



ASSESSMENT REPORT:
The Health Situation at EU Southern Borders -
Migrant Health, Occupational Health, and Public Health

GREECE

Field work 6–15 November 2013

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ACRONYMS

ART	Antiretroviral Therapy
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
ECDC	European Centre for Disease Prevention and Control
EWRS	Early Warning Response System
FRA	Fundamental Rights Agency
FRC	First Reception Centre
GG	Government Gazette
HDCDP	Hellenic Centre for Diseases Control and Prevention
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug User
IHR	International Health Regulations
MDM	Médecins Du Monde (Doctors of the World)
MED IN	MEDical Intervention (Greek NGO)
MDR TB	Multidrug resistant Tuberculosis
MoH	Ministry of Health
MSF	Médecins Sans Frontières (Doctors without Borders)
NaHOC	National Health Operations Centre
NGO	Non-Governmental Organization
NHS	National Health System
RABIT	Rapid Border Intervention Team
RAO	Regional Asylum Offices

EXECUTIVE SUMMARY

Until the 1980s, Greece was primarily a country of emigration. Migration inflows consisted mainly of refugees of Greek origin from the region who integrated quickly in Greek society. Until almost the end of the 20th century, the economic development of the country did not encourage migration to Greece. The increase in migration inflows peaked in the early 1990s, with extensive arrivals of irregular migrants from neighbouring Albania. Only 10 years later, the 2001 Census recorded nearly 800,000 foreign nationals living in Greece, comprising 7.3 per cent of the total population; more than half of them from Albania and another 16.2 per cent of them from Central/Eastern Europe and the former Soviet Union. Irregular migration to Greece continued to increase rapidly in the period between 2008 and 2010. In 2011, the situation at the Greek–Turkish land border in the Evros region, where most irregular arrivals happened at that time was assessed as a humanitarian crisis.¹ Consecutive legal and administrative reforms, including the opening of several detention centres with the objective to improve the management of the migration process as per international and EC recommendations, were implemented. Latest data as of this year suggest continuous inflow of migrants, crossing the sea border between Greece and Turkey, often in very precarious conditions, mainly coming from war torn countries (Syrian Arab Republic, Afghanistan, Iraq, Somalia, Eritrea, and the Occupied Palestinian Territory).

This report presents the results from the assessment on migrant, occupational, and public health, which took place in November 2013 in Greece as part of the EQUI-HEALTH project. **Migrant Health** in this report encompasses the physical, mental, and social needs of migrants; **occupational health** refers to the health needs of first line staff, engaged in the reception process; while **public health** discusses the local population's health needs. As such, the latter includes an analysis of the national public health policies and practices addressing migration related challenges.

Policy and legal framework

Greece is a signatory of core European and international legal frameworks on the protection of human rights of migrants; it also adheres to international documents regulating the protection of refugees and the prevention of human trafficking. While the Ministry of Interior has overall responsibility for immigration issues,² Law 3907/2011 from 26 January 2011 has given jurisdiction for the set up and operation of a new Asylum Service (based on the development of First Reception Service, pre-removal/detention service, and specific measures for vulnerable migrants) to the Ministry of Public Order and Citizen Protection, and following the revised Action Plan on Asylum and Migration Management from 2013, submitted to the EC. In fact, Law 3907/2011 has aligned Greek legislation to the provisions of EU Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals (EU Return Directive). The new Asylum Service and Appeals Authority have been operating since 7 June 2013, defining the roles of responsible asylum authorities in Greece. Access to the asylum procedure is currently provided by five Regional Asylum Offices (RAOs) – located in Attica, Alexandroupolis (including Komotini), Orestiada (inside Fylakio

¹ Fundamental Rights Agency (FRA), Coping with a fundamental rights emergency; the situation of persons crossing the Greek land border in an irregular manner (2011). Available from http://fra.europa.eu/sites/default/files/fra_uploads/1500-Greek-border-situation-report2011_EN.pdf

² See the EU Immigration Portal, Country Profile: Greece. Available from <http://ec.europa.eu/immigration/tab1.do?searchFromTab1=true&searchByCountryCountryId=0&searchByIdFromMap=0&intCountryId=7&strIdSection=10&subSec=10&language=7&en&langDefault=&userLang=7&languageLocaleId=7>

First Reception Centre),³ Lesbos, and Rhodes.⁴ Financial needs are mainly covered by the State Budget (EUR 8.9 m) and EU funds (EUR 1.5 m). Health care services in FRCs and pre removal/detention centres are under the responsibility of the Ministry of Public Order and Citizen Protection.

Although Greek law provides for proper conditions for persons deprived of their liberty, the UN Working Group on Arbitrary Detention found in January 2013 that conditions in most detention facilities fall far below international human rights standards. It was specifically observed that **irregular migrants were mixed in with criminal detainees and that detention may take place for months in police holding cells and border guard stations** designed for a maximum stay of 24 hours. This is in direct violation of article 31, Law 3907, which expressly prohibits the mixed detention of administrative with criminal law detainees and/or convicted persons. The Council of Europe's Human Rights Commissioner noted in his report following his visit in January and February of 2013 that the lack of access to adequate health care in the police run detention facilities was an important issue.⁵ He noted that even though the Ministry of Public Order is aware of it, **"a lack of funds hinders the implementation of any regular health care programme"**.

