, asylum seekers and refugees can access to health assistance trough Local Health Units, first aid and hospitals.
Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
A first health screening is provided in the hotspots, mainly to identify infectious diseases and to assess children's age (wrist x-ray). The procedure of wrist x-ray in order to assess children age has been extremely criticized by NGOs present in the hotspots. The screening is carried on by health workers from the Local Health Unit. Once migrants and asylum seekers are provided with the STP code, they can access to health assistance trough 'normal' channel: first aid, hospitals and Local Health Units. In this context, there are no special procedures dedicated to asylum seekers and refugees. Health workers we interviewed, did manifest the necessity of specific guidelines for asylum seekers and refugees in case of vulnerable migrants (pregnant women, unaccompanied children, migrants subjected to torture and violence). According to this, special procedures and guidelines could be useful in order to assess mental health.
How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
Interpreters and cultural mediators are provided in the hotspots and first reception centres depending on the capacity of the place. The provision of interpreters and cultural mediators is managed at a local level, by local institutions and organizations.

Regarding the presence of interpreters and cultural mediators in the Local Health Units, hospitals and first aid services, this is extremely variable depending on the territory. On average, the workers we have interviewed were satisfied by the effectiveness of the service. For example, the Careggi Hospital (one of the main hospitals in Florence) has 4 languages present in the service: Chinese, Arab, Romanian and Albanian. Interpreters and cultural mediators are not available 24 hours a day but only in limited time slots, mainly in the morning. There is also a service of telephone mediation, called Help Voice. Health workers mainly facing with urgencies (e.g., first aid, women giving birth, urgent necessity of informed consent) judged the service of cultural mediation insufficient. References: (1) National Institute for Health, Migration and Poverty, http://www.inmp.it/index.php/ita/Servizi-Socio-Sanitari/Modalita-di-accesso/La-mediazione-transculturale/Progetti-sul-territorio (2) Azienda Ospedaliera Universitaria Careggi, http://www.aou-careggi.toscana.it/internet/index.php?option=com_content&view=article&id=3018&Itemid=1016&lang=it
Biggest challenges and barriers for primary health care providers?
According to health workers we interviewed, biggest challenge are considered language barriers and lack of sufficient cultural mediation; migrants difficulties in acceding health assistance; bad use of first aid services; lack of specific guidelines for vulnerable migrants (pregnant women, unaccompanied children, migrants subjected to torture and violence); lack of specific guidelines for mental health assessment; management of severe pathologies. We have noticed that the perception of the barriers and challenges is considerably variable according to the qualification of the health worker and to the context he's/she's working in. The perception varies depending on the specialization of the health workers and on the context they are working in. For example, people working in first aid services and people working in hospital wards or GPs have different perceptions because they deal with different situations and necessities.
Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?
There are no data available on this issue. Anyhow, every health worker we have interviewed agrees on the fact that migrants with health care experience could surely represent an important resource. Nonetheless, according to recent data, the majority of migrants arriving to Italy in the last years is assumed to have a very low level of education, however, there is no data on that. In this sense, it could be difficult to involve them in projects for migrants' health assistance.

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

The number of migrants arriving to Italy in the last two years has extremely increased. For this reason, the whole refugees reception plan has been reorganized. The creation of hotspots and Regional Hubs wants to represent a solution for the increasing number of arrivals. Simultaneously, the number of available places in the SPRAR Project has definitely increased in the last two years. Nonetheless, there are still situation of overcrowding, mainly in the hotspots and in the government centres, and access to the SPRAR Project is not so easy. Situations of inhumanity have been denounced by NGOs involved.

Since Primary Health Care staff is not provided in the reception centres for asylum seekers and refugees, it seems difficult to analyze the situation in terms of capacity. What needs to be taken into account is the possibility migrants have to access to health assistance, and the effectiveness of the service given.

According to our research and to the results of the interviews, and considering the peculiarity of the Italian situation, these are a few recommendations.

The service of interpreters and cultural mediation should be improved and should be available to every GP. Often, GPs are not able to communicate with their patients because they do not speak English and because the service of cultural mediation is not provided.

It is essential to provide special procedures and guidelines in order to assess mental health. Considering the dramatic nature of the trip people make to arrive in Italy, traumas and mental health issues are extremely common. At the moment, health workers do not have the instruments to recognise them.

It should be important to set up a better communication between the Local Health Units and migrants' users, in order to make a proper use of the services given (e.g., first aid services).

A4. Country Report Croatia

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report for Croatia – Version 15/05/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Authors:

Helana Bakic, Lana Pehar, Nikolina Stankovic, Dean Ajdukovic

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Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?

- **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**

According to the data provided by the Croatian Ministry of Interior and The United Nations High Commissioner for Refugees (UNHCR), the estimated overall number of refugees and other migrants who entered Croatia was 558.242 in 2015, and 100.487 in 2016[1]. This leads to a total of 658.729 persons that passed through Croatia on their way to Western Europe in the period from September 2015 to March 2016 during which the Balkan route was open.[1.1]. Of these, 152 persons applied for asylum in 2015 and 379 from the beginning of 2016 until March 31st.[1.2,1.3] Throughout most of the crisis, Croatia remained a transit country for refugees and migrants traveling to other European countries. Only after the introduction of more restrictive measures for the control of refugee and migrant influx in mid-February, the number of people expressing intention to apply for asylum increased (between the start of the crisis and February 16th 2016 only 29 requests were filled)[1.4]. A more detail overview of the number of refugees and other migrants who came into Croatia since 1st of March 2016 can be found in the Table 8. Following the closure of the Balkan route on March 8th, Croatia also closed its borders on March 9th and was no longer receiving new refugees and migrants.

Table 8 Daily number of refugees and migrants who came to Croatia during March 2016[2.1]

Date	Number
1.3.2016	436
2.3.2016	476
3.3.2016	0
4.3.2016	410
5.3.2016	253
6.-31.3.2016	0
Total	**1,575**

References:

1.1 United Nations High Commissioner for Refugees. (2016). Croatia snapshot YTD 2016. https://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Org%5B%5D=77.

1.2 Croatian Ministry of Interior (2015). International protection statistics for 2015. http://www.mup.hr/UserDocsImages/Publikacije/2016/medjunarodna_zastita_2015.pdf1.3.

1.3 Croatian Ministry of Interior (2016). International protection statistics for the first quarter of 2016. http://www.mup.hr/UserDocsImages/Publikacije/2016/3_16_mz.pdf

1.4 Friedrich Ebert Stiftung. (2016). At the gate of Europe: A report on refugees on the Western Balkan Route. http://www.irmo.hr/wp-content/uploads/2016/05/At-the-Gate-of-Europe_WEB.pdf

2.1 United Nations High Commissioner for Refugees. (2016). Daily estimated arrivals per country-flows through Western Balkans route. http://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Country[]=94&Type[]=3

Main countries where refugees and other migrants come from?

A majority of refugees and migrants who arrived in Croatia during 2016 have had a Syrian background, followed by people arriving from Iraq and Afghanistan. This structure of refugee and migrant population by nationality was probably caused by the Government of Slovenia's request on November 18th 2015 for readmission of people from non-war torn countries (all nationalities except Syrians, Iraqis, and Afghans), which lead Croatia to no longer accept such people. From the total number of refugees and migrants that came to Croatia in January 2016, 47% were Syrians, 32% were Afghans and 21% were Iraqis. Similar percentages by ethnicity remained in February during which there were 47% of Syrians, 28% of Afghans and 25% of Iraqis. Given that the Macedonian and Serbian authorities have decided to close the border for individuals from Afghanistan on 22nd of February[2.1], the percentage of Afghan refugees and migrants in March dropped down to 0%, while the percentages of Syrian and Iraqi arrivals were 85% and 15 %, respectively. [1.1]

References:

1.1 United Nations High Commissioner for Refugees. (2016). Croatia snapshot YTD 2016. https://data.unhcr.org/mediterranean/documents.php?page=1&view=grid&Org%5B%5D=77

2.1 Kantouris, C. & Testorides, K: (2016). Greece: FYROM has closed its borders to Afghan migrants. http://www.ekathimerini.com/206204/article/ekathimerini/news/greece-fyrom-has-closed-its-borders-to-afghan-migrants

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

The massive influx of refugees and migrants traveling across the Balkan migrant route and entering the territory of Croatia through the border crossings with Serbia began on September 16th. During the first few days all the people crossing the Croatian border (including refugees and migrants passing through Croatia on their way to other destination countries as well as those who expressed their intention to apply for asylum) were transferred by buses and trains organised by the Croatian Ministry of Interior to several temporary

reception centres in Tovarnik, Čepin, Beli Manastir, Zagreb - Dugave, Zagreb - Velesajam, Ježevo and Sisak. As the influx of refugees and migrants continued to grow, the Croatian Government decided to open a large reception centre in the village of Opatovaci in eastern Croatia on September 21st. All centres established during the first few days have been completely vacated as migrants left for Hungary and Slovenia and all people entering the border since September 21st were transferred to the Reception Centre Opatovac. [1.1] In order to provide adequate conditions for a large number of refugees and migrants during winter months, the Government opened a Winter Reception and Transit Centre in Slavonski Brod on November 3rd. On the same day the Reception Centre in Opatovac was closed while the 2000 remaining refugees and migrants from Opatovac, as well as all of the equipment, were transferred to Slavonski Brod. After November3rd, the Winter Reception Transit Centre Slavonski Brod remained the only functional transit centre in Croatia where all new refugees and migrants arriving in Croatia from the Serbian border were directly transported. [1.2] After the Balkan migrant route was officially closed on March 30th, Croatian authorities closed the Winter Reception Transit Centre Slavonski Brod on April 15th and the remaining refugees and migrants were transferred to existing long-term accommodation facilities for foreigners in Croatia.[2.1] Individuals who applied for asylum in Croatia were moved either to Reception Centre for Asylum Seekers Kutina (mostly vulnerable groups of asylum seekers) or to Reception Centre for Asylum Seekers Porin in Zagreb (single men and other categories of asylum seekers). A majority of individuals who did not apply for asylum were directly moved to Detention Centre for Irregular Migrants Ježevo, except for those pertaining to vulnerable groups such as families who were transferred to a separate part of the Reception Centre Porin. As of the closure of the borders, all new refugees and migrants that come to Croatia mainly due to readmission from other EU countries are situated in one of these long-term accommodation facilities

References:

1.1 International Federation of Red Cross and Red Crescent Societies. (2015). Emergency plan of action, Croatia: Population movement (October 2015).

1.2 International Federation of Red Cross and Red Crescent Societies. (2016). Emergency plan of action final report, Croatia: Population movement (April 2016).

2.1 News that moves. (2016). Croatia closes SlavonskiBrod transit centre. file:///C:/Users/Kerumica/Downloads/Croatia%20Closes%20Slavonski%20Brod%20Transit%20Centre.pdf

How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved)

Provisional reception centres in Tovarnik, Čepin, Beli Manastir, Zagreb - Dugave, Zagreb - Velesajam, Ježevo and Sisak that were active during the first few days of migrant surge in Croatia, served only as a temporary point where The Croatian Ministry of Interior officials registered newly arrived people and The Croatian Red Cross staff provided humanitarian assistance. Once registered, migrants and refugees were transported by bus or train directly to the Slovenian or Hungarian border.[1.1]

Reception Centre Opatovac was a temporary tent settlement opened from September 21st to November 3rd near the Croatian border with Serbia (where the majority of refugees and migrants at the time entered

Croatian territory). The camp had a capacity of maximum 4000 people. The refugees and the migrants stayed in the centre for no more than 36 to 48 hours during which they were registered and provided with primary assistance and were subsequently transported to the borders.[1.1]

Winter Reception Transit Centre in Slavonski Brod was opened by the Croatian Ministry of Interior to ensure more appropriate short term accommodation during cold weather and heavy rainfall. Since its opening on November 3rd 2015 until March 5th 2016, when last arrivals were reported by the Croatian Ministry of Interior, the centre was the main transit point for migrants and refugees passing through Croatia. The centre was set up on a rearranged warehouse near the railway in the industrial zone of the city Slavonski Brod with a capacity to accommodate 5000 people. It was divided in several sectors including two halls for reception, registration and distribution of humanitarian aid. Each sector had air-heated tents, separate housing containers for families and particularly vulnerable individuals, child friendly spaces, special mother-baby areas, medical assistance unit and several heated hygiene facilities with warm water. On average, refugees and migrants stayed in the centre for four to five hours during which they would register, receive medical assistance if needed and use the needed services (food, clothes, sanitary facilities etc.) and boarding the train that would bring them directly to Slovenian or Hungarian border.[1.2] Since late November the centre also had closed sectors (sector 3 and 4) under the control of the Croatian Ministry of the Interior which was used to separate individuals that were returned from Slovenian border because they did not meet the conditions that Slovenian Government had implemented as of November 18th 2015.[1.3] At the time when the Balkan route was closed, there were approximately 320 individuals stranded in the closed sector of the centre who were presented with an official ban from leaving the centre and could only apply for asylum in Croatia or leave the European Economic Area voluntarily. Out of these, 224 individuals expressed their intention to apply for asylum and were subsequently transferred to Reception Centres for Asylum Seekers Kutina and Porin to wait for the resolution of their asylum application. However, many of them illegally left Croatian territory within a short period of time.[3.1] The centre in Slavonski Brod was closed on April 15th, and all people who had been placed there were transferred either to Detention Centre in Ježevo or to the Reception Centre Porin in Zagreb. 62 family members who did not apply for asylum were transferred to Porin and 21 single men not applying for asylum were moved to Ježevo.[3.1]

The “permanent” Reception Centre for Asylum Seekers Kutina was opened in June 2006 in the Traffic Police building in the town of Kutina, located 80 km east from the capital of Zagreb. It was briefly closed due to devastation in 2013 and opened again after renovation in 2014 to provide long term accommodation for vulnerable groups of asylum seekers such as unaccompanied minors, families, pregnant women, persons with disabilities and persons suffering from mental disorders.[1.4] This is an open type of facility so that the residents can go outside whenever they want but they have to be back by 10pm. If they want to leave the centre for a longer period of time they have to get permission from the administrator of the facility. The centre can accommodate up to 100 people in 22 two-bedded rooms and family members are always accommodated in the same room. It has several sanitary facilities, sports hall, playground and child friendly spaces, infirmary, TV room, restaurant, small kitchen and laundry service. Residents receive three meals per day and can get specific diet food if necessary (e.g. halal, vegetarian, diabetic etc.). They can prepare meals by themselves in the small communal kitchen. [3.2] Before the surge of refugees and migrants had reached Croatia, there were approximately 10 asylum seekers already accommodated in Kutina.[3.3] In September 2015, when Croatian authorities closed the second reception centre for asylum seekers (Porin), 45 single male

asylum seekers were moved from Porin to Kutina and since then everyone who applied for asylum until March 2016 was placed in Kutina. [3.3] When the Balkan route was closed and Porin was reopened, refugees and migrants who remained in Slavonski Brod were transferred to Reception Centres in Kutina and Porin whereby the majority of vulnerable individuals were placed in Kutina until the capacity of the centre was reached. In addition, approximately 30 single men that were at that time located in Kutina, were moved to Porin.[3.3] At the moment of writing this report there were 54 individuals at Kutina, mostly particularly vulnerable individuals.[3.2]

Because of the increased number of asylum claims, in 2011 Croatian Ministry of Interior opened a second Reception Centre for Asylum Seekers, initially intended to accommodate single male asylum seekers, in a leased part of the former railways hotel Porin located in Zagreb's neighbourhood of Dugave. In 2013, the centre was expanded to us the whole hotel space and adapted so that it can accommodate up to 600 persons.[1.4] The centre can be reached by public transport and it takes about 45 minutes by bus or a tram to get from the centre of Zagreb to Porin. In addition to the reception of refugees and migrants, Porin is also a registration centre where asylum seekers provide their fingerprints, submit asylum applications and receive their seeker's identity card. Just like in Kutina, the residents of the centre are free to go outside and are entitled to similar conditions (four bedded rooms, meals three times a day, restaurant, sanitary facilities, gym, laundry service, room for creative workshops, room for educational activities). They also receive primary health care on the location. According to the people we interviewed and our own observations, asylum seekers often complain that there is not enough space around the centre for a playground or to engage in outdoor activities.[3.4, 4.1] The centre was briefly closed at the beginning of the Croatian migrant crisis in September 2015 because most of its staff were detached to work in Opatovac and Slavonski Brod reception centres, so that the few previously present asylum seekers in the centre were moved from Porin to Kutina. The centre was reopened in March 2016 when the authorities started planning to close the transit centre in Slavonski Brod. A majority of refugees and migrants who were returned from Slovenian border and at the time stranded in Slavonski Brod were transferred to Porin because Kutina and Ježevo had almost filled up their capacities. [1.3] Besides the individuals who decided to seek asylum while staying in the Slavonski Brod transit centre, approximately 60 irregular migrants who refused to seek asylum in Croatia but belonged to a vulnerable group (mostly families with children) were moved to Porin to stay in a separate part of the centre but without restrictions to movement or services. [3.3] As in the case of other individuals who do not apply for asylum in Croatia, these refugees and migrants can voluntarily return to a safe country of origin or third safe country from which they entered Croatia or they will be forcibly deported after a maximum of 18 months in Croatia. The centre currently accommodates 221 persons in total, including 169 asylum seekers and 42 family members who did not apply for asylum and are located in the separate part of the centre.[3.4]

Detention Centre for Irregular Migrants Ježevo is located in outskirts of the village Ježevo (next to the highway), 30 km east from Zagreb. It is a closed detention facility with permanent solid-built structure for people who did not apply for asylum and are awaiting deportation due to illegal residence or work in Croatia or for asylum seekers who for some reason specified by law had their freedom of movement limited. Maximum detention time is 3 months, with the possibility of further prolongation for another 3 months and two further prolongations each for 6 months. The capacity of the centre is around 100 persons.[1.5] The refugees and migrants located in Ježevo are not allowed to leave the complex at any time, but they can spend

few hours a day outside in the yard. Their personal belongings (e.g. mobile phone) and money are taken away upon registration and their possibilities of contact are reduced to one phone call with the embassy or representatives of the country of origin, additional phone call in maximum duration of 3 minutes and one visit in duration of up to one hour.[1.6] The centre is under the strict control of Croatian Ministry of Interior so that non-governmental organisations (NGOs) can only do an external monitoring of the centre. Therefore, it is difficult to gather additional information about the number of people detained, overall conditions in the centre or available services. The only information currently available is that the majority of people transferred from Slavonski Brod have expressed intention to voluntary repatriation to their countries.[1.7]

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3.1 Interview with a volunteer coordinator from the Centre for Peace studies

3.2 Interview with occupational therapist (CRC) working in Reception Centre for Asylum Seekers Kutina

3.3 Interview with a psychologist from the Society for psychological assistance

3.4 Interview with a social worker from CRC working in Reception Centre for Asylum Seekers Porin

4.1Participatory observation of the Reception Centre for Asylum Seekers Porin

How is Primary Health Care provided in your country in general?

The health care system in Croatia is organized by the Ministry of Health, which is responsible for monitoring health condition and needs of the population, health care legislation, health policy planning and evaluation, regulation of standards for health services and training, public health programmes, implementation and regulation of standards in health facilities and supervision of professional activities.[1.1] The system is based on the principle of social health insurance by which citizens are required to participate in the expenses for basic health care services with an exception for certain categories of insured persons (e.g. children under the age of 18 years, those suffering from certain diseases such as malignant diseases or chronic mental illnesses). The main financing body for financing health services is the Croatian Health Insurance Fund, which provides

universal health coverage to the whole population, defines basic health services and prices covered under the mandatory, as well as voluntary health insurance. Basic health insurance is mandatory for everyone in Croatia, including temporary residents. All employed citizens and their employers pay health care directly from the salaries while dependant family members are covered through the contributions made by working family members. Vulnerable groups of citizens such as retired, disabled, unemployed, students, war veterans and those on low income are exempt from paying and their health services are funded from the state budget.[2.1] Although the scope of mandatory health insurance is broad, patients must participate towards the costs of many medicines and services, either through co-payments or through the purchase of complementary voluntary insurance covering user charges (except the unemployed, disabled, children under 18, students, war disabled, and regular blood donors). Besides that, all patients pay for non-prescription drugs.

Primary health care in Croatia includes general practice (family) medicine, school medicine, hygienic and epidemiological care, dental care, emergency health services, and occupational health, primary healthcare of women and children, community nursing and pharmacies. It is provided by various health service institutions such as private practice offices, larger units comprising several offices (including small laboratories), community health clinics, institutions for emergency medical care, institutions for home health care and pharmacies. The primary care physicians are usually patients' first point of contact and each insured citizen has to register with a general practice doctor, a paediatrician, a gynaecologist and a dentist of their choice. If necessary, primary health care physicians refer the patient for further treatment to secondary or tertiary specialist health care facilities. Secondary health care includes specialist-consultative healthcare, hospital health care in general and specialized hospitals and health resorts. Tertiary health care refers to most complex forms of health care in specialised clinical centres and national health institutes. Mental health services are mainly provided within institutions such as general and university clinical hospitals as well as specialist psychiatric hospitals. Local county governments own most of the public primary and secondary health care facilities while the state owns and controls tertiary health care facilities.[1.1] Provision and funding of health services are largely public, although there are private providers in the market. Privately owned facilities can be contracted by the Croatian Health Insurance Fund and become a part of the publicly funded system or they can choose to operate on their own and charge private fees.

Health care standard in Croatia is mainly satisfactory, with better accessibility to health care facilities in major cities. For example, the largest number of hospitals is located in central Croatia, mainly in the capital of Zagreb, while the remote parts of the country and the islands have considerably less access to health care. However, primary health care and emergency medicine facilities are available in all parts of the country. In 2015 the healthcare facilities included 77 hospitals and clinics with 25.219 beds, 21 institutes of emergency medicine, 49 health centres and 22 institutes of public health. There were a total of 65.757 health workers in the country, including 14.057 medical doctors of which 9.538 specialists.[1.2] Due to rising costs of health care, especially expenditure on drugs, Croatian health care system suffers from lack of funding, which so far has not affected drug supply within public health care institutions.[2.1]

Regarding the health care for refugees and migrants, it is necessary to distinguish different categories of protection depending on their legal status in Croatia. According to the Croatian Act on International and Temporary Protection[1.3], applicant for international protection is a third country national or stateless person

who has applied for international protection up until the final decision on the application. International protection in Croatia includes asylum and subsidiary protection. Asylum is granted to applicants who are outside the country of their nationality or habitual residence and have a well-founded fear of persecution owing to their race, religion, nationality, affiliation to a certain social group or political opinion, as a result of which they are not able or do not wish to accept the protection of that country. Subsidiary protection is granted to an applicant who does not meet the conditions to be granted asylum if justified reasons exist to indicate that if returned to his/her country of origin he/she would face a real risk of suffering serious harm (threat of death, torture, inhuman or degrading treatment or punishment and serious threat to the life) and who is unable, or, owing to such risk, is unwilling to avail himself/herself of the protection of that country. Applicants for asylum and subsidiary protection have a right to emergency medical assistance, and necessary treatment of illnesses and serious mental disorders. Applicants who need special reception and/or procedural guarantees, especially victims of torture, rape or other serious forms of psychological, physical or sexual violence, should be provided with the appropriate health care related to their specific condition or the consequences of those offences. Foreigners who have already been granted asylum or subsidiary protection and their family members have the right to health care to the same extent as a person insured under mandatory health insurance in Croatia. Beside international protection, foreigners can be granted temporary protection in situations of a mass influx of displaced persons from third countries who cannot be returned to their country of origin, especially if it is not possible to conduct an effective procedure for approval of international protection. Health care for foreigners under temporary protection includes emergency medical assistance and, for vulnerable groups, appropriate medical and other assistance. Costs of health care for all of the above mentioned categories of foreigners are paid by the national budget of Croatia.

