World Health Organization
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# Serbia: assessing health-system capacity to manage sudden large influxes of migrants

Република Србија
МИНИСТАРСТВО ЗДРАВЉА

## 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

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## Abstract

Recent large influxes of migrants into southern Serbia from Greece and the former Yugoslav Republic of Macedonia have challenged the capacity of the Serbian health system to respond rapidly and effectively. Serbia is coping well with the migrant influx, a situation that will likely continue for the foreseeable future. At the moment, most migrants entering Serbia intend to travel onwards to Hungary and, ultimately, to other European Union countries, and therefore remain in Serbia for only a few days. Currently migrant processing is managed humanely and efficiently. Only a minority of migrants enter asylum centres, where they receive a medical examination and any treatment they need. However, Serbia is vulnerable to changes in entry and exit flows and to any increase in the number remaining in the country, whatever the reason. A joint assessment between the Ministry of Health of Serbia and the WHO Regional Office for Europe in June 2015, supplemented by an expert field assessment mission in August 2015, has indicated a need for contingency planning for the further development of both local and national health policies to respond to any future large influx of people in transit.

### Keywords

DELIVERY OF HEALTH CARE – organization and administration

EMERGENCIES

EMIGRATION AND IMMIGRATION

HEALTH SERVICES NEEDS AND DEMAND

REFUGEES

TRANSIENTS AND MIGRANTS

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# Contents

**Acknowledgments** ..... iv
**Contributors** ..... v
**Abbreviations** ..... vi
**Executive summary** ..... vii
**Introduction** ..... 1
*Scope of the mission* ..... 1
*Method* ..... 2
*Site selection* ..... 3
*Constraints* ..... 3
**Overall findings** ..... 3
*Public health risk assessment* ..... 4
**Leadership and governance** ..... 5
**Health workforce** ..... 9
**Medical products, vaccines and technology** ..... 10
**Health information** ..... 10
**Health financing** ..... 12
**Service delivery** ..... 13
**Site visits** ..... 14
**Conclusions and recommendations** ..... 20
*Conclusions* ..... *20*
*Specific recommendations* ..... 21
**References** ..... 22
**Annex. Expert field assessment mission 25–27 August 2015** ..... 23
*Background* ..... 23
*Key findings* ..... 23
*Summary of assessed needs* ..... 27

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# Abbreviations

| | |
|---|---|
| ICMHD | International Centre for Migration Health and Development |
| PHAME | Public Health Aspects of Migration in Europe |
| UNHCR | Office of the United Nations High Commissioner for Refugees |

## Executive summary

Recent large influxes of migrants into southern Serbia from Greece and the former Yugoslav Republic of Macedonia have challenged the capacity of the Serbian health system to respond rapidly and effectively. In April 2015, the Ministry of Health of Serbia, together with the WHO Country Office and the WHO Regional Office for Europe, began collaboration under the project Public Health Aspects of Migration in Europe (PHAME) *(1)*, aimed at strengthening the country's capacity to manage the public health challenges related to the influx. An assessment took place from 29 June to 3 July 2015, using the WHO toolkit for assessing health-system capacity to manage large influxes of migrants in the acute phase. A further expert field assessment mission took place on 25–27 August 2015 in response to increasing migrant numbers (see Annex).

Serbia is coping well with the migrant influx, a situation that will likely continue for the foreseeable future. Most migrants entering Serbia intend to travel onwards to Hungary and, ultimately, to other European Union countries, and therefore remain in Serbia for only a few days. While procedures for asylum-seekers in the centres are already in place, the majority of the people "in transit" are not in these centres. Limited health needs have been demonstrated so far, mostly for emergency care, with some acute medical, maternity and minor surgical needs.

Currently, migrant processing is managed humanely and efficiently. However Serbia is vulnerable to changes in entry and exit flows and to any increase in the number remaining in the country, whatever the reason. What is needed now is a shift from a focus on emergencies to a systematic approach, with contingency planning for the further development of both local and national health policies to respond to any future large influx of people in transit.

It is suggested that a unit on migrant health should be established at the Ministry of Health and/or a focal point on migrant health should be appointed. Such planning would require improved information systems to contribute to evidence-informed migrant health policies, as well as a communication strategy to develop key messages for policy-makers and the general public. Such a strategy would also enable intercountry exchanges of knowledge and best practices. Important issues are the provision of cultural mediation and translation services for migrants. Unaccompanied minors appear to be very vulnerable, and protection for this group should be strengthened.

# Introduction

Serbia (its full name is the Republic of Serbia) is a country of some 7.2 million people, situated at the crossroads between central and south-eastern Europe. Serbia is landlocked, and borders Hungary to the north, Romania and Bulgaria to the east, the former Yugoslav Republic of Macedonia to the south, and Croatia, Bosnia and Herzegovina and Montenegro to the west. The capital of Serbia, Belgrade, is one of the largest cities in south-eastern Europe.

Serbia is a member of the United Nations, the Council of Europe, the Organization for Security and Co-operation in Europe, the Organization of the Black Sea Economic Cooperation, and the Central European Free Trade Agreement. It is also an official candidate for membership of the European Union and is negotiating its accession. Serbia is an upper-middle-income economy with a dominant service sector, followed by the industrial sector and agriculture. It has a high Human Development Index, being ranked seventy-seventh in the world *(2)*.

In response to the recent large influxes of migrants arriving in Serbia, the Ministry of Health requested WHO to conduct a joint assessment to review the Serbian health system's capacity to manage large and sudden influxes of migrants. Therefore, in April 2015, the WHO Regional Office for Europe, under the project Public Health Aspects of Migration in Europe (PHAME), started a collaboration aimed at strengthening capacity to manage adequately the public health challenges related to large influxes of migrants.

The assessment contributes to the implementation of World Health Assembly resolution WHA61.17 on the health of migrants *(3)*, which requests the WHO Director-General to analyse the major challenges to health associated with migration and to explore policy options and approaches for improving the health of migrants. The PHAME project was set up to address these requests.

As part of the PHAME project, following repeated, sudden, large-scale influxes of migrants in several countries of the WHO European Region, the WHO Regional Office for Europe developed the WHO toolkit for assessing health system capacity to manage large influxes of migrants in the acute phase. It was developed in collaboration with the International Centre for Migration Health and Development (ICMHD, a WHO collaborating centre based in Geneva, Switzerland) through a consultative process involving experts from various European countries.

The assessment tool was first tested in Sicily, Italy in October 2013. Since then, it has been used in assessment missions in Bulgaria, Cyprus, Greece, Malta, Portugal and Spain. The tool was then used in the assessment of health-system capacity to manage sudden large influxes of migrants in Serbia which took place from 29 June to 3 July 2015.

## *Scope of the mission*

The aims of the mission were to assess the preparedness of the Serbian health system to manage sudden large influxes of migrants. The assessment was a joint exercise between the Serbian Ministry of Health and WHO. The International Organization for Migration also participated in the assessment.

## *Method*

The assessment methodology follows the WHO toolkit for assessing health-system capacity to manage large influxes of migrants in the acute phase. It comprises site visits and semistructured interviews, carried out with key Government officials, managers of migrant centres, health staff working in migrant centres and experts from nongovernmental organizations. The assessment tool, and consequently the interviews, are based on the WHO health systems framework, which addresses six key functions: leadership and governance; health care financing; health workforce; medical products, vaccines and technology; health information; and service delivery.