Greece's health-care system provides universal coverage in terms of free of charge health care for all insured. However, austerity measures and the sharp rise in unemployment figures have resulted in a large number of citizens being excluded from the former universal health system, thus limiting their choices to a few mainly Athens-based NGOs which offer free primary health-care services to vulnerable groups such as undocumented migrants. In principle, legally residing migrants are covered by the same system as nationals, meaning that they enjoy the same rights as nationals under their membership in the social insurance funds that provide health-care coverage for all categories of employees, including the self-employed.⁶ However, Law 4251/2014 prohibits public servants and employees of public from providing health-care services to third country nationals who have not entered and/or are not residing legally, except in cases of emergency and/or for minors (under 18 years of age).

Thus, in the context of a prolonged economic crisis and increasing mixed migration flows to Europe, the national legal and policy framework is becoming more and more restrictive to uninsured people, including irregular migrants, who have access to health care only in cases of emergencies. Disabled people, elderly persons, pregnant women, single parents with minor children and victims of torture, rape or other serious forms of psychological, physical or sexual violence are increasingly vulnerable as a result.⁷

A number of protocols and procedures have been developed in recent years, including on age assessment, vulnerability assessment, and for health screening at arrival. However, interviews with stakeholders suggest that in practice due to the limited financial and/or human resources capacity very few cases are dealt properly and in accordance with the law. Proper implementation of national

³ The asylum unit operating in the First Reception Centre (FRC) of Fylakio, which is not an open centre, also receives Asylum applications made only by its residents.

⁴ For more information see at: www.yptp.gr/asylo.php?option=ozo_content&perform=view&id=3506&Itemid=465

⁵ Council of Europe: Commissioner for Human Rights, *Report by Nils Muižnieks Commissioner for Human Rights of the Council of Europe following his visit to Greece from 28 January to 1 February 2013*, 16 April 2013, CommDH(2013)6, para. 144.

⁶ The risk-sharing system for health care costs is based on compulsory insurance through membership with employment linked social insurance funds.

⁷ Ansamed, "Domestic violence up in Greece, sex drive down", 23 May 2013. Available from www.ansamed.info/ansamed/en/news/sections/generalnews/2013/05/23/Domestic-violence-up-Greece-sex-drive-down_8756047.html

and European legal framework remains one of the biggest challenges of the new asylum and migration management system in Greece, including in respect to the right to health.

Partnerships, networks, and multi-country frameworks

Several national and local stakeholders are engaged in the *reception process* in Greece – from rescue at border (sea or green border), first reception, transfer to centres, and later in centres and outside of centres. In line with their roles and responsibilities, the Hellenic Coast Guards and the Hellenic Police are the main actors in the reception process, while the police are also responsible for the administrative procedure. With respect to health, local health authorities, NGOs, and/or volunteers are the counterparts who take initial care of arriving migrants, including by providing first aid. Migrants are then transferred to the First Reception Centre (FRC). The roles and responsibilities of all actors providing health and social support in the FRC are formalized by a law which defines the triage procedure and the services that should be provided.⁸ In the detention centres are held undocumented migrants who have arrived in the country before the passage of Law 3907/2011. Most of the time, it is medical NGOs, rather than the public health-care system, which provide health care to migrants in detention. Considering the limited presence of health-care staff in detention centres, it is at the discretion of the law enforcement officers on duty to decide if a migrant is sick and if he/she needs to be referred to a hospital when there is no doctor available onsite. There are no more than fifteen NGO managed open reception centres in Greece, and most of them face problems with ensuring continuous funding of their activities.⁹ A significant problem in the reception process, as reported during the field visit, is the transfer of migrants and asylum-seekers from the FRC to detention centres and/or to open shelters for asylum-seekers due to lack of funds and/or places. This is especially dramatic for unaccompanied minors and other vulnerable groups, who are – according to the regulations – to be transferred to appropriate accommodation by police vehicle (even if this isn't an official police responsibility), once they file an asylum claim in the FRC. Once outside FRC and/or detention centres, migrants visit hospitals/other health-care facilities mostly after a doctor referral. The major problem remains health-care services access for the uninsured and undocumented.

In relation to *public health surveillance* in the border regions, no outbreaks have been recorded, however local population shared unsubstantiated fears of diseases that migrants may be carrying, supported by the xenophobic tone of the media. However, according to interviewed health professionals, public health is not endangered by migration as much as by other factors, such as the economic crisis and the near collapse of the public health-care system in Greece, which has affected the availability of staff, medical supplies, and provision of health-care services.

Monitoring Migrant Health

Upholding *migrant health* is challenging, given the increased number of unaccompanied minors, pregnant women, babies, elderly, and disabled migrants arriving by sea. The long trip and the trying migration conditions before embarking on the final transit of the sea border between Greece and Turkey (with no proper documents, transportation means, long walking distances for many hours or days, and feelings of helplessness at sea) have significant impact on both the mental and physical health of migrants arriving in Greece.

⁸ "Program of medical check and psychosocial support diagnosis and referral of incoming undocumented third-country nationals in the first reception structures" GG 2745 29/10/2013.