References:

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1.3 Croatian Ministry of Interior. (2015). Act on International and Temporary Protection 2015 [http://www.refworld.org/docid/4e8044fd2.html

2.1 Croatian Health Insurance Fund. Croatian health care system. http://www.hzzo.hr/en/croatian-health-care-system/

Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

The primary health care in temporary reception centres that were active at some point in the refugee and migrant crisis in Croatia was provided by several international and civil society organisations and agencies. The Croatian Ministry of Interior appointed the Headquarters for Crisis Coordination to coordinate all activities related to the arrival of refugees and migrants in Croatia and Croatian Red Cross (CRC) to coordinate all other organisations involved in providing care for refugees and migrants in temporary reception centres

and border crossings. CRS staff and volunteers were present at all reception centres as well as at the entrance and exit border crossings providing food, water and hygiene items to refugees and migrants in cooperation with State Commodity Reserves. In addition to CRS, The United Nations High Commissioner for Refugees (UNHCR) and the United Nations Children's Fund (UNICEF) provided psychosocial assistance and child friendly corners, Caritas Croatia provided relief items and additional assistance on field operations, Zagreb Islamic Community Mesihat ensured food and recruited Arabic and Farsi speaking volunteers. International Organisation for Migration (IOM) with their expertise on the population movement crises on large scales conducted migration flow surveys, Jesuit refugee Service (JRS) provided interpreters for Arabic and Farsi and assisted in the distribution of food, water, hygiene items and medications, while local NGOs, such as Centre for Peace Studies (CPS) and Society for Psychological Assistance (SPA) provided volunteers and psychosocial support. [1.1,1.2] In the Winter Reception Centre Slavonski Brod the Government established a well organised system for providing humanitarian response and health care for refugees and migrants in transit, which included 20 organisations and around 320 volunteers and staff members.[2.1] National health system employees (physicians, nurses and medical technicians) organised by the Croatian Ministry of Health provided immediate medical services with the support of CRC and Magna. In the case of a more serious medical problem medical staff transported the patients to a nearby hospital in Slavonski Brod with a dedicated ambulance vehicle. Interpreters from various organisations assisted medical personnel during medical interventions in the centre and local hospitals. UNICEF, Save the Children International and Magna were responsible for providing specialised care for children and babies in child friendly spaces and mother-baby areas. UNHCR had a permanent presence in the centre in order to identify people with specific needs or at risk and to refer them to other organisations and services if needed and also provided the majority of non-food necessities.[1.2] CRC and other NGOs (ADRA Croatia, Volunteer Centre Osijek, Volunteer Centre Slavonski Brod, Intereuropean Human Aid Association, JRS, Caritas Croatia, Union of Baptist Churches in Croatia, Samaritan's Purse, CPS, SPA) provided food, water, blankets, raincoats, hygienic kits, specific children supplies and psychosocial support. Considering that the transit centres in Croatia are now closed and that a part of the staff now work in the two Reception Centres for Asylum Seekers in Kutina and Zagreb, in the remaining part of the report we will focus on these, currently active centres.

The primary health care in both reception centres for asylum seekers is provided by a nurse who is a full-time employee of the Ministry of Interior, a general physician (GP) from the local medical health centre (also has a contract with the Ministry of the Interior) and several NGO workers in the helping professions. Nurses in the centres are usually present for eight hours a day, but at the moment they are both on a maternity leave and they have not yet been replaced. The GP in Reception Centre Kutina comes when the centre employees call him (usually 2-3 times a week)[3.1] and the one in Reception Centre Porin provides medical examinations 2 times a week for 4 hours and is also on call for emergency cases.[3.2] According to the GPs working in these centres, the level of medical care currently provided is sufficient considering the number and the severity of health problems of asylum seekers.[3.1,3.2] Besides the medical staff, CRC and JRS have contracts with the Ministry of Interior in both centres which allow them to employ full-time staff working on distribution of necessities and medicines, translation, transportation of people to medical examinations and treatments outside of the centre, organisation of medical records and the provision of psychosocial support.[3.3] In addition, staff and volunteers from the CPS and SPA, although they're not full-time employees, often provide psychological assistance and organise various activities with asylum seekers (workshops, language courses, recreational activities…).[3.4,3.5]

References:

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3.1 Interview with the GP working in Reception Centre for Asylum Seekers Kutina

3.2 Interview with the GP working in Reception Centre for Asylum Seekers Porin

3.3 Interview with occupational therapist (CRC) working in Reception Centre for Asylum Seekers Kutina

3.4 Interview with the volunteer coordinator from the Centre for Peace studies

3.5 Interview with the psychologist from the Society for Psychological Assistance

Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?

As already stated, medical staff at each reception centre for asylum seekers is composed of one nurse working full time and one general practitioner from the local community health clinic who provide medical examinations several times a week.[3.1, 3.2] In addition, one social worker and one occupational therapist from CRC are also working full time in every reception centre and the CRC psychologist comes on a weekly basis.[3.3,3.4,] Finally, SPA teams visit the centres every week to provide counselling and psychosocial support mostly consist of psychologists and interpreters who are specially trained to translate psychological counselling.[3.5]

References:

3.1 Interview with the GP working in Reception Centre for Asylum Seekers Kutina

3.2 Interview with the GP working in Reception Centre for Asylum Seekers Porin

3.3 Interview with the psychologist from CRC

3.4 Interview with the occupational therapist (CRC) working in Reception Centre for Asylum Seekers Kutina

3.5 Interview with the psychologist from the Society for Psychological Assistance

Primary health care staff situation (numbers, capacity, payment, safety, …)? If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

As previously mentioned, the only medical staff available in Reception Centres for Asylum Seekers includes one medical nurse in charge of basic medical care (e.g. monitoring and administering medication, measuring temperature and blood pressure) and a general practitioner who provides primary medical care as necessary. The GP in Reception Centre Porin has a small office in the centre supplied with typical medicines (funded by the Croatian Health Insurance Fund) and he is responsible that the necessary medications are available.[3.1]

The Reception Centre in Kutina has a contract with a local pharmacy so when the GP writes a prescription, the centre puts an official stamp and JRS or CRC workers pick up the necessary medication at the pharmacy whose costs are covered by the Croatian Health Insurance Fund.[3.2] Typical health problems of asylum seekers include common cold and viral infections. There is a small number of patients with chronic diseases, especially in Reception Centre in Kutina (e.g. heart conditions and diabetes). When needed, the GPs refer patients with chronic diseases, acute mental disorders and pregnant women to specialist treatment in community health clinics or hospitals .[3.2] JRC or CRC personnel accompanied by an interpreter (if available) transport them to the hospital and, when possible, cover the costs of specialized medical examinations and treatments, which are not provided by the national insurance.[3.3] Although no paediatricians or other children's health specialists are present in the centre, the GPs refer children to appropriate specialist in the community health clinic or hospital.[3.1] If a medical intervention is needed outside the doctor's working hours and the nurse alone is not able to help, asylum seekers are transported to the nearby hospital and provided with emergency medical help.[3.2] SPA also sees the asylum seekers in need of psychological therapy and counselling in their offices in the centre of the city for free. CRC employees and volunteers as well as psychologists from SPA provide psychosocial support and counselling. Given that asylum seekers are not entitled to dental care, but only tooth extraction, two dentists with private practices in Zagreb provide free dental services to asylum seekers from Porin and Kutina. There is also a general practitioner who works in a county health centre but, as she is not allowed to receive asylum seekers there, they usually meet outside of working hours and a gynaecologist who provides free services mostly to non-pregnant women in her private practice. Unfortunately, primary medical providers who, unlike health personnel working in the reception centres, do not have a contract with the Ministry of Interior are not allowed by the law to provide services to refugees and migrants. However, volunteers in reception centres usually find a way to contact and organise appointments with several external health care providers who volunteer to give free medical examinations and treatments of asylum seekers[3.4]

References:

3.1 Interview with the GP working in Reception Centre for Asylum Seekers Porin
3.2 Interview with the GP working in Reception Centre for Asylum Seekers Kutina
3.3 Interview with the volunteer coordinator from the Centre for Peace studies
3.4 Interview with the volunteer from the Centre for Peace studies

Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?

According to the general practitioner from Reception centre Kutina, all asylum seekers have gone through an initial health screening during their stay in Winter Reception Centre Slavonski Brod and they carry their medical records (in Croatian) with them[3.1]. Because of this, the doctor in Kutina doesn't carry out a thorough medical examination of asylum seekers once they arrive at the centre, but only inquires whether they have some kind of a medical problem or take any medication. The general practitioner from Reception Centre Porin claims that all refugees and migrants in Porin, not only asylum seekers, are offered to take an initial check-up. Although there is no special protocol for initial health screening of asylum seekers, these check-ups usually include a clinical interview about the health status and possible complaints, taking blood pressure

and pulse, mouth and throat inspection and examinations of lung and hearth functions using a stethoscope. He also mentioned that the asylum seekers have had initial health assessment while staying in Slavonski Brod. However, there is no initial assessment nor screening for mental health issues. Also, no recommendations for triage are formalized specifically for asylum seekers.[3.2]

References:
3.1. Interview with the GP working in Reception centre for Asylum Seekers Kutina
3.2. Interview with the GP working in Reception centre for Asylum Seekers Porin

How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?

Some asylum seekers in Kutina and Zagreb speak English well and can mostly communicate on their own. When this is not the case, there are enough interpreters from different organisations that can help asylum seeker communicate their needs, especially during medical examinations which are always done in the presence of an interpreter. According to CRC social worker whom we interviewed, around 30 interpreters are available in Reception Centre Porin only.[3.1] Croatian Ministry of Interior provides official interpreters for various languages free of charge but only during the asylum application procedure or other legal issues. However, CRC and JRC both have unofficial interpreters in their teams who regularly visit the centres Porin and Kutina, although these are mostly people who are fluent in the required languages but not trained for translation. CRC has 6 interpreters (3 for Arabic, 1 for Urdu, Pashto and Farsi)[3.1] and JRS employs 5 native speakers of Arabic and Farsi who have been granted asylum in Croatia few years ago (before the European migrant crisis started) and are now helping in translation and communication with the medical staff. SPA provides 8 interpreters for various languages who are specially trained for interpretation during psychological counselling.[3.2]

References:
3.1 Interview with the social worker from CRC working in Reception centre for Asylum Seekers Porin
3.2 Interview with the psychologist from the Society for Psychological Assistance

Biggest challenges and barriers for primary health care providers?

Although both GPs working in the Reception Centres for Asylum Seekers think that the available medical care in centres is generally sufficient, they point out that the greatest current difficulty is the absence of medical nurses which have still not been replaced.[3.1, 3.2] Another specific issue is that the medical data on the asylum seekers is not entered into an official, national data base such as those of regular Croatian patients. Although CRC keeps some kind of a medical record, this complicates the work of the GPs and prevents establishing continuity of care and easy access to health records that GPs want to have each time they see the same patient.[3.2] In addition, asylum seekers often expect the GPs to help them understand their legal situation, their future and the options they have, even though doctors have no knowledge of it. There are also a number of highly distressed, apathetic or tense individuals in the centre who require help that is outside of the primary domain of work of the GP or a nurse.[3.2] These problems require additional mental health services that are not covered by the national insurance. According to the volunteers from CPS, there are external

health care providers who would like to help asylum seekers free of charges but they are forbidden by the law to do so and they don't have the right of access to the reception centres.[3.3]

3.1. Interview with the GP working in Reception centre for Asylum Seekers Kutina
3.2. Interview with the GP working in Reception centre for Asylum Seekers Porin
3.3 Interview with the volunteer from the Centre for Peace studies

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

According to the people we interviewed, no primary medical care staff among the asylum seekers in reception centres have been identified. However, there is a dentist from Syria in the Reception Centre Porin who consults the GP in the centre when the patients suffer from acute dental conditions.[3.1]

References:
3.1 Interview with the GP working in Reception centre for Asylum Seekers Porin

Conclusions

From the total number of refugees and other migrants that are currently located in Croatia, around 300 have applied for asylum and are located in Reception Centers for Asylum Seekers in Kutina and Zagreb. Families and vulnerable groups are mostly located in Kutina, while Porin currently accommodates different profile of refugees and migrants, including single men and vulnerable individuals, some of which have not applied for asylum (mostly families with children) and are located in the separate part of the reception center. According to country of origin, most refugees and other migrants come from Syria, Iraq and Afghanistan. Reception Centers for Asylum Seekers in Kutina and Zagreb together have the capacity and the necessary staff to accommodate and care for approximately 700 people, which is sufficient only for the current needs. However, due to the Dublin Regulations which state that the member state where the asylum applicant first entered Europe is responsible for its accommodation, there is a possibility that a large number of asylum seekers will be transferred to Croatia from other EU countries. It is unlikely that Croatia's asylum system in its current state will be able to take care for additional asylum seekers. The Croatian Government is therefore preparing for such a scenario, so that two additional reception centers in Tovarnik and Trilj are currently under construction (each with the capacity to receive approximately 100 people.

Residents of both reception centers usually have sufficient access to primary health care which is provided by a nurse who is present in the center for 8 hours a day and a local general medical practitioner who provides service in the center a few times a week. There are a significant number of interpreters for various languages, especially in Porin, who are present during medical examinations, although they are mostly not professionally trained for translation. Psychosocial and logistical support is provided by several NGOs, predominantly CRC and JRS. Currently, a big barrier

to providing continuous health care is the temporary absence of nurses in both centers due to maternity leaves.

Asylum seekers have right to emergency medical care and treatments for chronic conditions but other medical services (e.g. dental care, gynecological examinations, mental health services) are not covered by the national insurance until they're granted asylum.

Although there are a number of external health care providers who seem to be willing to volunteer services, they are limited by the law to do so. Two GPs who have been interviewed consider the level of medical services appropriate and comment that the majority of refugees and migrants in the two reception centers are young and healthy. In this sense they agree that their general health status is better than the rest of their regular, local patients. However, they consider that a large number of refugees and migrants could benefit from psychological assistance.

A5. Country Report Slovenia

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (SLOVENIA) – Version 15/05/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Name of authors Danica Rotar Pavlic, Mateja Žagar, Alem Maksuti, Eva Vičič, Erika Zelko

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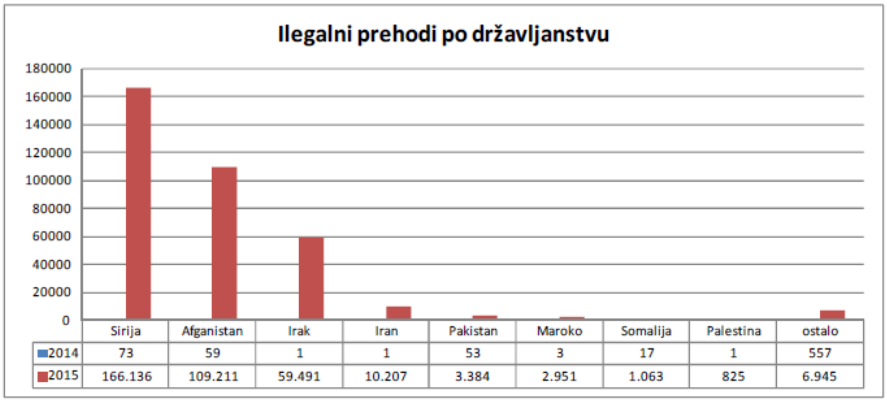
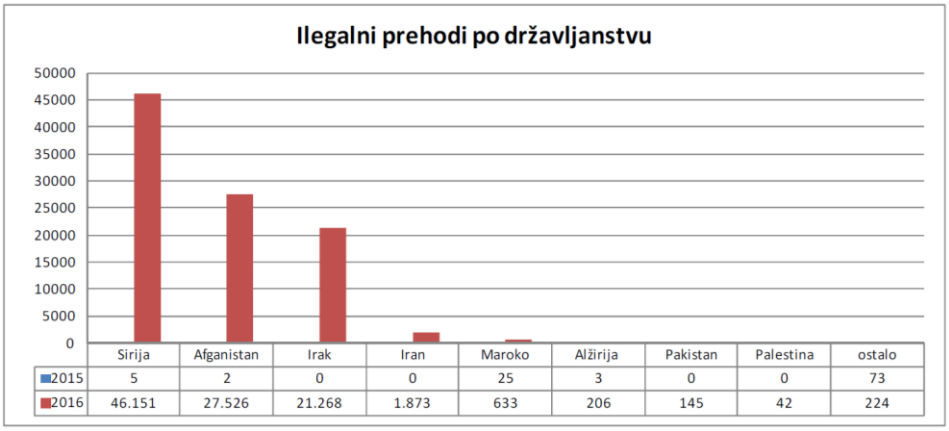
Results

The situation should be described like it is at the moment (March/April 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)? ○ **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**
Over the last year, the work was mainly dictated by the intensified security situation caused by masses of migrants entering Slovenia. It appears that the situation, which Slovenia has so far managed with great efforts, began to ease. Table 1: Number of refugees to Slovenia by country of origin, 1.1.2015-31.12.2015    It could be seen that Slovenia was a country which 360.213 migrants reached in the year 2015. Data about the migration flow from 1st of January till 31. March 2016 are presented in table 2. Table 2: Number of illegal migrants to Slovenia by country of origin, 1.1.2016-31.3.2016

	Sirija	Afganistan	Irak	Iran	Pakistan	Maroko	Somalija	Palestina	ostalo
2014	73	59	1	1	53	3	17	1	557
2015	166.136	109.211	59.491	10.207	3.384	2.951	1.063	825	6.945

(obdobje od 1.1. do 31.3.2016)



	Sirija	Afganistan	Irak	Iran	Maroko	Alžirija	Pakistan	Palestina	ostalo
2015	5	2	0	0	25	3	0	0	73
2016	46.151	27.526	21.268	1.873	633	206	145	42	224

Slovenia has been doing its best to ensure that the entrance of migrants is effectively directed, controlled and coordinated with the neighbouring security authorities. Only in this way, we can, in fact, manage the security situation, provide appropriate care to migrants and ensure the safety of both migrants and residents of Slovenia. Unannounced, disorganised and uncontrolled arrivals of large groups of migrants outside the designated entry points were creating significant security and logistics problems since we didn't want the migrants to spend hours waiting out in the cold and rain without protection. Our capacities allowed to daily receiving, in an organised and orderly way, between 2,000 and 25,000 migrants and new groups could enter only after previous groups left for Austria. We would like to draw the attention to the fact that already upon arrival in Slovenia a large number of migrants were in 'bad shape' since previous countries did not ensure optimal care to them. Therefore, they had first be provided with food, clothes, accommodation, and, where needed, medical assistance.

Reference: http://www.policija.si/index.php/statistika/mejna-problematika/622

At the end of March 2016 Slovenia closed a temporary accommodation center in Vrhnika. On Monday 21. 3. 2016 at 19.00 last migrants left temporary accommodation center in Vrhnika. The statistics about migrants settled in the center of Vrhnika is as follows:

- On Thursday 17. 3. 2016 at 10:00 9 migrants (family) accommodated including 2 women, 3 men and 4 children.
- On Wednesday 16. 3. 2016 at 14:00 12 migrants (family) accommodated including 4 men, 3 women and 5 children.
- On Tuesday, 15. 3. 2016 at 8:00 am 11 migrants accommodated. At 12:30 pm 5 left center. On Monday 14. 3. 2016 at 8:45 Vrhnika 13 migrants accommodated. At 11.30 they 11 migrants left.
- On Sunday 13. 3. 2016 at 14:00 33 migrants accommodated, 10 men, 10 women and 13 children, respectively. 25 citizens of Syria, 6 citizens of Afghanistan and two Iraqi citizens.
- On Saturday 12. 3. 2016 at 14:00 43 migrants accommodated, of which 16 men, 12 women and 15 children.
- On Friday 11. 3. 2016 at 19:00 52 migrants accommodated, of which 18 men, 15 women and 19 children.
- On Thursday 10. 3. 2016 at 17:40 52 migrants accommodated of which 18 men, 15 women and 19 children.

- On Wednesday 9 3 2016 at 10:00 am 68 migrants accommodated, of which 15 women, 30 children and 23 men.
- On Tuesday, 8. 3. 2016 at 18:00 82 migrants accommodated, including 20 women, 40 children and 22 men. Most of them are citizens of Syria, Afghanistan, 4 are from Iraq .
- 6. 3. 2016: 93 migrants accommodated; 42 children 17 men and 24 women.
- On Saturday, 5. 3. 2016 at 11:00 107 migrants accommodated.
- On Friday, 4. 3. 2016 at 18:00 121 migrants accommodated. According to data published on Friday www.policija.si at 6:00 pm in Vrhnika there were 135 migrants.
- On Thursday 3. 3. 2016 at 18:00 there were 135 migrants. According to data published on Thursday www.policija.si 3. 3. 2016 at 6:00 pm in Vrhnika were 117 migrants.
- On Wednesday, 2. 3. 2016 at 8:00 am 128 migrants accommodated. According to data published on Wednesday www.policija.si 2. 3. 2016 at 6:00 pm in Vrhnika were 144 migrants.
- On Tuesday, 1. 3. 2016 at 18:00 143 migrants accommodated.
- On Monday, 29. 2. 2016 at 18:00 141 migrants accommodated.
- On Monday, 29. 2. 2016 at 8:30 am 125 migrants accommodated.
- 28. 2. 2016 at 18:20 129 migrants accommodated.
- On Saturday 27 2nd 2016 133 migrants accommodated.
- On Thursday 25. 2. 2016 84 migrants were accommodated. At 16.00 there were transported another 49 migrants from home for foreigners in Postojna, who were in the process of removal from the country. Emergency health care team treated 8 migrants with different problems, two of them were referred to further treatment in hospital.

Reference: http://www.vrhnika.si/?m=news&id=16034

Current situation:

Place	Type of centre	Number of people
Asylum Home in Ljubljana (AH LJ)	Accommodation	189
Kotnikova-part of AH LJ	Accommodation	63
Logatec – part of AH LJ	Accommodation	29
Youth Crisis Centre	Accommodation	10
Private flats and houses	Accommodation	11
Foreigners Centre in Postojna	Accommodation	38

Total Number	340

On 11 May 2016, there are 340 migrants on subsidiary protection in Slovenia.

Table 3: Number of migrants housed in the Centre for Foreigners (CT) and the Asylum Home (AD) and their branches

Reference: http://www.policija.si/index.php/component/content/article/35-sporocila-za-javnost/84145-tevilo-migrantov-nastanjenih-v-sloveniji-podatek-za-11-maj-2016

European relocation plan: The first 10 asylum seekers will be transferred to Slovenia in the coming days

Slovenia will be part of a plan transfer of 567 refugees in the coming days most of these will be men from Eritrea. The Secretary of State in the Ministry of the Interior Bostjan Šefic said "The Italian colleagues are already very far. I'm counting to ten, fourteen days, this group of ten people will come from Italy to Slovenia," he said.
Most of the Eritreans, mainly men, among them also claimed to be a woman.
"In Greece, we already send basic parameters, but from there we do not have all the answers. For Greece this moment difficult to tell the exact date," he commented a relation with Greece, where Slovenia is sending material assistance. Slovenia is committed to take 567 people from the relocation project, and 20 of the project of permanent migration, in addition to compliance with the agreement between the EU-eat and Turkey is drafting a new mechanism. The Slovenian Press Agency reported that there were, only 17 applications for asylum in January were in February there were already 270 and in April 350, what was the reason for exceeding the accommodation capacity of the asylum home. It was for this reason that the government decided to establish two branches of asylum in Kotnikova in Ljubljana and Logatec. On April 13 th , in Slovenia was 350 asylum applicants, among them 90 children. In 2015 were 385 asylum applicants (90 Syrian, 75 from Afghanistan, 25 from Pakistan, 20 from Iran, 20 from Kosovo and 15 other) in Slovenia and 44 of them became a asylum in our country.

References:

http://www.policija.si/index.php/statistika/mejna-problematika/622

http://www.vrhnika.si/?m=news&id=16034

http://www.policija.si/index.php/component/content/article/35-sporocila-za-javnost/84145-tevilo-migrantov-nastanjenih-v-sloveniji-podatek-za-11-maj-2016
http://www.rtvslo.si/begunska-kriza/prvih-10-prosilcev-za-azil-bo-v-slovenijo-premescenih-v-prihodnjih-dneh/390496,
siol.net/.../slovenija/slovenija-v-stevilkah-koliko-tujcev-koliko-prosilcev-za-azil-kolik...

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

Main countries where refugees and other migrants come from?

Most transit refuges in Slovenia (1.1- 31.3.2016) were from Answer: use as much space as necessary

Syria (47%), Afghanistan (28.3%), Iraq (21.6%), Iran (1.9%), Pakistan (0.14%), Morocco (0.6%), Algeria (0.2%), Palestine(0,04%) and 0.22% others.

Reference: http://www.policija.si/index.php/statistika/mejna-problematika/622

160429_002 Interview:
"Most of them were from Syria, some were also Iraqis, from Afghanistan."

160505_001 Interview:
"The first wave was more varied. Most of them were, of course, Syrians and Pakistanis but included others, such as from the countries of North Africa, Lebanon. Some children were, so they say, born in Lebanon in refugee camps. Mainly Syria and Pakistan. In the second wave only from Syria and Pakistan."