- The assessment began with a series of preparatory meetings coordinated by the Ministry of Health, with the participation of the Institute of Public Health of Serbia, the Ministry of the Interior (Asylum Office and Border Police), the Commissariat for Refugees and Migration and the Serbian Red Cross.
- To allow the assessment of national capacity through intersectoral collaboration, the Ministry of Health convened stakeholder roundtables and meetings at national and local level (Belgrade and Presevo) involving the Institute of Public Health of Serbia, the Commissariat for Refugees and Migration, the Ministry of the Interior (Asylum Office and Border Police), the Ministry of Labour, Employment, Veteran and Social Policy, the Coordination Body's Office of the Government of the Republic of Serbia for the Municipalities of Presevo, Bujanovac and Medvedja, local public health institutes in Vranje and Sabac, the Dom Zdravlja (primary health care centres) in Presevo and Loznica, the Serbian Red Cross and the Danish Refugee Council to collect and share information.
- Coordination was established between the Ministry of Health, WHO, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees (UNHCR), the Office of the United Nations Resident Coordinator and the United Nations Country Team, and in the field with Médicins Sans Frontières (Fig. 1).
- In addition, visits took place to migration centres at Banja Koviljaca and Belgrade, as well as the newly established processing centre in Presevo, in order to identify best practices/gaps and identify ways forward.

Fig. 1. Meeting with the United Nations Country Team in Belgrade, Serbia

### *Site selection*

Assessment locations were selected because they were sites of migrant centres and/or locations of migrant health services and/or institutions for emergency management, and also to give as complete an overview as possible of the reception and processing of migrants in Serbia. During these visits, it was possible to interview all key actors.

### *Constraints*

The main agenda of the mission was the stakeholder roundtables at national and local level in Belgrade and Presevo. In addition, the team visited migration centres at Banja Koviljaca and Krnjaca in Belgrade, as well as the newly established processing centre in Presevo, in order to identify best practices/gaps and identify ways forward. During these visits, it was possible to interview all key actors, including managers and staff of the centres (Fig. 2). A small number of migrants were also interviewed. A meeting was held to discuss the international perspective and response to the migrant influxes with the United Nations Country Team, and briefings and debriefings were provided to UNHCR. However, it was not possible to visit all asylum centres in the country because of time constraints.

Fig. 2. Meeting with the Institute of Public Health in Belgrade, Serbia



## Overall findings

Serbia has been faced with a sudden increase in the number of migrants crossing from Greece and the former Yugoslav Republic of Macedonia. According to data provided by UNHCR (UNHCR, unpublished data, July 2015), by the end of June between 600 and 1000 people a day were entering Serbia.

Serbia takes an open approach to management of the migrants. Those seeking asylum are registered and provided with the appropriate paperwork before being invited to report to an asylum centre. At the moment of the assessment, most, however, fail to do so, and essentially disappear, most of them making for the border with Hungary. Serbia is therefore essentially a country of transit, and migrants mostly remain in the country for only a few days. Those remaining in the asylum centres make up only a small part of the transit flow.

Serbia has considerable experience of managing migrant flows. From 1992 to 1999, some 1 million refugees entered Serbia during the series of conflicts that led to the break-up of former Yugoslavia. Serbia then had some 700 refugee centres. This familiarity with refugees is seen both in the responsible administrations and in the general population, who are mostly accepting and supportive.

### *Public health risk assessment*

Public health risks arise both from health issues in the migrants' native countries and from health conditions during the journey and settlement. They mostly relate to unsafe travel, overcrowded arrival settlements with inadequate water and sanitation systems, and cultural barriers. Vaccine-preventable diseases represent health risks in people coming from countries where immunization coverage is low.

In Serbia, most migrants have travelled overland through several countries, sometimes for several weeks. They may have been exposed to physical and psychological trauma, dehydration, nutrition disorders, hypothermia and infectious diseases. The conditions of the journey, together with overcrowding in reception centres for those migrants living there (the minority in the case of Serbia) can facilitate the transmission of infectious diseases.

The migrants are mostly young people of working age (20–40 years), mostly from Somalia, South Sudan and the Syrian Arab Republic. The majority are in good health at the time of departure, although on arrival they may demonstrate the expected health problems – exhaustion, respiratory and diarrhoeal diseases, scabies, lice, blisters and small injuries, for example on the feet. So far, there have been no reports of unexpected communicable diseases.

Some are affected by chronic diseases and in need of continuity of care, which is very difficult to provide and receive in their present circumstances. The absence or interruption of treatment for chronic diseases can be life-threatening and represents a health risk. Health risks are particularly high in vulnerable groups of migrants, such as pregnant women and very young children. For young children, vaccination is a public health concern. Vaccination records are often absent or deficient; in the absence of these records, vaccination of all children is indicated, and this policy has been put in place by public health institutes in Serbia, using the normal vaccination schedule in use in the country.

Migrants in Serbia are subjected to medical triage at the point of entry. More specific medical care is available at asylum centres. If highly specialized care is required, patients may be transferred to the relevant health-care institution. The Ministry of Health conducts medical surveillance of migrants at the asylum centres, and collects figures from asylum centres and local health centres. Effective public health surveillance is in place.

Mental health needs may be very significant; in a programme supported by the Danish Refugee Council, two psychologists provide psychological support and counselling for asylum-seekers in asylum centres, and support and information sessions on anti-trafficking measures, potential risks and available protection mechanisms in Serbia.

## Leadership and governance

The Serbian approach to immigration mostly focuses on acceptance and integration, rather than control and expulsion. The over recent decades, Serbia experienced large-scale immigration as a result of the conflicts in the former Yugoslavia, and the local population remains largely sympathetic to the migrants.

Relevant laws are the United Nations Convention relating to the Status of Refugees of 1951 and its Protocol of 1967; the Constitution of the Republic of Serbia; the 2007 Serbian Law on Asylum, the 2008 Serbian Law on Foreigners, and the 2012 Serbian Law on Migration Management (No. 107/2012 of November 2012), which extended the mandate of the Commissariat to both refugees and migration. In addition, there is a Rulebook on Medical Examinations of Persons Seeking Asylum upon Arrival at the Asylum Centre.

There are several ministries and Government institutions involved with migration: the Commissariat for Refugees and Migration; the Ministry of Labour, Employment, Veteran and Social Policy, which chairs the governmental working group for solving the issues of mixed migration flows; the local centres for social work; the Ministry of the Interior (Border Police Directorate and Asylum Office); the Ministry of Health; and the network of public health institutes.

At the level of the Government, a political interministerial working group on migrants has now been established to deal with migration issues, led by the Minister of Labour, Employment, Veteran and Social Policy. An early warning system is in operation for migration patterns. The Commissariat coordinates closely with ministries through monthly meetings to exchange information about what is happening; new arrivals; accommodation capacity; any problems in the last 30 days; and what has been done since the last meeting.

The local response is a matter for the local municipality. The Law on Migration Management obliges local authorities to create a local council for migration, a body which will implement migration policies locally. A total of 128 local governments have established local councils for migration composed of representatives of various institutions at the local level relevant for the realization of the rights of migrants, with the goal of coordinating activities of the local administration, police administration, employment service, school administration, local trustees, health centre, centre for social work, Red Cross and civil society organizations *(4)*.

Asylum centres are based at Banja Koviljaca, Bogovadja, Sjenica, Krnjaca (Belgrade) and Tutin. The number of asylum-seekers used to be small, but has increased each year and now stands at 30 000 in 2015. Asylum-seekers are issued with a document which provides confirmation of their intention to seek asylum, and are referred to an asylum centre (Fig. 3). Migrants who have received documentation showing their intention to seek asylum have 72 hours to arrive at the asylum centre.

