Case study

A COLLECTIVE WHO EUROPEAN FRAMEWORK FOR ACTION TO SUPPORT REFUGEES AND MIGRANT HEALTH

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ABSTRACT

Background: The recent influx of refugees and migrants into the World Health Organization (WHO) European Region challenged Member States to consider a coherent, regional response based on both international law and the values and principles that the European Region had already established in considering public health and health system policy. The aim was to respond to public health needs, prevent avoidable morbidity and mortality, and mitigate human suffering among refugee and migrant populations.

Methods: A series of country assessments conducted during 2013–2015 with the support of Member State governments reviewed the current health situation of refugees and migrants, and assessed the capacity of health systems to respond rapidly and effectively.

Results: Based on these assessments, the WHO migration team made a number of initial recommendations and a High-Level Meeting on Refugee and Migrant Health was held in Rome in 2015 to develop a coordinated, regional approach. The outcome document led to the adoption by the WHO European Regional Committee in 2016 of a strategy and action plan for refugee and migrant health comprising nine priority areas to promote coordinated and collaborative action across the European Region.

Conclusion: The strategy and action plan is an excellent example of Member States working collectively to share problems and establish solutions based on shared values and an analysis of their accumulated experience.

Keywords: MIGRANTS, REFUGEES, PREPAREDNESS, UNIVERSALITY, HEALTH CHALLENGES, HEALTH SYSTEM RESPONSES

INTRODUCTION

The recent influx of refugees and migrants into the World Health Organization (WHO) European Region challenged Member States to consider a coherent, regional response (definitions used in this paper are shown in Box 1). It was recognized that this was not an isolated crisis but rather an ongoing reality that will affect European countries for some time to come, with medium- and longer-term security, economic and health implications *(1)*.

Migration is clearly a global phenomenon, significantly the product of global inequity, which poses key political, social and economic challenges. It has a number of positive societal effects, including economic and employment benefits *(2)*. However, the recent large-scale population movement has given rise to a number of epidemiological and health system challenges *(3)*, to which public health institutions and health systems of Member States need to adjust.

Member States wished to develop a response based on both international law and the values and principles that the European Region had already established in considering public health and health system policy. Throughout, the aim was to prevent avoidable morbidity and mortality and to mitigate human suffering among refugee and migrant populations. While the response should contain elements of immediate humanitarian relief, it was recognized that a longer-term development perspective was also necessary. Refugees and migrants should not be served by parallel health and social service processes in the longer term.

BOX 1. DEFINITIONS

Asylum seeker: An asylum seeker is an individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum seeker.[a]

Migrant: At the international level, there is no universally accepted definition of the term "migrant". Migrants may remain in the home country or host country (i.e. settlers), move on to another country (i.e. transit migrants), or move back and forth between countries (i.e. circular migrants such as seasonal workers).[b]

Migration: Migration is the movement of a person or a group of persons from one geographical unit to another for temporary or permanent settlement.[c] Temporary travel abroad for purposes of recreation, holiday, business, medical treatment or religious pilgrimage does not entail an act or migration because there no change in the country of usual residence.[d]

Refugee: A refugee is a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his or her nationality and is unable or, owing to such fear, unwilling to avail himself or herself of the protection of that country.[e]

Unaccompanied minor: An unaccompanied minor is one who arrives on the territory of the Member States unaccompanied by an adult responsible for him or her, whether by law or by the practice of the Member State concerned. This definition persists for as long as he or she is not effectively taken into the care of such an adult and includes a minor who is left unaccompanied after he or she has entered the territory of Member States.[f]

[a] UNHCR master glossary of terms. Rev.1. Geneva: United Nations High Commissioner for Refugees; 2006 (http://www.refworld.org/docid/42ce7d444.html, accessed 5 October 2016).

[b] How health systems can address health inequities linked to migration and ethnicity. Copenhagen: WHO Regional Office for Europe; 2010 (http://www.euro.who.int/en/publications/abstracts/how-health-systems-can-address-health-inequities-linked-to-migration-and-ethnicity, accessed 5 October 2016).