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible (4) Result from participatory observations
What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?
With various solutions and, in cooperation with local communities, the Police and the Ministry of the Interior addressed the problems caused by the arrivals of a large number of migrants to the Slovenian residents of places situated near the border crossings and accommodation and reception centres. At Šentilj, an emergency makeshift railway platform was set up for the arriving migrants to get off the train in the immediate vicinity of the overburdened Šentilj accommodation centre and avoid crossing the settlement itself. The accommodation centre in Šentilj, the point of exit from Slovenia with the heaviest refugee traffic, has up to 7000 people passing through it each day. According to the staff running the centre, all the people accommodated there were/are well taken care of. Some 160 to 200 people are caring for the refugees at the centre each day, not counting members of the police. The refugee reception procedure is conducted by the police with the support of the Armed Forces and at least one Arabic, Kurdish and Iraqi interpreter was assisting at all times. The tents were/are heated and have wooden floors. In addition to a total of 2,000 beds, refugees could also make use of shower facilities. A regular routine has been established at the centre; refugees were/are provided with all the necessary care, and once the tents are vacated, they are thoroughly cleaned. There are adequate supplies of food to ensure that no refugee goes hungry. Four thousand hot meals are cooked each day at lunchtime, normally pork-free. If possible, everyone is provided with three meals. Refugees are also given medical care at the centre. During the day, regular medical teams, each comprising a physician and two nurses, are assisted by volunteers, whose ranks include paediatricians and infectious disease specialists. Together, they are able to examine 100 to 150 people in eight hours. The most common medical issues are respiratory infections, diarrhoea and colds, along with frequent reports of fatigue and aggravated chronic conditions. Since most patients can be treated on site, transportation to hospitals is not needed. The situation is manageable. Refugees' families are often separated along the way, mainly because women with children are frequently given priority, causing the men to be left behind. A vital role in reuniting them is played by the Slovenian Red Cross, who are doing their best to find missing family members in other countries in collaboration with partner organisations. They receive 40 to 50 new cases every day and have been very successful in resolving them. Food and clothing is distributed by volunteers, who work in two shifts, with a night shift soon to be introduced. Each shift has around 20 volunteers, most of them regulars. Every new volunteer is first familiarised with the work and briefed on the rules they need to follow. There are adequate supplies at the moment, as they are constantly replenished, the only exception currently being men's shoes.

Photo: Tents in accomodation transit center Šentilj

Reference: http://reliefweb.int/report/slovenia/care-and-treatment-refugees-accommodation-centre-entilj At Dobova the migrants were arriving by a Croatian train first underwent the security check at the Dobova railway station, were they also received medical assistance. Then, they boarded the Slovenian train and were transferred to accommodations centres, where they underwent the registration procedure; with a view to simplifying and speeding up the registration of migrants, some technical improvements have been introduced, such as e-application, which enables fast entry of personal data into the police records; the procedure also includes the taking of fingerprints and photographs. The number of registration points has also been increased. The camp of Dobova is the major and only camp at the border of Croatia. It is close to the train station where the trains from Croatia are arriving and the refugees are transferred to the authority of the Slovenian government. Recently, the camp was enlarged with new tents for food distribution and sanitation, and the floor was concreted to avoid mud and flood. On Thursday 19. november 2015 about 2000 refugees were expected to transit through Dobova (camp). When the refugees arrived at Dobova station, they were separated in two groups in order for the police to proceed with the registration. The first one was going to the camp Livarna in Dobova, while the other group remained at the train station. Registration included identity controls and issuing of “permission to remain” on the Slovenian territory. After registration, refugees were transferred to other camps in Slovenia (mainly Šentilj, or they were taken by train through Jesenice to Austria). The general situation in the camp was good. Food distribution was done efficiently, but water bottles could also be distributed when refugees are leaving the camp. Refugees were first given food and water when they were arriving into the camp, before going to the registration procedure. After registration, they could rest and eat in one of the heated tents. Sanitation in Dobova: Sanitations (toilets, water valves and sinks) were installed inside of two tents in the camp. Restoring Families Link in Dobova: The Red Cross RFL was providing wifi and hotspot signal for refugees who were searching for their family members. They could connect to internet in order to communicate and transmit information about their location to their family members. However, this service was available just for the persons who were searching for their family at the RFL container and not as a general service for the whole camp. Lack of translators and doctors in Dobova: Sometimes there was just one doctor and one translator for Arabic available per shift. It means that when the refugees were arriving at the camp, the medical tent was saturated with requests. Many refugees did not have time to see a doctor before leaving the camp. The

translator could not come to help the medical staff with translation as he was constantly needed at the registration.

Photo: Dobova transit center

Reference: http://www.mirovni-institut.si/en/report-from-dobova-2/

Refugees who apply for international protection or asylum in Slovenia are transported in receiving asylum home, where there are also health controls, carry out the entire procedure for obtaining asylum and the favorable settlement of such persons housed in asylum centers. The majority of refugees only transit, so most of refugees do not apply for international protection (asylum).
Persons who cannot be returned and who do not apply for asylum can apply for a 6-month permit of the retention in Slovenia. They are provided with accommodation and basic care in accommodation centers. Those persons whose return to the neighbor or the country of origin can temporarily stay in the centers for foreigners.
Slovenia has 3 asylum homes/centres (2 in Ljubljana, 1 in Logatec) and one national Centre for foreigners in Postojna. 342 migrants were accommodated on in these centers on 28 April 2016. There were 10 young people accommodated at Youth Crisis Centre.
Table 3: Number of migrants housed in the Centre for Foreigners (CT) and the Asylum Home (AD) and their branches in April 2016.

Place	Type of centre	Number of people
Asylum Home in Ljubljana (AH LJ)	Accommodation	187
Kotnikova-part of AH LJ	Accommodation	65
Logatec – part of AH LJ	Accommodation	29
Youth Crisis Centre	Accommodation	10
Private flats and houses	Accommodation	11

Foreigners Centre in Postojna	Accommodation	40
Total Number		342

Asylum Home Ljubljana is located on the southwestern edge of Ljubljana on the road Cesta v Gorice 15. Accommodation of the Asylum Home is composed of following divisions: for families, for single men, unaccompanied minors, for single women, persons with disabilities. Total number of possible accommodation is 203 persons. The asylum home daily organise diverse activities such as: Slovene and English courses, sports activities, creative workshops for children and adults, excursions and visits to interesting places in Slovenia, computer courses, photography courses, editing of internal magazine Voice of asylum etc. They carried out by the psycho-social service of the Asylum Home and various NGOs as a rule through the programs co-financed by the European Refugee Fund (ERF).

Because of the needs of asylum seekers and the Government of the Republic of Slovenia 22 April 2016 adopted a resolution on the establishment of two new branches asylum home Ljubljana. The two new branches are in a home for single people on Kotnikova in Ljubljana and Training Centre for Civil Protection and Disaster Logatec. There were 342 asylum seekers in all asylum homes in April 2016. 10 young asylum seekers are accommodated in a crisis center for young people, which is not part of asylum home.

The Centre for Foreigners in Postojna is intended for foreigners who are illegally staying in the Republic of Slovenia, namely the following: foreigners who have failed to depart from the country within a specified period and who cannot be removed immediately; foreigners whose identity has not been established; foreigners for whom expulsion has been ordered; unaccompanied minor foreigners; foreigners who are staying illegally in Slovenia and are awaiting extradition to foreign law enforcement on the basis of a bilateral agreement; foreigners who are to be deported; and foreigners who have not departed from the country and reapplied for international protection. The Centre also provides accommodation for applicants for international protection who have been issued with either a decision restricting their freedom of movement in line with the International Protection Act or a decision based on a Council Regulation (EC). The Centre for Foreigners provides basic care for foreigners in respect of their religious and cultural habits, healthcare services and psychosocial care. In this context the Centre works hand in hand with healthcare providers, the National Institute of Public Health, the Sanitary Inspectorate, non-governmental organisations, other authorities and organizations, Slovenian embassies, foreign law enforcement agencies and international institutions.Foreigners have visiting rights in accordance with the rules on residing at

the Centre. Visits are allowed to relatives, friends, acquaintances and other persons wanting to visit them. Visits are also paid by NGOs performing voluntary work or providing legal aid (e.g. PIC) and by the International Organization for Migration. Read more about the Centre for Foreigners: http://www.policija.si/index.php/delovna-podroja/mejne-zadeve-in-tujci/241

What is the procedure for minors?
First, a minor is subject to procedure under the *Protocol on cooperation between social work centres and the Police in providing assistance to unaccompanied foreign minors*: According to the Aliens Act, a foreign minor who is not accompanied by his parents or a legal representative may not be deported to his country of origin or a third country which is willing to accept him until reception is ensured for him there. Prior to deporting a foreign minor, it needs to be ascertained that he will be returned to a member of his family, a nominated guardian or adequate reception facilities in the country of return. Prior to deporting an unaccompanied foreign minor, the police must immediately inform a social work centre, which must immediately assign a special case guardian to the foreign minor. The police may deport a foreign minor only after the special case guardian, having carefully considered all circumstances, establishes that this is in the best interest of the foreign minor. Article 82 of the Aliens Act also stipulates that a foreign minor must be accommodated, in agreement with a guardian for special case, at adequate accommodation facilities for minors, where he is guaranteed all the rights and freedoms laid down in conventions and in the Protocol on cooperation between social work centres and the Police in providing assistance to unaccompanied foreign minors. On apprehending an unaccompanied minor who illegally entered the country or has resided in the country illegally, the police station immediately notifies the territorially competent social work centre during their opening hours. If a foreign minor has been travelling for a long time with a group with people he personally knows (neighbour, second degree of kinship), he is considered accompanied. Outside opening hours (afternoon, night, Saturday, Sunday and holidays), the police station notifies the intervention social work service that covers the area of the police station and requests the cooperation of a social worker. The social work centre is briefly informed of the current findings, the condition of the unaccompanied foreign minor and of the planned action. Then the social work centre appoints a social worker and immediately sends him to the police station. The social worker conducts an interview with the foreign minor, provides him with the first social aid and acquires his statement on assigning a special case guardian. Where necessary, the social worker accompanies the foreign minor in his transfer to the adequate accommodation facilities.

According to the aforementioned Protocol, such a person is subject to special treatment (the processing of unaccompanied minors). But he has every right to express his intention to apply for international protection. We observed that most minors have a good command of the English language. In the event of problems in communication, official interpreters are provided. The age of minors is determined on the basis of the submitted identification documents (passport) or other documents they have, as well as on the basis of data a minor provides to the Police. Physiognomy recognition (age comparison) is also carried out. If a person is presumed to be a minor, actions to his benefit are taken in compliance with the Protocol. The length of procedures of establishing data authenticity may vary considerably. It depends on whether the minor has a document that can be used to verify data authenticity (officially issued documents) or not. If the minor does not have such a document, the procedure of establishing data authenticity is longer. There are also cases where the identity cannot be established as data cannot be verified in the country of origin (the reasons may include war or no concluded agreement on data exchange or cooperation). In any case, the foreign minor is accompanied by a social worker, who offers psychosocial assistance at all times.

Photo: The branch of asylum home in Logatec

Photo: The asylum home Ljubljana

At the end of March 2016 Slovenia closed a temporary accommodation center in Vrhnika. On Monday 21. 3. 2016 at 19.00 last migrants left temporary accommodation center in Vrhnika.

Reference: http://www.policija.si/index.php/component/content/article/35-sporocila-za-javnost/83923-tevilo-migrantov-nastanjenih-v-sloveniji

http://www.vrhnika.si/?m=news&id=16034

http://www.mnz.gov.si/si/mnz_za_vas/tujci_v_sloveniji/mednarodna_zascita_azil/azilni_dom/

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be “detention centres”, immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)

Table 4: **Total Capacity of beds in Accommodations and Asylum homes (AH) in Slovenia**

Place	Type of Centre	Number of beds
Šentilj	Accommodation	4152
Dobova	Reception and Accommodation	4000
AH Ljubljana	Accommodation for Asylum seekers	203
AH LJ Kotnikova	Accommodation for Asylum seekers	90
Logatec	Accommodation	220

Postojna	Accommodations for foreigners and asylum seekers	50
Total		8715

The first group of migrants reached the Logatec Accommodation Centre on 19th September 2015. The five buses brought 131 people, mostly citizens of Syria, Iraq, Afghanistan, Lebanon and Somalia. **Health Centre Logatec** was informed about the upcoming group of refugees a few hours before the arrival of the first bus. Some health workers from HC Logatec come back from their homes outside their working hours and prepared appropriate protective equipment, medicines, dressings, instruments and other medical devices and appliances for which they assumed that they will need. Health workers were immediately ready for work with so far unknown population. The teams of GPs included the pediatrician, who took over the medical care of children. Refugees were helped by a Slovenian citizen, Syirian by origine, who has long been living in Slovenia. At the arrival the staff gave instructions to refugees concerning the place of accommodation and they presented the possibilities offered by the accommodation center. This was followed by a medical examination of all incoming refugees. Support was given to those who need medical assistance. People were then assigned to rooms and staff invited them to have a hot meal. Within a few hours all the incoming refugees were offered appropriate clothing and provision of medical and psychological assistance. Refugees stayed the Logatec Accommodation Centre all the night. In the morning, soon after breakfast there left complex and went to the station to continue their journey.

By each new arrival of refugee groups Health workers from HC Logatec involved in the process of supplying migrants gained new experiences. Health Centre in Logatec established a well-functioning system of organized health care of migrants. 10 Gps, nurses and paramedics who already regularly work on call had been prepared to accept the increased workload. Health Centre organized a permanent medical standby from September to December 2015. Notifications regarding possible new influx of migrants were given by the Civil Protection administration twice a day. In the case of the announced arrival of a new group a team of GPs on call, along with the nurse or technician went to the accommodation center and then inspected all incoming refugees.

The Ministry of Health was regularly sending new directions on admission and medical treatment of migrants.

References:

Accommodation center in Logatec is an example of good practice in cooperation with the local community. Department of Defense. Media center. Available at http://www.mo.gov.si/nc/si/medijsko_sredisce/novica/article/12332/7526/ Date: 04/30/2016

Refugees: According to Postojna in Logatec. Inner Sky News. Available 04/30/2016 at:http://notranjskoprimorske.si/2015/09/begunci-po-postojni-aktiviran-tudi-logatec-v-pricakovanju-dveh-avtobusov-najranljivejsih/

The first accommodation highlight the Asylum Centre in Logatec. Logatec. Available 05.01.2016at:http://logatec.si/index.php/homepage/migranti/4641-prva-nastanitev-v-izpostavi-azilnega-doma-v-logatcu-7-3-2016

In Logatec peaceful, immigrants are slowly integrated into the local environment. Portal of RTV Slovenia. Available 05/01/2015 at:http://www.rtvslo.si/begunska-kriza/v-logatcu-mirno-prebezniki-se-pocasi-vkljucujejo-v-tamkajsnje-okolje/388388

160501_004 Interview (Dobova) »At the beginning, approximately one week, we operate two technicians without a doctor on site. The police have not yet had established dispensaries. We work without doctors at the beginning. We did what was within our competence. “Load ang go” system. Then the system slowly began to develop and different doctors have come, we have had some volunteers like Doctors without Borders. We worked well with them. They came from different places, from different areas of family medicine specialists, internists, pediatricians, and some were also surgeons. But we would need more paediatricians. We had a good pediatrician who was trainee from Ljubljana – she has worked with us for one week continuously. Then we called around ... if anyone knew any doctor, he called him, if she or he can come to help. We did not have any psychiatrist. We would have to go to a psychiatrist because we were quite tired. There was no one who would deal with them via social care. We did not have any protocols at the beginning. Nothing. I, too, personally, I repeatedly called on the Ministry of Health and talked to them - they did not believe that such a situation. For all we used our own cars. We did a lot of kilometers.”

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

(4) Result from participatory observations

How is Primary Health Care provided in your country in general?

Health care in Slovenia is funded by a mix of public and private spending. The public sector is the primary source of health care funding. On average across EU countries, three-quarters of all health care spending was publicly funded in 2012. Slovenia's health system is funded by compulsory health insurance for everyone meeting statutory requirements, by state revenues, voluntary health insurance, and out-of-pocket spending.

The delivery of PC is organized in health care centers and health stations and independent contractors, so called concessionaires.. Health care personnel involved in PC include Family Practice (FPs)/ General Practice (GPs), primary gynecologists, and pediatricians, specialists in occupational medicine, and nurses with diploma in model practices. There are pomologists in some health centers . FPs in Slovenia act as "gatekeepers," controlling access to secondary services. Patients must choose their own personal FPs, who is responsible for providing PC for their patients, including emergency care 24 hours a day provided by physicians working in rotation outside regular office hours. This requirement has had a great impact on both the quality and cost of health care. Most first-patient contacts are made by FPs, and continued good access is of the utmost importance. Low or unequal access results in low patient satisfaction. Previous studies have examined several factors affecting access: having a relationship with a PC source with characteristics of a medical center, the availability of timely and/or easy phone access, after-hours care, physician knowledge of the patient's medical history, adequate time allotted to consultation, the attitude on the phone of the doctor's assistant, patient opinion of FP treatment, waiting time, the ability to obtain an outpatient appointment for the same or following day, time spent in the waiting room, and seeing the same FP most of the time.

There are 7,153 physicians registered with the Medical Chamber of Slovenia. At the primary level, there are 1,057 FPs working at health centers and around 343 FPs in the form of independent contractors. The Health Insurance Institute of Slovenia (HIIS) concluded contracts with 1,784 providers: 224 public institutions and 1,560 concession-holders in 2011. The number of contractors fell by six in 2011 compared with 2010.

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Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

Slovenia have ensured that the migrants get the medical care that is provided by the medical teams in the reception and accommodation canters. This has been organized in cooperation with the health canters from individual regions. The coordination on the ground is in the hands of health canters closest to the reception canters; if necessary, other health canters in the vicinity are set in motion. Representatives of the Slovenian and Hungarian Caritas, volunteer health professionals and Doctors Without Borders are also engaged in providing medical care to the migrants on the ground. The head of a reception centre informs the nearest health centre about the arrival of the migrants. If it is not possible to assemble a medical team of professionals on regular duty or volunteer doctors, such a team is sent to the reception centre by the head of the emergency medical service. All persons who are assessed to urgently need medical help are examined. If there is a suspicion of any contagious disease among the migrants, the Epidemiological Service of the National Public Health Institute is activated. Migrants from the reception canters who are in need of emergency treatment in a healthcare institution are accompanied there by the medical staff. The health care workers attend to the reception centers always wen a new contingent of refuges was arriving the point and stayed there 2 to 8 hours. At the accommodation canters were the healt care providers present according the number of migrants there (Šentilj and Dobova 24 hours; Gornja Radgona and Lendava 4 hours per day and later on call if they were needed; Logatec and Vrhnika on call) If the staff was on call they manage the work additionally to their usual workload, but at the places were the hours were fix the work every day at the fix hours and were extra paid for their work in the receptions or accommodations canters.

Reference: http://www.policija.si/eng/index.php/component/content/article/13-news/1753-police-work-during-the-intensified-security-situation-caused-by-the-escalating-migrant-crisis-in-recent-weeks-explanations-and-answers

Different health workers had difference experiences. Some of them have witnessed good organization of work without problems with necessary equipment and logistics, while others mentioned inadequate organization and problems with medical equipment and other supplies. Here are two completely different experiences: "*My impression is the camp as a whole functioned perfectly and was very well organized, all services. I would say everything was perfect, as far as possible*" (HW6); "*In the camp health care was not adequately provided". There was something but definitely not enough for routine care standard for refugees, as we know it today*" (HW2).

160505_001 Interview (Vrhnika): "The Ministry of Health - when he came the first migrant wave - ordered the directors of the local health centers to organize the entire primary health care for refugees. This includes urgent medical care, the implementation of emergency medical aid and a continuing everyday health care. Which organizations were therefore involved: Health center Vrhnika. Then wen called neighboring health centers from our region, including the Health Centre and Ljubljana University Medical Centre. From civil organizations they were involved mainly the Slovenian Red Cross, Association of Fire Fighters Vrhnika and Caritas. In principle, we need two teams per day, this means two doctors and two nurses. We helped you with volunteers, including specialists pediatrics and trainees, who entered into our system as an additional physicians. We had an extended network. Mostly they were doctors and nurses from our health center, as well as dealers in our region, then we become a matter of expanding to other health centers. Figures I would not be able to tell. Probably it was a network of 40 people."

160501_004 Interview (Dobova) »At the beginning, approximately one week, we operate two technicians without a doctor on site. The police have not yet had established dispensaries. We work without doctors at the beginning. We did what was within our competence. "Load ang go" system. Then the system slowly began to develop and different doctors have come, we have had some volunteers like Doctors without Borders. We worked well with them. They came from different places, from different areas of family medicine specialists, internists, pediatricians, and some were also surgeons. But we would need more paediatricians. We had a good pediatrician who was trainee from Ljubljana – she has worked with us for one week continuously. Then we called around ... if anyone knew any doctor, he called him, if she or he can come to help. We did not have any psychiatrist. We would have to go to a psychiatrist because we were quite tired. There was no one who would deal with them via social care. We did not have any protocols at the beginning. Nothing. I, too, personally, I repeatedly called on the Ministry of Health and talked to them - they did not believe that such a situation. For all we used our own cars. We did a lot of kilometers."

160505_001 Interview (Vrhnika): We are providing primary health care 24 hours a day, but for this there was no need. Realistically speaking, there was no need. Our way of working was that we have adapted to the needs that stand out on the ground. We referred seriously ill patients to the clinical center in Ljubljana. Some children were hospitalized at the Clinic of Infectious Diseases because they were so dehydrated that otherwise would not survive. One of the children had a much osteosynthesis material inserted in the leg, which was damaged in the war. The child had wires in the leg for 7 months – this osteosintetic material should be removed after one or two months ... We

then arranged together with pediatrics and trauma specialists that they removed osteosintetic material. The child was a few days in the hospital, then returned back to the accommodation center. For refugees we have provided the same level of care as for our residents. As if they were our residents ... if they had to be moved to a secondary or tertiary level, they get referrals. **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?
ATŠ interview (Logatec): "The Health Care Centre in Logatec established a well-functioning system of organized health care of migrants. Ten family doctors, nurses and paramedics who already regularly work in the call had been prepared to accept the increased workload, so the Health Centre Logatec from September to December 2015 organized a permanent medical standby. Notifications regarding possible new influx of migrants were received from the Civil Protection administration twice a day. In the case of the announced arrival of migrants a new group of doctors on call, along with the nurse or technician went to the accommodation center and then inspected all incoming refugees." The organisation shema of other centres is described in other part of the report. 160505_001 (Vrhnika) Interview: "GPs took over the entire health care refugee center, which meant that we had to provide medical care. In the first wave, especially for emergencies, in the second wave as well as a continuous treatment with prevention included. In the first migrant wave there was a day from 300 to more than 1000 (I think it was more than in 1100), the second migrant wave is approximately 150 refugees. They are the ones who have been staying for three weeks respectively. On average, we had somewhere between 15 to 20 medical treatments per day in the first wave, when there were very large, as well as 120 in one day. Given that we receive mostly families with children and the elderly, almost one third of children. According to sex but hard to say." References: (1) Report/Publication: Authors, year, name of report/article, link if possible (2) Web based report/article: Title, Link (3) Result from interviews, also quotes are possible (4) Result from participatory observations

Primary health care staff situation (numbers, capacity, payment, safety, …)?

If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

Centre	**Staff**	**Hours of health care providers presenc**
Dobova	GP and nurse, paramedics, Red Cross workers,interpreters	24
Vrhnika	GP, nurse, pediatrician, psychologist, interpreters	24 in of call commbination
Ljubljana	GP, nurse, emergency medicine, psychologist, interpreters	24 in of call commbination
Šentilj	GP and nurse, paramedics, Mobile Czech Republic Military Hospital, Red Cross workers, interpreters	24
Gornja Radgona	GP and nurse, paramedics, pediatrician, Red Cross workers, interpreters	4 every day
Lendava	GP and nurse, paramedics, Red Cross workers, interpreters	2-4 at the arrival time of refuges and every day on call if there were people at the centre
Postojna	GP and nurse, paramedics, interpreters	24 in commbination of call
Logatec	GP and nurse, paramedics, social workers, interpreters	24 in commbination of call

160501_002 Interview (Dobova):« If the health care team has to go on the field or in a case that there was only a team from the Red Cross – they always had phone numbers of doctors and nurses and they can call. But there was always one of the health technicians stayed in the center, we did not leave nonmedical staff alone. Regardless of external experts, we had a lot of Médecins Sans Frontières, a lot of doctors from other places from Slovenia came to help us. Voluntarily, really a lot of doctors." **References:** **(1) Report/Publication: Authors, year, name of report/article, link if possible** **(2) Web based report/article: Title, Link** **(3) Result from interviews, also quotes are possible** **(4) Result from participatory observations**
Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
ATS Interview (Logatec): "There is no initial health assessment for persons who applied for asylum. February 2016, the Government of the Republic of Slovenia due to the increased number of applicants for international protection activated contingent plan and as a branch of the asylum home also providing complex in Logatec. Eearly in March 2016 Logatec accepted the first 5 families. At the end of April 29 refugees were accommodated in an asylum home Logatec. They feel good, some of them have in the vicinity of the complex arranged garden plots, school-age children are already involved in a local primary school and is already starting to learn the Slovenian language. Health care is organised in the health center Logatec. When they need medical help, the head asylum home announce their arrival to medical personnel in Health Center Logatec. Social workers from the asylum home accompany the ill person to the medical center, where, if necessary, over the phone they contact the translator and thus agree on health issues and guidelines for treatment." References: (1) Report/Publication: Authors, year, name of report/article, link if possible (2) Web based report/article: Title, Link (3) Result from interviews, also quotes are possible (4) Result from participatory observations
How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators? **In every place (reception, accommodation) are present the translators, but not the cultural mediators or intrepreters.**

160508_002 Interview (Logatec): »Communication. Sometimes it has been difficult to explain where the dining room is, to translate what hurts and how. In principle, it was interesting, because the young or. minor were able to speak English much better than the older, including for example persons of 25 plus. So minors they also help with the translation. The main problem was the communication."
160429_002 Interview (Dobova): »The biggest challenge and thus an obstacle is because a refugee does not understand. In a case if a refugee does not speak English or speak very badly, and you are in situation that currently you do not have a translator available. It's really challenging because you do not know what and how to help him."