Fig. 3. Migrants waiting to start their asylum application process at the police station in Presevo, Serbia



In 2014, fewer than 200 people spent more than two months in the asylum centres. During 2015, although 30 000 certificates of intent were issued, only 6000 people came to the asylum centre(s) and followed the procedure. By mid-June 2015, 31 600 people had registered their intention to seek asylum. Three hundred and twenty-eight procedures were stopped voluntarily, when the people concerned decided to give up their applications since they did not intend to live in Serbia. About 350 people are currently living in these centres (Ministry of the Interior, unpublished data, 2015).

When migrants entering the country are identified by the Border Police, they are registered and then the Police refer them to a specific asylum centre, based on an electronic database of all asylum-centre beds in the country. This database is regularly maintained, as there is a fair amount of traffic: people come; they stay a few days – up to a month – and then they disappear. Most are irregular migrants to Serbia, who use this procedure as a way to avoid remaining in Serbia illegally.

When a potential asylum-seeker reaches the asylum centre, the registration process is started. A bath and a medical triage examination are provided. Except for their own statements about the countries they have come through, there is often no way to determine whether migrants originate from, or have travelled through, a particular country. Internationally agreed definitions of asylum are used. Attempts are made to verify identity. Sometimes the requests are rejected, although there is then the possibility of an appeal, and the application can be resubmitted. This law needs to change by 2016 to make it consistent with international requirements.

There are four potential decisions that can be made in relation to asylum-seekers:

- adoption;
- rejection;

- suspension (procedures are stopped if migrants give up their request or simply leave the centre); or
- refusal.

If the request is refused, the authorities enquire whether the migrant could find a safe place in his/her country of origin (as an internally displaced person). However, in this case, migrants usually do not wait until they get an answer – they leave. If they are then arrested by the police, they are sent to court as illegal persons, although in practice the judges usually reject the criminal charges, as they consider the person to be in the process of applying for asylum. Deportations are rare. People who have fled war zones are not returned.

The most usual reason for rejection is that the migrant has a passage to a safe third country – a country which obeys human rights law. Serbia has no agreement with Turkey. There is an agreement with the former Yugoslav Republic of Macedonia regarding people coming from Greece, although in practice it is difficult to return them to the former Yugoslav Republic of Macedonia. Serbia has not signed the Convention determining the State responsible for examining applications for asylum lodged in one of the Member States of the European Communities (Dublin Convention) *(5)*. However, the country plans to align itself with European legislation, and also to sign the Dublin Regulation *(6)*.

A total of 1300 unaccompanied minors entered Serbia in the first five months of 2015. Unaccompanied minors amongst the migrants are sent to centres for social work under the protection of the Ministry of Social Protection, and then to shelters for unaccompanied minors. There are five such shelters in Serbia (Belgrade, Nis, Novi Sad, Subotica and Vranje). The age of the minor is certified only by interview. A guardian is appointed for these minors. Although the necessary legal system is in place, there is no tracking system, and many minors are not tracked and may not go to the centre allocated to them. They do not speak the Serbian language, and in practice they may simply disappear.

Some interpreters are available for Arabic, Pashto, Urdu and Somali, although not enough. UNHCR also provides interpreters.

If irregular migrants,[1] or those whose documentation has expired, are captured by the police, they are referred to the asylum centre. Under the law, because their identity is not confirmed, they are classified as irregular migrants unless and until they apply for asylum status, and detained at a detention centre at Prihvatilisteza Strance in Padinska Skela, a suburb of Belgrade. This procedure is for those migrants who failed to register at asylum centres in the three days following their registration with the Border Police as immigrants. The centre is connected with a prison, and a contract with the Ministry of Justice enables health care to be provided. Detention can only continue for 90 days, after which the migrants must be released. They should then leave the country within three days.

Medical care is provided at all centres, although medical staff come from other institutions. Migrants at asylum centres who have expressed their intention to seek asylum are given a medical examination and provided with the level of care considered appropriate by the physician.

1 Regular migration is defined by the International Organization for Migration as migration that occurs through recognized, legal channels. Irregular migration is defined by the same organization as “Movement that takes place outside the regulatory norms of the sending, transit and receiving countries ... From the perspective of destination countries it is illegal entry, stay or work in a country without the necessary authorization or documents required under immigration regulations”. However, the term “illegal migration” tends to be restricted to cases of smuggling and trafficking of migrants *(7)*.

The asylum centres are not closed centres – residents are allowed to come and go. If they stay in the asylum centre, after the second stage of the procedure, they receive a ID card identifying them as an asylum-seeker and can freely move from town to town. Residents have to obey the rules of the centre. If they do not return to the centre each evening, they are considered to have left. Another possibility is for the migrants to live in private accommodation, if they have enough money.

The Commissariat for Refugees and Migration was established in 1992 as a special State authority responsible for reception, status determination, accommodation, integration and other specialized tasks related to migration. It finances the asylum centres through its State budget. There were some 1 million refugees between 1992 and 1999, representing the largest migration and the longest protracted refugee situation in Europe.

In accordance with the Law on Migration Management, the Commissariat performs tasks related to:

- proposing to the Government the objectives and priorities of migration policy;
- monitoring the implementation of migration policies;
- proposing and implementing the Government programme related to migration management;
- providing State administration bodies, autonomous provinces and local self-government with information relevant to the preparation of strategic documents in the field of migration;
- proposing projects in the field of migration management within the scope of its work and preparation of an annual report to the Government on the situation in the field of migration management.

The Commissariat communicates three times per day with the Ministry of the Interior regarding the number of available asylum centre beds. According to the referrals to asylum centres (for people who obtained certificates of intent), only some 300 people are currently in centres. Many migrants simply leave Serbia. Even people who have serious medical problems leave. These migrants usually go to Hungary or further on into western Europe. Currently, Serbia enjoys good cooperation on migrants with Bulgaria. Most influxes come from the former Yugoslav Republic of Macedonia.

In principle, the Serbian Law on Health Care makes provision for health care for all, including migrants. Provision is not limited to emergency care. The costs of health care for migrants, both documented asylum-seekers and/or undocumented persons, are covered from a budget line at the Ministry of Health, which does everything in its power to support refugees. This budget is not substantial, and the assessment team heard anecdotally about invoices from local health facilities that have not been covered.

Medical triage is available in principle at the point of entry, and this will be facilitated at the new processing centre at Presevo. More specific medical care is available at asylum centres. Refugees, asylum-seekers and internally displaced persons have the same rights to health services, and receive the level of care considered appropriate by the examining physician, at primary, secondary and tertiary levels. If highly specialized care is required, patients may be transferred to Belgrade.

The migrants are mostly young people of working age (20–40 years), mostly from Somalia, South Sudan and the Syrian Arab Republic. They demonstrate the expected health problems – exhaustion, scabies, lice, blisters and small injuries, for example on the feet. So far, there have been no reports of unexpected communicable diseases.

At the asylum centres, the health check consists of a clinical examination including laboratory tests, a stool sample, a chest X-ray and nose and throat swabs. Once migrants have undergone

their health check and the physician has prescribed tests and prescriptions, a health form provided by the Ministry of Health serves as the record of the migrant's health status and health risk information. This form is kept at the centre. The centres for asylum-seekers send regular monthly electronic reports regarding medical examinations and investigations, through the local public health institutes, to the Institute of Public Health of Serbia. At the asylum centres, the Institute conducts regular surveillance of water and sanitation conditions and carries out disinfection.

The health check in the asylum centres is a priority issue to be addressed. Current procedures are slow and top-heavy, with too much emphasis on laboratory testing and X-rays. Most people do not go to the asylum centres and, even if they have tests done, the migrants are gone by the time the results become available. The detailed health profile and needs of refugees crossing Serbia are currently unknown.