[c] Essentials of migration management for policy makers and practitioners. Geneva: International Organization for Migration; 2004 (http://www.rcmvs.org/documentos/IOM_EMM/resources/glossary.html#m, accessed 5 October 2016).

[d] Recommendation on statistics of international migration. Revision 1. New York: United Nations; 1998 (ST/ESA/STAT/SER.M/58/Rev.1; http://unstats.un.org/unsd/publication/SeriesM/seriesm_58rev1e.pdf, accessed 5 October 2016).

[e] United Nations General Assembly. Convention relating to the status of refugees. Geneva: United Nations; 1951 (A/CONF.2/108/Rev.1; http://www.refworld.org/docid/3be01b964.html,accessed 5 October 2016).

[f] Regulation (EU) No 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (2013/L 180/31). OJEU;L 180:31–59 (http://eur-lex.europa.eu/legal-content/en/TXT/?uri=celex:32013R0604, accessed 5 October 2016).

This paper is written as a case study describing the development and timeline of the European Regional approach. Member States considered that action focused solely on host countries would be less effective than integrated global, interregional and regional programmes, and the paper describes how six Member States proceeded to achieve this goal.

RATIONALE FOR ACTION

The Member States of the WHO European Region have a population of approximately 900 million people. Overall, migration has led to an increase in the population by some 5 million since 2005. During 2015, it was estimated that 75 million migrants lived in the WHO European Region, amounting to 8.4% of the total population and 39% of all migrants worldwide *(4)*. Women represented 52% of migrants. Furthermore, over 1 million refugees and migrants entered the European Region during 2015, while more than 3700 refugees and migrants were known to have died or gone missing at sea *(5)*.

The challenges came from the need to rapidly mobilize public health measures and access to health services while preserving the fiscal sustainability of the health systems. There were implications for the health needs and services of host populations, and for the quality and sustainability of health care overall.

The human dimensions were important. Often, refugees and migrants have suffered a traumatic journey, do not speak the local language and are fearful. Thus, migrant-sensitive health systems should aim to eliminate barriers to health care such as language, administrative hurdles and lack of information about health entitlements, and should take account of cultural and religious differences.

REGIONAL AND GLOBAL POLICY CONTEXTS

With the financial support of the Ministry of Health of Italy, the WHO Regional Office for Europe established the Public Health Aspects of Migration in Europe (PHAME) project in 2012 to assist Member States in adequately responding to the public health challenges emerging from migration and to protect the health of refugees and migrants and of the host population.

The European policy framework for health and well-being, Health 2020, adopted by the European Regional Committee in 2012, was also important. This policy framework acknowledges the right to health and commits Member States to the principles of universality, solidarity and equal access as the guiding values for organizing and financing their health systems. These should be provided with dignity and without discrimination, irrespective of age, sex, disability, race, ethnicity, origin, religion, or economic or other status, or ability to pay. The agreed principles also include fairness and sustainability, quality, transparency and accountability, and the right to participate in decision-making.

Health 2020 also focuses on the health dimensions of a wide range of governmental and societal policies which have an impact on health in the early 21st century, and the necessary multisectoral whole-of-government, whole-of-society and health-in-all-policies approaches that lie at the core of modern health policy development.

Several WHO resolutions adopted at global and regional levels are also relevant to the health of refugees, asylum seekers and migrants, particularly World Health Assembly resolution WHA.61.17 on the health of migrants *(6)*, adopted in 2008, which was followed up by a WHO/International Organization for Migration global consultation on an operational framework during the Spanish Presidency of the European Union in 2010 *(7)*.

STATUS OF MIGRATION AND HEALTH IN EUROPE

Refugees and migrants are a heterogeneous group comprising individuals of all age groups with different health needs. While most refugees and migrants arriving in the European Region are young adults, migrant populations also include many elderly and disabled persons. There are increasing numbers of minors, many of whom are unaccompanied children. Women comprise half of all migrants and are often disproportionately represented in vulnerable groups, for example, the victims of human trafficking for sexual exploitation *(8)*.

Epidemiological data, where available, generally indicate lower life expectancy for refugees and migrants compared with the general population and, in some cases, increased rates of infant mortality *(9)*. There are substantial variations among groups, countries of origin and health status.