160501_005 interview (Dobova):«In the refugee camps the availability of interpreters and mediators was very scarce at the very beginning. With time, when things were more organized it was better. UNHCR, the Organization for Refugees United Nations High Commissioner for Refugees provided interpreters. They provide a lot of translators. In principle, they were primarily planned to help in police operations and people seeking asylum, to inform them. But they were also constantly available for health care. When there were large numbers of refugees - refugees themselves helped us if they were able to speak English. At the beginning, definitely a shortage of interpreters."
After the begging's problems with interpreters (lack of them), were later in every place the interpreters present, but not always in the appropriate number they were needed.

References:

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Biggest challenges and barriers for primary health care providers?

In our research we identified four problem areas: communication (language barriers); refugees' social deprivation and traumatic occurrences; negative attitudes among health workers and refugees; and cultural differences. Those categories are broad and comprehensive, and they include different problems we recognized though coding interviews.

Probably the biggest and most common were communication problems. Data obtained in some of the previous studies (e.g. 3) indicated that language barrier is a biggest obstacle for comprehensive health service provision for refugees. Our study showed that making a diagnosis, due to language difficulties, was real challenge for health workers. The latter were in permanent stress due to incomplete communication and possible wrong diagnosis or misidentified treatment of refugees that needed health service provisions.

Some interviewees outlined translators while other used different techniques to communicate with refugees. Present translators were mostly volunteers, which means health workers did not have translator as an integral part of their medical team. In that context some interviewees engaged "*Google translate and tried to pronounce some Arabic words*" (HW 6), other have tried to improvise and use "*arms and legs to explain something*" (HW 10).

Next problem was refugees' social deprivation and traumatic occurrences. Those people have come from war zones and besides medical problems they survived different war situations, which resulted in a social deprivation and traumatic occurrences. This was additional problem for health workers because people were therefore suspicious and introverted. Majority of interviewed health workers outlined greatest need of those people was psychological (moral) support, understanding, and a sense of security and acceptance. Most common diseases, injuries and other problems were: malnutrition, injured foot, diarrhoea and vomiting, respiratory infections and colds. For the majority of refugees medical treatment was less important that best illustrated by the statement of one of the interviewees: "*migrants are mainly healthy, but exhausted*" (HW 6).

The results of social deprivation and trauma experiences were negative attitudes among health workers and refugees. The latter did not want to be separated from the group; they have mostly rejected hospitalization and more detailed medical examination because of fear. Partly this could be also explained through cultural differences. Majority of refugees were Muslims from socially deprived parts of Syria, Afganistan and Iraq. According to their cultural heritage those people sometimes have different understanding of illness and treatment. Some of interviewees emphasized issues about privacy, family ties and ethical dilemmas (should they stay in the camp or should they go further; should they leave their children in a hospital etc.). All of this further hampered the work of health workers at the ground.

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

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(4) Result from participatory observations

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

In Šentilj and Gornja Radgona we met some migrants they worked themselves like health care staff in land of origin, but we didn't documented them.

160429_002 Interview (Dobova): »I worked in Brežice and Dobova and I do not have any information about people who have applied for asylum and what their education."

160505_002 Interview (Logatec):"I think I did not have contact with any such person. So I do not know."

160505_001 Interview (Vrhnika):"This did not happen. Sometimes they are involved as interpreters, especially in the first period. I remember a veterinarian who was six hours with us, when we reviewed the people, because he knew Arabic and some small even medicine. Maybe this is happening now with what, who applied for asylum."

160501_002 Interview (Dobova):“ I remember at the beginning of anesthetists, father and son. But they two have been in Slovenia for a long time, so they come here to help. Others did not.”

160501_001 Interview (Dobova):“Among migrants, there were some doctors who then helped us with translations because there have not had enough translators. There were a father and son, father was anesthesiology specialist ... But they were not now a migrant, but already before.”

References:

(1) Report/Publication: Authors, year, name of report/article, link if possible

(2) Web based report/article: Title, Link

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Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

In Slovenia, we therefore once again demonstrated that we can be sympathetic and humanitarian, that we can stand together and help people in distress. We can be proud that refugees feel happy and retain fond memories of Slovenia.

1. Health workers have to be trained for mindful of refugee specific difficulties and barriers
2. The communication barrier is the biggest obstacle in the work with refugees on the ground and should be systematically solved.
3. Financing of the health care teams should be better defined and should be conducted on time.

The main problem area was communication between health workers and refugees. Other problem areas included refugees’ social deprivation and traumatic occurrences, negative attitudes among health workers and refugees and cultural differences. The European values, such as human dignity, solidarity, freedom, democracy and equality were tested when the migration flow began to increase. The fact is that national governments were not well prepared and/or did not show enough interest for the huge number of refugees that crossed the transit countries, which led to inefficient organisation and lack of human resources, medical equipment and other supplies. The health workers involved however have proven to be extremely philanthropic and provided great moral support. They served not only as medical professionals but also as psychologists and social workers. Refugees were proven to be friendly and grateful for the help they got, although they sometimes rejected hospitalisation and detailed medical examination because of fear and/or in order not to be separated from their families.

A6. Country Report Hungary

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report on HUNGARY(rev) – date 31st May 2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, HUNGARIAN National report for Deliverable 6.1

Name of authors **Prof. Imre RURIK** MD, PhD, DSc, MSc

László R. KOLOZSVÁRI MD, PhD, MBA

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Historical overview. Hungary and the migration.

After the 1st World War Hungary, previously a joint-kingdom of the Austrian-Hungarian Empire had been detruncated. While the country becomes independent again, most of the territories were lost. All of *Transylvania* went to the Romanian Kingdom, the Northern part of Hungary went to the freshly established Czechoslovakian Republic (*Upper-Hungary*) and the bigger part of the southern counties were occupied by the freshly created Yugoslavia, that was merged from Serbia, Croatia Slovenia, Macedonia and Montenegro. In this decade (1919-1929) the flow of Hungarian refugees from the occupied part of the country become a political and economical issue. The general population was very helpful toward the freshly arrived families.

In the 2nd World War Hungary, helped by Germany reoccupied these areas.

After the lost war, some of the Easter counties were occupied by the Soviet Union and other parts were annexed again to the neighbouring countries. Some part of the population went to Hungary again. The most serious and systematic repatriation was performed by the Czechoslovakian government, forcing ten-thousands of inhabitants of Hungarian origin to leave that part of Slovakia, which belonged earlier to Hungary. Based on governmental regulations, some of German-origin people (schwabisch) were forced to leave Hungary; most of them went to Germany (Bundesrepublik Deutschland)

During decades of socialist-and communist regime, a systematic migration was only in 1956, but out of the country and not within.

At the late 80s thousand of people of Hungarian origin escaped from Romania, where the Caucescu-regime followed a brutal policy, including repression of other nationalities. (In these decades, ten-thousand Saxon origin people moved to Germany based on the deal between the governments of Romania and Germany who paid for every refugee to let out from Romania). The actual Hungarian government opposed this incoming migration; it was not supportive toward arriving people of native Hungarian origin. The Hungarian population and individuals accepted this serious situation as reason for migration and helped the incoming people. They got job and accommodation as well.

The incoming migration of non-Hungarian people started in the early 90th as consequence of civil war when Yugoslavia disintegrated.

These were the first “strange” arrives (*Croatians, Kosovians*) while Hungarian also come from Serbia, families and young men who did not want to be recruited by the Serbian army.

In this time the government helped to solve this situation new camps were established and organized support was provided. The first refugee camp (Debrecen) has been established in this time

Since then, in the last 2 decades the numbers of people arrived in Hungary was manageable by the government, and by local authority and by the population as well. Asylum seeker was used as terminology, because almost all wished to remain in Hungary.

The Office of Immigration and Nationality (in Hungarian: ***Bevándorlási és Állampolgársági Hivatal,*** abbreviated later as ***BÁH***) was established in 2000. This governmental office coordinates every new citizenship application countrywide, closely supervised by the Ministry of Interior.

Results

Changes in 2015, thousands of migrant coming to Hungary.

In Hungary, the problem of migrants and refugees become an important issue mainly since 2015, when hundred-thousands of people came to Hungary.

It was unexpected previously that thousands of people were crossing the border that was not defended by soldiers or policemen; there were no fence or any technical barrier.

The government was also not ready to manage this emerging situation. Many “rightist” or nationalist politicians tried to influence the public media and thorough this, the whole population of Hungary.

By the middle of 2015, temporary residency places (public parks, around railway stations) were established spontaneously, mainly in Budapest had catastrophic circumstances regarding hygiene and personal care. Thousands of people spent open air nights, without housing opportunities.

Government was in delay to manage this humanitarian situation. It lasted weeks when police organized accommodations, establishing places and replacing shelters for a temporary stay of refugees.

Most part of the population was compassed when seeing women with newborns and taking small children. Thereafter many people become upset when media presented atrocities and violence when young refugee attacked the police.

It was a real fact that many Hungarian made their own business when taking the refugees with their cars toward Austria. Shop owners had also a big deal when sold their items, mainly foods and cigarettes at the highest price they could achieve.

(Hungarian Tax Authority regularly controlled the shop owners around cities where refugee stayed, whether they issue an invoice or receipt when selling items).

- Bicske
- Debrecen
- Körmend
- Nagyfa
- Vámosszabadi
- Békéscsaba
- Győr
- Kiskunhalas
- Nyírbátor

By the middle of 2015, almost all Hungarian camps were opened for refugees (see map). Four of them were a closed area, supervised by the police, for those persons who were ordered for expulsion by the authorities or curt. These persons did not get a permit to stay in Hungary and they had to wai for the transport to their countries of origin.

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

The **transit zones** are legal open points of entry into Hungary. They will be registered, they can claim asylum. They only stay for a short period there (hours, max. days), before they go to one of the centres. There are living containers also available for them in the transit zones.

The main types of reception centres: open (they can leave the centre whenever they want) and closed (they cannot leave the centre, maximum stay 12 months, mainly for detained asylum-seekers and for the majority who are people waiting for their deportation). Community shelter (semi-open camp): maximum stay 2 months, they can leave the camp during the day but must return before 10pm).

There were some changes last months. According to the latest official data and terminology, there are 3 main types of reception facilities: *Open reception centres*, *Closed asylum reception centres* and *Community shelters*.

Transit zone are: at *Röszke, Tompa, Letenye, Beremend.*

Open reception centres operate in Hungary (with a maximum capacity) in *Bicske* (439) and in *Vámosszabadi* (216).

Nagyfa (300) is the newest reception centre which opened on 12 January 2015, which was initially meant as a temporary facility but since September 2015 it is being used as a regular reception centre. The centre consists of heated containers. *Nagyfa* is located inside the territory of a penitentiary institution and it is far away from the nearest settlement.

Refugees how are accommodated in open camps have to register, they can apply for asylum. While it is an open camp, they can leave the camp and some of them really leave before the end of the asylum process.

Closed asylum reception centres operate in *Békéscsaba, Nyírbátor* and *Kiskunhalas*. They could be leave upon permission only.

The biggest reception centre in *Debrecen* was closed in October 2015 one new open centre just was opened in *Körmend.* There were approximately 200 people in *Körmend* in May 2016, the capacity can go up to approx. 300-500 people.

The **Community Shelter** in *Balassagyarmat* (111), co-operates with different societies, NGOs, charity, international, partner, local governmental and law enforcement organizations.

Among others with the Hungarian Red Cross, the Menedék as an NGO (Association for help of migrants, in the field legal assistance with the Hungarian Helsinki Committee).

This community shelter works for asylum seekers, persons tolerated to stay, persons in immigration procedure and foreigners who have exceeded 12 months in immigration detention, and now also receives beneficiaries of international protection.

The centres are managed by the **BÁH**. The reception centres operate financially under the direction of the Director-General as an independent department and perform their professional tasks under the supervision of the Refugee Affairs Directorate of the **BÁH**. Thus, only one central body is responsible for the financial operation and the professional duties of the reception centres. Nevertheless, NGOs who work in the field of asylum cooperate with the refugee authority in providing supplementary services for applicants. The **BÁH** coordinates their activities carried out in the reception centres.

Migrants asking for asylum at the border zones are kept inside the transit zones, unless they are exempted from the border procedure, whereby they are transferred either to the asylum detention centre or are directed to go to the open reception centres. Where the detention grounds do not apply, they are given a train or bus ticket and are taken to the closest station so as to travel to the designated reception centre. Those asking for asylum at the airport can stay in a small facility (maximum capacity of 8 persons) within the airport transit area up to 8 days.

Asylum seekers can also request to stay in private accommodation at their own cost; however, they are then not entitled to most of the material reception conditions.

As of 1 November 2015, there are 2 homes for **unaccompanied children** in Hungary. They are not placed together with adults but are accommodated in specialised structures. *Fót* is a home for unaccompanied children, which belongs to the Ministry of Human Resources.

Hódmezővásárhely is a small house for unaccompanied children maintained by a Catholic charity under a contract with the Ministry of Human Resources.

2016

The situation changed significantly in the last month. Hungary has erected a fence on the Serbian-Hungarian border and it stopped the movement of migrants in the country. People who crossed legally the border here are transported to the open camps. Most of them did not stay long here, they are moving toward Austria.

The Austrian government started controlling the border in the last months and they do not allow crossing persons without official documents.

Since last Autumn, refugees have chosen alternative routes, through Croatia and Slovenia. The direction of official transfers have therefore changed, busses and train, organized and financed by the government were taken persons toward Austria and the smallest part to the Hungarian camps.

It is planned erecting a fence between Hungary and Rumania as well, closing predictable alternative routes. Between Hungary and Croatia the border is supervised most seriously as on the Slovenian border. There are the first technical barriers between the countries of European

Union and “Schengen” countries.

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Office of Immigration and Nationality, Statistics

http://www.bmbah.hu/index.php?option=com_k2&view=item&layout=item&id=177&Itemid=1232&lang=hu

http://www.bmbah.hu/index.php?option=com_k2&view=item&layout=item&id=551&Itemid=1297&lang=en

http://www.bmbah.hu/index.php?option=com_k2&view=item&layout=item&id=539&Itemid=1287&lang=en#

http://www.bmbah.hu/index.php?option=com_k2&view=item&layout=item&id=537&Itemid=1285&lang=en#

How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year?

The equipment was a little bit improved. Almost all centres provide a free wifi- network for inhabitants.

Meals are served 3 times a day, religious expectations are considered regarding food choices.

Most of the families are allowed to stay in common rooms, while independent asylum seekers are staying in bigger sleeping rooms. (more information was provided in our WP2 Local report).

In open camps, other items could be purchased in the nearby shops. There is an unofficial trade within camps; some are selling items for the rest, making good financial benefits for themselves. The homepage of BAH provide updated information for asylum seekers.

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of March

2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)?

This huge number could be only estimated. According to some observers and media sources, the overall number of migrants could have been above half million. There are no official estimation

available, while nobody counted it properly, only those who were officially transported by trains and busses. Approximately ¾ of them passed Hungary in 2015.

The available official data are presented below. These figures present the official data, issued by the BÁH. As seen, 95 thousand persons were allowed to stay legally in Hungary, temporarily for a limited periods or permanently.

Name of status	**State of 30/04/2016**
Immigration permits issued by the OIN	4 994
Permanent residence permits issued by the OIN	2 641
Residence permits	50 550
National residence permits	195
Registration certificates	116 190
Permanent residence cards	18 994
Residence cards for third country national family member of a Hungarian citizen	3 611
Residence cards for third country national family member of an EEA citizen	402
EC permanent residence permits	597
National permanent residence permits	12 982
Interim permanent residence permits	7
Having an identity card as refugee**	1 804
Having an identity card as subsidiary protected person**	1 366
Persons authorized to stay***	62

Total	**214 395**

***Data of Central Office for Administrative and Electronic Public Services; State of 31/12/2015,*

****State of 31/12/2015*

The situation in the camps at the moment (April 2016).

In the largest Hungarian camp (*Bicske*), 41.700 persons were stayed in the first quarter of 2016. The average *daily/night* number of inhabitants was 456; therefore it means an enormous turnover in this open camp, where people can walk out as well. In the *month of March*, the distribution of nationalities were (Afghanistan 727, Algeria 85, Bangladesh 22, Egypt 37, Eritrea 19, Iraq 652, Iran 351, Morocco 128, Pakistan 495, Turkey 40, Syria 198, Somalia 47).

These ratios reflect to the date of other camps, but no comparable to not-registered data of people who were not involved in the official procedures.

Health services delivery and expenditures in 2015

During the busiest days in 2015, some of the migrants needed medical services provided by hospitals and ambulatories of the National Health Insurance Fund (NHIF). There are no data how much expenditure was for OTC products and private medical providers.

It is visible that primary care was not significantly involved in the care of migrants.

NHIF expenditures 2015	**in Million HUF**
total expenditures	62.479
primary care	**19**
Inpatient care (hospital)	30.390
Outpatient care (secondary)	24.219
dialysis	2.748
drugs, medications, healing aids	4.078

exchange rate: 1 million HUF = 3200 EUR

How is Primary Health Care provided in your country in general?

Primary care in Hungary has been reorganized in 1992. The traditional service is provided by a one doctor (GP), one nurse system, based on a single handed practices of 6800 GPs. Half of them serve for an adult population, a quarter for children only and the last quarter cares a mixed population, from newborn to elderly. There are no group practices in Hungary. They mostly are working as private enterprisers contracted with the local municipalities for services and with the NHIF for financing. It is based mostly on capitations with other elements and small quality incentives.

References:

www.oep.hu (and data upon personal request)

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Rurik I. Primary Care in Hungary. MEMBER'S COLUMN of the European Forum for Primary Care - Hungary, 2012. http://nvl007.nivel.nl/euprimarycare/column/primary-care-hungary

Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

Health services are provided in the official camps by doctors employed or contracted with the BÁH. There are also nurses and medical assistants as well. In some camps, NGOs provide specialists (paediatricians, gynaecologists, psychiatrists).

There is continuous access to medical care in all facilities (centres, shelters ...etc). There is a nurse 10 hours a day in *Bicske* and *Vámosszabadi*, who triaging the cases and she informs the GPs or paediatricians, who do surgery according to the needs (approx. 4-8 hours a day, sometimes more). There is access to urgent-emergency medical care 24/7, every day in the nearby location (village or city), if required.

The situation in the camps remained the same level, but more effort is needed by the staff because of the turnover of inhabitants. Recently, in the last month this turnover decreased. People who wanted to move to Western countries left and the remaining inhabitants asked for asylum or temporary permit for staying in Hungary.

Primary health care staff situation (numbers, capacity, payment, safety, …)

We do not have exact information about their payment, but were told unofficially that their payment is higher, when compared to other GPs, while all are below the average salaries of doctors in the western countries. The permanent or contracted staffs of each centre include 4-6 doctors, usually in daily changes, 2-3 in each shift, during the opening hours.

If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

The biggest challenges were defined as the cultural barriers and language barriers.

"There is continuous medical care, a nurse there for 10 hours a day available, the doctors seeing patient as many patients as necessary a day, from I see from 50 up to 200 patients a day, depending how many refugees need treatment. "

Experiences of volunteers who served in the middle of 2015 will be summarized later,

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum? In what way are these resources documented and used already?

"Approximately 1% in healthcare and primary care, about 2000 people last year, there was surgeons and whole surgical ward from Iraq, health masseuse, psychologist, nurse, and dentist. We could not get them involved in the care of the refugees, sometimes they did not tell us, what their job was."

Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?

Firstly, there is quick general health assessment in the transit zones, than another health assessment in the centres, for all migrants/refugees/asylum seekers. The health assessment includes more tests in the centres (blood test, X-ray, screening for infectious diseases, other investigations if necessary). The documentation is paper and computer based.

"They receive the same medical care, as the Hungarian population; there are also special operational plans, regulated by the National Public Health and Medical Officer Service. The care starts when they get off the bus-there is general health assessment, test for infectious diseases eg. , screening for parasites, x-ray, general health check-dehydration, malnutrition of if there is a need for hospital admission."

How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?

The staff is usually helped by interpreters, who are available in all centres/camps for certain time if required, but not all the times (not day and night).

"There are native language interpreters, we (the doctors and nurses) also speak basic Farsi, Arabic.etc or English if they speak English. "

Biggest challenges and barriers for primary health care providers?

"Most of them never received any treatment from primary care in their country. Some of them don't cooperate and don't understand why these examination investigations needed."

Experiences of health professionals who worked in the summer of 2015 on voluntary basis.

They joined spontaneously to others providing humanitarian aid when governmental and official bodies did not. These happened mainly in Budapest around the railway stations where migrants stayed for days or often longer without any appropriate infrastructure.

There was a lack of professional organization while the Association of the Primary Care Paediatrician cooperated with NGOs and other charity organisations. People who lived in the nearby areas often taken alimentary and clothes, playmates for children.

They reported that paediatricians should be more professionally involved in any type of humanitarian aid, even organized by official bodies. They often claimed that governmental behaviour was not supportive. In theory, the so-called ambulatory log recorded the events, but because of the mass care, language barriers, access to information was communicated by generalising fear of the documentation was incorrect and superficial ". (by the volunteers, at the railway station transit zone). Most of the patients were young men, with women and children. Two doctors are worked usually together, a specialist and a trainee, helped with nurses, Red Cross people, in addition to Migration Aid volunteers.

Primary care profile cases have been seen: respiratory, enteric diseases, dermatological problems, mild traumatic injuries. Most of the refugees were young men, but there were, women and middle-aged ones, we have seen, although initially organized child care. 4 hours per day, alternating each day, we were on duty, we saw an average of 30 cases a day. Following the closure of some transit zones mainly helped organize workers involved in supplying financial assistance to Hungary, Croatia, Greece, between children of refugees, support groups activities." "…

"with the help of competent professional organizations care much more structured been able to provide"….

"Without public support, volunteer groups only unsuitable for the task".

"Stunned, we found the lack of child care professionals trained in collaborative, professional, voluntary (NGO) organization gained a lot of experience in care catastrophe. Equally strong, but the experience was a positive sign to help those who want a large number of refugees and their satisfaction section of the (then) behaviour and the results of their work."

Please, summarize the capacity situation and suggest a few recommendations.

The recent capacity of the Hungarian primary care is insufficient to manage a higher amount of patients, with different origin, having quite different cultural background, and high linguistic communication barrier.

If more people will arrive in Hungary their care should be much better organized and more financial resources will be needed. Beside this, more professional support is also requested, about never seen morbidities and developing communication skills with people having different languages.

Reference:

Kórász K. Asylum-seekers'mental and physical health problems: practices and recommendations. Orv Hetil 2016; 157(1):23-29.

Conclusion

The „migrant crisis“resulted big social, emotional, political and professional disputes in Hungary. Data and personal opinions, presented in this report could be diverse and we were unable to solve some of discrepancies. Government keeps these „crisis“always on the stage and politicians forced a national referendum about the management of deployment of upcoming refugees, supported by a visible part of the population.

We cannot predict what the summer of this year brings, perhaps other and bigger wave of refugees and asylum seekers.

In 2015, the medical care for refugees was provided mainly by volunteers and contracted staff in different camps. Hungarian primary care system was only partially involved in the migrant care and our colleagues need more professional help in this topic. Perhaps in the future they have to use new knowledge and skills.

Debrecen, 31th May, 2016.