⁹ AIDA (Asylum Information Database). National Country Report: Greece, 2013. Available from www.asylumineurope.org/files/report%20download/aida_greece_second_update_revisedasylumservice_final_uploaded_0.pdf

Hospitals, NGOs, and volunteers are the main actors engaged in providing initial health care for newly arrived migrants. They offer medical services when there is an emergency or when the doctor and/or the NGO believe there is need for further specialized medical care. The most frequent medical conditions registered amongst arriving migrants are **fever, dermatological issues, infectious diseases** such as scabies, parasitic infections, etc., and wounds due past living conditions.¹⁰ There are fewer chronic diseases, as migrants mostly are in their 20s and 30s. Cases of TB, Human Immunodeficiency Virus (HIV)/AIDS, and other more complex infectious conditions are treated in Alexandroupolis, Thessaloniki, or transferred to Athens where more specialized treatment is available; local hospitals (at the border and/or islands) generally do not have the necessary equipment and specialists to handle such cases.

Usually there are one or two doctors, one or two nurses, a psychologist and a social worker in the centres where NGOs operate. Most often, services provided include basic health care. Health-care NGOs do not provide medical tests for HIV/AIDS, Hepatitis, Syphilis and/or other infectious diseases; other more specialized health services are provided in hospitals. Vaccinations, health promotion programmes, specialized services for chronic conditions, disabled persons, people with mental health needs, and dental services are very difficult to handle and treat due to the ongoing financial crisis and the concomitant limitations of the Greek health-care system. Lack of interpreters and health mediators further limits irregular migrants' access to free health care in Greece to only a few NGO operated policlinics.

In respect of *health data collection*, most health staff interviewed in visited centres and hospitals reported they collect data locally, following different templates for basic health screening; this data has not been aggregated in a central database (beyond some basic summative NGO statistics). The detention centres visiting team found neither a system of routine health surveillance (regular disease reporting or syndromic surveillance), nor epidemiological analysis being done. One area of concern reported by health authorities is TB among migrants, and in particular – drug resistant and multidrug resistant tuberculosis (MDR TB). According to the Hellenic Centre for Diseases Control and Prevention (HCDCP), it is obligatory for hospitals to collect and declare infectious diseases centrally.¹¹

Health professionals informed us that there is no web based computerized hospital or emergency registry in the country (besides the information collected on infectious diseases via NaHOC and HCDCP)¹² to be used for exchange of medical files between interested doctors and facilities, which is especially important in the case of transfer of migrants between different centres. Often, relevant health information is locked, filed, or put away and forgotten, which clearly hinders the exchange of information when it is needed by migrants or HPs. In principle, when the patient leaves the hospital, it is very difficult to track him/her or refer to any other service with the complete set of documents, including even between detention/reception centres.

A common procedure for medical screening, psychosocial diagnosis, support, and referral of undocumented migrants entering the country is supposed to be followed in FRCs, according to the recently passed Law 2745 – 29/10/2013 (“Programme of medical control, psychosocial diagnosis,

¹⁰ See also: MSF report: Migrants in detention – Lives on hold, 2009–10. Available from www.doctorswithoutborders.org/article/greece-lives-hold, MSF report: Emergency intervention in Evros (2011). Available from www.msf.org/article/more-60-percent-medical-problems-faced-detained-migrants-evros-greece-caused-inhumane-living, MSF report: Medical assistance to migrants and refugees in Greece (2013). Available from www.msf.org.uk/sites/uk/files/greece_refugees_2013.pdf

¹¹ See at: www.keelpno.gr/en-us/epidemiologicalstatisticaldata.aspx

¹² See at: www.keelpno.gr/en-us/epidemiologicalstatisticaldata.aspx

support, and referral of third country nationals entering without legal documents”), however its implementation in practice was found to be limited and/or lacking.

Migrant-sensitive health systems

Extensive literature exists describing the *inadequate infrastructure and physical conditions* of detention centres in Greece. Significant improvement was observed in the newly opened FRC and First Screening Centre, while the situation remains problematic and critical in the other three detention centres visited – Amygdaleza, Fylakio, and Xanthi. Most of them had problems with heating and hot water, and the detainees complained about insufficient amount and poor quality of food, lack of soap and other hygiene products, as well as insufficient clothing, shoes, and blankets. While there have been many reports of severe overcrowding in the past, at the time of the visit, the situation in the detention facilities seemed to have improved, except for Fylakio where that problem remains unsolved. Commonly reported problems included lack of ventilation, limited sanitation, extreme room temperatures, and poor hygiene. Access to functioning latrines was mentioned as an issue, especially in Fylakio Detention Centre, with dozens or even hundreds of detainees having to share a single toilet without any privacy.

Regarding the occupational health of staff working in visited facilities, our team observed psychological, emotional, and physical stress amongst both health professionals and law enforcement officers; however, any such observations are subjective and based on anecdotal evidence as there are no studies on this topic in Greece. All the interviewees in public hospitals referred to their feelings of insecurity for the future because of the financial crisis. They also felt stress related symptoms (psychosomatic) and burnout. Detention centre employees experience high levels of job related stress and related health concerns. Some of them were particularly stressed out by hygiene conditions and the fear that they could contract a contagious disease from the detainees. They all referred to physical weakening as a result of exposure to constant stress and excessive job demands. Law enforcement officers confessed they feel at high risk of physical injury as well. In terms of health promotion and prevention programmes, interviewees from different institutions informed us they were not aware of any extra vaccination programmes offered as part of their occupational health care package plan (for example Hepatitis B), besides the standard national health programme ones. At the same time, interlocutors at FRCs said that additional vaccination is possible and simply entails the employees going to a public health to be vaccinated free of charge. HCDCP informed us that there is a national programme for vaccination of health workers in every hospital in Greece.