Differences in health status are also manifest between men and women. Women are more exposed to sexual violence, abuse and trafficking, as well as to risks related to pregnancy and childbirth. Risk factors that affect men in particular include exposure to accidents, physical stress and other work-related health hazards *(4)*.

Migrants account for a high percentage of the working age population in low-paid jobs and are more likely to be employed on insecure, temporary contracts. These factors can contribute to social exclusion, depression and early-onset cardiovascular disease *(10)*.

Evidence also suggests higher mental distress among refugee and migrant populations, with an increased risk for women, older people and those who have experienced trauma, and with further risk caused by lack of social support and increased stress after migration *(11)*.

EARLY WORK BY THE WHO REGIONAL OFFICE FOR EUROPE

A series of country assessments (in Bulgaria, Cyprus, Greece, Hungary, Malta and Serbia) were conducted by

PHAME during 2013–2015 with the support of Member State governments. These aimed to support the existing collaboration between ministries of health, WHO country offices and the WHO Regional Office for Europe, and to strengthen each country's capacity to manage the public health challenges related to the influx. A WHO toolkit to assess health system capacity to manage large and sudden influxes of migrants in the acute phase had been previously developed, piloted and consequently adapted during a number of country assessment missions *(12)*.

The assessments reviewed the current health situation of refugees and migrants, and assessed the health system's capacity to respond rapidly and effectively, including arranging medical examinations and treatment. Important issues were the availability of cultural mediation and translation services for refugees and migrants. A particular concern was the number of unaccompanied and vulnerable minors; it was recommended that their protection should be strengthened throughout the assessment and reporting processes.

In these assessments, a number of health needs were reported, including physical and psychological traumas from travel, as well as dehydration, nutritional disorders, hypothermia, acute respiratory infections, diarrhoeal diseases, HIV/AIDS, tuberculosis, skin infections, and a number of noncommunicable diseases. Vulnerable groups were particularly affected, including elderly persons, those with disabilities, pregnant women and young children.

Immediate responses were often provided with the help of nongovernmental organizations. Thereafter, longer-term health system capacity was assessed, as well as the capacity for effective public health surveillance. Some countries were clearly vulnerable to increases in entry and exit flows, as well as to increases in the number of refugees and migrants remaining in the country. Here, joint assessments indicated a need for contingency planning. Countries often needed to shift from an emergency focus to the longer-term, systematic development of both local and national health policies to respond to the needs of refugees and migrants, for example by all-hazard generic plans including contingencies for migrant surges, health system response planning, coordination between ministries of health and nongovernmental organizations, and communications strategies for refugees, asylum seekers, migrants and resident populations.

The WHO migration team made a number of suggestions to Member States during the assessments. For example, in Serbia these included shifting from an emergency focus to a systematic approach including contingency planning to respond to a potential large influx of transiting people, improving information on migrant health for developing evidence-informed migrant health policies, developing a communication strategy on public health and migration (including the development of key messages for the general public), and strengthening cultural mediation and translation services (*13*).

Recommendations in other countries included reorganizing primary health-care services and rationalizing the use of resources (Bulgaria) *(14)*; improving disease surveillance early warning and response systems (Bulgaria) *(14)*, promoting training and curricula for cultural mediators (Cyprus) *(15)*; improving immunization policy and delivery for migrants (Cyprus) *(15)*; promoting study tours and exchange workshops (Cyprus) *(15)*; and creating effective sustainable and equitable systems for preparedness and response and for advocating health rights (Malta) *(16)*.

Further recommendations were that units on migrant health should be established within ministries of health including nominations for a focal point on migrant health to liaise with WHO. Improved centralized information systems were recommended for developing evidence-informed migrant health policies and planning their implementation. Communication strategies were recommended to develop key messages for both policy-makers and the general public.

HIGH-LEVEL MEETING ON REFUGEE AND MIGRANT HEALTH, ROME, 23–24 NOVEMBER 2015

The work of the PHAME project and the country assessments provided insight and experience to guide strategic thinking and policy development by the European Region and its Member States.