A7. Country Report Austria

EUR-HUMAN

WP 6: Enhanced capacity building strategy for primary care staff as well as preparation and implementation of recommended interventions in selected implementation sites in Greece, Italy, Croatia, Slovenia, Hungary, and Austria

National Report (AUSTRIA) – Version 07/04/2016

Identification and assessment of existing capacity of local organizations regarding primary health care for refugees and of refugees and other migrants who have themselves worked in medical care

WP6, National report for Deliverable 6.1

Elisabeth Sophie Mayrhuber, Elena Jirovsky, Kathryn Hoffmann

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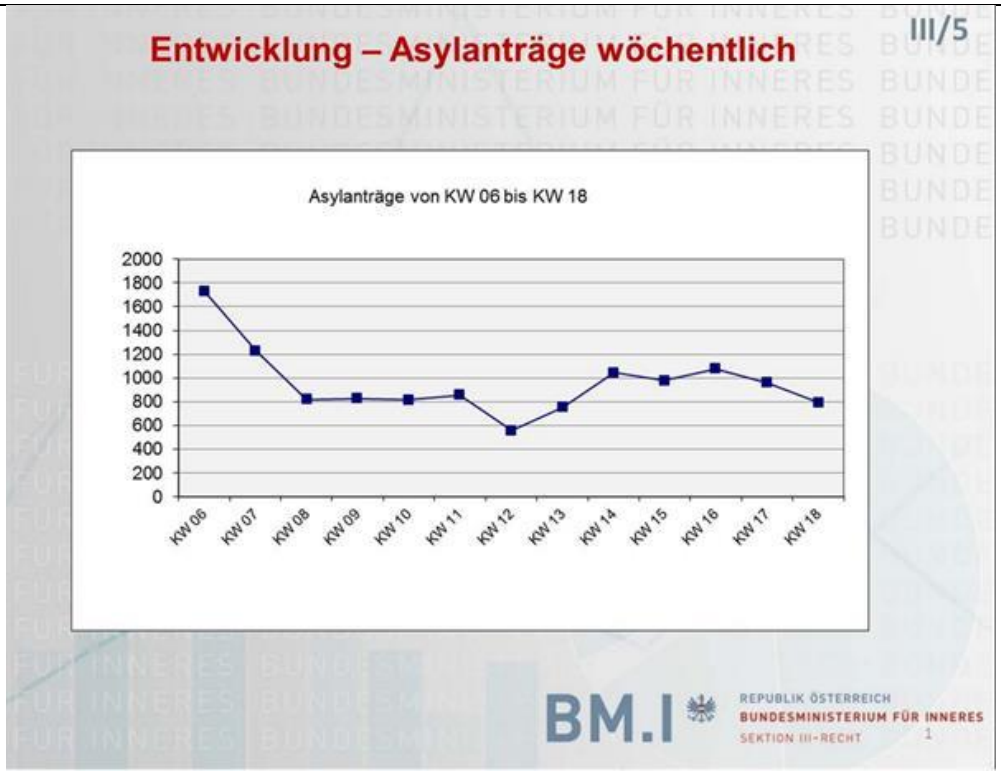
Results

The situation should be described like it is at the moment (March/April/May 2016).

Estimated overall number of refugees and other migrants which came to your country in the years 2015 and 2016 as well as numbers per week, and month since 1st of April 2016 (number of "transit" persons, number of refugees and other migrants who applied for asylum)? ○ **If it applies, please also indicate the number of refugees and other migrants "trapped" in the country (e.g. Greece due to the closing of the Balkan route)**
As of March 8th the Western Balkan corridor has been officially closed for all refugees. The EU-Turkey agreement was signed on March 18th and intends for legal channels of resettlement of persons, for every Syrian being returned to Turkey, another Syrian from Turkey will be resettled to the EU directly (1). According to several humanitarian organisations the situation at the border between Greece and Macedonia near the village of Idomeni is disastrous, as thousands of refugees are waiting there (1). According to reports, on March 9th there were already approximately 14.000 people in the "camp", but more people are arriving every day. As "Europe's biggest favela" the Guardian reports on the camp's chaotic scenes, not only the hygienic situations is devastating also officials to medics warn of a health time-bomb (1). Humanitarian problems also deteriorate also in Greece as arriving refugees have limited options for onward travel and more and more persons are "trapped" in the country (1). The data on refugees who applied for asylum in Austria is provided through the MoI statistical recording. The department III/5 (asylum and alien matters) of the MoI reports that 793 asylum applications were registered in week 18 (02.05.-08.05.2016), after 961 asylum applications in week 17 (25.04.-01.05.2016), 1079 asylum applications in week 16 (18.04-24.04.2016), 977 asylum applications in week 15 (11.04.-17.04.2016), 1.045 in week 14 (04.04.-10.04.2016) and 752 in week 13 (28.03-03.04.2016) (1). The following graphic gives an overview of the weekly asylum applications from week 6 to week 18.



Detailed monthly records show that in March 2016 a preliminary total of 3.265 asylum applications were submitted, in February 2016 a preliminary total of 5.112 and in January 2016 a total of 5.951 asylum applications. Statistical records from 2015 show that 7.282 applications were submitted in December 2015, 12.079 in November, 12.288 in October, 10.666 in September, 8.556 in August, 8.802 in July, 7.682 in June, 6.405 in May, 4.038 in April, 2.941 in March, 3.283 in February and 4.129 in January 2015 (1).

How long an asylum application takes depends on different factors, e.g. the date of application, the place of application and the nationality of an asylum seeker, until a decision is made asylum seekers are entitled to receive care according to the Basic Welfare Support Agreement 2004 (1).

With regards to transit persons who travelled through Austria, numbers are only available from newspaper articles and NGO reports. On December 18th 2016 *the Standard* newspaper reported that according to the MoI more than 600.000 refugees travelled through Austria since 5th September 2015. The MoI ministerial spokesman Karlheinz Grundböck indicated that as of 18th December 2016 around 2.000 to 5.000 refugees would use Austria as transit country on a daily basis (2), however, these numbers were not confirmed anywhere else officially. The Austrian Red cross reports on January 25th 2016 that since September 4th 2015 about 730.000 persons have crossed the border

into Austria (1). According to UNHCR statistics from January 2016 until the end of March 2016 there were 114.124 persons arrivals to Austria recorded (1).

References:

(1) Report/Publication:

EU-Turkey Statement, 18 March 2016. http://www.consilium.europa.eu/en/press/press-releases/2016/03/18-eu-turkey-statement/; (last access: 12.05.2016)

Smith, Helena, 17.03.2016, "Migration crisis: Idomeni, the train stop that became an ‚an insult to EU values", http://www.theguardian.com/world/2016/mar/17/migration-crisis-idomeni-camp-greece-macedonia-is-an-insult-to-eu-values; (last access: 12.05.2016)

MoI, Asylanträge wöchentiches Update, http://www.bmi.gv.at/cms/bmi_asyl_betreuung/_news/bmi.aspx?id=38515332424841532B46633D&page=0&view=1; (last access: 12.05.2016)

MoI, Vorläufige Asylstatistik, Februar 2016, http://www.bmi.gv.at/cms/BMI_Asylwesen/statistik/files/Asylstatistik_Februar_2016.pdf; (last access: 12.05.2016)

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Foitik, Gerry. 25.01.2016, Menschen auf der Flucht, Flüchtlingshilfe, Österreichisches Rotes Kreuz, Power Point Präsentation (only accessible internally)

Krutzler, David. 05.04.2016, Wien will Vier-Euro-Öffi-Monatsticket für Flüchtlinge, http://derstandard.at/2000034245557/Wien-will-Vier-Euro-Oeffi-Monatsticket-fuer-Fluechtlinge, (last access: 12.05.2016)

Europe Refugee and Migrants Emergency Response – Daily Estimated Arrivals per Country – Flows through Western Balkan Route. 1. October 2015 – 23 April 2016. UNHCR.

(2) Web based report/article:

APA/derStandard Newspaper, 18.12.2015, „85.000 Asylanträge in Österreich, weltweit so viele Flüchtlinge wie nie", www.derstandard.at/2000027777432/Bereits-rund-85-000-Asylantraege-2015-in-Oesterreich, (last access: 12.05.2016)

Main countries where refugees and other migrants come from?

Based on the data provided by the MoI the majority of refugees who applied for asylum between January 2015 and February 2016 in Austria came from Afghanistan (28.070), Syria (27.111), Iraq (14.611), Iran (4.410) and Pakistan (3.303) (2).

	2015												2016	
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Afghanistan	677	433	582	772	1506	1834	1781	1892	2314	3999	5516	3169	2037	1558
Syria	894	665	836	1018	1822	2429	2429	2694	3703	3796	2833	1529	1272	1191
Iraq	291	204	311	606	1138	1268	1268	1283	2763	2171	1482	789	524	513
Iran	104	70	86	111	98	120	212	158	320	781	757	615	599	379
Pakistan	82	67	97	207	329	415	548	948	120	71	67	72	109	171

The chart is based on the numbers by the MoI on persons who applied for asylum in Austria; there are no numbers available on countries of origin of transit refugees.

References:

(2) Web based report/article: Title, Link

MoI, 2015, Vorläufige Asylstatistik Dezember 2015, http://www.bmi.gv.at/cms/BMI_Asylwesen/statistik/files/Asylstatistik_Dezember_2015.pdf; MoI, 2016, (last access: 12.05.2016)

Vorläufige Asylstatistik Februar 2016, http://www.bmi.gv.at/cms/BMI_Asylwesen/statistik/files/Asylstatistik_Februar_2016.pdf, (last access: 12.05.2016)

What kind of refugee centres/camps/shelters (hot spots, first contact, transit, emergency shelters, detention centres, permanent for persons who applied for asylum) and how many exist?

In the case of Austria we differentiate between facilities that are intended for refugees who seek asylum in Austria such as federal refugee centres, initial reception centres, distribution centres, refugee camps and on the other hand facilities, which primarily aim at transit persons, such as emergency shelters, transit centres and other temporary emergency structures. Additionally, there are also detention centres, for persons who receive a negative asylum decision and are obliged to return to their country of origin.

It is important to note that we found different organisations also using different terms for respective centres/ camps/ shelters, and as the following description shows a clear distinction between such facilities sometimes proves to be difficult since facilities were also converted from (temporary) emergency shelters to longer-term facilities for persons who then applied for asylum. From a procedural point of view the asylum procedure is a multi-stage process, at the beginning at the initial registration (at an initial reception centre or a distribution centre or at a BFA site) the person gets a procedure card (*Verfahrenskarte*, a green coloured card). After the person is admitted to the asylum procedure he/she gets a white card, an asylum application card, which is a residence permit for the length of the asylum proceeding.

As of May 2016 there are five federal refugee centres in Austria (*Bundesbetreuungsstellen*), whereof two are located in Lower Austria Traiskirchen (Bundesbetreuungsstelle Ost) and Reichenau an der Rax (Bundesbetreuungsstelle Süd), and two in Upper Austria Thalham in Str. Georgen in Attergau (Bundesbetreuungsstelle West) and Bad Kreuzen (Bundesbetreuungsstelle Nord), and in Vienna Alsergrund (Bundesbetreuungsstelle Mitte). Two of these federal refugee centres also function as initial reception centres (*Erstaufnahmeeinrichungen*), and additionally, there is an initial reception centre at the international airport Vienna Schwechat, which is directly run by the Federal office for Immigration and asylum (.BFA), an authority directly reporting to the MoI and the final authority conducting first instance asylum procedures (2). Until summer 2015 the initial reception centres were responsible for the registration procedures for refugees who want to seek asylum in Austria. Refugees stayed there for the time that was required for checking if a person is admitted to asylum procedures in Austria (Dublin III). An asylum application can also be submitted at any police department or police officer and the first inquiry takes place. In the admissibility procedure
an examination takes place to find out whether a person is admitted to the asylum process in Austria (Dublin III) (1).
Around summer 2015 with the increasing number of refugees coming to or transiting through Austria, seven so called distribution centres (*Verteilerzentren*) were established in several federal states, in order to disburden the two overcrowded initial reception centres Traiskirchen East and Thalham West. Not all of these distribution centres were newly established, some existed already as federal refugee centres and were converted into distribution centres. The distribution centres are set up by the federal government at the following locations: Bad Kreuzen (Upper Austria), Vienna Alsergrund/Nussdorferstraße (in charge of Burgenland and Vienna), Traiskirchen East (Lower

Austria), Gaisberg (Salzburg), Innsbruck (in charge of Tyrol and Vorarlberg), Fehring (Styria), and Ossiach (Carinthia). Through the adoption of a new law Fremdenrechtsänderungsgesetz 2015 (BGBI. I Nr. 70/2015) asylum seekers do not need to be initially registered in one of the two initial reception centres, but can directly be brought to any of the distribution centre, where the first registration, first inquiry and the initial health assessment takes place. After the admissibility procedure, which should in principle only take 2 days, but can in fact take up to several weeks, the refugee either enters the basic welfare support scheme and is brought to a permanent refugee camp, or, if it is decided that Austria is not competent to examine the application of asylum, the person is transported to the initial reception centre Traiskirchen or Thalham, and is brought back to the country where he/she was first registered (Dublin III). The MoI reports that currently (May 2016) asylum seekers are only transferred to one of the initial reception centres if it is expected that another EU country is responsible for the asylum proceedings (1) (Dublin III) or if the person is identified or presumed to be an unaccompanied minor (1).

In addition to general federal refugee centres there are also UMR federal refugee centres (specific focus on unaccompanied minor refugees) (UMF-*Sonderbetreuungsstellen*), these are also supervised by the MoI. As of January 15th 2016 there were 8 UMR federal refugee centres operated by the ORS Service GmbH: SBS Korneuburg, SBS Hörsching, SBS South-Reichenau an der Rax, SBS Mondsee, SBS Finkenstein, SBS Steyregg, SBS Lower Austria-Mödling, SBS Styria-Spital am Semmering (1.9). However, there are also 5 federal refugee centres, which are not designed and identified as UMF-federal refugee centres but still accommodate unaccompanied minors. According to the ORS Service GmbH these are the following federal refugee centres: Leoben, Magdeburg, the centre Traiskirchen East, Schwarzenberg-Wals-Siezenheim and the federal refugee centre Graz/Andritz (1). It is assumed that the centre East-Traiskirchen was in the meantime converted into an UMR federal refugee camp, details on this are unknown.

Asylum seekers (except they are identified as or assumed to be unaccompanied minors), who are admitted to the asylum procedure in Austria, ought to be directly transferred from a facility by the federal government (distribution centre) to one of around 700 different refugee facilities in one of the nine provinces. These facilities are thereinafter referred to as refugee camps, which can be differentiated in different types of camps with different kinds of places. They are either categorized as a) organized refugee camps or as b) private refugee accommodations. In the case of organized refugee camps, the provincial authority makes an agreement with an NGO, an association or a

business either under a full-supply contract or under a self-supply contract. The organized refugee camps are differentiated as either UMR places, as places solely for women (with children) or for men, or as places for families. In each province a different official authority has an overview of the different capacities of places (3). In the case of private refugee accommodations asylum seekers themselves search for an apartment and sign a tenancy agreement (3).

The asylum seekers staying in either one of the aforementioned forms of camp are entitled to receive basic welfare support called "*Grundversorgung*". The provisions include food supply, accommodation, health insurance, medical services, services for persons in need of care, clothing, information and legal advice, interpreting costs, leisure activities, pocket money, school supplies, special demands, care for unaccompanied minors, costs for transport, German courses, funerals as well as administrative costs (1). The Basic Welfare Support Agreement was contracted between the federal government and the nine Austrian provinces, and regulates the basic welfare support scheme "Grundversorgungsgesetz – Bund 2005" (BGBI. Nr. I 100/2005 idF BGBI. I Nr. 122/2009). Thus, the Basic Welfare Support Agreement defines the kind of reception conditions and maximum allowances to be provided, also the special conditions for UMRs are therein outlined in Article 7 and Article 9. The provisions are transposed into the respective provincial laws as well as the Federal Government Basic Welfare Support Act. According to Article 5 of the Basic Welfare Support Agreement in each province, a federal government/ -province government –coordination council has been set up, which coordinates the interpretation and implementation of the Basic Welfare Support Agreement (1). Based on the Federal government-Provinces-Agreement various NGOs work on a contractual basis for the federal government/provinces, and provide mobile social support services for asylum seekers both hosted privately and in organised camps (3).

The provinces are responsible for the operative work (finding places in refugee camps). The federal government refunds 60% of the costs for the camps while the other 40% comes from the province budget (3: Interview 6, stakeholder). This 60:40 distribution is valid for one year of basic welfare support, if there is no asylum decision reached after 12 months procedure the federal government refunds 100% of the costs to the provinces. While asylum seekers are then in this basic welfare support scheme in one of these refugee camps, a comprehensive inquiry is made by the Federal Office for Immigration and Asylum (BFA), which then will ultimately lead to a decision upon the asylum claim. In January 2016 there were 85.000 asylum seekers in the basic welfare support scheme in Austria (1) housed in various different forms of refugee camps.

In terms of provision of refugee camps a huge political debate between the federal government (*Bund*) and the provinces (*Länder*)- proceeded in Austria and intensified in summer 2015. Several provinces did not provide/ refused to provide enough refugee camp facilities or spaces for setting up refugee camps. On August 18th 2015, a new constitutional law was adopted in Austria, which now provides the federal government with a right to house refugees in the provinces in federally owned buildings (1). Thus, facilities-, such as barracks etc., that are owned by the federal government can be opened up for refugees to be accommodated without the consent of the province – provided that the number of asylum seekers is not yet equalling the benchmark of 1,5% of the resident population (1).

We found that the capital city Vienna, which at the same time is a province, accepts a much higher quota of asylum seekers in refugee camps than all of the other provinces. As of April 5th 2016 a total of 21.100 refugees were in the basic welfare support scheme in the capital city (1). In May 2016, the FSW reported that in Vienna currently 56% of the asylum seekers in the welfare support scheme live in organised refugee camps (about 9000 persons), and 44% of asylum seekers live in privately organised accommodations (3). Before the summer 2015 a much larger number of asylum seekers lived in privately organised accommodations but due to the housing shortage in the capital city, private accommodations become increasingly hard to find (3: Interview 6, stakeholder).

As of April 6th 2016 there were currently 4890 asylum seekers in camps in Salzburg, whereof 323 were located in federal refugee camps (*Bundesbetreuung*), which also include distribution centres (1.). In Vorarlberg, there are 3.820 refugees accommodated in 558 camps, on average 40 continue to arrive on a weekly basis as of beginning of April (1). In Lower Austria, there are currently 15.200 persons in refugee camps, out of which 11 camps are container villages (2). From Upper Austria, it is reported that 12.438 places in refugee camps are available. Additionally it is noted that 3.900 places in transit quarters are available, however these are not counted as permanent camps (1). In Styria, about 12.000 asylum seekers are in permanent camps (2). No reliable data was found on asylum seekers accommodated in refugee camps in Burgenland, Carinthia or Tyrol. Overall, the exact number of refugee camps existing all across Austria remains relatively due to the different responsible authorities on a federal and a provincial level. Furthermore the number of camps is constantly changing with the changing number of asylum seekers as decisions on asylum applications are made. The basic welfare support scheme also regulates that if the decision on asylum applications is positive, a person can still stay at the refugee camp within the basic welfare support for up to 4 months (3).

Unaccompanied minor refugees are admitted to the asylum process in Austria and are assigned to UMR camps in the provinces. There they are accommodated in three different categories of reception facilities, depending on the degree of care and supervision they need (1: cf. Koppenberg 2014). The facilities are apartment-sharing groups, residential homes, or supervised accommodations (Art. 7 para 1 and 2 of the Basic Welfare Support Agreement). According to the UMR report 2014, the majority of facilities are apartment-sharing groups (1: cf. Interview Glawischnig, in: Kloppenberg 2014). The UMR camps are refugee camps which are also provided and organised by the provinces with special arrangements. Specific accommodation and reception arrangements are provided for unaccompanied minors, such as material reception conditions, care supervision and health care. However, these arrangements differ for unaccompanied minors who are covered by basic welfare support and for those who are in care of the Children and Youth Service (1: cf. Koppenberg 2014: 50). Exact numbers on UMF camps in the different provinces was equally impossible to obtain.

After an asylum seeker gets a negative decision on the asylum claim he/she can file a complaint against the decision, yet after it is final and negative the person has, under certain circumstances the obligation to leave. In this case he/she is admitted to one of the 18 police detention centres across the provinces. These detention centres are administered by the federal government (MoI) whereof 17 independent police detention centres and one sole detention centre in Vordernberg exist. The 17 police detention centres hold detainees who were charged with administrative penalties, while the detention centre Vordernberg in Styria is in principle also a police detention centre, but exclusively designed and built for detainees pending deportation after a negative asylum procedure, thus holds a special position. The detention centre Vordernberg is officially subordinate to the Styrian provincial police headquarters (*Landespolizeidirektion*) and was opened in January 2014.

Emergency shelters/ transit centres: Emergency shelters/ transit centres are primarily intended for transit refugees and emergency situations.

> *"There are shelters which were set up in the course of the transit refugee situation. Thus between September 4th and December 9th, or 1st [2016]. The shelters were set up because the people who were fleeing and had the goal to go to Germany, Sweden or wherever, could often not immediately travel further to Germany, but were forced to spend one night in Austria. Either because the transport capacity was not enough to get them to Germany or later because the German authorities only accepted a*

certain quota of people in 24 hours. The shelters were set up just along the routes." (Interview 6, stakeholder)

In principle, a division between disaster relief (emergency shelters and transit centres) and refugee camps (described above) that are formally intended and legally required for asylum application proceedings (initial reception centres and refugee camps/*Grundversorgungseinrichtungen*) is essential. The Austria Red Cross (ARK) representative explained that shelters were also set up in existing buildings, which were more or less suitable for this purpose, such as vacant office buildings, commercial properties, shopping centres, sports halls, vacant shopping halls, or other vacant often federally owned buildings, often with a very short lead time of only several hours (3). Furthermore, shelters were set up as tents directly at border crossings (*Grenzbetreuungsstellen*). The emergency shelters/ transit centres are usually characterised by a short duration of stay. Persons stay there only until onward transport continues, therefore, the emergency shelters are only equipped for one night stays (3). It was explained that the Red Cross made a distinction between transit centres which were only suitable for one night and transit centres which were suitable for up to 3 nights, as longer backlogs occurred (3). During 2015 and 2016, various emergency shelters were set up and run by different organisations, or as a collaboration of different organisations. About 80% were set up and run by the Austrian Red Cross, the rest was set up and run by the Samariterbund, Caritas, Diakonie and other NGOs (3). In order to coordinate emergency shelters/ transit centres and adapt to the changing situation. The ARK set up a sort of core coordination team in Inzersdorf, which coordinated transport and free shelters, capacities of the regional associations from September until December 2015 (3).

Around 80 emergency shelters/ transit centres were set up in Austria along the transit routes, either directly at border crossing points, such as e.g. Nickelsdorf at the Hungarian border in the east, Spielfeld at the Slovenian border in the south or around Rohrbach at the north-west of Austria at the German border. Obviously the emergency shelters were set up according to the number of people in transit and because the situation was very dynamic the setting up of emergency shelters was run flexible and according to demand. Due to the political changes the hot spots shifted over time. For example while the region around Nickelsdorf was the main emergency hot spot in September 2015, after Hungary closed its border the emergency shelters in and around Nickelsdorf (e.g. Nova Rock) were shut down. In the period thereafter the border crossing point Strass/ Spielfeld in Styria became the central hot spot in Austria (Oct, Nov, Dec, Jan). As of March 31st also the last emergency shelter in Styria, the Euroshopping-Hall, which has a capacity of 2000 beds, was put on stand-by-status. The other two larger emergency shelters in Styria (Schwarzlhalle in Premstätten

with a capacity of around 1.000 beds, and the Bellaflora hall in Feldkirchen with a capacity of 800 beds) were also closed in the beginning of 2016. In Bad Radkersburg, another entrance hot spot at the Slovenian border, emergency shelters were built up in tents, these were also closed after transit refugees stayed away (unclear on what date exactly closed). In the province of Salzburg, three emergency shelters were set up, and all of them are already closed. They were located at the main train station (closed at the beginning of November), at the old Asfinag-Autobahnmeisterei (closed on March 21st 2016) and at the old Zollamtsgebäude (closed on December 18th 2015) which was close to the border from Salzburg to Freilassing in Germany. On peak times up to 3.000 persons spent the night in the emergency shelters in Salzburg (1). In Vorarlberg, Austria's most western federal state, one refugee emergency shelter exists, which, however, has never accommodated any refugees until April 2016. Its capacity amounts to 200 persons (1). In Carinthia, three emergency shelters/ transit camps were set up that accommodated 1.500 refugees on peak times, the Dilling-Hall in Klagenfurt with a capacity of 1.000 persons, and two halls in Villach, all of which were closed in the first couple of months of the year 2016. In Upper Austria, several emergency shelters were set up, some of which were entirely removed, while others still exist but are empty. The shelter in Rohrbach was closed, in Braunau there are still two tents, which are not operating, also in Schärding there is still a built up tent (1). The Postverteilerzentrum in Linz was put up for a capacity of 900 persons and was now decreased to a capacity of 200 persons (2). Equally in Tyrol, the emergency shelters for refugees are not accommodated at the moment; their capacity is 400 persons (2). According to the *Fond Soziales Wien* (FSW) there are 25 emergency shelters still operating in the capital Vienna as of April 6th 2016. They provide a maximal capacity of around 6.000 places, whereof 4.200 are still currently occupied by asylum seekers who have not yet admitted to a refugee camp. As these emergency shelters were set up as temporary facilities they are actually not adequately equipped for long term stays for people who applied for asylum (3). In Vienna these emergency shelters continually close one after the other and as soon as a permanent refugee camp place (*Grundversorgungseinrichtungs* place) is made available, the person is transferred to the permanent refugee camp. In other cases emergency shelters were adapted and rebuilt until they fitted the standard of (permanent) refugee camp places (3). These transition from emergency shelters into refugee camp spaces occurs gradually (3). In Vienna, two of the largest emergency shelter/ transit centres that were set up were the Dusika Stadium and the nearby Sport and Fun Halle; both first opened up in September 2015 as emergency shelters mostly for transit refugees. Persons would only stay there around 1 night or 1 to 2 days and then continue to travel further to Germany,

however, also people who applied for asylum in Austria and followed the proceedings described above were sheltered there as permanent refugee camp places were unavailable. And although right from the beginning, the Dusika Stadium was set up as an interim solution and as a transit centre, it was reported that it became a permanent shelter for more than 300 asylum seekers who live there since November 2015 (1).