Large influxes of migrants began in June 2015, and immediate humanitarian assistance upon entry to Serbia, for example shelter and food, has so far been provided by UNHCR (including medication expenses), local authorities in Presevo and the Serbian Red Cross. The migrant influx has been designated a level-2 emergency by UNHCR, allowing for more flexible procurement and distribution arrangements. UNHCR statistics indicate that 94% of the migrants come from countries which are the source of large numbers of refugees, with 50–60% of them originating from the Syrian Arab Republic (Fig. 4).[1]

Fig. 4. Painting by a Syrian migrant in the asylum centre in Krnjaca, Serbia




## Health workforce

Asylum centres have a small permanent staff, including a manager, an administrator dealing with reception and legal paperwork, and a staff member dealing with health, family and social protection. For example, at Banja Koviljaca, medical staff are available on call 24 hours per day,

1 Detailed statistics are available on the UNHCR website (http://www.unhcr.org).

although a physician is only physically present at a fixed time each week. The physicians have some training in migrant health. Two nongovernmental organizations, the Belgrade Centre for Human Rights[1] and the Asylum Protection Centre[2] provide legal and psychological services for all centres in Serbia, functioning as mobile teams. Two language teachers (English and Serbian) are employed by UNHCR, and they also carry out some other educational activities. Two asylum-seekers who have been given subsidiary protection act as interpreters and live on the premises. One comes from Afghanistan and the other from Iraq. The migrants trust them to act as mediators, and prefer to talk to them in the first instance. The mediators then bring the migrants to staff and explain the issue. They are paid for their services.

## Medical products, vaccines and technology

The Health Insurance Fund is responsible for financing the system, paying both physicians and revenue costs. There is no national basic package of services defined. The Fund enters into contracts with health institutions, which have been performance-related since 2014. Salaries are defined in the contract, which also provides for infrastructure, drugs and medical devices. For some services or medicines, patients have to make a larger copayment (a percentage of the real cost) or pay the full price (nonstandard services).

Regular vaccination uptake among the resident population is monitored by the Institute of Public Health of Serbia. In the past, coverage has been over 90%, although an anti-vaccination campaign has commenced in the country. The Institute vigorously promotes vaccination. There is no overall standing guidance on vaccination of migrants, only for those entering asylum centres. It is often not clear whether migrant children have been vaccinated in the past; in the centres, if they do not possess vaccination cards, it is assumed they are unvaccinated. Vaccinations are then given according to the national schedule (Fig. 5).

There are difficulties with vaccine supplies, and emergency supplies can be slow in arriving. For example, during the recent flood crisis, hepatitis A vaccines were requested in case of need, but they did not arrive until one year later.

At a meeting at the primary health care centre in Presevo, a request was made by the Director for practical assistance from WHO, to include supplies and medication, emergency vehicles and financial assistance.

## Health information

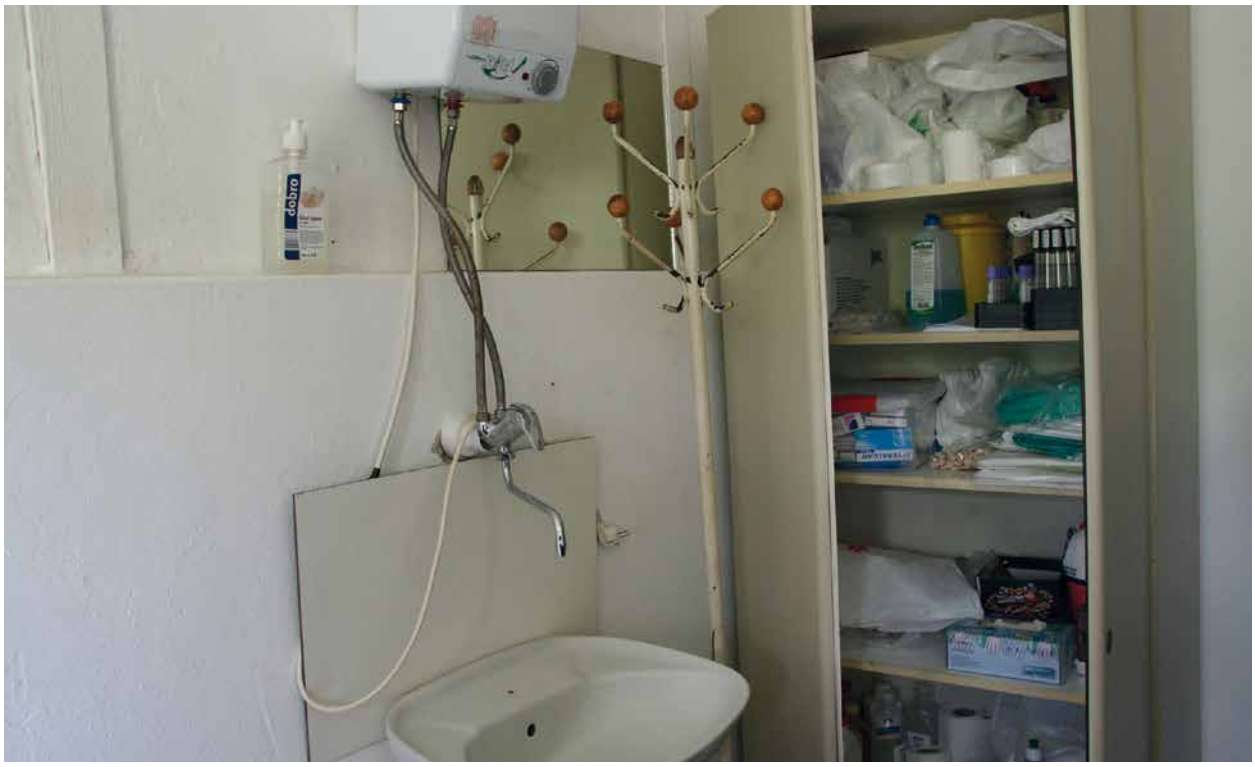
In public health, Serbia is served by a long-established network of 23 active regional Institutes of Public Health, with a further institute under construction. Together, these cover 25 districts. The Institute of Public Health of Serbia "Dr Milan Jovanovic Batut" (including regional institutes) supports the formulation of health policies and the strategic and legislative framework and contributes to the protection and improvement of the population's health. The Batut Institute performs tasks related to control and health prevention of infectious and non-infectious diseases; monitoring health

1 Belgrade Centre for Human Rights website (http://www.bgcentar.org.rs/bgcentar/eng-lat/, accessed 27 August 2015).

2 Asylum Protection Centre website (http://www.ecre.org/alliance/members/profiles/member/67.html, accessed 27 August 2015).

issues and reporting on health service quality to the public and relevant institutions; monitoring of environmental risks to the health of the population, and monitoring food and water safety, sanitary inspection and hygiene standards.

Fig. 5. Medical supplies at the asylum centre in Krnjaca, Serbia






The institutes of public health cover epidemiology, hygiene, microbiology and health promotion. Under epidemiology, surveillance of communicable diseases is carried out as defined by legislation. The primary care centres have a duty to report communicable diseases as a routine practice, using specialized forms. Surveillance is also carried out for other health threats, including noncommunicable diseases. Rates of coronary artery disease, stroke and cancer are relatively high. Waterborne and enteric diseases are also prevalent in some rural areas and villages without reliable, properly monitored water supplies. Other than for emergency events and mass gatherings, there is no regular syndromic surveillance. Data are collected and analysed and passed to the Institute of Public Health of Serbia in Belgrade, with general reports being sent to the Ministry of Health.

