

# Increased influx of migrants in Lampedusa, Italy

Joint report from the Ministry of Health, Italy and the  
WHO Regional Office for Europe mission of 28–29 March 2011

# Lampedusa




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# Glossary and abbreviations



|                      |   |
|----------------------|---|
| CIE                  | Centre for Identification and Expulsion   |
| Displaced population | Persons who have fled their country due to persecution, generalized violence, armed conflict situations or other man-made disasters. These individuals often flee en masse.   |
| EMS                  | Emergency medical services  |
| IOM                  | International Organization for Migration  |
| Migrant              | The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of “personal convenience” and without intervention of an external compelling factor. This term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family. |
| MDR TB               | Drug- and multidrug-resistant tuberculosis (resistant to isoniazid and rifampicin)  |
| MMG                  | General practitioners   |
| MSF                  | Médecins Sans Frontières  |
| NATO                 | North Atlantic Treaty Organization  |
| OCHA                 | Office for the Coordination of Humanitarian Affairs   |
| Refugee              | A person, who “owing to 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 nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (UNHCR Convention relating to the Status of Refugees, Art. 1A(2), 1951 as modified by the 1967 Protocol)               |
| TB                   | Tuberculosis  |
| UNHCR                | United Nations High Commission for Refugees   |
| XDR TB               | Extensively drug-resistant tuberculosis (resistant to isoniazid and rifampicin and to any one of the fluoroquinolone drugs and to at least one of the three injectable second-line drugs: amikacin, capreomycin or kanamycin)   |
| WHO                  | World Health Organization   |

The definitions of ‘Displaced Population’, ‘Migrant’ and ‘Refugee’ have been extracted from the IOM Glossary on Migration

# Executive summary



In the context of the evolving crisis in north Africa, and in particular the Libyan Arab Jamahiriya, a meeting between the Italian Minister of Health, Professor Ferruccio Fazio, and the WHO Regional Director for Europe, Zsuzsanna Jakab, took place. This resulted in the WHO Regional Office for Europe assessment mission to Italy. The main objectives of this mission were to review the current situation of the displaced populations arriving in Italy as a result of the crisis in north Africa; and to assess the level of preparedness of the Italian health system to cope with the public health consequences of a potential mass influx. The purpose was to provide recommendations on how to improve the international coordination and cooperation of preparedness efforts.

The unexpected flow of migrants in 2011, coupled with an earlier decrease in the flow of migrants from 2009, had resulted in the downsizing of the holding capacity in the Italian island of Lampedusa. The Italian authorities made a major effort to increase the capacity for migrants. In addition, contingency plans have been elaborated; and a multisectoral coordination mechanism has been established.

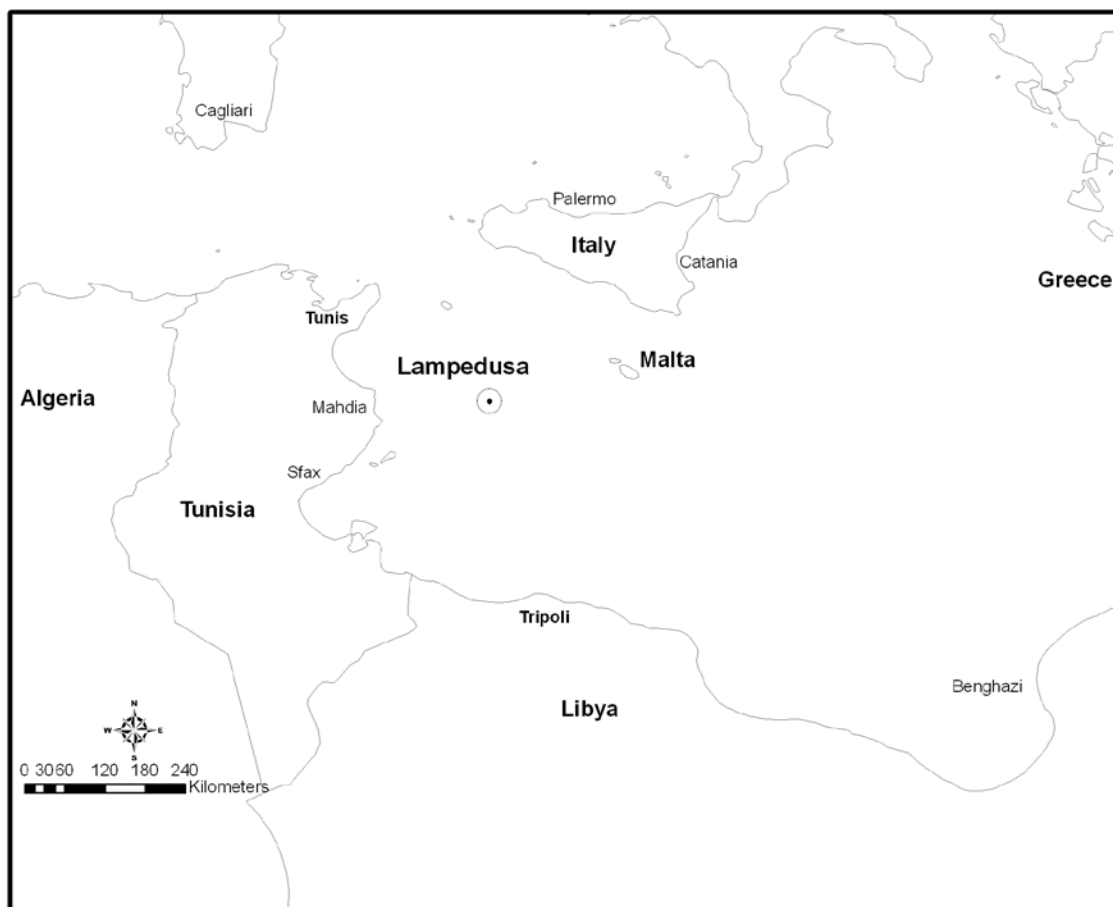
The crisis has created a moment of strategic importance in revising health-care preparedness and identifying gaps. The WHO Regional Office for Europe, in a joint effort with the Italian Ministry of Health and other key government officials involved in the preparedness planning efforts, assessed what is needed to face the emergency and any potential future scenarios. Two assessment missions took place in March 2011. The mission teams used the WHO health system crisis preparedness assessment method as a framework for providing recommendations.