In view of the increased and shared regional experience, as well as Member State requests to develop a coordinated, regional approach, a High-Level Meeting on Refugee and Migrant Health was held in

Rome, Italy, on 23–24 November 2015. The outcome document from the Meeting committed Member States to establishing a common framework for collaborative action on refugees and migrant health to avoid fragmented, uncoordinated single-country solutions and to align political will with sound health and social policies and technical capacities.

AN AGENDA FOR ACTION

Adopting a human-rights-based approach means that refugees' and migrants' rights, including the right to health, are integral to all priorities and actions, and that each Member State should meet its obligation to respect, protect and fulfil the right to health of all persons within its jurisdiction, including refugees and migrants.

The country assessments showed that a number of principles are important for achieving this goal, and these provided an agenda for action (summarized below).

1. Public health interventions aimed at protecting and promoting the physical and mental health of refugees and migrants, as well as the host community, need to be developed both as short-term measures and for the longer term.

2. Access to responsive, people-centred health systems without discrimination should be provided to guarantee accessibility to health care for all refugees, asylum seekers and migrants throughout the migration journey.

3. Refugees and migrants should be integrated as soon as possible into existing national health structures.

4. Attention should be paid on behalf of refugees and migrants to the broader social and economic issues related to inclusion and well-being that are at the core of Health 2020.

5. It is important to improve living conditions that influence health, for example by preventing overcrowding and ensuring access to clean water and sanitation.

6. The health needs of refugees and migrants should be included in national health policies, strategies and plans as well as in local, regional and global funding mechanisms via a broad intersectoral approach.

7. Training of health professionals and relevant non-health actors is a key element throughout.

8. Comprehensive immunization programmes should be ensured.

9. Systems should be established for ensuring essential health data is continuously available as individuals move around.

10. The health needs of refugees and migrants should be included within national action plans for the prevention, systematic monitoring and control of noncommunicable diseases.

11. Efforts should be directed to groups in the most vulnerable situations within the migrant and refugee population, such as children, with priority attention given to unaccompanied children, pregnant women, the elderly, people with disabilities and victims of torture.

12. Sexual and reproductive health issues, gender-based violence, and mental health and care should receive special attention. There is also an increased need for trauma and injury care among refugees coming from countries affected by conflict and violence.

13. Rapid epidemiological surveillance capacities need to be strengthened to capture information relevant to refugees and migrants, particularly in health districts with substantial refugee and migrant populations.

14. Communication efforts should receive priority attention to dissipate fears and false perceptions among refugees and other migrants, as well as among host populations.

15. Appropriate measures should be taken to foster active participation and empowerment of refugees and migrants throughout all stages of health service provision, including design, planning and delivery.

16. Member States need to periodically assess whether the health system and public health interventions

are meeting the needs of refugees and migrants, and whether health system capacity and public health interventions are sufficient. These assessments could be conducted by national and local governmental institutions with the support of WHO and other relevant international partners.

STRATEGIC PRIORITY AREAS AND ACTION PLAN FOR IMPLEMENTATION

These considerations informed the Member States during the WHO European Regional Committee in Copenhagen in September 2016, where a strategy and action plan for refugee and migrant health was adopted. Nine priority areas were identified.

PRIORITY AREA 1: ESTABLISHING A FRAMEWORK FOR COLLABORATIVE ACTION

The objective is to strengthen collaboration with and among United Nations agencies, the European Commission, the International Organization for Migration, and other national and international organizations with roles in the migration and health landscape, including nongovernmental organizations, which should be involved throughout.

In this respect, the United Nations General Assembly High-Level Summit on Large Movements of Refugees and Migrants, which was held in New York in September 2016, was a watershed moment in strengthening governance of international migration and creating a more responsible, predictable system for responding to large movements of refugees and migrants.

PRIORITY AREA 2: ADVOCATING FOR THE RIGHT TO HEALTH OF REFUGEES, ASYLUM SEEKERS AND MIGRANTS

Positive political and societal will and commitment are required to promote migrant-sensitive health policies that aim to provide equitable access to health promotion, disease prevention and care for refugees and migrants. Such policies should go hand in hand with advocacy to recognize human rights and reduce discrimination and stigma.