A coordinating group for migrant health is being set up within the Institute of Public Health of Serbia in Belgrade, as the health needs of migrants who are passing through the country also require surveillance. The members come from the ministries of Health and Social Protection, local health centres and the public health institute for the region. This only applies to regions where asylum centres exist. In 2013, the working group developed a draft protocol for monitoring the health status of migrants and asylum-seekers, based on the 2008 Rulebook on Medical Examinations of Persons Seeking Asylum upon Arrival at the Asylum Centre.

Reports from the asylum centres include the number of migrants admitted; the number of medical checks; the number of suspected tuberculosis cases; and the number of unaccompanied minors.

When migrants are referred for specialist services, they are sent with their medical papers. There is no formal communication between levels of the health system during referral, but there is good informal communication, including arrangements for transfer, etc. Informal methods are used to arrange for referral and further testing/treatment, and these appear to work well. If the need for care is urgent, it is provided the same day.

Near Presevo, in Vranje, it was reported that the local public health institute takes note of migrants' country of origin, potentially identifying diseases according to the area from which they come. For instance, there have been no cases as yet of plague or Middle East respiratory syndrome coronavirus, which were both diseases of concern. If a case of Middle East respiratory syndrome coronavirus or another emerging communicable disease occurs, the public health team feels able to control the situation. National epidemiological and laboratory support is available in Belgrade (the Torlak Institute), and international assistance under the WHO global alert and response system would also be available.

In Vranje, the public health institute is in regular contact with the media. However, on migrant health issues, the Institute of Public Health sends regular information to the Ministry of Health, and the latter makes any necessary public announcement. There is a fear of communicable disease among the public, although the local culture is not given to panic.

## Health financing

In the Serbian health system, health care is mainly financed by mandatory contributions to the publicly owned Health Insurance Fund. The Fund is responsible for financing the system, paying both physicians and revenue costs. No national basic package of services has been defined. The Fund enters into contracts with health institutions, and since 2014 these have been performance-related.

A copayment system is in operation, although a large group of patients (e.g. vulnerable groups, poor people and tissue and organ donors) is exempt from copayments. Another source of financing is private expenditure on health, mainly out-of-pocket payments for medicines and some services in the private sector.

Financing of services for migrants remains difficult. In principle, a State budget is available through the Ministry of Health. Receipts and bills for treatment are sent to a special committee of the Ministry of Health, which decides whether the expenditure is justified and reimburses the primary health centres and hospitals. These costs are not paid by the Health Insurance Fund.

In practice, many costs fall to the primary care and hospital facilities, whose regular funds are allocated in advance for the following year. An influx of migrants was not predicted, and costs may be relatively high, for example if persons need to be sent from the primary care centre to Presevo, Nis or Vranje for secondary or tertiary care. In practice, reimbursement may be difficult. For example, in 2014, there were numerous cases of medical interventions where no bill or invoice could be sent for compensation, because no medical documentation or identification were available. It is hoped that future financial planning can take this, and potential future, migrant influxes into account, possibly by providing an emergency budget.

## Service delivery

Health care reached a fairly high standard in the former Yugoslavia. Preventive services were well established. However, the break-up of the country and the subsequent political conflicts, economic decline and sanctions led to a sharp deterioration in standards. By 2000, the main challenges were the lack of strategies for development; a shortage of essential medicines; the poor condition of equipment; outdated technology; a lack of continuing medical education; and the poor development of evidence-based medicine and clinical guidelines. By 2000, a framework for reform had been established, giving priority to primary care and encouraging all health professionals to give attention and priority to working "upstream" and delivering modern health promotion and disease prevention services.

Following the adoption of the Law on Health Care in 2005, primary care has been decentralized to local authorities. The goal is for primary care to become the main institutional focus and assume the function of "gatekeeper" of patients entering the system. Municipalities are now responsible for capital investment in primary health care, including equipment and maintenance, monitoring the population's health status and developing specific programmes for environmental protection and people's health.

Local health councils have been established in most municipalities, with participation of local institutes of public health. The institutes communicate regularly with the local health council, providing regular reports on population health which are used by councils to adopt and inform policy. There therefore exists a tripartite system for health governance at primary health care level. The Ministry of Health is responsible for overall strategy and national planning; municipalities for capital provision and other local service developments; and the Health Insurance Fund for revenue costs and medical salaries.

Primary health care is based on the selected physician ("chosen physician"). A team of chosen physicians may consist of general practitioners and occupational medicine physicians for the adult population, paediatricians for children of preschool and school age (including antenatal care, immunizations and preventive child health programmes), gynaecologists for women over 15 years, and dentists. Primary health centres are established, depending on health needs, the number of citizens in a municipality, and the distance to the nearest general hospital or other health-care facility.

Primary care physicians work on health promotion issues. Primary care centres may also provide some specialist and consulting work; diagnostics and treatment of acute and chronic diseases; and maternity services. In addition, there are emergency services, diagnostic services, certain specialist-consultative outpatient services, community nursing services, etc. Primary health care prescriptions are dispensed at both State and private pharmacies, with some copayments. There are exemptions e.g. for Roma, people with tuberculosis, elderly people and children

Overall, secondary and tertiary care is still under reconstruction since the time of the former Yugoslavia. The Clinical Centre of Serbia in Belgrade has been restructured. Few patients go outside the country for care. Facilities are predominantly public, although there are a few private-sector facilities e.g. diagnostic imaging, and some physicians work privately. The Ministry of Health finances major investment at secondary and tertiary levels.

Since 2000, the basic pillars of an integrated health information system have been established. New health information and electronic medical billing services were set up in 2009. Electronic medical records should be introduced into health-care facilities soon.

In the context of migration, health services are provided for people who need them when they enter the country. The Ministry of Health conducts medical surveillance of migrants at the asylum centres, and collects figures from asylum centres and local health centres. Of the total number of migrants entering Serbia between January and May 2015, 25% or fewer enter asylum centres. Forty per cent of those who enter an asylum centre undergo a medical examination – this figure is relatively low because the migrants stay for short periods and leave quickly. Some 70% of those receiving an examination also undergo laboratory tests, whilst 25% undergo a chest X-ray.

Mental health services remain the responsibility of the Ministry of Health. The services are largely institution-based, with few community services developed to date. A new law on mental health has been adopted, with a focus on community service development, including day care, with the strong involvement of nongovernmental organizations. Under a programme supported by the Danish Refugee Council, two psychologists provide psychological and counselling advice for asylum-seekers in asylum centres, and support and sessions on anti-trafficking measures, potential risks and available protection mechanisms in Serbia.

## Site visits

The Asylum Centre at **Banja Koviljaca**, visited by the mission, may be used as an example of asylum centre provision. This is the oldest asylum centre and is funded by the Commissariat for Refugees and Migration. The centre was designed as a collective centre for hosting people from the earlier conflict and crisis in the former Yugoslavia. It has a capacity of about 100 beds. The centre had an average population of 34 people during June 2015. This was unusual, as previously it had usually run at full capacity. In the past, the centre had received Somalis, but currently it was hosting mostly Syrians. The centre had taken in 170 children in 2015. About one third of these were unaccompanied. The unaccompanied minors were in their late teens; the youngest was 14. They lived on the second floor of the centre, with the families and single women.

The centre has a dormitory area, with rooms with two or four beds each. The dormitory has a dedicated floor for men alone, women alone, women with children, and families. The centre offers shelter, food, basic needs including hygiene kits and feminine hygiene supplies, and clothing on arrival. Food is supplied by an external company. Security guards are present 24 hours a day.