The receiving centre in Lampedusa, with a capacity of 800 beds, in March 2011 suffered a serious deterioration of public health conditions due to approximately 500 migrants arriving daily during that period. Responding to this type of health challenges requires the immediate improvement of several facilities. The missions revealed the urgent necessity of increasing the availability of access to water and sanitation; the need to rapidly increase the storage capacity for drinking-water; the need to increase the number of bathing and shower facilities; and the implementation of socio-psychological measures. The report also addresses the possibility of a worst-case scenario, where Italy could be affected by a mass influx of displaced populations as a result of a severe humanitarian crisis.



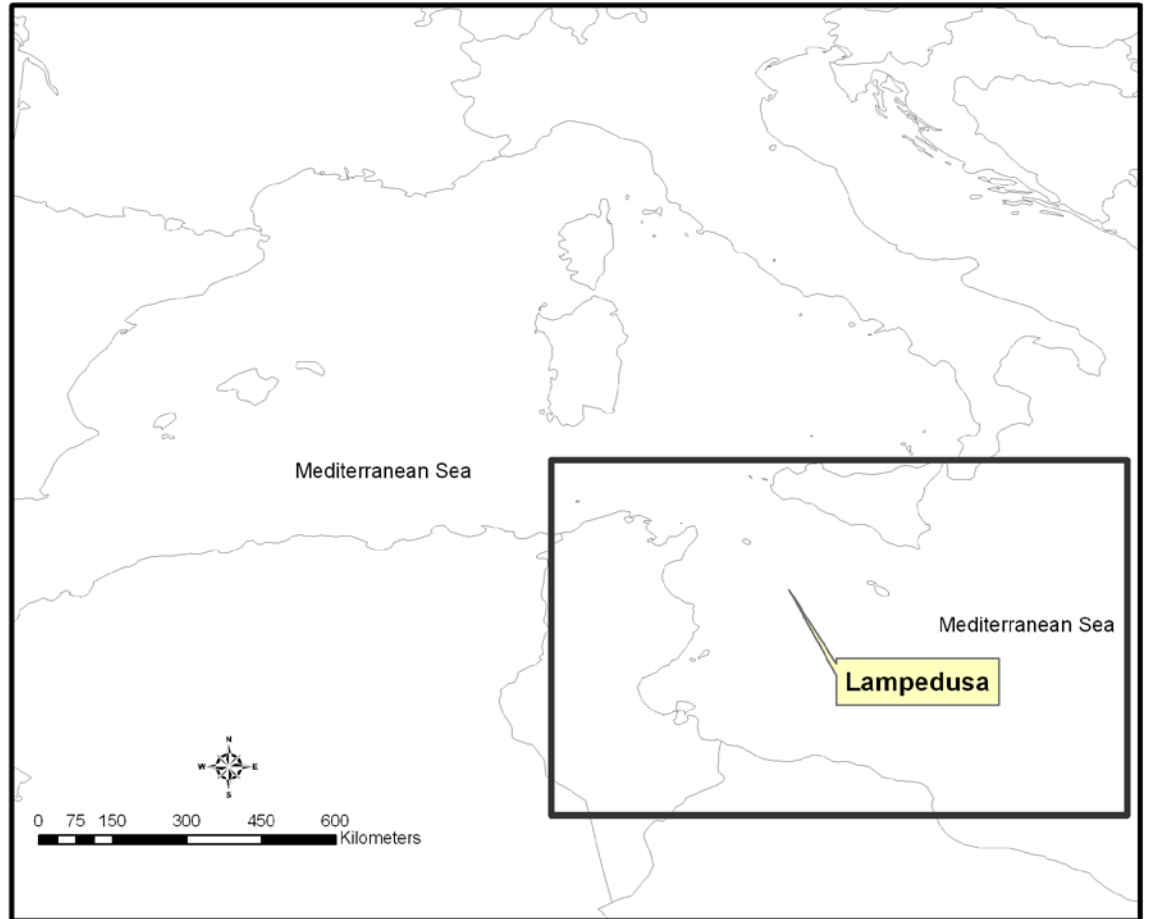
# 1. Introduction

Due to its geographical position, Italy represents one of the points of entry into Europe for African migrants. Since the 1990s, Italy, and the Trapani and Lampedusa coastlines in particular, have been landing points for immigrants coming from Tunisia. Today, with the northern African political crises and in particular the conflict in Libya, displaced populations and immigrants have arrived from all over the Maghreb area, including sub-Saharan Africa. Currently, Sicily is a hub for Mediterranean migrants.



The majority of these migrants arrive in Lampedusa. Over the past five years, an increase in the arrival of migrants on the island of Lampedusa has been registered, with 8800 people in 2003; 10 477 in 2004; 15 527 in 2005; 18 047 in 2006; and 11 749 in 2007. The peak of this immigration phenomenon was reached in 2008 with 31 250 migrants arriving on the island (86% men and 14% women).

The flow of migrants was interrupted in 2009 with a bilateral agreement between Italy and Libya. Following this agreement, only a few hundred people arrived annually to Lampedusa. The Coast Guard, Revenue Officers and the Navy are usually engaged in intercepting all the boats at sea and escorting them to Lampedusa, where migrants are retained before the completion of all the bureaucratic procedures of identification.



In 2011, as a result of the turmoil in northern Africa, the movement of people towards Lampedusa resumed, with approximately 23 000 people arriving between January and the end of March. The majority of them are Tunisian males, aged 18-45 years. However, towards the end of this period, boats also arrived from Libya, bringing people fleeing from Eritrea, Somalia and Libya.

On 17 March, the Security Council adopted Resolution 1973 authorizing Member States “to take all necessary measures ... to protect civilians and civilian populated areas under threat of attack in the Libyan Arab Jamahiriya” and on 19 March an international coalition launched air strikes on Libyan Government forces. This increased the already high flow of labour migrants out of Libya. The number increased from an estimated 250 000 to about 400 000 according to international organizations. This situation raises a serious concern about the increasing numbers of undocumented immigrants and now also refugees to Lampedusa and Sicily.

Until 2009, Italy had an excellent system of reception in place, with a specific procedure for asylum applicants and immigrants entitled to “international protection”. The Italian authorities have solid experience with this model of cooperation between central and local administration, and the Ministry of Interior and the network of municipalities have undertaken the main role in the development of policies and strategies in this field.

The unexpected increase in the flow of migrants in early 2011, along with the interruption of the flow of migrants in 2009 that resulted in the downsizing of the reception capacity, is the basis for the distressed situation in Lampedusa. The Italian authorities are currently making a major effort to scale-up the capacity, and this is also a strategic moment to revise public health preparedness and to identify gaps.