PRIORITY AREA 3: ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

Explicit consideration should be given to the main social, economic and environmental determinants of the differential health risks and outcomes experienced by refugees and migrants. The health sector has a key role in ensuring that the health aspects of migration are considered in the context of broader government policy and by all relevant governmental and non-state actors.

PRIORITY AREA 4: ACHIEVING PUBLIC HEALTH PREPAREDNESS AND ENSURING AN EFFECTIVE RESPONSE

Public health preparedness is weak in many countries. To identify and respond to the health needs of refugees and migrants, improvements are needed in health systems capacity, public health and health systems preparedness, surveillance and response, and public health participation in health systems planning and development.

PRIORITY AREA 5: STRENGTHENING HEALTH SYSTEMS AND THEIR RESILIENCE

Member States should have in place minimum health systems capacities to enable them to address the health challenges associated with migration and to mitigate mortality and morbidity. Refugees and migrants should be provided at the initial stages of the migration process with the health support necessary to overcome the difficulties of arriving in a new environment. Thereafter, the health system should provide essential health services that, wherever possible, should be fully integrated into existing national health structures and provided without discrimination.

PRIORITY AREA 6: PREVENTING COMMUNICABLE DISEASES

Communicable diseases are often a local concern, although it must be stressed that, in general, refugees and migrants do not pose a health security threat to host communities.

The challenge to communicable disease surveillance and control is equivalent to that presented by the general population and should be dealt with using the national and international framework and principles, established by the *International Health Regulations (2005) (17)*.

However, migrant populations may originate in countries with a high prevalence of certain communicable diseases (e.g. a higher prevalence of hepatitis is seen in many countries of origin). Such concerns need to be addressed on a risk-specific basis using well-functioning public health services that include surveillance and health protection, necessary and proportionate interventions, and good public and community information.

PRIORITY AREA 7: PREVENTING AND REDUCING THE RISKS POSED BY NONCOMMUNICABLE DISEASES

Limited access to health promotion, disease prevention and health care during the transit and early insertion phases of migration may increase the burden of untreated noncommunicable conditions. Refugees and migrants should form part of the national strategy for the prevention and control of noncommunicable diseases.

PRIORITY AREA 8: ENSURING ETHICAL AND EFFECTIVE HEALTH SCREENING AND ASSESSMENT

The reasons for carrying out frequently deployed health assessments, massive screenings and mandatory examinations should be explained and their effectiveness assessed. The use of such screening should be evidence based and serve the true interests of refugees and migrants. WHO is opposed to mandatory large-scale screening, which may be logistically demanding and costly.

PRIORITY AREA 9: IMPROVING HEALTH INFORMATION AND COMMUNICATION

Priorities include improving the collection of and access to adequate, standardized and comparable information about the health status, modifiable risk behaviours and access to health care of refugees and migrants. This information should be made available to these population groups to facilitate access to health care. Data disaggregation and comparability is required, and more data is needed on irregular migrants.

Communication efforts should aim to dissipate fears and false perceptions among refugees and migrants, as well as among host populations.

CONCLUSION

There is a key role for WHO to act both globally and regionally as coordinator of the health sector, working together and collaboratively with other involved actors and agencies.

The agreed strategy and action plan gives a basis for coordinated and collaborative action across the European Region. It is an excellent example of Member States working collectively to share problems and establish solutions based on shared values and principles, as well as on an analysis of their accumulated experience.