Some NGO staff reported anxiety and distress at work, as their programmes depended very much of EU funding, thus lacking sustainability and limiting long term planning of activities.

None of those interviewed reported having received any specific *training* on migration health and/or intercultural mediation. Language barriers and difficulties in communicating with migrants coming from different cultural and religious backgrounds further pose difficulties to staff we met during the field visit. FRC managers informed us they have trained their staff in intercultural issues, as well as edited a booklet on the Muslim residents; interpreters are also available in the areas operated by the asylum services. Most health professionals and law enforcement officers have not received special training on migrant health, intercultural communication, or human rights/legal aspects of migration, but do want to be trained in a participative way.

Conditions and safeguards afforded to immigration detainees who have committed no crime are often worse than those of criminal detainees. Conditions can be appalling (dirty, unsanitary, lack of beds, clothing and food, lack of sufficient health care, etc.) and the detention regime is often inappropriate or almost entirely absent (activities, education, access to the outside and fresh air).

Parliamentary Assembly, Council of Europe, 2010

1. INTRODUCTION

A traditionally emigrant-producing country, Greece since the 1990s has become a key entrance point into the European Union for an ever increasing number of migrants, many of whom arrive without appropriate documents. Many of these migrants face severe difficulties during their migration journey, which may last anywhere from one day to several years, and during which they experience various traumatic and health/life threatening events.

This report presents the results from the assessment on migrant, occupational, and public health, which took place in November 2013 in Greece as part of the EQUI-HEALTH project. **Migrant Health** in this report encompasses the physical, mental, and social needs of migrants; **occupational health** refers to the health needs of first line staff engaged in the reception process; while **public health** discusses the local population's health needs. As such, the latter includes an analysis of national public health policies and practices addressing migration related health challenges.

Based on desk research, field visits, and interviews¹³ with a range of stakeholders including law enforcement officials, public authorities, health professionals, non-governmental organisations (NGOs) providing health care, social, and legal services to migrants, and migrants themselves, the report examines the policy and practical obstacles that hinder migrants' access to health care in Greece. The report does not provide a comprehensive overview of the situation of all migrants' access to health services in Greece; its focus is limited to the provision of health services to migrants crossing the European Union's external border of Greece. Setting as a specific objective to describe the management of complex migration flows during the different stages of the reception process (from rescue at sea onwards, including in detention and reception centres), the report further explores gaps in the provision of health services to migrants, actual coordination mechanisms in place, and possibilities for support and detection of vulnerabilities.

The content of the report is structured following the IOM/WHO/Spanish Presidency of the EU "Global Consultation on Migrant Health" conceptual framework (Madrid, 2010) (annex III), according to the following four pillars:

- I. **Policy and Legal framework**
- II. **Partnerships, networks and multi-country frameworks**
- III. **Monitoring Migrant Health**
- IV. **Migrant-sensitive health system**

¹³ Interviews were held in Athens, Lesbos (northern Aegean island where an increase in arrivals has been registered since August 2012) and Evros area. Members of the research team visited a number of locations incl. FRCs and Detention centres in Attica and in the main entry points' where migrants arrive from Turkey in addition to hospitals in Athens, Lesbos and Alexandroupolis and NGOs headquarters/local offices.

The *Recommendations* section at the end of the report will enable policy-makers to better understand and address the problems arising from lack of and/or insufficient access to health care for migrants in Greece. The information contained in this report will be useful for all stakeholders in Greece to do more and be more responsible as providers of health care for undocumented migrants. It can be used as a tool for influence, pressure, empowerment, and innovation.

2. BACKGROUND INFORMATION

Until the 1980s, Greece was primarily a country of emigration. Migration inflows consisted mainly of refugees of Greek origin from the region who integrated quickly in Greek society. Until almost the end of the 20th century, the economic development of the country did not encourage migration to Greece. On the contrary, Greek citizens migrated in significant numbers to Western Europe, the USA, Australia, and Canada. Emigration, however, nearly came to halt in the mid to late 70s after a tightening of migration policies in Western Europe and North America. The migration trend started reversing after 1985, when a large number of Polish and other Eastern European migrants arrived in Greece. By 1986, the number of legal migrants was estimated to be 92,440, and by 1990, 173,436; though residence permit data from that time points to 60,000 regular migrants in 1990.¹⁴ Approximately 100,000 irregular residents were estimated in 1990, bringing the percentage of migrants in Greece to 2–3 per cent of the country's population at that time.¹⁵ The increase of migration inflows peaked in the early 1990s, with extensive arrivals of irregular migrants from neighbouring Albania. The new situation created administrative and political confusion as the country did not have any immigration policy in place, whereas a significant number of undocumented migrants were already employed in the black market.¹⁶

The 2001 Census recorded nearly 800,000 foreign nationals living in Greece, comprising 7.3 per cent of the total population; more than half were from Albania, and another 16.2 per cent from Central/Eastern Europe and the former Soviet Union. Estimates place this figure as high as one million foreign nationals, including ethnic Greek migrants and recent arrivals. Table 1 provides an overview of the population in Greece and respective changes in the number of non-nationals between 1991 and 2011.

Table 1: Population (1991–2001–2011)

	1991	2001	2011
Total population of Greece	10,260,000	10,964,000	10,815,197
Non Nationals	167,000	797,091	909,939

Source: National statistical service of Greece.