The Austrian Red Cross also set up 6 emergency shelters in Vienna, some of which are now operated as permanent centres, PWH Baumgarten Pav.6, Leystraße 2, Vordere Zollamstraße (opend in September 2015 and will close on May 31st 2016), Kurierhaus (was set up as transit centre, but some persons stayed there for several months), Primavesigasse (used as transit centre for up to 160 persons which already applied for asylum), Gasgasse (transit centre opened December 1st 2015 and closed 14th March).

The Samariterbund ran the emergency shelter/ transit centre Unionsstraße in Upper Austria (opened 5th of September 2015 and closed 30th of March 2016) where up to 450 people were housed daily, other locations were the main train station in Linz and others. In total the Samariterbund estimates to have cared for about 50.000 refugees, the shelters were run by employees and volunteers (2).

NGOs and aid organisations (Red Cross, Caritas, Diakonie, Hilfswerk, Samarterbund and Volkshilfe) highly criticise the fact that huge numbers of asylum seekers are still housed in emergency shelters although they ought to be in refugee camps. On December 15th 2015 it was reported that around 7.000 refugees still lived in emergency shelters in Vienna (2). On April 13th 2016, only 4200 persons were reported to still live in emergency shelters (2). The number continually decreases as more and more refugees are accommodated in permanent camps that fulfil the standards for being such a camp according to the Basic Welfare Support Agreement. The housing shortage is particularly severe in Vienna, on the one hand this province has the highest quota of asylum seekers in refugee camps and on the one hand a large number of persons, who gained the refugee status or subsidiary protection status, decide to move to Vienna (3).

During autumn 2015 and beginning of 2016, especially train stations turned out to be important hubs mainly due to the high number of refugees passing through Austria. Therefore, various transit structures were set up at highly frequented train stations. In Vienna, at the Westbahnhof (literally the Western train station), the Caritas provided and organised emergency relief for the arriving refugees. The refugees received food and clothing, and basic medical care was organised. A huge

number of volunteers were mobilised. They made donations, such as clothes, toys or food, assisted with distributing food and with arranging and distributing the aforementioned donations (1). At the Hauptbahnhof, the main train station Vienna, the emergency relief was exclusively provided by a group of volunteers, who then founded the politically independent association "Train of Hope" (2). The association received donations, collected and organised food and clothing, but also organised basic medical care for arriving refugees on transit to Germany. Both train station transit centres in Vienna ceased their work when less and less refugees were passing through Austria via Vienna. Other temporary transit structures were set up at the train station in Linz, the train station in Salzburg and the train station in Graz, these were often initiated by volunteers who brought and organised donations.

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How are these refugee centres/camps/shelters equipped in terms of capacity and how did the situation change during the last year? (e. g. the Greek hotspots are going to be "detention

centres", immigrants living in tents, in Hungary centres are closed, in Slovenia centres are moved etc.)

The capacity and the operation of the above described facilities for refugees vary. As by Art. 3 para 5 and Art. 4 para 2 of the Basic Welfare Support Agreement the federal government as well as the provinces can outsource these provisions of basic welfare support services to companies, NGOs and other institutions. The majority of provinces have outsourced the basic welfare support to NGOs and church-based organisations (1: cf. Interview Glawischnig, in: Kloppenberg 2014). In 2010, the federal government, the MoI has contracted a private company, the ORS Service GmbH, to provide health care and other support services in the federal refugee centres, the initial reception centres, the distribution centres and the UMR federal refugee centres since 2010. The ORS Service GmbH thus operates on behalf of the federal government and the MoI; in some cases also on behalf of some individual provinces (at provincial level) (2).

According to the ORS Service GmbH website the company is currently in charge of 34 facilities (2).

	Type	Level	Place/ Name
1	distribution centre	Federal government	Salzburg/ Gaisberg
2	federal refugee centre/ initial reception	Federal government	West/ Thalham
3	refugee centre	Federal government	Tyrol
4	refugee centre	Federal government	Styria
5	federal refugee centre	Federal government	South/ Raichenau an der Rax
6	federal refugee centre/ initial reception/ distribution centre	Federal government	East/ Traiskirchen
7	refugee centre (special)	Federal government	Lower Austria
8	refugee centre	Federal government	Erdberg
9	federal refugee centre/ distribution centre	Federal government	Mitte*
10	federal refugee centre/ distribution centre	Federal government	Nord/ Bad Kreuzen*

11	refugee centre (special)	Federal government	Upper Austria
12	refugee centre	Federal government	Hörsching
13	refugee centre	Federal government	Linz
14	refugee centre	Federal government	Mondsee
15	distribution centre	Federal government	Innsbruck/ Tyrol
16	refugee centre (special)	Federal government	Ledenitzen, Finkenstein
17	refugee centre	Federal government	Villach
18	distribution centre	Federal government	Kärnten, Ossiachersee
19	distribution centre	Federal government	Steiermark, Fehring
20	refugee centre	Federal government	Klingenback
21	refugee centre	Federal government	Eisenstadt
22	refugee centre	Federal government	Gaboikovo
23	refugee centre	Federal government	Magdeburg, Klosterneuburg
24	refugee centre	Federal government	Salzkammergut, Ohlsdorf
25	permanent camp	Province level	Haus Bildgasse, Götzis
26	permanent camp	Province level	Haus Mösleweg, Dornbirn
27	emergency shelter	Province level	Krumpendorf
28	permanent camp	Province level	Haus Graz
29	refugee centre	Federal government	Althofen
30	refugee centre	Federal government	Steyregg
31	refugee centre	Federal government	Korneuburg
32	refugee centre	Federal government	Schwarzenbergkaserne
33	refugee centre	Federal government	Postalm am Wolfgangsee
34	refugee centre	Federal government	Nofels

* both were federal refugee camps before they were converted to distribution centres. (1)

The two initial reception centres have different capacities: Traiskirchen is the largest with about 1500 to 1800 places, while Thalham has about 120 to 150 places (1). The two initial reception centres reached their capacity during the summer months of 2015. With 3.800 asylum seekers Traiskirchen was severely over-occupied reached; up to 1.600 people were housed in tents (2). Extra tents were also set up in the second initial reception centre Thalham. As of May 14th 2015, Thalham accommodated around 200 asylum seekers and additional tents were set up close to the site. These tents were removed around July 2015 and distribution centres were occupied to receive asylum seekers. Currently, it is unclear how the capacity of the two initial reception centres is utilised.

The initial reception centres were over-occupied and received huge media attention, therefore, the MoI converted several federal refugee centres into distribution centres and set up new distribution centres in the provinces. Exact capacity of the distribution centres are as follows: Bad Kreuzen 180 beds, Vienna 150 beds, Traiskirchen EAST 180 beds, Gaisberg 160 beds, Innsbruck 200 beds, Fehring 150 beds, and Ossiach 200 beds (1).

It was impossible to get information about the exact capacity of the remaining federal refugee centres because the MoI did not respond to email inquiries and the question for an interview (3).

During an interview, the Red Cross representative reported that the distribution centres currently have free capacities after the influx of refugees stopped with the closing of the Austrian borders and the deal between the EU and Turkey (3).

For UMFs, the Traiskirchen East facility has specific divisions: male minors above the age of 14 are accommodated in a separate wing of the building (referred to as “house 5”), while male minors below the age of 14 and female minors are accommodated in a designated wing for women (referred to as “house 8”) (cf. Interview Malz, in: Koppenberg 2014). Exact numbers on the capacity of Traiskirchen for the UMFs or the capacity of other UMF federal refugee centres were not available.

The detention centre Vordernberg has a capacity of 200-220 persons covering an area of 9.500 square meters. It is operated by the MoI (1). Since its opening in January 2014 it was frequently in the news because its low level of utilisation and its high personnel costs (2). Towards the end of 2015 and the beginning of 2016 newly arrived refugees were accommodated there up to a maximum of 2 days (2).

The minimum standards for accommodation in refugee camps and UMR camps, including their capacity, are defined in the Basic Welfare Support Agreement (*Grundversorgungsvereinbarung* Art. 15.a B-VG, BGBl. I Nr. 80/2004). The agreement refers to different requirements and can vary slightly

in the different provinces. For instance, it ensures that a central point of contact is established in every province: in Vienna it is the Mariannengasse, on behalf of the Fond Soziales Wien it is operated by the Caritas; in the other provinces the central point of contacts are often integrated in the provincial government departments. Generally, in each case before opening the location for camps are checked if they meet the minimum standards. According to a Red Cross documentation, a camp location has to fulfil space requirements (per person/ child about 4 m^2, and one bed per person/ child). It has to have adequate sanitary facilities (per 20 persons one toilet is required; additionally 1 urinal per 15 men; sufficient toilet paper; soap and disposable towels have to be provided; per 25 persons there has to be 24/7 water supply; per 20 persons one shower has to be provided; per 20 persons one washing machine has to be provided), relates to food (there should be kitchen facilities for the refugees to prepare their own food), fire protection needs to be available, as well as communication facilities, in particular internet access points (1). In all camp locations, the accommodated refugees should clean the facilities and organise a cleaning plan by themselves (1). This list of requirements provides only an overview (1). According to one of the interviewed stakeholder, the list of criteria for minimum standards for accommodation of refugees in permanent camps varies in each federal state (3).

The number of personnel that has to be present in the camps depends on the nature and the size of the camp, from 50 people onwards one permanent staff has to be present in the camp (3). There is no nationwide standard. Large privately run permanent camps often employ staff themselves and also offer social support services for the asylum seekers (3). In smaller privately run camps often NGOs provide the necessary social support. For example, mobile teams visit the camps on a regular basis (3). These organized refugee camps are supported by the different social service organizations of the different provinces. The camp administration also administers the monthly allowance and assist with immediate question on social services. In the section below (‘Primary Health care staff situation,. If there is no…’) there is a detailed description of the organizations and the kind of mobile social support services they provide in the different provinces.

During the recruitment for the PLA-Sessions for WP2, we visited three refugee camps, one was run by the Caritas, and two by the Arbeiter-Samariterbund (4). Each camp had a form of reception desk or administrative office where staff in charge provided support services, information and logistical support. For example, according to the head of one of the houses of the Arbeiter-Samariterbund, the facility, which still was considered an emergency shelter, housed 257 people at the point of our visit. There were approximately 100 people more at the time of opening in October 2015. However, people

left and returned to their home countries or moved to other facilities. Two floors of the building were reserved for families, who each had their own bedroom and some of them also their own bathroom facilities. One floor of the building was reserved for male refugees, who then shared the rooms. The camp had 15 staff. There was a laundry and the NGO was in the process to set up kitchen facilities in each floor. A fitness room had already been established, as well as a playroom for children. The staff planned on organizing gardening on the surrounding property. Various courses took place in-house. The other camps we visited differed in terms of leisure facilities and room size due to the conditions and location of the building used for camp purposes (3, 4).

In terms of emergency shelters/ transit centres the capacity is based on the capacity of the location and the number of persons who are in need of emergency shelters/ transit centres. One GP who was actively involved in the transit centre along the German border reported the following:

> *"The decisions are made from one day to the other – there was no plan behind it. The ministry took the easy way out. They called those responsible and said okay we need within 1 to 2 days a transit centre and then it continuously grew. And the police got orders and the Red Cross was commissioned, and then they said this, this, this has to happen and has to be organised. You never knew how many would come […] busses were directed from Spielfeld according to free capacity […] it was very improvised." (Interview 3, GP)*

According to the Austrian Red Cross the personnel requirement during set up/registration is 1:10 and in operation it is 1:20 – 1:50 (1). In personnel intense phases this personnel requirement is often covered through volunteers but should soon be covered by professional staff, while continuous support through volunteers and "Team Austria"[9] members is advisable (1). The capacity of the main emergency shelters/ transit centres during 2015 and 2016 is already identified in the section above. In total around 730.000 individuals entered and often passed Austria as transit refugees (3). One GP who worked in an emergency shelter/ transit centre describes the situation as follows:

> *"[…] there was this Medical Aid for Refugees, I registered there, and they had different locations, and I registered for the Dusika stadium. There was this huge stadium accommodating male refugees and next to it this Sport and Fun hall for the families. There were about 400 or 500 men in the stadium and about 300 families and that was … I don't want to day difficult, but it was incredibly hard because they started off as a mattress camp. Just imagine one mattress next to the other, one blanket next to*

[9] Team Austria is a project between the popular Austrian Radio Station Ö3 and the Austrian Red Cross starting 2007 with the aim to motivate many people to help and volunteer in times of natural disasters.

the other. Few showers for many people, few toilets for many people. […] after a while they managed to hang up partitions with sheets" (Interview 2, GP)

It is important to note that since the official closing of the Western Balkan corridor on March 8th 2016 (1), the number of transit refugees decreased, but those who still transit are not visible any more. The interviewed Red Cross stakeholder mentions that refugees still transit through or enter Austria, however now they do it clandestinely, unnoticed and often with the help of traffickers (3). Because of the decline of numbers of incoming refugees, transit structures at train stations withdrew their work and remain inactive.

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Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Participatory observation on February 16th, 17th and 18th

How is Primary Health Care provided in your country in general?

The Austrian health care system provides universal coverage for a wide range of benefits, there is a free choice of providers, unrestricted access to all care levels such as general practitioners, specialist physicians and hospitals and population satisfaction is well above EU average (1). However, income-related inequality in health has increased in the last years, although it is still relatively low compared to other countries (1). The health care system is by constitution a federal responsibility and overseen by the Federal Ministry of Health assisted by a range of national institutions. The implementation of

health insurance has been delegated to social security institutions brought together in a national Federation of Austrian Social Security Institution (HVSV) (1). In terms of finance, the social insurance funds are the largest source accounting for about 52% of current health expenditure in 2010, while the federal level, the provinces and local authorities covered approximately 24% of expenditure on health care but also debt covers the cost (1). In 2011 almost the entire population (99,9%) had health insurance coverage, membership of a specific scheme is determined by place of residence and/or occupation and social insurance contributions are determined at federal level by parliament; there are also private health insurance funds made use of only by a small part of the population (1.1).

According to WHO definition there are three level of professional health care, primary, secondary and tertiary health care (1). In Austria a clear distinction on the three level of health care is lacking, e.g. it is unclear whether hospital outpatient departments or registered specialist (paediatrics or dentists) also belong to the primary health care system or not (1). In literature on Austria's health care differentiation is reduced to outpatient/ambulatory sector and impatient sector (1), which is why different data exists on use, employment rates and financial expenses exist (1). Based on the Primary Health Care Activity Monitor for Europe Austria's primary health care system was rated lacking in terms of:

- Structural training in general medical practice, which is no specification and which can still be entirely fulfilled in the hospital sector
- Weak coordination possibilities, as there is exists no gate-keeping function for general practitioners and no/ or patient list systems
- Structural difficulties to establish Primary Health Care Teams and the lack of a morbidity register for the primary health care sector
- Enough university departments for general practice and academic career and research possibilities
- The weak status, earning and the low number of general practitioners in comparison to specialists in the outpatient sector
- The lacking "community orientation" and the hardly existing financing of health promotion and prevention activities (1)

Furthermore the lack of a clear distinction of what accounts for primary health care and the weak primary health care development status of Austria negative effects on health and costs are observed (1). Consequently a negative development in terms of human resource development is reported, especially defined through quality of education and training, career possibilities, occupational

profile and possibility for professional practise as well as status within the medical profession and society (1). According to Hofmacher the income for GPs in Austria is around the average for OECD countries, yet, the income of specialist physicians is amongst the highest in the OECD (although behind that in Germany and the Netherlands) (1). As a matter of priority also the number of GPs is decreasing steadily and it becomes more and more difficult to find GPs especially who want to work in rural areas (1).

From a patient point of view it is remarkable that the free choice of provider incorporates that besides only a few exceptions (e.g. radiology or labour medicine) a person can seek out to extra- as well as intramural working specialists directly and without medical referral at the primary care level. Thus, if a person consults with a general practitioner first, is solely based on their own estimation of the disease situation (1). Unlike in other countries primary health care physicians are not always patients' first point of contact and persons are also not registered with a GP, paediatrician, gynaecologist or dentist of their choice. However, GPs as well as the other mentioned health care workers are often those who refugees or asylum seekers consult with, since they are sent there by camp managers (3). The challenges for primary health care providers in Austria exist on a structural level, and is also linked to invoicing modalities as small entrepreneur, with the care for refugees and asylum seekers these challenges become even intensified.

In general terms there are important structural imbalances in health care provision in Austria have to be noted as there exist an oversized hospital sector and insufficient resources available for ambulatory care and preventive medicine (1).

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Interview 1, GP
Interview 2, GP
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Who is providing primary health care in these different centres/camps/shelters officially and de facto (which organizations, what kind of primary health care professionals are involved, how many, employed or volunteers)? How did the situation change in the course of the last year?

Division of competences: Federal Ministry for the Interior (MoI) is responsible for the primary care (*Erstversorgung*) of transit refugees and carrying out an initial health assessment in federal refugee camps and initial reception centres. After an asylum seeker is admitted to the basic welfare support scheme, the provinces are responsible and the asylum seeker has access to the conventional Austrian health care system. The Federal Ministry for Health (MoH) together with the Federal State Public Health Authorities (*Landessanitätsbehörden*) are responsible for public health concerns, especially in terms of disease prevention in the case of outbreak of infectious disease (disease law, tuberculosis law). Furthermore the MoH is responsible for developing professional and health related guidelines and recommendations (3).

In the Basic Welfare Support Agreement Art. 15.a B-VG, BGBl. I Nr. 80/2004 several passages mention the provision of primary health care in the different settings and describe it along competences.

According to Art. 3, para 2, 3., the federal government is responsible for registration, deregistration and re-registration of health insurance, as far as the registered foreigner is recorded by the federal government or is located at a refugee centre operated by the federal government. According to Art. 4. Para 1, 5., the provinces are responsible for registration, deregistration and re-registration of health insurance, as far as the registered foreigner is admitted by the province or in a facility operated by the province. According to Art 6. (1) 4.-7. The basic welfare support includes:

- Conduction of a medical examination if necessary at the initial reception according to the guidelines by the health authority,
- securing of health care provision for the purpose of the General Social Security (ASVG) with payment of health insurance contributions,
- granting if need be the expenses in excess thereof necessary services, which are not covered by health insurance, after individual assessment,
- measures for persons in need of care; (translated from Basic Welfare Support Agreement Art. 15.a B-VG, BGBl. I Nr. 80/2004)

The federal government and more precisely the MoI, is required to provide health care for transit refugees as well as for asylum seekers who are located in federal facilities (both UMF and federal refugee centres), initial reception centres and distribution centres). According to the guidelines provided by the MoH, after a person has asked for asylum in Austria, and is admitted to the asylum process in Austria an initial medical assessment (dt. *Medizinische Untersuchung bei der Erstaufnahme*) is mandatory within 72 hours (3). (Also see below section: "Initial health assessment for persons who applied for asylum"). The initial medical assessment includes a physical examination, a mental health evaluation, a review of the vaccination records and an x-ray based screening for active TB (1). The MoI commissioned the ORS Service GmbH company (following a tender procedure), to conduct the initial medical assessment as well as to provide primary health care to refugees located in federal facilities. The government was criticized for preventing charitable institutions (NGOs) to participate in the tender procedure by the terms of the public call, as reported in the Viennese monthly Newspaper "Falter" (1).

The ORS Service GmbH officially provides primary health care in these federal facilities, but based on contractual provisions regarding confidentiality the company is not obligated to reveal the specific contractual content (1). In terms of UMFs, the federal reception facility east in Traiskirchen provides a 24 hours a day supervisor to whom she/he can refer with any questions or problems for

each UMR, and a special practice to be applied to UMFs below the age of 14[10], as they are taken care of additionally by selected women who function as so-called remuneration mothers (cf. Koppenberg 2014). The 24-hours care, psychological care and day-structuring measures, etc. were also reported in a response to the parliamentary question PA 7312/J dated January 26th 2016, where the MoI identifies all federal refugee centres (both UMF federal refugee centres and normal federal refugee centres) to be operated by ORS Service GmbH (1). Based on a care-giving contract and a "comprehensive care concept" for unaccompanied minor refugees the ORS Service GmbH is responsible for provision (1), however, details of what is included in the "comprehensive care concept" are again unclear and not accessible to the public. With regards to the situation in Traiskirchen and especially in the case of UMFs the ORS Service GmbH is caught in crossfire of criticism, children who were supposed to be transferred from Traiskirchen to Vienna could not be found, the NGO Amnesty International refers to the private institution as vicarious agents of the ministry (2). A particular problem in this context is that when the MoI engages a private service provider, they can require the agreement to be subject to non-disclosure, an obligation that is also imposed to subcontractors and employees (2).

As of August 17th 2015, the ORS Services GmbH employed 75 social workers and 6 educators in Traiskirchen (1). Details on medical health care workers were only found in NGO reports. The primary health care provision in the initial reception centre is in the following described based on a comprehensive report by Doctors without Borders (MSF) on Traiskirchen. As of August 2015, MSF reports that the medical care in Traiskirchen was provided by 11 doctors, who were employed by ORS Service GmbH. Provisions are made that four general practitioners are present on weekdays from 9am to 5pm. At the first MSF visit (Aug. 6th 2015) it was observed that on weekends there are three doctors (GPs) present, who are primarily occupied with the revision of the initial medical assessment. They are supported by three qualified nurses and several nursing assistants. During the night no medical personnel is present in the centre. In case of emergencies during the night the ORS-personnel calls an ambulance (1). One day before the MSF's second visit (Aug. 19th 2015) it was announced that increasing support of the medical team at the federal refugee centre Traiskirchen will be provided through mobile doctors teams of the Lower Austrian emergency physicians and the Lower Austrian Arbeits-Samariterbund (NGO) starting with August 20th 2015. This was based on an emergency-directive by the MoI as the precarious medical care gained further attention. In the MSF

[10] For unaccompanied minor refugees who are underage, thus under 14 years old, there are special provisions in the Basic Welfare Support Scheme 2004.

report it is quoted that the head of the ORS-medical team emphasizes the need of a psychiatric/ neurological service in Traiskirchen as well as the early access of persons from the centre to dental care (1). Additionally the pediatric care of young children and the counselling of pregnant women and mothers through midwives is stated to be desirable as well as the setting up of a ambulant polyclinic within the centre as a meaningful measure (1).

Towards the end of August 2015 the MoI instructed the Red Cross to set up a care and nursing station for around 40 patients as an international module "Advanced Medical Post (AMP)" in order to improve on-site primary health care (1). Together with regional Red Cross associations the unit is run, medical personnel came from all across Austria and also material was provided by the Red Cross regional associations. One Viennese GP reported from her work assignment there:

> *"During summer [2015] I registered again at the Red Cross for Traiskirchen, I worked at three weekends […] There they have this huge tent, also with in-patient beds. They provided sufficient personnel as well as drugs. They had a doctor and a paramedic who also walked through Traiskirchen in order to attend hidden sick persons who did not made it to the central tent. At the same time the ORS organization provided primary health care, but they were not there in Saturday and Sunday […] after the massive crowds decreased this has ceased" (Interview 2, GP)*

Summing up, primary health care in federal facilities is provided generally by the ORS Service GmbH. Due to the exceptionally large influx of refugees last summer and the overcrowding in Traiskirchen, these conventional structures were far from sufficient to provide appropriate (primary) health care for the refugees in these facilities. Various initiatives were started to meet the needs of refugees coming to Austria, in terms of health care provision the "Medical Aid for Refugees" (MARF) initiative is probably the most important one. They started in September as an initiative for medical care in Traiskirchen, sending persons to Traiskirchen, and aiming at continuous health care for refugees (1). The MARF initiative also provided care at emergency shelters and transit centres, and set up a mobile unit for various centres/camps/shelters (1). In the press release declaring the provision of (primary) health care has to be again ensured by regular operation within the federal government and the provinces, they announce that 250 voluntary doctors were working in over 500 missions, and a total of 2100 hours of medical care for in Austria arriving refugees was provided (1).