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REFERENCES

1. McGuinness F, Hawkins O. Impact of immigration on population and the economy. Commons Briefing Paper CBP 7659. London: House of Commons Library; 2016 (http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7659, accessed 5 October 2016).
2. Autumn 2015 Economic Forecast: moderate recovery despite challenges [press release]. European Commission. 5 November 2015 (http://europa.eu/rapid/press-release_IP-15-5996_en.htm,accessed 5 October 2016).
3. Gushulak BD, Weekers J, MacPherson DW. Migrants and emerging health issues in a globalized world: threats, risks and challenges, an evidence based framework. Emerg Health Threats J. 2010;2:e10. doi:10.3134/ehtj: 09/010.
4. How health systems can address health inequities linked to migration and ethnicity. Copenhagen: WHO Regional Office for Europe; 2010 (http://www.euro.who.int/en/publications/abstracts/how-health-systems-can-address-health-inequities-linked-to-migration-and-ethnicity, accessed 5 October 2016).
5. Refugees/Migrants Emergency Response – Mediterranean [website]. Geneva: United Nations High Commissioner for Refugees; 2016 (http://data.unhcr.org/mediterranean/regional.php, accessed 5 October 2016).
6. Resolution WHA61.17. Health of Migrants. In: Sixty-first World Health Assembly, Geneva, 19–24 May 2008. Resolutions and decisions, annexes. Geneva: World Health Organization; 2008 (WHA61/2008/REC/1; http://apps.who.int/gb/ebwha/pdf_files/WHA61-REC1/A61_REC1-en.pdf, accessed 5 October 2016).
7. Glossary on migration, 2nd edition. International Migration Law No. 25. Geneva: International Organization for Migration; 2011 (http://publications.iom.int/books/international-migration-law-ndeg25-glossary-migration, accessed 5 October 2016).
8. Human trafficking in Europe: an economic perspective. Geneva: International Labour Organization; 2004 (Declaration/WP/31/2004; http://www.ilo.org/global/topics/forced-labour/publications/WCMS_081992/lang–en/index.htm, accessed 5 October 2016).
9. Spallek J, Zeeb H, Razum O. Life course epidemiology: a conceptual model for the study of migration and health. In: Schenker MB, Castañeda X, Rodriguez-Lainz A, editors. Migration and health: a research methods handbook. Oakland, CA: University of California Press; 2014:38–56.
10. In it together: why less inequality benefits all. Paris: Organization for Economic Co-operation and Development; 2015 (http://dx.doi.org/10.1787/9789264235120-en, accessed 5 October 2016).
11. Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/en/publications/abstracts/public-health-aspects-of-migrant-health-a-review-of-the-evidence-on-health-status-for-refugees-and-asylum-seekers-in-the-european-region-2015, accessed 5 October 2016).
12. Toolkit for assessing health system capacity to manage large influxes of refugees, asylum seekers and migrants. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0018/325611/Toolkit-assessing-HS-capacity-manage-large-influxes-refugees-asylum-seekers-migrants.pdf?ua=1, accessed 5 October 2016).
13. Serbia: assessing health-system capacity to manage sudden large influxes of migrants. Joint report on a mission of the Ministry of Health of Serbia and the WHO Regional Office for Europe with the collaboration of the International Organization for Migration. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/2015/serbia-assessing-health-system-capacity-to-manage-sudden-large-influxes-of-migrants-2015, accessed 5 October 2016).
14. Bulgaria: assessing health-system capacity to manage sudden, large influxes of migrants. Joint report on a mission of the Ministry of Health of Bulgaria and the WHO Regional Office for Europe. Copenhagen: WHO Regional Office for Europe. 2015 (http://www.euro.who.int/__data/assets/pdf_file/0009/300402/Bulgaria-Assessment-Report-en.pdf?ua=1, accessed 5 October 2016).
15. Cyprus: assessing health-system capacity to manage sudden, large influxes of migrants. Joint report on a mission of the Ministry of Health of Cyprus, the International Centre for Migration, Health and Development and the WHO Regional Office for Europe. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/__data/assets/pdf_file/0020/293330/Cyprus-Assessment-Report-en.pdf?ua=1, accessed 5 October 2016).
16. Hannigan A, O'Donnell P, O'Keeffe M, MacFarlane A. Assessing health-system capacity to manage sudden, large influxes of migrants. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network Synthesis Report 46; http://www.euro.who.int/__data/assets/pdf_file/0004/280714/Malta-assessing-health-system-capacity-manage-sudden-large-influxes-migrants.pdf?ua=1, accessed 5 October 2016).
17. International Health Regulations (2005), 2nd edition. Geneva: World Health Organization; 2008 (http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf?ua=1, accessed 5 October 2016).