There is an office for the Director, a secretary and a representative of the Ministry of the Interior. The condition of the centre is good. The Director mentioned that additional resources for maintenance (ordinary and extraordinary) would be useful. It is an open centre and the residents can come and go freely. There are strict controls over alcohol or substance abuse on the premises. The centre has two interpreters, residents of the centre who have received subsidiary protection, who work with Arabic and Pashto, respectively.

The food is adequate, comprising: meat, soup, bread, fruits. A good quantity of varied foods is offered. The water supply comes from the city supply. Sanitation is provided by the city sewerage system. Each dormitory floor has separate men's and women's toilets and showers. On the first

floor, there are two toilets and five showers for the whole floor. Each room is provided with a washbasin with running water.

There is a TV room for recreation. Language classes are provided in Serbian and English. A room is available to teach tailoring skills, which are accessed mainly by women. There is a playroom for the children, with some education also offered.

The migrants are free to come and go – there is no detention policy. Screening for human trafficking is performed, with only two suspected cases reported. In this case, the people concerned left the centre, so there was no follow-up.

However, staying at the asylum centre is not the preferred option for most migrants. Serbia is a transit country, and migrants prefer to spend the shortest time possible getting through Serbia to Hungary. This creates problems for medical care, as people do not stay long enough to complete their treatment. Patients are given information before they finish their treatment, and medical advice, but migrants stopping therapy to continue their migration to the European Union is a problem. The Serbian medical authorities give the migrants photocopies of their medical records, but they are worried that migrants will not want to show papers from a previous country for fear that they will be sent back. There are also problems with vaccinations – medical staff are not sure whether the migrants have received vaccinations, or which ones.

A general practitioner comes to the centre on Tuesdays to complete the first medical assessments for the previous week's arrivals. There is a day for her to complete referral paperwork, and then on Thursdays, the migrants undergo testing. The protocol is as follows:

- a clinical examination to evaluate the health status, vaccination status, any chronic diseases, injuries from travel, and any infections;
- all adults provide stool samples (to look for intestinal parasites and bacterial infection), full blood count, erythrocyte sedimentation rate and chest X-ray to look for evidence of tuberculosis infection;
- children are evaluated by a paediatrician in town and undergo all the same testing as adults, except that the chest X-ray is omitted unless the paediatrician considers it necessary.

If migrants require further care or investigation, they are referred to a physician in town, or to emergency services as needed. Acute problems and complaints come up on a daily basis (headache, back pain, etc.) and these are identified by the migrants themselves, who report to a staff member that they are not well. Again, if they require further care by a physician, the staff refer them to physicians in town.

Everyone is given treatment when needed, and all are given medical papers. An electronic medical record is kept as well as a paper record. Between January and May 2015, 627 people passed through the centre in Banja Koviljaca. Many come over the weekend and stay only a short while, so there is not enough time to organize medical checks, laboratory investigations and X-rays. Hence only 202 of the 627 people referred to above, or roughly one third, underwent a medical examination.

One problem is that, under the normal reimbursement arrangements from the Health Insurance Fund, physicians are paid according to the number of patients on their capitation list. Physicians who care for migrants one day per week will not be able to care for, and thus be reimbursed for, the usual number of patients.

The mission team also visited the asylum centre in **Krnjaca** (Fig. 6). This is one of the remaining collective centres, housing Bosnian and Croatian families who have lived here for up to 25 years. One part of this centre is now organized as an asylum centre for 250–270 asylum-seekers although, at the time of the visit, 140 people were resident: 100 men, 37 women, and three children. There was one family and one unaccompanied minor (15 years old). The minor has been housed in the building where the staff have their office, so that they can keep an eye on him. He has a guardian appointed by the Ministry of Labour, Employment, Veteran and Social Policy.

Fig. 6. Asylum centre in Krnjaca, Serbia

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The centre has a staff of seven, plus two people who provide logistical assistance from the Commissariat; hygiene staff; cooks; medical staff who come to the centre twice a week (a team of five people); and staff providing educational services (kindergarten), creative workshops, art and painting. The Asylum Protection Centre provides daily programmes for psychological wellbeing[1] and two nongovernmental organizations provide free legal advice. In total, some 30 people provide services at the centre.

The facilities were housed in a single-storey building, and included bedrooms with three or four bunk beds per room, housing approximately 40 people; a separate house for women, and separate facilities also for families.

Each building had four squat toilets, with washbasins in the bathroom across from the toilet. There were four separate showers.

Sewerage and water were connected to the city services (main sewerage and water lines). An outsourced cafeteria provided three meals per day. For Ramadan, a lunch pack was provided, with a meal later at night. At the moment, it is not possible for the residents to prepare meals themselves, although this is being considered.

1 Asylum Protection Centre website (http://www.apc-cza.org/en/, accessed 27 August 2015).

A clinic room had a cabinet with basic supplies for examination and blood tests. The examination table was not padded, but a wool blanket was placed on it instead. One concern expressed was the lack of information about migrants' health status, as no documentation is available. Interventions are based on the current needs of people asking for help as required. There is an infirmary on the premises, with a team that comes to provide care, medical check-ups and laboratory tests two days per week. Follow-up is difficult, and many medications get left behind when the migrants leave.

The centre works together with the health centres in Krnjaca and Palilula. There have been no outbreaks of infectious diseases so far.

A visit was also made to **Presevo**. This currently has a resident population of around 10 000–15 000 people, the influx of migrants has reached 500 to 1000 per day, and primary care services in particular have been under great pressure. According to Serbian Red Cross statistics, 11 000 people arrived between 5 June and 29 June 2015. Migrants usually arrive exhausted (clinical diagnosis of exhaustion), undernourished and hungry, and have problems with digestion. Some have wounds. So far no unusual communicable diseases have been identified. There was one instance of a woman from Somalia giving birth in a field without medical assistance.

The primary care centre in Presevo serves a population of 48 000.[1] It has a total staff of 204, including 48 physicians. A variety of specialist services are available for consultations: tuberculosis; internal medicine; ophthalmology; dermatology; obstetrics and gynaecology; and psychiatry. Other services are provided by general practitioners. A laboratory and X-ray facilities are available.

A large influx of migrants arrived on 9 June 2015, and the local Commissariat for Refugees and Migration, the Department of Social Affairs of the Municipality of Presevo and the Municipal Emergency Management Team met, informed the Serbian Commissioner for Refugees and contacted UNHCR and Médecins Sans Frontières. The municipality decided to set up accommodation for the refugees in a field, with shelter provided by two tents made available by the Serbian Red Cross, with a capacity of 100 people each. Blankets and sleeping mats were also provided. Half of the people crossing the border have asked the Serbian Red Cross for assistance: 70% were men, 20% were women and 10% were children and babies. The other half have their own funds and buy food and take care of themselves. UNHCR assisted with basic hygiene items and food – three cans per person per day of pâté/fish/luncheon meat plus half a loaf of bread and water. Toothpaste and underwear were also provided. UNHCR covers medication expenses via an agreement with local pharmacies.

Here the migrants have been awaiting registration at the local police station nearby. The Serbian Red Cross is present daily, providing humanitarian assistance in cooperation with municipal services, including the primary health care centre. Médecins Sans Frontières is also present, with a small medical team providing essential primary care services. Currently it is estimated that some 10% of medical services are provided by Médecins Sans Frontières, with the remaining 90% provided by the primary health care centre. Teams are provided to care for the elderly, serviced and financed by the local municipality.