In three of Austria's initial reception/distribution centres a syndrome based surveillance system was established, Traiskirchen (1800 beds) was the first starting on 8th September 2015, after Innsbruck (200 beds) at 2nd of October 2015 and Thalham (180 beds) at 21st of October 2015 (1). The syndrome reporters are the centre physicians, the case detection occurs at the arrival examination or

consultation, they report daily to the surveillance department at the Austrian Agency for Health and Food Safety (AGES) who conducts a daily syndrome specific analysis for alerts and alarms (1). The alerts are reported to the public health districts and the MoH. The SbSS should complement and not substitute the national epidemiological case-based surveillance system (CbSS) in Austria, aiming at timely detection of potential public health emergencies caused by infectious diseases in order to take action for control and prevention of infectious disease spread in centre resident population and local population (1). Syndromes to consider include: upper and lower respiratory tract disease, bloody and watery diarrhea, fever and rash, meningitis/encephalitis or encephalopathy/delirium, lymphadenitis with fever, botulism-like illness, sepsis or unexplained shock, hemorrhagic illness, acute jaundice, cutaneous infection and unexplained death (1). As of 24th March 2016 AGES reported based on the SbSS that refugees present no relevant risk in terms of infectious disease, although cramped conditions during refugee treks and in refugee reception centres favor the transmission of pathogens (1).

In the detention centre Vordernberg the municipal authorities are the general contractor acting on behalf of the MoI. For the care of the detainees the municipal authorities made a contract with the private security service provider G4S. It is reported that around 100 employees were recruited. G4S is also responsible for the provision of health care (2). The detention centre Vordernberg also provides repatriation counselling co-financed by the European Return Fund and the MoI and the Caritas is commissioned with the task (2).

In facilities of the provinces, such as refugee camps and UMR camps, the asylum seekers have access to the conventional social security system, and no provisions to additional health care support is provided in the camps. Thus, every person who is admitted to the asylum process in Austria is entitled to the basic welfare support scheme, as defined by the "Grundversorgungsgesetz – Bund 2005" (BGBI. Nr. I 100/2005 idF BGBI. I Nr. 122/2009) and can access the conventional health care system. Based on that, asylum seekers who are admitted to the process are also automatically covered by the general social security system and are insured by the respective regional health insurance. There is no specific provision for provision of health care for asylum seekers and they fall under the conventional system of primary health care in Austria (3) (see above).

> *"Because they are all health insured the access to health care is in principal not a problem, they just go to .. in some provinces they have e-cards, in other provinces they have e-card alternatives [e-card Ersatzbelege] and with them they can go to*

any physician and GP. Thus, as soon as they have a social security number and it is activated this runs unproblematic." (Interview 4, stakeholder)

"They receive an e-card relatively quickly. They get it when they are registered in the initial reception centre, there they get a provisory social security number, and within a short time they get the e-card" (Interview 3, GP)

Sometimes, health care workers are also present in refugee camps. For instance, during recruitment of participants for WP2, we observed that in one of the refugee camp we visited two paramedics were present 24/7. Both of them had a migration background; one of them spoke Arabic and the other one Farsi (4). For refugees seeking health care while living in a refugee camp transport to the health care facilities is a problem: on the one hand people often do not receive transportation tickets (financial barrier), on the other hand most GPs do not have translation facilities, and few of them speak the languages of the asylum seekers (3).

In some larger refugee camps there is an emergency medical service (*Ärztefunkdienst*) available:

"So generally everyone has health insurance, and we have twice a week a sort of visiting doctors team, they are well equipped, they can treat people or refer people further. We have the problem that the persons do not know where to go if they are in pain, and of course the language. And within the camp they can translate for each other […] when the doctor comes there directly, of course this is much easier/more convenient" (Interview 7, camp manager)

The GPs come 2-3 hours twice a week and it was reported that this is sufficient for the 200 person refugee camp (3).

In UMR camps the supervision depends on the category of the facility but is equally ensured 24 hours a day. In apartment sharing groups the supervision rate is 1:10 (one supervisor for 10 UMRs), 1:15 in residential homes and 1:20 in supervised accommodation (Art. 9 Basic Welfare Support Agreement) (cf. Koppenberg 2014). The supervision teams consist of social workers, psychologists, socio-pedagogues, etc. depending on the organisation and category.

In terms of emergency shelters and transit centres the health care provision differed from one to another setting, first settings where people only stayed for a very short time, passed through quickly, or waiting only for further transport, is described.

At the time of high influx of transit refugees emergency hospitals were set up by the Red Cross in order to ensure that persons who enter Austria have access to urgent emergency health care.

> *"A mobile ambulance [was set up]. A tent with large marking, that there is first aid and a physician and those who have a need they got in and went in and they were treated, there we had volunteer physicians and nurses" (Interview 6, stakeholder)*

Later it was explained that this is a sort of first contact resembled to a sort of self-triage, and primarily was about providing health care to allow the persons further travel, people did not want to stay in a facility or loose time, their main concern was to get to their final destination (3).

In Upper Austria directly at the German border, one GP who worked in the transit centre that was set up by the Red Cross also described that the provision was not complete:

> *"At the beginning we started to organise medical care for the transit refugees […] I organised that many of my colleagues took part in this and we organised an ambulant service […] at the beginning we started that always one of us was there for 3 hours, and looked at transit refugees who were ill or who needed anything. The drugs we got from the province, we could give it to them without prescription. We did not note down the name even, only if male, female, approximate age, what he had and what he got and one Red Cross person wrote down everything […] but then when more and more people came we needed to be there the whole day until 10, 11pm because busses would come continuously. […] The Red Cross also employed around 17 or 18 persons for support because it was not manageable with only volunteers any more. Still around 30 volunteers were there all the time." (Interview 3, GP)*

In terms of triage transit refugees were attended *"who needed anything"* and health care was to a large extent provided with a focus on rapid emergency health care and which was possible with the available means.

> *„It was very overcrowded around 1000 to 1500 passed through per day, the tents were full, sometimes there were more than 100 persons inside, they lied on top of each other […] then once I was asked to come and see a sick women in a tent, then I saw it and there were 8 persons in it, it was a two persons tent, only their feet looked out, I could not even go in" (Interview 3, GP)*

Emergency organisations possessed different capacities and were often supported by private initiatives and individual primary health care workers who showed up at the spot and worked alongside the organisations. Progressively a structure developed where doctors and other medical personnel worked under e.g. the Red Cross, online voluntary service plans were sent out and fixed services were scheduled (3). In Kollerschlag the interviewed GP coordinated the medical service plans, the GP estimated that around 40 doctors were active whereof half of them were GPs, a quarter were doctors from the nearby hospital Rohrbach, and a quarter were other volunteers, who came from somewhere else and some also came from Germany (Interview 3, GP). Other health care

workers also helped at the emergency and transit centre, paramedics who assisted and some nurses, sometimes also practice assistants (Interview 3, GP).

It is noteworthy that mobile teams were appointed to visit large emergency shelters and transit centres in Vienna, as one of the questioned stakeholder reported: during the huge influx of refugees mobile teams were reaching out to emergency shelters/ transit centres such as the Medical Aid for Refugees initiative (MAFR), to provide additional medical support in these settings. After MARF finished their work the medical director of the Caritas Vienna explained that they could convince the Vienna Regional Health Insurance Scheme (WGKK) to provided budget for mobile teams to continue the reaching out to large camps until now (3).
At transit structures, especially highly frequented train stations basic medical care was provided by the Red Cross and other medical first aid organisations and the professional rescue (Berufsrettung).

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(3) Result from interviews, also quotes are possible

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(4) Result from participatory observations

Composition of the primary health care staff in/responsible for the different centres/camps/shelters (GPs/Internists/Paediatricians, nurses, psychologists, social workers, paramedics, …)?

As outlined above, only in selected centres/camps/shelters primary care staff is available, in federal refugee camps, distribution centres, initial reception centres the ORS Service GmbH does not provide concrete numbers or details on composition of staff.

In the refugee camps, usually no primary health care staff is available in the facility as asylum seekers have access to the conventional Austrian health care system. Depending on the size, from 50 persons onwards one permanently present person needs to be in the facility, assisting with administration, questions, etc. (3).

In terms of emergency shelters and transit centres the composition of the health care staff was first of all covered with personnel from the emergency service, a Red Cross stakeholder explained:

> "In the autumn phase it was like this, about 60.000 people which are trained and working in emergency services, for the whole emergency care we always had our emergency paramedic or our emergency medical technicans, or our emergency physician. And for the provision of basic medical care we also use them. And as the case may be, there were many physicians, who contacted us and said they wanted to help and we integrated them respectively into our system" (Interview 6, stakeholder)

Thus, volunteers and voluntary primary health care staff worked within NGO structures, a crowd management was used to allocate capacities of refugees as well as health care staff (3). For health care staff allowance schemes were adopted and physicians from all kind of disciplines could charge a certain tariff (3). At the German border a GP reported on the situation:

> "After a while we could issue a fee invoice to the Red Cross, in emergency cases there is a standard tariff depending on hours, thus you get for the whole day around 700 or 800 euros" (Interview 3, GP)

In terms of different health care staff the GP reported:

> "There were not enough GPs available. Then they tried to ask hospital physicians to support us. They even appointed foundation doctors (Turnusärzte), who have no Ius Practicandi" (Interview 3, GP)

Later it was also mentioned that retired GPs helped in health care provision, also paramedics were there who assisted them and nurses as well as practice assistants (Interview 3, GP). We also know that in emergency shelters/ transit centres paediatrics were involved and for example the interviewed Syrian dentist explained that he was more involved in translation, as he could not provide his dental services in these settings (3). We have no information on involvement of psychologists or psychotherapists in emergency shelters and transit centres.

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(2) Web based report/article: Title, Link

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Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Primary health care staff situation (numbers, capacity, payment, safety, …)?

If there is no primary health care staff in the centres itself how is primary health care for refugees provided? What are the primary challenges? What is the situation of the "external" health care providers?

The primary health care staff situation in refugee health care is complex and provision varies in terms of numbers, capacity, payment and probably also in terms of safety in the different centers.

One important initiative already mentioned above was Medical Aid for Refugees (MARF), an alliance of various aid organizations, private initiatives and volunteers. In mid-August 2015 already the initiative Medical Advice for Traiskirchen started where medical aid was provided for refugees in Traiskirchen, furthermore medical personnel was connected to the border crossing Nickelsdorf, to Wiesen, at the Nova-Rock-Hall, at the Viennese West train station and in various emergency shelters (1).

The initiative states that they provide additional services to existing structures, and started around September 2015 and announced on January 15th 2016 to stop their activities in refugee emergency

care, as the need for care was decreasing towards the end of the year. In their press release they state: “From that point onwards care and medical services need to be provided within the regular services of federal and regional authorities. Until then 250 doctors worked voluntarily, over 500 missions, provided 2100 hours of medical health care for refugees arriving in Austria” (1). When shortages occurred in primary health care for refugees the initiative connected voluntary doctors in a fast and un-bureaucratic way and also provided necessary drugs and medical products (1). The following organisations were part of this initiative: Ambermed, Doctors without Borders, Medical Association for Vienna, Asylcoordination, Caritas, Diakonie Flüchtlingshilfe, Happy thank you more, Johanniter, Red Cross, Austrian Association for Pediatrics and several private initiatives (1).

A primary challenge for asylum seekers who are in the basic welfare support scheme is accessing the conventional Austrian health care system because of insurance uncertainty and other barriers. In principle are the GPs in Austria “external” primary health care providers, as the situation differs in the nine provinces the situation is portrayed for each province. Since January 2016 all refugees located in Vienna are insured through the MoI, before some were insured and had a valid social security number, some had e-cards, and others had neither a valid number nor an e-card. The social insurance agency varies between the provinces and differences are primarily in the provision of e-cards and alternative health insurance documents and the assignment of mobile service partners (3). In the case of Vienna, various problems emerged at the beginning. Based on the findings from WP2 we know that in Vienna asylum seekers first get a service-card with an insurance number by the Fond Soziales Wien, and to some extent doctors and hospitals accepted it when the social security number was registered and activated. After a while (several weeks or months) they get an e-card, which is the standard personal smart card in Austria. It was reported that many of the refugees that lived in camps in Vienna faced huge problems with access to e-cards, activation of e-cards but also with seeking treatment without good German skills (WP2). In Austria there are several free clinics for people without insurance, such as Ambermed, FEM and Hemayat, doctors, social workers, psychologists, psychotherapists, psychatrists and nurses treat patients there without insurance or e-cards. In all other provinces the asylum seekers are insured through the provincial/regional health insurance fund (GKK) and usually do not receive e-cards but health services are accessed mostly with the help of e-card alternative documents (E-card-Ersatzbelege). In Upper Austria they receive a note with their social security number, which is put forward at e.g. the GP practice, the mobile social support service is commissioned to Caritas and Diakonie,

depending on geographical proximity. In Styria asylum seekers receive e-card alternative documents, mobile social support services are commissioned to the Caritas. Similarly is the situation in Lower Austria, asylum seekers receive their social security number and then e-card alternative documents, mobile support is commissioned to the Caritas in the east and the Diakonie in the west. Asylum seekers in Burgenland also receive e-card alternative documents, and a mobile social support service in organised camps is commissioned to the Diakonie. In Tyrol asylum seekers only receive an e-card if they had worked e.g. as harvester, otherwise they only receive their social security number, the note with the number is often stuck on the white card, and e-card alternative documents are used for billing, mobile support is provided by the Tyrolian Social Services and not commissioned to NGOs. Similarly to that receive asylum seekers in Salzburg a social security number and billing works through e-card alternative documents, and mobile support is commissioned to Caritas. In Vorarlberg asylum seekers also receive social security numbers and billing is through e-card alternative documents, mobile support services are provided by the Caritas. Carinthia constitutes an exception as asylum seekers receive an e-card and the mobile support is provided by the respective regional consultant. Additionally to mobile social service support NGOs and other organisations also operate refugee camps in the various provinces, amongst others Caritas, Red Cross, Diakonie, regional social service providers, the institutes for social services, and ORS Service GmbH operate camps (3).

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Medical Aid for Refugees, 2016, Presseaussendung: Ärzte fordern: Bund und Länder müssen medizinische Versorgung von Flüchtlingen sicherstellen http://medicalaidforrefugees.at/wp-content/uploads/2015/09/Medizinische-Versorgung-Fluechtlinge.pdf;

(2) Web based report/article: Title, Link

(3) Result from interviews, also quotes are possible

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR

Protocol, student (4) Result from participatory observations
Is there a sort of initial health assessment for persons who applied for asylum? Do primary health care providers follow an operational plan? Do objective criteria or recommendations for triage and referral exist?
For persons who seek asylum in Austria and are admitted to the asylum process and who entered Austria as refugees[11] there is an initial health assessment required. It is a standardized assessment procedure which is supposed to take within 72 hours after the registration process, in German it is called: *Medizinische Untersuchung bei der Erstaufnahme* translated as initial health assessment (3). According to the guidelines provided by the MoH an operational plan is followed and the assessment is free for the asylum seeker (3). As the federal facilities are operated by ORS Service GmbH, the ORS is responsible for the initial health examination as well as the provision of primary health care in these facilities, commissioned by the MoI and the MoH (3). The initial health assessment includes a self-anamnesis, an x-ray of the lung (obligatory) and a (voluntary) vaccination (Po-Di-Te & Ma-Mu-Rö). In an interview and informal meeting with a representative of the ministry of health, it was reported that as of March 2016 there is a huge backlog with initial health assessment, and that the ORS Service GmbH is several months behind (3). Furthermore it was reported that the ORS would not particularly propagate vaccinations and only few persons were actually vaccinated (Protocol 1, stakeholder). However, at the same time the MoH is not in the position to control the ORS or has no insight in how many people receive vaccinations. Overall the MoH representative estimates that around 4500 persons never had an initial health assessment although they are already in refugee camps, as the ORS was overwhelmed with the number of persons (3). Also a representative from the FSW reported that initial health assessments were conducted incompletely and sporadic during autumn months 2015, as the high number of asylum applications overstrained personnel and infrastructural capacities of BFA, MoI and FSW (3). Starting with March 14th 2016 the Austrian Red Cross was assigned to additionally conduct initial medical examinations (3) at one designated floor in the same building where the emergency shelter

[11] For persons who entered Austria through a Visa (e.g. student visa, working visa, etc.) and only after entering Austria applied for asylum there is no initial health assessment required.

Lindengasse is located, was set up. According to the agreement this Red Cross Unit is set up solely for initial health assessments, and an employed medical team conducts the assessment. The vaccines are covered and delivered by the federal government, thus no extra costs emerge for the Red Cross Unit whether they immunize or not (Interview 6, stakeholder).

As the situation in Traiskirchen worsened dramatically during summer 2015 and it remains relatively unclear how complete the initial health assessment was conducted. In terms of documentation, no information from the ORS Service GmbH was available, and a Red Cross stakeholder explained that until now there is no coherent documentation on who received the initial health assessment, not to mention the vaccination rates (3). Due to that, primary health care providers are particularly challenged when they later treat asylum seekers (see section below). One GP explicitly refers to the risk of not vaccinating refugees, other migrants and asylum seekers:

> *"In my view it was a catastrophe that there was no vaccination program started. I mean this is… measles, mumps and then meningococcal should have been vaccinated. We are very fortunate that nothing had happened." (Interview 2, GP)*

In the MSF report of August 2015 the medical care situation in Traiskirchen is described, the principal health care workers (11 doctors, of which 4 general practitioners are present on weekdays from 9 to 5, and on weekends there are three doctors (GPs) present), are primarily occupied with the revision of the initial health assessment. They are supported by other health care workers (three qualified nurses and several nursing assistants) (1). According to interviewed doctors the MSF report outlines, that the physicians start their working days with initial health assessments, only afterwards persons with acute problems are attended. For acute problems a numbering system is in place which, however, according to reports by inhabitants, is not functioning because "by far not all numbers are attended until 5pm, at the next day a new number has to be taken" (1). A triage system in order to detect acute diseases, which have to be treated as a matter of priority, is not in place as the priority is given to initial health assessments (1).

An interviewed GP indicates that he can only assume the initial health assessment took place:

> *"The district authorities (Bezirkshauptmannschaft) assured me that they all were assessed. Thus, we can assume that an x-ray was made and that they were examined for TBC. But we can only trust that, because there is no medical evidence of that which we could access." (Interview 3, GP)*

References:

(1) Report/Publication: Ärzte ohne Grenzen Österreich, August 2015, Bericht zur medizinisch-humanitären Lage im Erstaufnahmezentrum Traiskirchen, https://www.aerzte-ohne-grenzen.at/sites/default/files/msf_traiskirchen_bericht_2015.pdf; (last access: 12.05.2016) (2) Web based report/article: Title, Link (3) Result from interviews, also quotes are possible Interview 1, GP Interview 2, GP Interview 3, GP Interview 4, stakeholder Interview 5, dentist Interview 6, stakeholder Interview 7, camp manager Interview 8, camp manager Protocol, MoH Protocol, MAFR Protocol, student (4) Result from participatory observations
How is the situation in these different centres/camps/shelters regarding interpreters and cultural mediators?
In the asylum process, the asylum seeker is inquired about her/his personal circumstances, travel to Austria and the reasons for flight by a person from the Federal Office for Immigration and Asylum. This inquiry is conducted in a language which is understandable to the asylum seeker and translated by interpreters under oath (1). In detail, first the fingerprints and interview is made at the police, an interpreter should be present, then at the Federal Office for Immigration and Asylum an admission procedure is undertaken, inquiries on travel route, etc., an interpreter is present, after admission is granted the asylum procedure takes place, the interview on the reason for fleeing the home country, and again an interpreter is present (1). In the different other settings described above, outside of the interrogation for the asylum process, interpreters or cultural mediators were solely available on a voluntary and sometimes sporadic basis and the organisation in charge organised these services as voluntary work (for more details see below section: challenges for primary health care providers) (3). The self-anamnesis document which is to be filled out by the asylum seeker at the initial health assessment was reported to be available in various languages, certainly in Arabic, Farsi and English (3).

In emergency shelters/ transit centres a lot of volunteers, who had themselves migratory background worked as translators and helped out with their bilingual skills (4).

> *"Arabic from Tunisia is something completely different than Arabic from Iraq or from Syria and if sometimes then even little dialects came it was certainly a huge challenge [for the people who volunteered as translators]. I would say for acute symptoms it is not even necessary because we had really good pictograms" (Interview 2, GP)*

In cooperation with Red Cross, Caritas and Medical Aid for Refugees there were pictograms developed by buero bauer (http://buerobauer.com/projekte/first-aid-kit/)

Generally the GPs and other health care providers can use video or telephone translation systems. Salzburg is the first province who offers from March 2016 onwards telephone translation systems for resident doctors/GPs the province co-finances this with the Medial Association Salzburg (2). This 6 months pilot project is exceptional in Austria as in all the other provinces the expenses have to be covered by the GPs themselves. There is neither a refunding for purchase of the device nor for the actual translation service in all other provinces in Austria (3). The application of video translation systems are still in their infancy in the Austrian health care system, also in hospitals video translation tends to be the exception rather than the rule (1). In the federal government detention centre Vordernberg in Styria video translation is available since October 2014, on the website it reads: *"the introduction of video translation in the ambulance of the AHZ Vordernberg was a very good decision. The medical care of our clients is very important to us in our facility and through the quick availability and the linguistic diversity the provision of care is ensured"* (1).

References:

(1) Report/Publication:

UNHCR, Trainingshandbuch für DolmetscherInnen im Asylverfahren. 2015. Erste Auflage. http://www.bfa.gv.at/files/broschueren/Trainingsprogramm_WEB_15032016.pdf; (last access: 12.05.2016)

(2) Web based report/article: Anhaltezentrum Vordernberg/ Steiermark/ Österreich, http://www.videodolmetschen.com/portfolio/anhaltezentrum-vordernberg-steiermark-oesterreich/; (last access: 12.05.2016)

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First Aid Kit. Icon based Communication for Refugees, http://buerobauer.com/projekte/first-aid-kit/; (last access: 12.05.2016)

(3) Result from interviews, also quotes are possible

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Biggest challenges and barriers for primary health care providers?

Challenges and barriers exist for primary health care providers at different levels, first at the level of emergency shelters/ transit centres, 2nd at the triage and first assessment at entry point, and 3rd at the first contact with the primary health care system and at the level of long-term primary health care.

According to the interviewed stakeholders and our findings from literature there are particular challenges at the first level of emergency shelters/ transit centres. The logistical challenge to ensure that all different kinds of drugs are available in these settings was noticed (Interview 3, GP), and on the other hand the challenge to provide the adequate care and medical treatment for the refugees in a very short-time frame. For example some diseases require close monitoring and treatment, which is not possible when people only accommodated shortly:

> *"Such a continuous treatment is very difficult if the people often change their place of stay. That is why I said to all people who had a chronic disease: Please we do that now like this and that and if you have a fix [GP] another plan has to be made." (Interview 2, GP)*

The Medical Aid for Refugees initiative also reported on the medical-humanitarian situation in different emergency settings, they elaborate on emergency care challenges with complex problems like chronic diseases such as poorly controlled diabetes mellitus, hypertension or joint pains after

trauma lasting for weeks, which can often not be treated adequately (1). In other cases people would require immediate inpatient care, however, their main concern was to transit further:

> *"Again and again we had problems because the refugees did not want to go to a hospital. We really often had someone … okay if we do not get him into the hospital he might die, and maybe with stomach-ache, pregnant women with heavy pain and these stories. From the newly born baby who was born during the flight until the 81 year old men we had seen everything over there. And then we sometimes had discussions, they would not want to go to the hospital because they were afraid that their family would be separated and that they could not get to Germany. This was really their main concern that they would not get to Germany." (Interview 3, GP)*

A Red Cross representative refers to the medical care in transit settings as *"doping for further travel"*, he describes that refugees had clear priorities in what was of main importance to them, often this was in the first place reaching their target country and their second priority was their health condition (Interview 6, stakeholder). In response to the warning *"you might not survive if you continue your travel without proper treatment"* they explained it is a matter of reaching *"Germany"* this is their first priority, *"if I die, I die"* (Interview 6, stakeholder).