According to the 2011 Census, around 900,000 foreign nationals lived in Greece with different legal statuses: 199,101 EU citizens, 530,213 non-EU nationals (largest proportion coming from the Balkans i.e. 480,824 Albanians), 138,263 Asians, and 25,846 people from Africa. According to the OECD Report on international migration trends from 2012, foreigners in Greece – including irregular migrants – are estimated at 7.1 per cent of the total population.¹⁷

¹⁴ Baldwin-Edwards, M. (2009). Report Greece. REGINE, Regularizations in Europe. ICMPD. Available from http://research.icmpd.org/fileadmin/Research-Website/Project_material/REGINE/Regine_Appendix_A_country_reports_january_2009_en.pdf

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ OECD, International Migration Outlook 2012; www.npdata.be/BuG/165-NV-A-migratie/OECD-Migration-Outlook-2012.pdf

2.1. Irregular migration to Greece

Irregular migration to Greece increased rapidly in the period between 2008 and 2010. Data indicate that most apprehensions for unauthorized entry into the European Union during this period took place in Greece: 50 per cent in 2008, 75 per cent in 2009, and 90 per cent in 2010.¹⁸

However, besides the data on irregular border crossings, there is no reliable method to estimate irregular migrant stocks in the country due to the near-collapse of the Greek economy and its impact on the employment of both Greeks and migrants. Through the years, different estimates of undocumented migrants in Greece ranged from 150,000 to 400,000 people.¹⁹ For example, the Greek Ministry of Interior estimated around 250,000 undocumented migrants in 2003,²⁰ while the CLANDESTINO Project estimated 280,446 persons in 2008.²¹ Based on research conducted before the onset of the economic crisis in 2011, Maroukis estimated that approximately 391,500 irregular migrants were living in Greece.²² Recently, in his report on the situation in Greece, François Crépeau (Special Rapporteur on the human rights of migrants) referred to 470,000 people with irregular status in Greece.²³

For the period 2007–2009, most irregular arrivals occurred on the Aegean Sea islands (Greek–Turkish sea border). This trend is evident in official Greek police data regarding the number of apprehensions at the sea boarder, which were 16,781 for 2007, 30,149 for 2008, and 27,685 for 2009.²⁴ In addition, there were approximately 3,500 migrants detected every year at the Greek–Turkish land border in the Evros prefecture prior to 2010.²⁵ In 2010, Greek authorities reported 47,706 detections at the Greek–Turkish land border, or an increase of 45 per cent over 2009.²⁶ This represented one of the largest numbers of irregular arrivals ever recorded in Europe at that time. In response, the FRONTEX Joint Operation Rapid Border Intervention Teams (RABIT) was launched in November 2010 with the objective to decrease the migration pressure and to support national authorities in building up the national law enforcement capacity. The RABIT deployment ended after four months, when Joint Operations (JOs) “Poseidon Land” and “Poseidon Sea” got under way. Those operations led to a significant decline in detections at the sea border between Greece and

¹⁸ Charalambos Kasimis, Greece: *Illegal Immigration in the Midst of Crisis*, 8 March 2012. Available from www.migrationpolicy.org/article/greece-illegal-immigration-midst-crisis

¹⁹ Baldwin-Edwards, M. and Kraler, A. (eds.) (2009:41). *REGINE, Regularizations in Europe*, Vienna: ICMPD. Available from http://ec.europa.eu/home-affairs/doc_centre/immigration/docs/studies/regine_report_january_2009_en.pdf

²⁰ Fakiolas, R. (2003), *Regularizing undocumented immigrants in Greece: procedures and effects*, *Journal of Ethnic and Migration Studies*, 29 (3), pp. 535–561.

²¹ Maroukis, T. *Undocumented Migration. Counting the Uncountable. Data and Trends Across Europe. Clandestino*, Country Report. (2008). http://clandestino.eliamap.gr/wp-content/uploads/2009/10/clandestino_report_greece_final_3.pdf (11 June 2013)

²² Maroukis, T. (2012): *Update report Greece: The number of irregular migrants in Greece at the end of 2010 and 2011*, Database on Irregular Migration, Update report; <http://irregular-migration.net/>

²³ UN General Assembly (2013) Report of the Special Rapporteur on the human rights of migrants, François Crépeau Mission to Greece* UN A/HRC/23/46/Add.4.

²⁴ Triandafyllidou A., *Migration in Greece Recent Developments in 2014*, ELIAMEP, Athens. Available from www.eliamap.gr/wp-content/uploads/2014/10/Migration-in-Greece-Recent-Developments-2014_2.pdf

²⁵ International Catholic Migration Commission (ICMC), Mayday! *Strengthening responses of assistance and protection to boat people and other migrants arriving in Southern Europe*. (September 2011). Available from www.refworld.org/docid/4f02ebd92.html

²⁶ Frontex, Annual Risk Analysis 2011; http://frontex.europa.eu/assets/Publications/Risk_Analysis/Annual_Risk_Analysis_2011.pdf

Turkey between 2009 and 2011.²⁷ Detections continued to drop off in 2012 and 2013, following the implementation of a set of Greek operations,²⁸ as well as the continued implementation of Frontex-coordinated JOs (Aeneas, Hermes, and Poseidon Sea). Trends changed in 2014, when the number of migrants arriving via the eastern Aegean and Dodecanese islands increased by 223.22 per cent over the previous year, with most of the people coming from the Syrian Arab Republic, Somalia, Eritrea, and Afghanistan. In a press conference, UNHCR re-stated that the situation in Greece has already taken the characteristics of a humanitarian crisis. They presented figures showing that 22,089 refugees had entered Greece via its sea borders the first eight months of 2014, while in the same 2013 period the number had been 6,834. Just in September 2014, arrivals in the Aegean islands were estimated at 7,500 people, of which half were in the Dodecanese. The number of people who crossed the Evros River that same month was 1,133.²⁹