However, to cope with the increased numbers of migrants arriving in Presevo, a decision has been taken to provide continuous daytime and emergency night cover at the new processing centre which, at the time of the visit, was about to open. This was organized with the involvement of the governmental working group for solving the issues of mixed migration flows, chaired by

1 Data from the 2011 census, which was boycotted by the local population of Albanian ethnicity.

the Minister of Labour, Employment, Veteran and Social Policy and including the Ministry of the Interior, Ministry of Defence, Ministry of Health, Commissariat for Refugees and Migration, Presevo Municipality, Gendarmerie (police) and the Government coordinating body for the south of Serbia.

The aim is to provide safety, medical and social care and integrated, efficient and coordinated reception services in an old tobacco factory and to provide support for the primary health care centre, using teams of military physicians. Six teams of physicians and nurses would be working in the field, together with physicians and nurses from emergency services at the health centre. Ancillary staff would also be provided.

The old factory cafeteria has been turned into a processing centre (Fig. 7). Migrants will receive medical triage first, then register with police, then get a meal, and then if they have requested asylum and received documentation they will be allocated a reception centre to attend within 24 hours. If they need medical attention, they will be referred appropriately. There is an isolation room at the back of the building, if needed.

This plan has been launched as an emergency measure, although thought will be given to longer-term needs once it is operational. Further planning will be necessary if the facilities at the centre continue to be needed during the coming winter.

Fig. 7. Processing centre in Presevo, Serbia



Upstairs there is an area for people with small children. The centre expects to have an average of one toilet (and washbasin) for 16 people in that area. Showers and extra washbasins will be available. Although people are expected to pass through and leave quickly, in the grounds two tents had been erected at the time of the visit, with 40 foam camping mats each. Chemical toilets and showers were in the process of being erected. Large jerrycans were provided near a communal water tap, as there appeared to be no running water by the tents.

The facility was guarded by security personnel. A military clinical team was on hand – physician, nurse and driver (Fig. 8). The Chief Commander of the Gendarmerie indicated no major concerns

about safety or security. Some of the migrants had clearly been under a lot of pressure, anxious and queuing a long time outside the police station, and there had been some jostling and fights. One person had received minor injuries, but there had been no serious injuries.

Fig. 8. Military clinical team vehicle at the processing centre in Presevo, Serbia

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It is intended that medical services will provide good triage and primary care as close to the point of entry as possible, supported by referrals, together with good epidemiological surveillance and oversight. Screening will take place for infectious diseases, and the facility housed in a former tobacco factory also has an isolation unit.

So far, the local population in Presevo has been supportive, receiving the migrants warmly. The migrants reported that they did not receive such a reception in the other countries they had passed through. They also reported that the local population receives them in their own houses. When the Serbian Red Cross ran out of food one day, a private donor prepared 400 meals of water, hamburgers and other refreshments. There is, however, some fear of imported communicable diseases amongst the local population.

There is a good working relationship between the Serbian Red Cross and UNHCR. UNHCR purchases supplies and puts them at the disposal of the Red Cross. For example, supplies were sent to Presevo five days in advance of the opening of the centre. A good working relationship also exists with the Commissariat for Refugees and Migration, Government ministries, particularly the governmental working group for solving the issues of mixed migration flows, the Ministry of Health and WHO, which historically has supported the health prevention activities of the Red Cross and which was also very supportive after the recent floods.

Médecins Sans Frontières Belgium were on hand at the Presevo site. The representatives were registered in Belgium and were now applying for registration in the former Yugoslav Republic of Macedonia. They go to the area where the migrants register with the police and tell them about

the services they offer. They have one physician there, and the coordinator/head is from the team in the former Yugoslav Republic of Macedonia. They have a mobile clinic based not far from the police station. Patients come mainly with acute problems related to travel (blisters, wounds). If they have chronic diseases, they are referred to the Serbian health system. The unit does have some medications to tide patients over until they can access the Serbian health system.

## Conclusions and recommendations

### *Conclusions*

Serbia has been faced with a sudden large-scale influx of migrants, and this situation will likely continue for the foreseeable future. Almost all the migrants wish to leave Serbia for western European Union countries. Accordingly, the majority of migrants remain in Serbia for a limited number of days. Serbia is coping well at the moment, and current management practices for the migrants are progressive and humane. Basic humanitarian needs are being met. The plans for the new processing centre at Presevo are sound.

Limited health needs have been identified so far, mostly for emergency care, with some acute medical and minor surgical needs. Maternity support has occasionally been required. These health needs are also being met: primary care triage plus secondary and tertiary care support are in place. Effective public health surveillance is being carried out. However, while the medical procedures for asylum-seekers in the centres are already in place, the majority of the people in transit are not resident in these centres.

Serbia remains vulnerable to changes in entry and exit flows, and to any increase in numbers remaining in the country, whatever the reason. An intersectoral national contingency plan on migration is therefore needed to ensure that preparedness actions are implemented for an effective and coordinated approach in the management of a large influx of migrants, in line with potential future scenarios.

It is important to consider the regional situation, while continuing to make progress at the national level. It is also important to strengthen coordination at the municipal level. Here, the processing centre at Presevo could be used as a pilot plan, then revised and rolled out to other areas.

With regard to the health component of this plan, the goal is to identify the roles and responsibilities of national/local health institutions and of key organizations and individuals in order to secure, in alignment with national policies and guidelines:

- the efficient management of resources;
- an effective response to the health needs induced by a large influx of migrants; and
- defined communication procedures and modalities to secure consistent and “one-voice” communication.

The contingency plan should also specify the involvement of WHO and other United Nations agencies with regards to the mobilization of technical expertise and the procurement of medical products. One key issue is that of assessing the clinical utility and cost-effectiveness of current procedures. Another key need is increased surveillance of people who are moving quickly through the country.

A “one-voice” communication plan is required to deal with the sensitivity and stigma often associated with the idea that migrants are vectors for communicable diseases and, at the same time, to inform politicians, health professionals, security personnel and the media about the actual health risks and benefits associated with migration.

It is recommended that intersectoral collaboration should be strengthened and the health-in-all-policies approach promoted by convening an interministerial, interagency and intersectoral meeting at the Ministry of Health to present the results of the assessment, receive information from other sectors, discuss implications and plan future interministerial collaboration.

Local opportunities for resource mobilization should be promoted, and the Ministry of Health should make presentations on its contingency planning and the resources needed to deal with the situation, particularly in terms of capacity-building.

The unexpected influxes of migrants challenging Europe since 2011 have encouraged the international dialogue on health and migration among the Member States of the WHO European Region.

### *Specific recommendations*

- While the medical procedures for migrants in the asylum centres are already in place, the majority of the people “in transit” are not resident in these centres. A shift from an emergency focus to a systematic approach is required for the further development of both local and national health policies to respond to large influxes of people in transit (for instance, at the national level, compliance with the International Health Regulations (2005) and, at the local level, the need to include migrant health needs in local health planning).
- Contingency planning is needed now, in the context of national and local planning and coordination structures.
- Very limited WHO logistic and supply support may be appropriate, if supported by UNHCR and the United Nations Country Team.
- Overlap with UNHCR activities should be avoided through close operational liaison.
- While the regular information system is sound, health information on migrants’ health should be collected in order to develop evidence-informed migrant health policies.
- A communication strategy on public health and migration is needed including, for example, the development of key messages for the general public.
- Documenting the process will contribute to intercountry exchanges of knowledge and best practices.
- A review of procedures for triage examinations of migrants at primary care level (processing centre and primary care centre) should be conducted in order to ensure that all procedures are clinically justified and cost-effective.
- Cultural mediation and translation services for migrants should be strengthened.
- Risk assessments should be conducted before surveillance begins.
- Unaccompanied minors appear to be very vulnerable, and protection for this group should be strengthened.
- A unit on migrant health at the Ministry of Health should be established and/or a focal point on migrant health nominated.