## 2. Methodology of the assessment

The WHO health system crisis preparedness assessment method, summarized on the next page, was used as the orienting framework for the two assessment missions conducted in March. The first assessment visit, from 16 to 18 March 2011, addressed certain key elements of the current crisis; the second visit, which was jointly conducted with the Italian Ministry of Health from 27 to 28 March 2011, addressed other key elements. Semi-structured interviews were held with key government officials involved in the preparedness planning efforts and the contingency planning for various scenarios.

In the WHO health system crisis preparedness assessment method, health systems are defined as comprising all the resources, organizations and institutions that are devoted to taking interdependent action aimed principally at improving, maintaining or restoring health. In order to fulfil their purpose, health systems need to perform the following six key functions that constitute the WHO health systems framework:

1. Leadership and governance;
2. Health workforce;
3. Medical products, vaccines and technology;
4. Health information;
5. Health financing; and
6. Service delivery.

Organizing the assessment along the key components of the six functions allows a structured approach to summarize the key findings (see also Fig. 1).

**Fig. 1 Preparedness planning: Key elements by function**

| Core Function                                    | Key Element   |  |   |  |  |
|--|---|--|---|--|--|
| <b>Leadership and Governance</b>                 | National multisectoral emergency management legal framework                             | Health sector emergency management legal framework                 | National multisectoral institutional framework for emergency management | Health sector institutional framework for emergency management | Health sector emergency management programme components    |
| <b>Health Workforce</b>                          | Human resources for health emergency management   |  |   |  |  |
| <b>Medical products, Vaccines and Technology</b> | Medical supplies and equipment for emergency response operations                        |  |   |  |  |
| <b>Health Information</b>                        | Information management systems for risk reduction and emergency preparedness programmes | Information management systems for emergency response and recovery |   | Risk communication   |  |
| <b>Health Financing</b>                          | National and subnational financing strategies for health emergency management           |  |   |  |  |
| <b>Service Delivery</b>                          | Response capacity and capability  | Emergency Medical Services System and mass casualty management     | Management of hospitals in mass casualty incidents                      | Continuity of essential health programs and services           | Logistics and operational support functions in emergencies |

## WHO health system crisis preparedness assessment method

The assessment is based on the six key functions of the WHO health systems' framework:

*Leadership and governance of health systems*, also called stewardship, is arguably the most complex but critical building block of any health system. Stewardship of the health system is achieved through careful and responsible management that results in influencing all sectors with regards to policy on and action for population health. In connection with preparedness planning, this means ensuring the existence of a national policy to prepare the health system for any kind of crises. It also means having effective coordination structures and partnerships in place and involves advocacy, risk assessment, information management and monitoring and evaluation.

*Health workforce* refers to the health workers, who are the cornerstone of the health-care delivery system, influencing access, quality and costs of health care and effective delivery of interventions for improved health outcomes.

A well-functioning health system should *ensure equitable access to essential medical products, vaccines and technologies* of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. This key function also includes medical equipment and supplies for pre-hospital activities, hospitals, temporary health facilities, public health, pharmaceutical services, laboratory services and blood services (as a reserve) in case of a crisis.

A well-functioning *health information system* is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems' performance and health status. The health information system also includes data collection, analysis and reporting, including hazard and vulnerability assessments, disease early warning systems and overall information management issues.

The *health financing* function ensures the collection of revenues, their subsequent pooling and the purchase of health services from providers. In terms of crisis management, a good health financing system ensures that there are adequate funds for health system activities related to risk prevention and mitigation, preparedness and response. It also provides financial protection in case of a crisis and ensures that crisis victims have access to essential services.

*Service delivery* relates to a service production process that, when needed, combines the input of various providers into health interventions that are effective, safe and of high quality, and ensures their delivery to relevant individuals or communities in an equitable manner. The organization and management of services are reviewed from a health system crisis management perspective to ensure access to health facilities during a crisis as well as the quality, safety and continuity of care across health conditions and health facilities.

# 3. Leadership and governance

In Italy, all key elements of the governance and stewardship building blocks in relation to the preparedness to cope with the consequences of a massive influx of displaced populations are addressed through the Italian Ministry of Interior, with coordination leadership from the local authority for the area of Lampedusa represented by the special commissioner for the immigration emergency, the Prefect of Palermo.

Legal frameworks and institutional arrangements are in place, showing a good basis of readiness by the Italian health system to address public health challenges triggered by a potential mass influx of migrants. There is an effective legal framework for multisectoral crisis management arrangements and the public health law and regulations allow for any extraordinary measures necessary to effectively manage a public health emergency.

In addition, while the Italian Government has implemented European laws with regard to immigration, the Sicilian Regional Government<sup>1</sup>, after responding to past crises with massive debarking of migrants, issued several law directives aiming to provide “essential and continuative treatment” to the immigrant population. These include:

- Regional Law n. 5/2009 – Norms for the Re-organization of the Regional Health System – Art. 28 – Health Care Assistance to Foreigners Coming from Outside the EC countries;
- Regional Law n. 55/1980 and further modifications – New Provisions in Favour of Immigrant Workers and Their Families;
- Regional Law 2 March 2009 – “Regional Programme of the Social and Socio-Health Policies 2010–2012” covering programming of activities suggested for the period from 2010 to 2012;
- Decree of the Health Councillorship of the Sicilian Region (D.A.) n. 1270 of 4 July 2003 – Guidelines for the Health Care of Foreigners Coming from Outside the EC Countries;
- D.A. n. 30447 of 28.10.1999 – Recognition of the Regional Reference Centre for Travellers’, Tourists’ and Migrants’ Medical Care;
- Sicilian Region Circular 17 April 2008, prot. DIRS/2/0781 Note of the Ministry of Health 19 February 2008. “Clarifications Regarding Health Care Assistance to the New E.C. Citizens Living in Italy”.

The institutional framework foresees a multisectoral emergency management structure under the “Special Commissioner for the Immigration Emergency”. This was activated to coordinate the logistical challenges of managing the emergency immigration in Lampedusa, the transfer of migrants to hospitality centres on the mainland, and repatriations.

Preparedness and management efforts of the current situation in Lampedusa are coordinated and led by the Ministry of Interior, the Civil Protection, which falls under the Prime Minister’s office, the police, the Armed Forces, the Ministry for Health, and the Regional Health Authorities. In Lampedusa, the Ministry of Interior is also supported through a legal agreement with the United Nations High Commission for Refugees (UNHCR), International Organization for Migration (IOM), Italian Red Cross, and the nongovernmental organizations Médecins Sans Frontières (MSF) and Save the Children.