In this context physicians working in emergency settings also reported cases in which cooperation with border authorities were hindering provision of adequate health care:

> *"The German authorities were relative restrictive. Once they even would not let a colleague pass the border to Wegscheid [in Germany], who treated a heart emergency patient. Because Wegscheid is only 5 kilometres away from there and they have a hospital there and he wanted to go there with the patient. And the German authorities said: no he is not allowed to pass the border. Only after 15 minutes of discussion and with the threat of informing the press the German policemen agreed that he can pass the border." (Interview 3, GP)*

Another huge challenge was the lack of documentation of disease cases in emergency shelters/ transit centres, in a press release the MARF initiative stresses the necessity of a standardised form to document patients brought to hospitals, or for patients who have chronic disease, such as dialysis patients, for onward journeys (1). On the one hand this would also be helpful for hospital personnel, which often lack interpreters, and anamneses would be made easier while additionally it would decrease the barriers to provision of (primary) health care (1). The difficulties in documentation of diseases as well as health care provision in general was also identified by GPs who worked in emergency shelters, initially set up only for transit refugees, but slowly converted into an emergency reception centre for people who applied for asylum in Austria:

> *"… we had to ensure that a certain registration takes place. […] There were some sort of securities, they ensured that everyone had a wristband with a number, and that these data were recorded and that they receive any sort of card as soon as possible ... a refugee identity card, and that took 2 months, until they receive this card where a social security number is on. […] that was the most difficult task in terms of organisation. […] of course we treated everyone but we checked closely, I mean we were many doctors, but I first asked anyone for some sort of ID, or number. It was less about if he was entitled to receive treatment or not but we tried to write a protocol so we can reproduce: he was here daily and needed painkillers. Or he has some other health needs. So that we have less chaos in medical treatment." (Interview 2, GP)*

From a health care standpoint documentation was one thing, but then also division of competences posed a challenge:

> *"For example with wound care. Well some wounds need daily wound bandaging and some were not so special cases however sometimes they require Betaisadonna or Octenisept. Thus medical products, yet there were enough paramedics there but it is not allowed for them to apply medical products. When they were alone then they could not even hand out drugs, nothing, they only could apply a dry bandage, nothing else, not even disinfect […] I inquired at different places, yet even after an exact instruction they are not allowed to do it. […] I mean that is just crazy in regards to the structures, and hierarchies and limitations. These things complicate the treatment, and that is the problem, you need unnecessary huge personnel for nothing. (Interview 2, GP)*

In addition, the challenges that emerged for provision of health care in emergency settings were linked to the fact that facilities were to some extent converted from emergency shelters into emergency reception centres for asylum seekers, especially in Vienna (3). The most prominent example is the Kurierhaus at the Lindengasse in Vienna, where the vacant building was operated by the Red Cross and the Fond Soziales Vienna as an emergency shelter and after a high number of people decided to apply for asylum in Austria it reception structures were established. The police and the FSW made a cooperation agreement and a temporary BFA office, where people could directly apply for asylum was established in the 5th floor, the FSW administered the asylum seekers and organised their placement in refugee camps, and several months later the Red Cross also set up their Unit for the initial health assessment there (3). According to the FSW the follow up work with registration of asylum seekers is not yet finished until May 2016 (3).

The MARF initiative emphasises that these emergency shelters often lacked sufficient material and medical equipment in first medical supply points, and furthermore, sanitary facilities were not adequate for longer stays in emergency shelters (1). In this regard it should be noted that

additionally to limited spatiality and unclear documentation which increase health risks, also the difficulty to respond to and address psychological concerns and the lack of access to water can lead to overmedication:

> *"More and more the psychical component appeared; with families it was the case that the parents were really concerned. With the slightest rhinitis they came, which is understandable, or also with a small cough or if the child was tired or it cannot walk any more, or I don't know. This overreaction, but understandably that they are so worried, who could calm them down and payed attention that we would not over medicate them." (Interview 2, GP)*

> *"Also in the Dusika stadium there was a strong desire for painkillers. But this is with too little water, or too little liquid not always favourable. […] we saw that people with too many painkillers developed stomach problems" (Interview 2, GP)*

From an operational perspective the challenges for health care providers are strongly linked to the inadequate accommodation situation, a stakeholder explains this as follows:

> *"The biggest challenge was in fact that there were two situations, which occurred parallel. The one is an accommodation crisis, what the republic of Austria did not manage, because of the political hickhack in the last months and years. […] The federal government and the provinces could not agree collaboratively that the number on persons [who applied for asylum] were adequately housed. And from September, October together with the refugee wave [sic!], that Traiskirchen was reduced and the person which still arrived and applied for asylum, could not be brought to refugee camps [in the provinces] but to emergency shelters. […] The huge difficulty was that persons who came longer than 3 nights, because they applied for asylum, these shelters are not adequate for them, that was a huge problem for our people. That is unacceptable but on the other side you don't have an alternative." (Interview 6, stakeholder)*

In terms of direct challenges for health care providers working in emergency shelters/ transit centres, one interviewed GP identified work overloading and burn out prevention of physicians as important:

> *"There are colleagues they see it … and then they put all their power into that. And I observed that this has to have boundaries and I said: okay once or twice a week and if you were there more often we said: no you have to have a break. It is not possible, because it is also not good for your own psychical health […] especially when it was all additionally to the work in the practice." (Interview 3, GP)*

Additionally it was relevant that a balance was found between health care provision for the local population and health care provision for transit refugees:

> *"Because no one had time or was there and then we also had on-call duty for the whole district, but they have duty for the whole district, and some thought they attend the people [in the transit centre], but then they had to leave again [when someone called] And then I said, I ordered: under no circumstances can we ignore the health care of the local population or attend a patient later or not at all because we provide health care for refugees. Except there is an emergency, no question there… " (Interview 3, GP)*

Two GPs also raised concerns about their legal standing as health care providers, how their insurance was, and how they informed themselves (Interview 2, GP; Interview 3, GP).

The interviewed red cross stakeholder emphasised particularly on the legal framework challenges for providing primary health care at first level emergency shelter/ transit centres:

> *"Austria is a well administered/managed country, but it has fair-weather-legislation. That means when something is written down in the law, then public management which implements it can work fairly well accordingly. Yet if there is a case which is not provided by law […] then everyone says, what do wo do now? And there is no flexibility […] What we need urgently in Austria is a legislative framework, so that we remain capable of acting in exceptional situations. […] And especially that there are political and administrative proceedings and competences for exceptional occurrences" (Interview 6, stakeholder)*

At the 2nd level at the triage and first assessment at entry point we found partially overlapping barriers and challenges for provision of (primary) health care as well as providers. After registration the arriving refugees are provided health care in a federal refugee facility by the ORS Service GmbH, the main challenges are assumed to be limited human resources and high workloads, however, employees are under duty of confidentiality. MSF recommends in their report that the provision of health care to ill and vulnerable persons, to pregnant women, children, as well as to old and disabled persons should be prioritized over the initial health assessment (1).

For external or additional health care providers at the level of triage and first assessment at entry points several other issues were raised. For example it became apparent that because of the often long flight the people had no treatment for several months, as for example:

> *"asthma, which was not treated for a very long time, and from time to time also metabolic diseases which existed before already, but which were ignored during the flight" (Interview 2, GP)*

Also the interviewed dentist explained, that people who often come after a long time without treatment to his practice (Interview 5, dentist). He specifically refers to the crisis in Syria which has been going on for 5 years:

> *"Most people come here with problems, with huge problems, not only regarding their teeth, really with all sort of health situations, yes. […] with no dental check-up for years, or an open tooth for years, or I don't know how many problems. It starts with children, adults, all. And before they come to Europe most of them stayed in camps e.g. in Greece or in Turkey or I don't know where they were, and also there they did not have treatment." (Interview 5, dentist)*

At the same time delays in health seeking are indicated in the MSF report on the medical-humanitarian situation in Traiskirchen:

> *"Many persons are hesitant to visit a doctor, not only because of the long waiting hours, but above all because they fear the transfer of personal medical data to the authorities and a delay of their procedure or a transfer caused by that." (MSF 2015)*

Similarly it is reported that refugees are reluctant to visit a physician or a dentist:

> *"There are a lot of people who do not want … they are ashamed, they would not come, I say why did you not come? Why did you wait? Because I have no insurance, I have no money, I cannot come. […] but there are larger problems than with dentists, with women there have a lot of problems, children, etc." (Interview 5, dentist)*

In terms of challenges similarities to emergency settings were described, and apparent challenges and barriers again have to be considered together with shelter capacities and access to water and tea:

> *"In Traiskirchen when temperatures came down they got colds, we advised them to drink a lot of warm tea. One asylum seeker explained, that would be wonderful, I would love to but I am glad if I even get a cold tea after I wait in line in from the early morning onwards. But we don't have nothing, only cold water." (Interview 2, GP)*

Another aspect was the difficult for primary health care providers to transfer refugees and registered asylum seekers to specialists, or hospitals, as these referrals were mostly informally organised:

> *"I tried to send all people to the medical specialists at the Engertstraße. There is a huge eyes clinic, there the Ms. Dr. xxx is the head of the medical specialists from the Medical Association and they have a huge practice and I think her husband was Iraqi or Syrian […] I tried to send as many as possible to GPs and not to outpatient departments, unless it was immediately required. (Interview 2, GP)*

> *"I treat all refugees also when they have no insurance or if they are just transit. There were a lot of them in Austria, now it is less… we do what is necessary for individuals or sometimes whole groups come, because of the Diakonie, Caritas and other organisations, […] I said all people who speak Arabic and who need dental care, I am a dentist and I will take them without insurance, no problem. And there are also*

other doctors, GPs and other people, so we established a network." (Interview 4, dentist)

In some cases the cooperation with surrounding hospitals who were equipped with the necessary medical devices or laboratory was difficult:

> *"In Traiskirchen we had mainly new injuries, exhaustion, pain from walking for days, etc. Viral infection, very rarely a pneumonia, an exsiccosis, but also things where you do not know how to proceed for example recurrent fewer attacks over 40 degrees. We send them to the hospital in Baden, but they did not lift a finger. In Traiskirchen we had enormous cooperation difficulties with the surrounding hospitals, or also with medical tests. There is just a certain border where we cannot do anything further. We do not have a roentgen available or could we do a blood count or other of those things. We could decide based on what we saw, heard, felt and smelled but sometimes other medical tests are required. Thus that was very difficult, and sometimes patients were sent back [from the hospital] which were not checked." (Interview 2, GP)*

Especially problematic was the situation for persons who required special assistance, such as children and pregnant women or especially vulnerable persons:

> *"In Traiskirchen I can remember an especially dramatic case. That was a young man, in a wheelchair user, with a huge decubitus. He changed his catheter himself and this decubitus was a festering whole to the bone. That is something that you cannot really treat in a refugee camp. We sent his to the hospital 2 or 3 times, I don't know what happened to him. We thought he should be hospitalised and this has to be treated properly and plastically supported and I don't know what. But there on a camp bed… really catastrophic. And it is the same in the case of providing health care for pregnant women. Some are just hospitalised shortly for delivery and after 2 hours they were released again, with their child to the refugee camp. In Traiskirchen the cooperation with the surrounding hospitals was not good. That was bad." (Interview 2, GP).*

The MSF report identifies specific barriers and challenges for providing (primary) health care in Traiskirchen with regard to vulnerable persons, amongst other things the absence of a women- and children-specialist medical care, the lack of dental acute-care as well as the lack of a psychiatric-neurological service as well as psychological crisis intervention available on a 24 hours basis (1).

After a registered asylum seeker who is admitted to the asylum procedure in Austria is transferred to a refugee camp or lives in a privately organised accommodation, he/she has the same access to the health care system as Austrian citizens. Nevertheless, at the 3rd level which is the first contact with (conventional) the primary health care system and at the level of long-term primary health

care there exist specific challenges for the (primary) health care providers. The most frequently identified barriers in the long-term primary health care are subsumed by GP:

> *"The biggest barrier is the difficulty in remuneration. The second is the language barrier, which only can be solved through appropriate interpretation services and if they are not available it becomes quite difficult. And the third is also – let's put it this way, the learning needs of the practitioners. Hence not every single one of them is familiar, […] with the post-traumatic stress disorder." (Interview 1, GP)*

The difficulty or rather impossibility to get remuneration for the additional time effort was mentioned by several interviewees (Interview 1, GP; Interview 2, GP; Interview 3, GP; Q3). Challenges in remuneration of services were also reported by the interviewed Arab speaking dentist. He explained that he handles this quite flexible, generally he treats all patients independent of asylum or insurance status, for transit emergencies remuneration is in principle never possible, however, for others who are asylum seekers in Austria and who e.g. need several sessions over a longer periods of time he can settle the costs via health insurance afterwards (Interview 5, dentist). From a GP perspective:

> *"If you take up the effort, the increased time requirement and the communication problem and interpretation and all that, and then you don't even get the fees for that – that is quite odd." (Interview 1, GP)*

As one of the biggest challenges for health care providers was the language barrier identified while there were no free translation services available to them (Interview 3, GP; Q1; Q2; Q3; Q4). With regards to first anamnesis and explanation of diagnosis and treatment the physician faces this barrier and often has to rely on Google translate, which is experienced as tedious and no proof of correct translation is given (Q1). The head of the MARF initiative also reported that the situation for pediatrics is especially problematic and challenging, as the first anamnesis takes even more time with children and without translation services, and also because it is often unclear and undocumented what medical assessment occurred beforehand.

Another GP explained that in emergency situations they worked with pictograms and similar to that also in long-term care translation is necessary:

> *"Communicating with hands and feet worked very well, I mean for acute things. Whenever there is a longer explanation then of course a translator is very helpful. With translators you have to … I sometimes felt there were ambivalences. The translator was not sympatric to the asylum seeker" (Interview 2, GP)*

The lack of freely available interpretation service is basically a decision of the health insurance services, a pilot project was started in October 2013, however, an extensive implementation across the country is not envisaged.

> *"In the entire health care system no interpreting services are available, either you have someone who joins you and translates or you have nothing, that is a huge problem and it does not only affect refugees but also all migrants" (Interview 4, stakeholder)*

Furthermore culture related communication differences are mentioned and the challenge for the GP to interpret traumatising experiences of patients (Q2) as well as cultural differences in non-verbal communication (Q4). Another GP refers to his lack of knowledge in terms of possibilities for psychological support for refugees and how such further care can be organised (Q4). In this context the challenge that the primary health care provider faces is that even if he/she knows how to organise appropriate further care especially psychological care the facilities that provide that are very busy. Facilities such as Hemayat (http://www.hemayat.org/) or the Trauma Centre you-are-welcome (http://www.you-are-welcome.at/) have long waiting lists up to several months or even years. As a GP elaborates there are relevant directors in the health care sector, which are the health insurances. According to the design of the honoraria they reinforce certain activities of GPs:

> *"People who suffer from PTSD for decades, because they are not treated, they cost a lot of money to the health insurances. In these cases a reasonable period of let's say 1 to 2 years intensive therapy would be absolutely cost-effective." (Interview 1, GP)*

With regard to the information and documentation about the initial health care assessment, several primary health care providers and stakeholders point to the huge challenge that results from the lack of knowledge about the assessment and specifically the vaccination status (Protocol 1, Ministry of Health; Protocol 2, stakeholder; Interview 3, GP; Interview 6, stakeholder; Q1; Q3;). One GP asks if it can be expected that children are in a vaccination program like in Austria (Q1), it was noted that an Arabic explanatory information sheet for vaccination would be helpful to overcome vaccination barriers (Q3) and generally the lacking information flow as well as documentation of initial health assessments poses challenges for the primary health care providers:

> *"The initial health assessment is made, and sometimes they also get vaccinated if they are unvaccinated. But the thing is, they don't get any information. They do not get the anamnesis document, they don't receive any document, they might get the vaccine pass but then they say, yes I got immunisation but we [the GPs] don't know what and how. There is no information flow whatsoever. Actually I think the persons*

should get a copy of the anamnesis document and which vaccination they got, so that we, who continue to care for them know what he received or what is the medical history behind it. That would make our job a lot easier." (Interview 3, GP)

It was mentioned that costs for vaccination are also a barrier and basic vaccines should be provided for free (Q3) also lacking information about vaccine status of children seemed obstructive:

"As far as I know the children are not immunised, they hardly have vaccination passes from Syria or Afghanistan… you try to find out which ones they received and when, this is all quite tedious" (Interview 3, GP)

In terms of information, some GPs also refer to the lack of information about the health care system of the country of origin of the refugee, the home country in general as well as flight conditions, etc. and other documentation of previous disease of refugees (Q2, Q3). Then also knowledge about nutrition habits and taboos of refugees were mentioned to be helpful to overcome health related barriers (Q3).

As one GP explained many refugees have developed post-traumatic stress disorders (PTSD) and he was glad he knew how to deal with psycho-trauma in order to provide specialised health care for refugees, which was hardly a focus when he studied medicine:

"Gladly I had experience with psycho-trauma, because before it was only necessary on a marginal level. Now due to the mass movement of people fleeing they see the need. And of course it would be very good if there are GPs who open up for this issue and continually learn and then also develop capacity for these patients, which is a precondition…" (Interview 1, GP)

"In principal doctors are not really aware, that the somatic symptom disorder has an important role in medicine. Many people manage, the majority of people manage to prevent psychological symptoms to come out. But then they suffer tremendously from pain in all body parts, they think that their heart is ill, they have horrible stomach problems and pains, all sorts of things, back- and neck-pains, headaches, migraine. That is a somatic symptoms disorder, which occurs as a consequence of psycho-traumatisation. Now these patients who suffer so heavily are many, and they attend the ambulances and then the doctors there know already, that they are physically not really ill, but still they cannot help them, because they don't understand anything about PTSD. I would say this is […] a huge obstacle, so to say the limitation of medical-psychological knowledge, or psychiatric [knowledge]. (Interview 1, GP)

For an asylum seeker in the asylum process, who suffers from mental health problems a primary health care provider can make a referral to a psychotherapist, with the same procedure as with persons with Austrian origin. But what remains problematic is that in fact services are quite limited, as in the conventional system there are not enough places covered by health insurance, and waiting

periods are long (e.g. Hemayat). Apart from language barriers for treating mental health problems, the limited therapy places need to be recognized in this context.

A challenge in staying healthy for the refugee has also structural roots, as a GP explains:

> *"I was well aware even before studying medicine, that the medical profession also involves dealing with psychological and social matters. Refugees are characterized by a high degree of social problems. Therefore they develop psychological problems and furthermore an exacerbation of their physical health, health problems. I have seen many refugees who became seriously ill due to the actual stress, the longstanding sometimes harassing handling by the authorities, … thus not only having psychiatric illnesses but also serious physically illnesses." (Interview 1, GP)*

From the point of the refugees/ asylum seekers one stakeholder argues that a huge problem and health provision challenge are transportation costs. As the people are sometimes located in very suburban areas and often no budget for public transport tickets is provided which effects on the primary health care:

> *"A specialist visit is then a matter of 2 to 3 months, nothing is quick, and that I have also seen in practice, that things are delayed when you first need someone who looks after the children, and someone who makes an appointment and so on." (Interview 3, stakeholder)*

Overall the systemic challenge of the asylum procedure, inherent in the procedure as such should not remain unmentioned,

> *"The really heavily traumatized people cannot talk about it [their flight history]. There are very few who can right away narrate that and that has happened. They are affected by the PTSD to such an extent that they will not find the words. Also the flash backs and the torture procedures … people can only bear it by dissociating. […] This explains the mental blanks, which then become an obstacle when the asylum judge demands a coherent narrative." (Interview 1, GP)*

The specific challenges and barriers for primary health care providers who treat refugees/asylum seekers and other migrants as well as for receiving (primary) health care are illuminated based on the findings; in part they are overlapping in all different levels. Recommendations to meet these challenges and respond to the barriers are provided below in the last section.

References:

(1) Report/Publication:

Medical Aid for Refugees, 2015, Zwischenbericht zur medizinischen Versorgung der in Österreich ankommenden Flüchlinge, http://medicalaidforrefugees.at/wp-content/uploads/2015/09/zwischenbericht_MASF_2015_12_18.pdf; (last access: 12.05.2016)

Ärzte ohne Grenzen Österreich, August 2015, Bericht zur medizinisch-humanitären Lage im Erstaufnahmezentrum Traiskirchen, https://www.aerzte-ohne-grenzen.at/sites/default/files/msf_traiskirchen_bericht_2015.pdf; (last access: 12.05.2016)

(3) Result from interviews, also quotes are possible

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

(4) Result from participatory observations

Number of refugees and other migrants who have themselves worked in (primary) medical care and have now applied for asylum in your country? In what way are these resources documented and used already?

Similar to other countries, in Austria the occupational status is only officially registered at the Public Employment Service Austria (AMS) after an asylum seeker receives international protection status or subsidiary protection or another residence permit due to extenuating circumstances. There was an *AMS competence check* introduced for this group of people and in January 2016 there were already 898 registered persons with asylum status who attended the competence check and the AMS planned to extend it to 13.500 persons until the end of 2016 (1). As of March 2016, there were 112 persons who were granted asylum or subsidiary protection who were medical professionals, whereof about 83 in Vienna, three quarters are from Syria, after Iraqis and Afghans (1). Many of these persons as well as asylum seekers who are still in the asylum process are preparing for the validation of foreign studies and degrees, referred to as *Nostrifikation*. Up to now these people had

the possibility to work as assistants in refugee camps, however, without treating patients they often fulfilled merely a translator function (1). Furthermore these professionals could do a traineeship (*Hospitanz*) at hospitals and from the next asylum novella onwards it should be provided that they can also engage in occupations as they are possible within clinical traineeships (*Famulaturen*) (1).

Additionally to the official data from the AMS on persons with asylum status, there exists also an informal network of Arab speaking doctors, whereof most of them are still in the asylum process (3). The network includes doctors and other health care workers mostly from Syria, but also from Iraq, Egypt and Libya, the communication is all in Arabic (3). The network goes back to the interviewed Syrian dentist who established this group as an WhatsApp group, for the purpose of networking, information exchange and service provision, it is now operated and organised by around 7 to 8 persons, who organise events and collect primary contact data of members. As of May 2016, there are already around 180 contacts in the overall group registered with number, email address, time of arrival in Austria, level of German and date which they are planning to make the *Nostrifikation*. Out of those there are around 65 dentists, 50 pharmacists and around 60 general practitioners (3) and the remaining contacts consists of specialists (Interview 5, dentist). The group organizers arranged meetings with the Ministry of Health, the Medical Association of Vienna, the Medical Association for Dentists, with the Medical University of Vienna and with NGOs and the AMS to negotiate about validation of foreign studies and diplomas and increase the information flow between asylum seekers and authorities (Interview 5, dentist). There are regular meetings monthly where all group members can attend. This network appears to function very well as direct support and is extended continuously.

> *"We built a huge group with around 200 doctors in Austria who came as refugees. We collected their name, data, telephone number, address […] We started to hold meetings every month, regularly […] We explain, where to go for the papers, where you can learn, where you find translators, many things we assist with in this group." (Interview 5, dentist)*

When there is new members who are not in the group yet, one of the members will ask the doctor responsible for the group to add the person, with a very low threshold the number of members is steadily increasing. From the network there are around seven members who already finished their *Nostrifikation*, mostly general practitioners and pharmacists. Some persons who are already registered at AMS were reported to be pushed into work in different kind of professions far from their original specialization: "there are some doctors when they apply for the AMS and they reach a

specific level of German they are pushed to work as taxi drivers, cleaning dishes or other unskilled workers job" (3).

References:

(1) Report/Publication:

AMS-Chef: Kompetenzcheck ist keine Studie, 14.Jänner 2016, http://derstandard.at/2000029053455/AMS-Chef-Kompetenzcheck-ist-keine-Studie; (last access: 12.05.2016)

Martin, Karin. 2016. Die Integration geflüchteter Ärzte, Medical Tribune (Österreich), http://pressespiegel.metacommunication.com/v3/clippings/pool/2016/05/09/_METAM64214627 70456261532672__10_iolz.pdf (last access: 12.05.2016)

(3) Result from interviews

Interview 1, GP
Interview 2, GP
Interview 3, GP
Interview 4, stakeholder
Interview 5, dentist
Interview 6, stakeholder
Interview 7, camp manager
Interview 8, camp manager
Protocol, MoH
Protocol, MAFR
Protocol, student

Conclusion

Please, summarize the capacity situation and suggest a few recommendations.

The Austrian national report points to some of the crucial capacity challenges in terms of primary health care provisions for refuges and asylum seekers.

Various primary health care workers were active during the high influx of refugees and the time when thousands of persons transited through Austria. The distinction between emergency situation, and emergency health care measures compared to provision of health care for persons who apply for asylum in Austria, is quintessential.

Generally there is a lack of multi-professional teams, which would be most perfectly suited to care for the needs of refugees. In terms of long term care, specific challenges were observed especially

in terms of the initial health assessment. This first assessment would need to become more transparent, and documents should be available to GPs who will treat the asylum seekers at a later stage. This applies also to vaccination status and a vaccination pass could be introduced and distributed wherever this is not already done.

Comprehensive information for doctors, GPs and other health care workers on health issues of refugees and asylum seekers as well as the Austrian health care system would be essential. Another aspect which poses huge challenges is translation and language barriers. We would suggest the Federation of Austrian Social Security Institution (HVSV) to provide cost coverage for video interpretation for GPs, hospitals, etc. Additionally, it would be pivotal to establish contact with health care workers who are asylum seekers in permanent refugee camps and integrate them earlier into the workforce. In Germany for instance, health care providers (GPs, dentists, etc.) can already work while being in the process of nostrification. Furthermore, we argue that specifically in terms of psycho-social needs, the extension of existing and setting up new care support institutions in this area is crucial. Lastly we believe the provision of scaled training offers for persons who work with refugees, supervision, etc. would also help health care workers to better care for asylum seekers.