2.2. Regularization programmes

Since 1997, Greece has launched a few regularization programmes, enacting in November of that year for the first time legislation that allowed irregular migrants to apply for a "white card"—an initial six-month residence permit, which in itself was a prerequisite for a "green card" application—a renewable (for one to five years) work and residence permit. During this first legalization programme, over 370,000 migrants applied, of whom 65 per cent were Albanian citizens. Because of the requirements (*to qualify for a green card, an immigrant had to prove legal employment since 1 January 1998 and had to be employed for 40 days at minimum wage*), 150,000 migrants who received a white card were unable to move to the second legalization phase, and only 220,000 applied for green card.³⁰ By February 2000, 107,000 cards were awarded (75% of which with one year duration).³¹

In 2001, Greek authorities launched the second regularization programme for undocumented migrants. According to Law 2910/2001, the "Green Card II" regularisation programme allowed for a six-months residence permit that would need to be replaced by work and residence permit (registration: June 2001-August 2001). To qualify, migrants had to prove either legal status in the past and continuous residence in the country since their documents had expired, or that they had been living in the country for one year since the date of the law's enactment.³² The law's 2002 amendments allowed for migrants who had been residing legally for two years to be granted residence for another two years; after 10 years, they could apply for permanent residence. By mid-2003, approximately 580,000 migrants were legalized. Almost 300,000 migrants failed to participate in either programme.

²⁷ Frontex, Annual Risk Analysis 2012;

http://frontex.europa.eu/assets/Publications/Risk_Analysis/Annual_Risk_Analysis_2012.pdf

²⁸ Shield Operation with 1800 law enforcement officers in Evros region, building of fence, and Xenious Zeus Operation since August 2012.

²⁹ UNHCR Greece, Invitation to Press Conference-Refugee arrivals on the Aegean Islands 2 October 2014; www.unhcr.gr/nea/artikel/d4244887209f51a48c77ea02267844bf/invitation-to-press-conference-refug.html

³⁰ Reyneri, Emilio. 2001. *Migrants' Involvement in Irregular Employment in the Mediterranean Countries of the European Union* [online]. Geneva: International Labour Organization; www.ilo.org/public/english/protection/migrant/download/imp/imp41.pdf

³¹ Baldwin-Edwards, Martin. 2004a *Albanian Emigration and the Greek Labour Market: Economic Symbiosis and Social Ambiguity*. South East Europe Review.

³² Lykovardi, Kalliopi and Eleni Petroula. 2003. *EU and US Approaches to the Management of Migration: Greece* [online]. Eds. Jan Niessen et al. Brussels: Migration Policy Group: www.migpolgroup.com/uploadstore/Greece.pdf

In 2005, Law 3386/2005 introduced a new regularization programme for undocumented migrants who had entered Greece before 31 December 2004. A new, smaller regularization programme was introduced in 2007 (Law 3536/2007), targeting those who had not been able to renew their permits according to Law 3386. The aim of these two programmes was to provide with legal status certain specific categories of migrants who have lived in Greece for several years but who, for various reasons, have not been able to regularize their residence and employment in the country.³³ The 2005 programme also targeted rejected asylum-seekers, who were required to present a statement declaring their occupation, the reason for residence in Greece, family members residing in Greece, and an affidavit confirming they had not committed any crimes.

Table 2: Synopsis of regularization programmes in Greece

	1997	1998	2001	2005	2007
# applicants	371,641	228,200	367,504	n.d.	n.d.
# permits issued	n.d.	219,000	341,278	185,000 (est.)	20,000
# original duration of the permit	6 months	1–2 years	6 months	1 year	1 year

Source: ICMPD (2009)³⁴

2.3. Number of asylum applications and main countries of origin

Since June 2013, there have been two asylum systems working in parallel: the earlier where police was handling and processing the applications prior to 7 June 2013, and a new Asylum Service for subsequent applications when the new Asylum Service (Law 3907/2012) becomes fully functional.³⁵

According to Eurostat, in 2013 the number of asylum-seekers in Greece was 8,225, and most were Pakistani, Afghani, Bangladeshi, Albanian, or Georgian. Older data on the number of refugees and asylum-seekers is not publicly available, though it is partially communicated to Eurostat.

Table 3: Asylum applications and positive decisions in Greece

	2008	2009	2010	2011	2012	2013
# Applicants	19,885	15,925	10,275	9,310	9,575	8,225
# Refugee status first instance	15	35	60	45	30	255
# Humanitarian status first instance	25	25	30	45	20	70
# Refugee status final decision	345	30	35	195	185	325
# Humanitarian status final decision	15	0	0	135	255	365

Source: Eurostat, extracted on 17 September 2014.

³³ Triandafyllidou, A. (2009) "Greek Immigration Policy at the Turn of the 21st Century. Lack of Political Will or Purposeful Mismanagement?" *European Journal of Migration and Law* 11.2.