<sup>1</sup> Italy is divided into administrative regions which hold the responsibility of providing and managing health care. Sicily, constituting one of these regions, holds additional administrative autonomy in the areas of taxation and legislative capacity.

Contingency plans have been elaborated and adapted to the evolving situation in northern Africa. Areas for initial reception have been identified in Lampedusa and there is a centre with a capacity of 800 beds. Temporary accommodation facilities, in the form of tents, have been stored in Lampedusa in case the arriving flow turns into a massive influx of migrants and refugees. In terms of the health sector, on 3 March 2011 the Sicily Regional Health Authorities established a coordination table with the participation of the directors of all health services in the region. Their goal is to coordinate actions in response to the Lampedusa emergency and develop a modular emergency contingency plan to secure the provision of effective health services.



*Lampedusa receiving centre. Photo: WHO Regional Office for Europe*

A site visit was conducted to the Centre for Identification and Expulsion (CIE), a centre for migrants in Lampedusa. This is basically a dedicated closed “contention” facility administered by the Italian Ministry of Interior and guarded by police. This facility has been refurbished in 2010 and is currently capable of hosting up to 800 people, but given the emergency situation, its capacity is being overstretched with 2800 people, while the overall presence on the island reached 8000 migrants.

This facility is operated by a private contractor of the Ministry of Interior (Cooperativa Lampedusa Accoglienza) who provides assistance to the migrants at the centre in the form of accommodation and personal supplies, health care (basic emergency or referral to specialized health centres), psychosocial assistance, cultural and linguistic mediation, catering, cleaning and environmental hygiene services. The contractor has an outpatient post within the receiving centre with three doctors and three nurses, and the health workers are in liaison with the territorial health authorities in cases that need emergency health care. Emergency cases are referred to the island’s primary health-care post and in the case of specialized treatment are referred to hospitals in the Sicily via helicopter.

Links with the surveillance of communicable diseases should be established and a standardized electronic collection of epidemiologic data should be encouraged. At the moment, the data of patients assessed in the centre are collected on epidemiological forms.

The mission team noted that retaining this closed detention centre for asylum seekers for prolonged periods might be associated with an increased demand for psychosocial support services.

# 4. Human resources for health management

Health care for legal immigrants is provided through public or private accredited institutions of the Regional Health Service and through volunteer centres; these are the same institutions and centres that provide care and assistance to Italian citizens.

Irregular migrants, on the other hand, receive hospitality and health care in centres that are often managed by the major catholic or lay voluntary associations.

Health care is also provided within the facilities that accommodate and assist illegal immigrants, under the coordination of the Ministry of Interior. These are divided into three types:

- Reception Centres, which have the capacity to guarantee first aid to illegal immigrants;
- Reception Centres for Asylum Applicants; and
- Identification and Expulsion Centres, which are used for the detention of illegal immigrants awaiting expulsion.

Lampedusa has a primary health-care centre, with only day-hospital capacity. The resident medical staff is highly qualified and experienced, and includes the Health Director, three doctors and ten nurses. All health specialties are available from specialists arriving from Sicily (Palermo health district), but only on certain days of the week. The limited number of health professionals is a critical bottle neck in the Lampedusa health system, however the Regional Health Authority is responding to the need to expand the availability of a health workforce for the emergency response in Lampedusa. Additional doctors and nurses have been provided to the primary health-care centre in Lampedusa and in other areas of Sicily and Linosa Island, where other displaced people are arriving. A second helicopter has been located in Lampedusa, on standby, to support a higher demand for medical evacuation (MEDEVAC).

Under emergency influx of people the system can be stressed. It faces the challenge of a health system with a limited capacity, and facility and installation maintenance that needs to cope with a substantial extra patient load for an undefined, extended period of time.

# 5. Medical products, vaccines and technology

## 5.1 Medical supplies and equipment for emergency response operations

The Regional Health Authorities and Civil Protection have deployable additional health staff, stocks and supplies that can be mobilized to meet the health needs in an evolving crisis situation, and health centres are equally well stocked with emergency supplies.

Extra lab and diagnostic capacity to diagnose communicable diseases and tropical infectious diseases might be required if rare diseases are detected. Lab confirmation of such diseases might require WHO technical support to identify reference laboratories and to facilitate sample shipments.

Provisions exist for migrants to receive medications and medical supplies, as displaced people basically have the same entitlements to receive treatment and pharmaceuticals as Italian citizens. There are sufficient vaccine stocks to ensure the essential immunization coverage of displaced populations.

## 5.2 Water and sanitation

Given the high number of arriving migrants in early 2011 (about 500 daily), the civil protection department and local island authorities have identified dedicated accommodation space near the port reception area, which is, exceptionally, temporarily accommodating about 8000 displaced people as a result of this emergency. Basic stocks of tents, blankets and other supplies have been mobilized by NGOs, Italian Red Cross and by governmental authorities.

Managing the emergency in Lampedusa is additionally complicated by the insufficient availability of access to water and sanitation infrastructure. Some chemical toilets have been installed in Lampedusa but toilets and sanitation are still seriously insufficient, and the health authorities of the island report that large areas in the surroundings where migrants are stationed are “turning into open toilets”.

Lampedusa has peculiar infrastructural and natural conditions. The island is 25.83 square kilometres, with about 4500 inhabitants. Lampedusa does not have natural water resources of drinking-water: this comes mainly from Sicily. Careful planning and control of the water supply is crucial in reducing the health risks from water scarcity; this is especially linked to the increased demand and to weather conditions, which make the ferrying of water to the island challenging, resulting in the need to restrict and prioritize water use.

Supplying such a large number of migrants with bottled drinking-water does not appear to be the most sustainable way of supplying water, as this also includes the need to cater for the collection and disposal of large amounts of plastic bottles.

There is a need to rapidly increase the storage capacity of drinking-water on the island, to cater for rapid fluctuations in the demand for water supply and water consumption needs. This can be achieved by using bladder tanks. Such tanks can be delivered and set up on Lampedusa with one week's notice. In addition, to maintain the necessary levels of personal hygiene among migrants and prevent transmission of faecal-oral and respiratory infections, the number of shower facilities and hand-washing facilities needs to be greatly increased.





*Drinking-water from Sicily. Photo: WHO Regional Office for Europe*

## 6. Health information



Routine surveillance requires that any public health concerns about communicable diseases are reported. The mission teams discussed the need to shift from regular disease reporting to a syndromic surveillance system and active surveillance, which would provide for an early warning function. There are existing plans in the Ministry for Health to establish a syndromic surveillance system, which should be extended to centres managed by the Ministry of Interior for monitoring disease patterns in the case of large numbers of arrivals of migrants.