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# Annex. Expert field assessment mission 25–27 August 2015

In response to increasing migrant numbers, an expert field assessment mission was carried out in southern, central and northern areas of Serbia on 25–27 August 2015. The mission visited the locations most affected by the influx of refugees and migrants: Presevo, Miratovac, Belgrade, Kanjiza and Horgos. The mission comprised representatives of the Government of Serbia working group for solving the issues of mixed migration flows, the United Nations Country Team (including UNHCR, the Office of the United Nations Resident Coordinator, WHO, United Nations Children's Fund, United Nations Population Fund, United Nations Office for Project Services), the United States embassy, the European Union delegation to Serbia, the Danish Refugee Council, local self-government representatives and local civil society organizations.

The aim of this visit was to perform a rapid assessment which will contribute to the development of a contingency plan. This field visit was jointly organized by UNHCR and the above-mentioned governmental working group.

## *Background*

Since January 2015, approximately 100 000 migrants have entered or passed through Serbia, and applications of intent to seek asylum have risen to 4000 so far. It is estimated that an equal number of migrants transit through the country without registering with the authorities. On 23 August, 7000 new arrivals were recorded in a single night after migrants managed to break through the police blockade in the former Yugoslav Republic of Macedonia and enter Serbia through the village of Miratovac. This necessitated the introduction of a 24-hour police presence in the south and the establishment of yet another transit centre, at Miratovac near the border with the former Yugoslav Republic of Macedonia.

In southern Serbia, there was already a one-stop transit centre (Presevo), opened in July 2015 for the fast-track procedure for obtaining documents and receiving necessary assistance, including medical treatment. Also, an interim reception centre was set up in the north (near Kanjiza), where large tents were erected in August 2015 for 1200 refugees. On 24 August, an Asylum Information Centre was established in Belgrade to inform migrants about the procedures in their mother tongue.

The capacity of reception centres is well below that needed to accommodate the increasing number of refugees (at the moment the expert field assessment mission took place, there were 4000 entering southern Serbia every day). The number of children and pregnant women is rapidly increasing, including people with chronic diseases (patients on dialysis, people with disabilities or cardiovascular disease, etc.).

## *Key findings*

### Presevo reception centre

The reception centre for migrants in Presevo is a one-stop combined registration and first-aid centre (see Fig. A.1). It is situated in an old tobacco factory, in the vicinity of the city centre. Three medical teams provide daytime health services, and the Presevo primary health care

centre provides night-time on-call cover. A separate space is to be arranged for people in need of medical services, to keep them separate from people awaiting registration and to provide a more private space where examinations and medical interventions can be performed. A container will be supplied by UNHCR for this purpose. Medicines and medical supplies are provided by UNHCR through the Danish Refugee Council, and planning of needs is done on a daily basis with local pharmacies. If patients need more than basic medical interventions, they are referred to the primary health care centre in Presevo or the nearby hospital in Vranje. According to the Ministry of Health and local health authorities, there is a need for additional medical supplies, provision of which is to be supported by WHO or other partners.

Mobile toilets and shower cabins are available, provided by UNHCR, but the current capacity is insufficient to meet the growing needs. The Serbian Red Cross provides hygiene kits, but more are needed. Food packages are available only for women and children, while men have to find some way to buy food outside the camp. Bottled water is available, provided by the Red Cross. There is a need for guidelines on breastfeeding and nutritional support for infants and young children in reception centres.

Fig. A.1. Left: Presevo one-stop reception centre. Right: Presevo registration and medical centre

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Municipal representatives have also asked for electricity generators for the Presevo centre, because of the age of the electrical installations in the factory. Waste management is a problem, as there are only a few garbage containers and the municipality does not have enough trucks to clean the area regularly.

### Miratovac camp

This camp was opened recently. On the day of the visit, only tents and three garbage containers were seen (see Fig. A.2). One tent was occupied by a medical team, comprising a physician and a medical technician, mobilized from the nearby emergency health department in Leskovac. Since this camp must be better equipped in order for the medical team to provide basic health check-ups and interventions, UNHCR will provide a container, with a refrigerator and other necessary equipment. Only first aid can be provided in this camp, but this is enough since Presevo is only 4 km away. UNHCR is providing several buses to shuttle between Miratovac and Presevo, bringing refugees to the centre in Presevo. Some people have also decided to walk. Waste management is a problem, since there are only a few garbage containers in the area. Food is not provided at this stop.

Fig. A.2. Left: Miratovac camp medical team. Right: Miratovac camp, garbage container

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## Belgrade

Krnjaca asylum centre was visited: more information about this centre and the services provided can be found in the in the section “Site visits” above.

The newly opened asylum information centre was visited (see Fig. A.3). It is located near two city parks where refugees are living, and close to the railway station. There are computers available with free wireless Internet access, and legal advice can be obtained in this centre. Refugees can also obtain a variety of information, including health-related information. The centre is funded by the City of Belgrade, and has highly educated volunteers (medical students, psychologists, lawyers). They share leaflets and information about services of interest for refugees in the parks. Volunteers refer migrants to two primary health care centres, providing health services free of charge, but also to the asylum centre in Krnjaca. Food and water supplies, including toilets and shower cabins, are provided by the city and the Serbian Red Cross. Approximately 100 persons per day ask for legal advice.

Fig. A.3. Asylum information centre, Belgrade


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### Old brick factory, on the road to Subotica

This place is the most unfit for hosting migrants and is in very bad condition (see Fig. A.4). It was not set up by the municipality, but has been on a refugee route for many years. It is situated on private land, and the municipality cannot invest to improve the conditions. A few toilets were provided recently, as well as some small tents. Médecins Sans Frontières workers were present at the time of the visit, providing first aid and transportation to the nearest health facility in coordination with the Subotica emergency centre. Between 30 and 200 people per day visit this stop and stay there from 12 hours to three days (deputy Mayor of Subotica, personal communication, August 2015). Food and water are distributed by the Red Cross on the spot. No garbage containers are available. There is an improvised field shower and, as in other places visited, the Red Cross distributes hygiene kits. Refugees walk from here to the border with Hungary, and also use public transportation and taxis.

Fig. A.4. Shelter in old brick factory




### Kanjiza camp

This camp (see Fig. A.5) is in the city of Kanjiza, which has 9000 inhabitants, with 1000-2000 migrants arriving per day (Mayor of Kanjiza, personal communication, August 2015). It was opened on 12 August 2015, in response to the increasing number of migrants staying in a city park. The camp does not issue registrations: it is only for migrants to rest. A medical team is also present, providing services three days per week. The medical team is contracted by a nongovernmental organization and, as in other camps and centres, provides first aid and basic health services. In case of need, the physician can issue a prescription which refugees can use to obtain medicines in local pharmacies free of charge. The medical team has an agreement with the emergency department of the local primary health care centre if treatment is needed. The financial burden on local authorities is significant. UNHCR, with the Danish Refugee Council, will support the local primary health care centre by contracting additional medical staff to provide health services.

Fig. A.5. Kanjiza camp


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### *Summary of assessed needs*

The following are needed:

- containers for medical teams, with equipment included;
- medicines and medical consumables;
- medical staff;
- garbage containers and waste management plan;
- water, sanitation and hygiene provision;
- regular food supplies;
- interpreters;
- guidance on breastfeeding and nutrition for migrant needs, nutritional support for infants and young children;
- hygiene kits;
- generators; and
- disinfectants.

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