³⁴ ICMPD (2009), *Regularizations in Europe, Study on practices in the area of regularization of illegally staying third country nationals in the Member States of the EU*, http://ec.europa.eu/home-affairs/doc_centre/immigration/docs/studies/regine_appendix_a_january_2009_en.pdf

³⁵ EDAL (2013): 'EDAL country overview: Greece'. European Database of Asylum Law. www.asylumdatabase.eu

The new system's online data show that from 1 January to 1 August 2014, 6,245 new asylum applications were submitted. Applicants' nationalities included Pakistani (17.5%), Afghani (17.2%), Albanian (7.7%), Bangladeshi (6.3%), and Syrian (6%).³⁶ In this period, 5,527 cases were closed at first instance, with 685 (17.2%) being granted convention status, and 300 (7.6%) subsidiary protection. The first instance recognition rates were 99.5 per cent for Syrians, 77.9 per cent for Eritreans, 66 per cent for Sudanese, and 61.9 per cent for Afghani; at the other end of the scale, they were 0.4 per cent for Albanian and 0.0 per cent for Georgian applicants. Regarding gender of applicants, 79 per cent were women, 21 per cent were unaccompanied minors, and 4 per cent were men.

³⁶ Hellenic Republic, Ministry of Public Order and Citizen Protection, Statistics of the new Greek Asylum Service (1.1.2014 – 31.8.2014). Available from www.yptp.gr/images/stories//2014/asylo/13092014GreekAsylumServiceStatisticalData_Jan14-August14_en.pdf

3. METHODOLOGY

3.1. Overview of data collection

The expert team pre-selected four locations to be visited in Greece based on the following criteria: to cover different type of facilities (FRC/detention/pre-removal centres); to visit different locations (land/sea border); and finally to encompass the different routes of migration flows to Greece.



■ Visited locations (blue circles)

As part of the visits, meetings with stakeholders were organised in Athens (IOM office), Lesvos Island, and in Alexandroupolis, and a focus group discussion with migrants was organized at the Lesvos IOM office. The stakeholder meetings were attended by representatives of Ministry of Public Order and Citizen Protection, Hellenic Centre for Diseases Control and Prevention, Pakistani Hellenic Cultural Welfare Society, Ministry of Labour, Social Insurance Welfare, National Centre for Health Operations, Ministry of Health (MoH), Council of Europe, Ministry of Interior, Municipality of Lesvos, Prefecture of East Macedonia and Thrace, Prefecture of North Aegean Region, Hellenic Coast Guard, FRONTEX, Act up Hellas, NGO Agkalia, Doctors of the World, Red Cross, Doctors without Borders (MSF), the North Aegean Centre for Social Welfare, NGO Siniparksi kai Epikinwnia sto Aigaio, NGO Arsis, Association for Repatriated and Migrants Argo and IOM.

We interviewed a variety of stakeholders, including representatives of eight NGOs, doctors, and nurses working in four public hospitals (two in Athens, one in Lesvos Island, and one in Alexandroupolis).³⁷ We also visited one FRC (Fylakio-Evros), three detention centres (Amygdaleza-Athens, Fylakio-Evros and Xanthi), and one temporary registration centre (planned to be turned into FRC as of 2015 – Moria, Lesvos island).

³⁷ For full list of hospitals and NGOs see Annex III.

National Consultative Committees (NCCs) were held in Greece before the field visit in order to adapt methodology and in order to validate findings and recommendations for finalizations of the Situational Analysis Report (SAR) after the assessment.

The facilities are described in details in the infrastructure and physical conditions section.

Table 4: Sites visited

Type of site	Region
➤ Amygdaleza pre-removal detention centre in Menidi	Athens
➤ Sotiria hospital for chest diseases, TBC department	
➤ Children's hospital Agia Sofia	
➤ Unaccompanied minors' shelter of SMA, Exarchia	
➤ Estia prosfygon - Refugee shelter for families, Arsis	
➤ Praksis centre/policlinics	
➤ MSF and MDM HQs	
➤ Moria Screening centre (FR Mobile Unit operating in the centre)	Lesvos island
➤ Coast Guard HQ	
➤ Vostaneion general hospital, Emergency department	
➤ PIKPA Open centre (currently closed)	
➤ FRC Fylakio, Orestiada	Thrace region
➤ Pre-removal Detention centre in Fylakio, Orestiada	
➤ Infectious Diseases Department, University General Hospital of Alexandroupolis	
➤ Unaccompanied minors shelter, NGO ARSIS, Alexandroupolis	
➤ Pre-removal Detention centre, Xanthi	

Source: IOM Equi-Health project.

3.2. Limitations

The limitations of the assessment in Greece are summarized below.

- **Visited locations:** the centres selected for the study are representative of the situation in Greece with the only limitation being that no centre from the southern part of Greece (Peloponnese) was included. Open centres for adult asylum-seekers were not visited beyond one shelter for unaccompanied minors managed by the Society for the Care of Minors (SMA), one shelter for families, and one for unaccompanied minors managed by the NGOs Arsis.
- **Migrants interviewed:** as the study focuses on access to health care for irregular migrants at the Southern EU borders, the focus was on interviews with migrants residing in FRCs and detention centres. During the fieldwork, the expert team had limited access to migrants in the centres. The majority of migrants' interviews outside of centres were done through IOM and/or NGOs contacts, and some of the migrants had have never been in detention centres.