Epidemiologic data analysis is done regularly by health posts within centres managed by the Ministry of Interior. The analysis of health data of migrants who have been screened as per established protocols, should be made available to public health authorities as planning references. One area of concern for the local health authorities is tuberculosis among the displaced people, particularly drug and multidrug-resistant tuberculosis (MDR TB) and extensively drug-resistant tuberculosis (XDR TB).

In order to manage the health aspects of the north African immigrants in Lampedusa (Sicily) and to draw up ad hoc guidelines to be used in each region where the immigrants are going to be relocated, the Italian Health Ministry drafted a protocol for syndromic surveillance and for vaccination to be applied in the Immigrant Reception Centres.

The protocol is based on the documents produced by WHO for syndromic surveillance and on the Italian childhood immunization calendar and vaccine schedules, according to national legislation and depending on the known/unknown certification of immunization.

The following syndromic surveillance protocols are to be carried out:

- diseases that cause substantial morbidity (i.e. diarrhoea and respiratory infections, with special attention for suspect tuberculosis cases);
- diseases that have the potential to cause epidemics (i.e. measles, cholera, meningitis, jaundice, scabies and haemorrhagic fevers);
- unexplained causes of deaths.

A person responsible for applying this protocol in each reception centre should be nominated through the regional health authorities and will be in charge of daily reporting of registered cases and of administering vaccinations at a regional and central level. The follow-up of cases, laboratory confirmations, epidemic investigation and mandatory notifications of communicable diseases should be performed according to national laws and public health plans.

The authorities, while managing the emergency in Lampedusa, have prepared a contingency plan to face the worst-case scenario, establishing the capacity to host up to 50 000 migrants/-refugees. This logistic challenge and its consequent problems should be addressed, since capacity in Lampedusa would be overwhelmed. The recommendation is that the health-care assistance provided within the hosting centres by the Ministry of Interior should be linked with the regional health authorities, but with a single point established for surveillance.

# 7. Health financing - national and sub-national financing strategies for health emergency management

Contingency funds are available with the Ministry of Interior and regional health authorities to financially support necessary preparedness and response measures.

## 8. Service delivery

### 8.1 Health services

The hospitals, as national and regional references, ensure highly specialized services through advanced and innovative diagnostic and therapeutic technologies.

The Sicilian Region ensures immigrants (with or without a residence permit) the right to access preventive services and to maternal and child health care, including access to vaccinations and emergency services. Health-care workers have no obligation to report illegal immigrants to the competent authorities.

Specific clinics at hospital trusts have been created to provide illegal immigrants with:

- primary care;
- social assistance services;
- issuing of the Foreigner Temporarily Present code (straniero temporaneamente presente or STP code);
- specialist examinations; and
- diagnosis and treatment.

It is important to note that services for immigrants are addressed mainly to illegal immigrants, as those who have a regular residence permit may turn to general practitioners (MMG), just as Italian citizens do.

The Immigrants' Services are present in five provinces in Sicily:

- in Palermo – the “Civico” Public Hospital and the “Buccheri La Ferla” Hospital;
- in Catania – the “V. Emanuele” Public Hospital, the “Garibaldi” Public Hospital;
- in Messina – the “Papardo” and “Piemonte” Public Hospitals;
- in Ragusa – “Médecins sans Frontières” (MSF) has opened specific outpatient departments within the health districts of Santa Croce Camerina, Vittoria, Scicli and Ispica; and
- in Caltanissetta.

The organizations that provide services for immigrants at a regional level are:

- the Regional Centre of Reference and Coordination for Migrant's Medical Services, within the Department of Clinical Medicine and Emerging Diseases of the "P. Giaccone" University Hospital in Palermo;
- the Regional Health Inspectorate, where the Social Medicine and Regional Epidemiological Observatory groups work; and
- the National Reference Centre for the promotion of migrant populations' health and for the adoption of the measures to counter diseases linked to poverty, located at the "San Giovanni di Dio" Public Hospital in Agrigento.

Primary care services (health centres), the emergency medical services (EMS) system, and the referral hospital are all well prepared to meet the health needs of a limited number of migrants. The migrants receive primary care services in health centres, which cover the main primary care service package. Cultural mediators, who are part of the migrant communities, have received basic training and are providing support to the migrant population, including translation services.

The main hospitals located in Sicily provide tertiary care referral services. The hospital facility in Sicily is equipped with the latest medical technology and is well prepared to handle any type of health emergency, including mass casualty incidents. The hospital has, jointly with the Ministry for Health, developed a medical contingency plan for migrants in Sicily and Rome to quickly establish additional care bed capacity. In addition, a short-term peak in demand for various tertiary care interventions can be absorbed without major disruption to the regular hospital services.

While the health services are generally well prepared, the health workforce and its limited number within the closed environment of a small island is the major problem.

## 8.2 Sanitation measures

With the average residence time of refugees on the island being two weeks, measures should be taken to avoid them lapsing into a state of total dependency. Furthermore, mandatory courses in personal hygiene including the need for personal cleanliness and the reasons behind an absolute interdiction of open defecation need to be given in the migrants' own language.



*Migrants in Lampedusa Centre. Photo: WHO Regional Office for Europe*

# 9. Risk assessment

Within the health system, different risk scenarios with health implications for neighbouring and south European countries can be identified:

- risks associated with violence, lack of access to health care and treatment of chronic diseases;
- lack of access to safe drinking-water and food supply, shelter and health care;
- outbreaks of infectious diseases among refugees from Libya;
- tuberculosis outbreaks in refugee camps if they become overcrowded;
- outbreaks of diarrhoea, typhoid fever, hepatitis A and E;
- acute respiratory infections and vaccine preventable diseases;
- the risk of malaria.

Due to the arrival of refugees from sub-Saharan regions, the current situation requires surveillance for tropical diseases.

Sanitation is the greatest threat in Lampedusa. Measures are needed to stop open defecation. In considering options, the long-term effects on environmental health for the resident population of Lampedusa need to be a priority. These considerations should take into account that the installation of chemical toilets may not be the best choice, in view of the very large number of people that need to be served.

There are two health system contingency planning scenarios:

- One scenario involves the potential influx of injured crisis victims fleeing the escalating violence in Libya in the context of a civil war.
- The second scenario involves a massive influx of displaced populations, with a worst-case scenario of 10 000 plus arriving in Lampedusa with the need for temporary settlements, which would challenge the immediate absorption capacity of the country.



Abandoned boats in Lampedusa. Photo: WHO Regional Office for Europe

# 10. Conclusions and recommendations

Over the years, Italy has developed substantial experience and expertise in receiving displaced populations and in addressing the public health challenges associated with migration. Several thousand migrants from north Africa have transited the country, and an estimated 8000 were in Lampedusa at the time of this assessment. From January to July 2011 an estimated 40.000 people disembarked in Lampedusa.

## 10.1 Coordination mechanisms

Italy has established a multisectoral coordination mechanism, which foresees central crisis coordination and involves all major government institutions and line ministries.

Italian health authorities are on the alert with a high level of readiness and have engaged in contingency planning, developing scenarios that are continuously revised and adapted to the rapidly changing situation in north Africa and within Libya. A technical coordination table has been established at the health ministry with the leading public health national institutions. On 3 March 2011, the Sicily Region established a technical health coordination table with the participation of all regional health authorities and with operational aims. While health sector coordination shows a reassuring situation, this is not the case for the overall local coordination. The leadership of the operation is with the Ministry of Interior, which is more inclined to a vertical management of the emergency. The result is that Lampedusa is suffering a serious deterioration of public health conditions.

The main challenge is the limited capacity available in Lampedusa. Taking into consideration the serious public health conditions and sanitation, and the scarcity of water, a strengthening of epidemiological surveillance with syndromic surveillance is recommended. The priority is to strengthen coordination among the involved institutions in Lampedusa to expedite faster decision-making and response measures.

## 10.2 Sanitation

When considering the sanitation options, the long-term effect on environmental health for the resident population of Lampedusa needs to be a priority. In view of the very large number of people that need to be served, installing chemical toilets may not be the best choice. The simplest solution would be trench latrines. These need to be sited in a place where there is no groundwater and preferably on public land to avoid upsetting the local population even more with expatriation measures.

When trenches have been filled with waste to within 30 cm from the top or when they have been in use for one week – whichever comes first – they should be completely filled. After filling, they should be compacted. Their location should be clearly marked, and it is preferable that trees be planted on top as an aid in composting. Trenches should then be left undisturbed for at least one year. As a rough indication, approximately five metres of shallow trench is needed for every 100 people. It is preferable to have several short trenches rather than one long trench and trenches should never be used for more than a week before they are completely filled, compacted and replaced with new trenches. A stock of shovels should be placed nearby and users should shovel in the trench enough soil to cover the excrement completely. Boards can be placed along the edges of the trench to provide stable footing and prevent the sides from caving in.

It is estimated, if mechanical equipment such as diggers are used, it would take two to three days to build basic latrines with an occupation rate of 20 per latrine.

A further recommendation is to use a deep trench latrine, which is deeper, longer and wider than other latrines. It can last for one to three months and can be constructed from a variety of easily obtainable material, such as wood or plastic. (Refugee camps in Kosovo were equipped using this method).

### **10.3 Water supply**

The provision of bottled water for such a large number of users does not appear to be the most sustainable way of supplying drinking-water because it also includes the need to collect and dispose of large amounts of plastic bottles. The authorities need to develop collection points for the plastic bottles and preferably arrange to take them off the island, for safe disposal.

Bladder tanks can be used to rapidly increase the storage capacity of drinking-water on the island, to cater for rapid fluctuations in the demand of water supply and water consumption needs. Depending on the type of bladder tank selected, they have a life span of 5 to 20 years and could therefore also improve the living conditions of the people of Lampedusa. Such tanks can be delivered and set up in Lampedusa quite rapidly (with one week's notice).

The island needs to be provided with equipment to test the quality of drinking-water. Free chlorine measurement kits would be considered the minimum essential, and can also be used to ascertain the water safety in the bladder tanks. Such equipment can be delivered to Lampedusa within a week.

It is recommended that the maintenance of the existing desalination plant be improved to ensure it comes back to design capacity.

To maintain the necessary levels of personal hygiene, the number of shower facilities needs to be greatly increased. It is recommended that more bathing and hand-washing facilities are immediately constructed, to prevent the risk of faecal-oral infection transmission.

Further clarification is needed regarding the disposal of wastewater from the showering and bathing facilities. This type of wastewater could become stagnant and open new exposure pathways; in the long term further endangering the health of the resident population. Systems for wastewater collection and safe disposal urgently need to be constructed.

### **10.4 Preparedness and response**

To support the local health workforce with the necessary extra surge capacity, the mobilization of temporary health facilities through international support mechanisms could be considered. This could be through bilateral arrangements, through NGOs or through United Nations mechanisms. Several countries have various stand-by capacities, which can quickly deploy temporary facilities and surge staff.

Options on how to mutually support preparedness efforts were discussed during the high-level preparedness meeting hosted by Italy in collaboration with the EU and WHO, on 13 April 2011 in Rome (see Annex I and II).

Technical support from WHO could be provided to develop syndromic surveillance capacity for communicable disease early warning and outbreak response.

The need for some specific guidance on technical aspects of tuberculosis (TB) treatment strategies was discussed and respective expert advice could be offered by WHO.

The practice of accommodating potential refugees in closed detention camps (CIE) until final decisions on asylum status could trigger an increased demand for psychosocial support services in detention facilities. Experts could be mobilized to help build additional capacities and to share best-practice experiences.

In a worst-case scenario, with a severe humanitarian crisis affecting Italy through a mass influx of displaced populations, the United Nations humanitarian response mechanism with the “cluster approach” to facilitate international response coordination, led by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), could be activated. WHO could support Italian health authorities in identifying priority health needs, developing donor appeals to support respective humanitarian health actions, and helping with the coordination of the international health response.



# Annex 1: WHO Regional Director for Europe keynote speech

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## **Keynote speech for the High-level Meeting: Increasing movement of displaced populations in the Mediterranean countries of the European Union: future challenges for health systems**

**13 April 2011, Rome, Italy**

Honourable ministers, dear colleagues, ladies and gentlemen,

The situation that brings us together today is unique and deserves particular attention from the health perspective. In this context, I thank the Government of Italy for having so promptly taken this initiative to jointly examine the health challenges posed by the rapid influx of displaced populations as a result of the serious and unprecedented situation in the southern Mediterranean.

To start with, I thank the Member States of the WHO European Region such as France, Italy and Turkey, which have provided medical evacuation and care to the people severely wounded in the conflict in northern Africa, in particular in the Libyan Arab Jamahiriya.

Although most migrants, particularly those leaving for economic reasons, are healthy young people, the public health systems of the recipient countries must ensure that each person has timely access to high-quality health care. This especially applies to the most vulnerable people, people who are physically injured or have chronic conditions, children, older people and everyone stressed by a demanding journey and a crowded environment. This will be the safest way to ensure that the resident population does not face any particular health risk associated with the migrant population.

Despite a common perception of risk arising from the hypothetical link between migration and the spread of diseases, I wish here to stress the fact that, in high-income countries, the risk of imported infectious diseases spreading into the resident population is extremely limited. Although individual cases cannot be excluded, a significant outbreak of tropical diseases such as malaria, cholera, advanced tuberculosis or viral haemorrhagic fevers is largely unlikely because of high standards for sanitation and infection control and the absence of a competent insect vector. We should instead focus on good surveillance to detect and treat the migrants who require health care for infectious diseases such as tuberculosis or non-communicable diseases.

In this context and with regard to the detection and treatment of tuberculosis, I am pleased to announce that a European consensus paper on cross-border tuberculosis control and care is being finalized. The WHO Regional Office for Europe, the European Centre for Disease Prevention and Control, the International Union against Tuberculosis and Lung Diseases and the Royal Dutch Tuberculosis Foundation (KNCV) have developed this jointly.

However, let me emphasize up front that the health sector alone cannot address the public health challenges posed by unexpected major migration. They require an effective intersectoral approach between relevant ministries and between pertinent international organizations at the regional and global levels. In this perspective, WHO will work within the United Nations framework, in close collaboration with our United Nations partners. This especially includes the Office of the United

Nations High Commissioner for Refugees and UNICEF, other partners such as the European Commission and the International Organization for Migration and other important actors, including civil society and nongovernmental organizations.

As you know, WHO supports high-level dialogue on the multidimensional aspects of international migration and development. This dialogue should examine how to provide equitable access to disease prevention services and health care for migrants, subject to national laws and practice, without discrimination on the basis of sex, age, religion, nationality or race. Health information systems must be established that take into account all population groups, including migrants, and share information and best practices for meeting migrants' health needs. In this circumstance, I wish to underline the importance of the core capacity requirements under the International Health Regulations. WHO will support all its Member States in acquiring such capacity for disease surveillance and response by the legally binding deadline of June 2012. I strongly encourage all WHO Member States to meet this deadline and even to anticipate it. Today's situation shows the importance of such capacity for all countries in having an effective disease surveillance system, ability to investigate outbreaks and capacity for case management and response.

Health issues related to migrants and displaced populations have been on the WHO agenda for many years, especially within the WHO European Region. In effect, the conflicts in the Balkans and the following massive population movements significantly challenged health systems and led to international interventions in which WHO played a specific and significant role in supporting the affected health systems.

Ladies and gentlemen,

In a world with profound disparity and globalized travel, even in the absence of natural or human-made disaster, migration is a fact of life, and governments face the challenge of integrating the health needs of migrants into national plans, policies and strategies. In March 2010 in Madrid, WHO, the International Organization for Migration and the Ministry of Health and Social Policy of Spain organized a Global Consultation on Migrant Health. The Consultation raised many critical points, including the importance of migrants being able to access health care, an essential point in rights-based health systems. It also stressed that policies and strategies to manage the health consequences of migration have not kept pace with the growing challenges related to the volume, speed and diversity of modern migration and do not sufficiently address the existing inequity in health and factors determining migrant health, including barriers to accessing health services.

The evolving crisis in northern Africa adds a dimension of urgency to the challenge posed by migrants and displaced populations. Are our health systems adequately prepared to handle a dramatic increase in displaced populations? Our collective preparedness is of utmost importance if we are to effectively protect the health of both the migrant and resident populations. In this context, in February I met with Italy's Minister of Health, Ferruccio Fazio, to scale up collaboration to face a possible public health emergency in Italy but also in other countries of the European Region. WHO and national health authorities subsequently conducted preparedness assessment missions in Lampedusa and Sicily, Italy, in Malta and in Greece, the one in Greece jointly with the European Centre for Disease Prevention and Control. The missions have highlighted some specific problems, such as insufficient access to drinking-water and proper sanitation or the lack of health care personnel, especially nurses, to provide adequate human resources for health screening or access to health care. They also underscored the need for better coordination and standardized procedures for public health interventions, particularly in of disease surveillance and early warning and response systems. Preparedness for psychosocial support services also requires increased planning and preparedness efforts. In close collaboration with our partners, WHO is ready to provide technical support as required to address these public health challenges. Surge capacity

and public health and clinical expertise can be mobilized through the Global Outbreak Alert and Response Network and through WHO collaborating centres. WHO stands ready to mobilize expertise as and when necessary to meet the needs of our Member States.

Ladies and gentlemen,

Sometimes the momentum for joint and consolidated action arises from shared vulnerability to a common challenge. Increased preparedness of the health sector, better coordination with the other sectors and solidarity between countries, whether countries of origin or countries receiving displaced populations and migrants, are essential to provide all migrants with timely access to proper health care and to safeguard the health of the local population. WHO stands ready to continue to assist its Member States in this important endeavour. I believe that we are here today to reconfirm the guiding principles for international work in public health: a commitment to equity and fairness to attain the best possible health outcomes for all people, including migrants, and to strengthen our collective efforts to pursue this noble goal.

Thank you.

# Annex 2: Concluding remarks of high-level meeting, 13 April 2011

High-level Meeting  
**Increasing Movement of Displaced Populations  
in the Mediterranean Countries of the EU:  
Future Challenges for Health Systems**

**Rome, 13 April 2011  
Ministry of Health – Via Ribotta, 5 – Centro Congressi**

## **CONCLUDING REMARKS**

The political crisis affecting northern Africa has prompted very large numbers of people to migrate, initially between countries within this geographic area, and then towards the Mediterranean shores of Europe.

This has induced European countries particularly affected by these movements, in collaboration with WHO, to come together to enhance international cooperation and coordination, in order to address the public health challenges that could emerge from the situation. In particular, two key issues were discussed: how best to provide aid to the displaced populations, while at the same time protecting the health of the populations in receiving countries; and what further public health measures should be planned and put in place in the upcoming months to allow national health systems to heighten their preparedness to respond to these emerging needs.

It is possible that migration phenomena may last for long periods of time, in relation both to the current north African crisis and to the emergence of new, currently unpredictable, scenarios. Even though such migrations have not thus far produced health problems of the type and size that would constitute an emergency for the health systems of the Mediterranean countries of the European Union (EU), and of Europe in general, it is important to be aware of the health needs of large displaced populations of heterogeneous people. Consequently, it is necessary to take suitable measures to be able to cope with such possible needs, which may include surveillance systems for infectious diseases, including emerging and/or re-emerging diseases.

An increased demand for treatments for acute and chronic health problems is often observed with the flow of migrants arriving at receiving countries, especially among those from conflict areas. Treatment actions and health workforce surge capacity need to be planned so that appropriate health care support can be provided where the presence of acute or chronic health problems is identified among the migrants and refugees.

The Ministry of Health of Italy organized the meeting, in collaboration with the EU (represented by the European Commissioner for Health and Consumer Policy) and with the support of the WHO Regional Office for Europe. The health ministers of Greece and Malta and representatives of Hungary (holder of the EU Council Presidency), Cyprus and Spain met with representatives of United Nations and EU agencies involved in the management of these issues (including WHO,

the International Organization for Migration and the European Centre for Disease Prevention and Control (ECDC)), in the presence of representatives of the Italian Government.

The first part of the meeting involved a review of the health situation and the initiatives taken in North Africa, Italy and other European countries. In addition, participants examined the impact of migration on health systems and on pre-existing plans.

In the second part of the meeting discussion focused on three main points:

1. what actions would be most useful and urgent to ensure the highest possible level of preparedness;
2. what forms of partnership and coordination would optimize the results of the efforts to ensure maximum health protection for the European population and for migrants;
3. what role might be played by international institutions in support of national efforts.

At the end of a broad and in-depth debate the ministers, the European Commissioner, the WHO Regional Director for Europe and the representatives of participating international organizations agreed on the following requirements:

- to strengthen the preparedness of EU countries to respond to a possible increase in need for emerging health care and management of chronic diseases, with the technical assistance of ECDC and WHO;
- to strengthen public health preparedness, through enhanced surveillance capacity and harmonization of procedures among EU countries, in order to prevent outbreaks and to protect populations from potential public health threats;
- to improve and strengthen the gathering and sharing of information and epidemiological data, using existing instruments (such as the International Health Regulations and the Early Warning and Response System);
- to strengthen coordination on public health and interventions in the case of crisis management through national intersectoral coordination, the EU Health Security Committee, WHO regional offices and, for the overall emerging response, the United Nations coordination framework;
- to improve research, analysis and training on the health impacts of mass migration at national, EU and international levels;
- to identify and address environmental health issues and enhance coordination among relevant institutions to ensure that provision of healthy and safe shelter to displaced populations takes into account the needs and circumstances of the receiving communities;
- to explore possible ways to strengthen the health systems of migrants' countries of origin and of transit;
- to involve civil society, in coordination with the public sector, through improved collaboration with nongovernmental organizations, the United Nations, public and private health care providers;
- to take any possible measures to guarantee respect for human rights and to avoid the stigma deriving from public health threats misattributed to the influx of migrants, and at the same time to grant migrants access to essential health services (irrespective of their legal status);
- to strengthen solidarity and support between EU countries and from EU countries to the affected northern African countries;
- given the economic constraints, to explore a possible allocation of additional financial resources at the European level for preparedness and response to the health implications of large migrations in the countries concerned. Details of financial resources to be dedicated to migrants' health care will be debated at the next council meeting of EU health ministers in Luxembourg on 6 June 2011.

Finally, there was an expression of appreciation for the efforts made by the Minister of Health of Italy, the European Commissioner and the WHO Regional Director for Europe in organizing and convening this high level meeting, which represents a fundamental starting point for future collaboration.

# Annex 3: Sixty-first World Health Assembly WHA61.17

## **WHA61.17 Health of migrants**

The Sixty-first World Health Assembly,

Having considered the report on health of migrants;<sup>2</sup>

Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue on the multidimensional aspects of international migration and development (New York, 23 December 2003);

Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;

Recognizing that the International Health Regulations (2005) include provisions relating to international passenger transport;

Recalling resolutions WHA57.19 and WHA58.17 on international migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;

Recognizing the need for WHO to consider the health needs of migrants in the framework of the broader agenda on migration and development;

Recognizing that health outcomes can be influenced by the multiple dimensions of migration;

Noting that some groups of migrants experience increased health risks;

Recognizing the need for additional data on migrants' health and their access to health care in order to substantiate evidence-based policies;

Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;

Mindful of the role of health in promoting social inclusion;

Acknowledging that the health of migrants is an important public health matter for both Member States and the work of the Secretariat;

Noting that Member States have a need to formulate and implement strategies for improving the health of migrants;

Noting that policies on migrants' health should be sensitive to the specific health needs of women, men and children;

Recognizing that health policies can contribute to development and to achievement of the Millennium Development Goals,

<sup>2</sup> Document A61/12.

1. CALLS UPON Member States:

- (1) to promote migrant-sensitive health policies;
- (2) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;
- (3) to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
- (4) to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
- (5) to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;
- (6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
- (7) to train health professionals to deal with the health issues associated with population movements;
- (8) to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;
- (9) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

2. REQUESTS the Director-General:

- (1) to promote migrants' health on the international health agenda in collaboration with other relevant international organizations;
- (2) to explore policy options and approaches for improving the health of migrants;
- (3) to analyse the major challenges to health associated with migration;
- (4) to support the development of regional and national assessments of migrants' health status and access to health care;
- (5) to promote the inclusion of migrants' health in the development of regional and national health strategies where appropriate;
- (6) to help to collect and disseminate data and information on migrants' health;
- (7) to promote dialogue and cooperation on migrants' health among all Member States involved in the migratory process, within the framework of the implementation of their health strategies, with particular attention to strengthening of health systems in developing countries;
- (8) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations and considering the impact of other policies;
- (9) to encourage the exchange of information through a technical network of collaborating centres, academic institutions, civil society and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;
- (10) to promote exchange of information on migrants' health, nationally, regionally and internationally, making use of modern information technology;
- (11) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

(Eighth plenary meeting, 24 May 2008 -  
Committee A, third report)



The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

#### Member States

Albania  
Andorra  
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Austria  
Azerbaijan  
Belarus  
Belgium  
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Cyprus  
Czech Republic  
Denmark  
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France  
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Hungary  
Iceland  
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Kyrgyzstan  
Latvia  
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Poland  
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San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
The former Yugoslav  
Republic of Macedonia  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan

“New diseases are global threats to health that also cause shocks to economies and societies. Defence against these threats enhances our collective security. Communities also need health security. This means provision of the fundamental prerequisites for health: enough food, safe water, shelter, and access to essential health care and medicines. These essential needs must also be met when emergencies or disasters occur.”

– Dr Margaret Chan  
WHO Director-General

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