For the focus group discussion with migrants in Lesvos, interpreters for all needed languages were not available, and the discussion was done through Urdu/Greek speaking migrant while not everyone in the group spoke these languages. Another limitation was that the researcher who led the focus group discussion was female, while the group of migrants was composed exclusively of Muslim men who were arguably reluctant to have an open and frank discussion with/in front of a female facilitator.

- **Migrants' self-reported data:** migrants' personal data are self-reported and as such contain several potential sources of bias that should be noted as research limitations: (1) selective memory (remembering or not remembering experiences or events that occurred at some point in the past); (2) recalling events that occurred at one time as if they occurred at another time; and (3) exaggeration.
- **Elaboration of data:** much of the work done in this report refers to EU and national legislative framework on migration, interception/reception/rescue at sea/green border, and detention centres. For critical assessment of the legal framework, a legal expert is most suited to analyze immigration legislation and legal aspects of access to health for irregular migrants, especially in detention centres.
- **Lack of data:** although there are numerous studies on migrant health, including health care for irregular migrants, the health burden and health needs of migrants are largely unknown; there is also an on-going academic discussion about the exact definition of "migrant" in scientific literature.

In Greece, there are few publications focusing on migration and health, one such being the work of the Ministry of Foreign affairs for HCDCP.³⁸ There is scarce data from individual studies on infectious diseases and migrants, information is not systematically collected. According to HCDCP, it is obligatory for hospitals to collect and declare infectious diseases centrally.³⁹

- **Research Instruments:** questionnaires for health professionals (HPs) were addressed to HPs involved in the migrant reception process and in detention centres. There were no special questionnaires for HPs in hospitals and thus the researchers had to adopt the available interview tool according to the professionals they interviewed.

³⁸ Ευρωπαϊκών Μελετών (ΕΚΕΜ), Κέντρο Ελέγχου και Πρόληψης Νοσημάτων (ΚΕ.ΕΛ.Π.ΝΟ), Ιούλιος 2012-07-23, ISBN: 978-960-7849-35-9 Migration and public health. Greek Centre for European studies, HCDCP July 2012, Ministry of Foreign Affairs.

³⁹ See at: www.keelpno.gr/en-us/epidemiologicalstatisticaldata.aspx

Table 5: Number of interviews per profile

The EQUI Health team performed a total of **66 individual interviews** during the field visits, as provided in table 4.

Doctors (State hospitals)	7	<p>Specialized doctors at the grade of director (highest grade of state doctor in Greece), all middle aged.</p> <p>Two are directors of the medical services at their respective hospital (a pulmonologist and cardiac surgeon for children). The rest include: a director of TB department, a paediatrician assistant director, an internist head of the emergency department, a pathology professor specialized in HIV.</p> <p>Almost all interviewees spoke good English and another foreign language (Italian and/or German), and the majority have also specialized abroad. They included head nurses of the clinics they work in, two nurses working in emergency departments, and one nurse from a children's hospital.</p>
Nurses (State hospitals)	5	Head nurses have MSc degrees and more than ten years professional experience in hospital settings. Besides nursing, they have administrative responsibility of their clinics.
Doctors (NGOs at field locations and/or HQ)	5	<p>They represent a variety of medical specialties. Among them, there are specialized activists – doctors as the ones from MSF trained in operations in resource poor settings or emergency medicine, young doctors waiting to start working in the NHS and/or continue with their studies.</p> <p>They are younger than the doctors from the state hospitals and all speak English.</p>
Nurses (NGOs at field locations)	2	Nurses without a state (i.e. university) degree; of young age.
Law enforcement officers	8	<p>Highly trained (police academy, USA, Germany) coming from the field of migration and/or drug use; having served in police departments of high-risk areas (i.e. centre of Athens and/or border); middle aged.</p> <p>The director of the FRC in Orestiada is a civilian who has worked in the Ministry of Public Order. He speaks fluent English.</p>
Social workers	17 (7 state hospitals)	Social workers in state hospitals all had at least 20 years professional experience; graduates of the faculty of Social Workers; one with degree in Sociology and postgraduate studies in social work from England. Two have worked in Psychiatric deinstitutionalization programmes.

	and 10 with NGOs)	<p>Three spoke English while one of them was fluent in Ethiopian. The rest were only fluent in Greek.</p> <p>The NGO social workers were younger, average age being 30. One of them was the coordinator of a shelter for unaccompanied minor migrants. They all graduated from the Social Worker Faculty while one of them had postgraduate degree in health crisis management and international medicine.</p>
Psychologists	3	<p>Two working with NGOs in detention centres and one at an NGO's HQ.</p> <p>The two psychologists working in detention centres are university graduates of psychology school; one had followed postgraduate studies in support of people with disabilities. Of young age.</p>
Migrants	19 interviews; One focus group	<p>9 migrants were interviewed in detention centres; 10 migrants were interviewed in IOM office; A focus group was organized with 12 URDU speaking migrants in Lesvos.</p> <p>Of the 31 migrants interviewed, two were women, 36 and 31 years old respectively. Both were married, one from Ethiopia and the other from Georgia. Insofar as the men, one was a minor from Afghanistan; the oldest was 54 year old.</p> <p>Migrants interviewed outside of detention came from the Islamic Republic of Iran, India, Pakistan, Bangladesh, and Afghanistan.</p> <p>Migrants interviewed in detention centres/FRCs came from Bangladesh, Afghanistan, Senegal, Congo, Iraq, Pakistan, Algeria, and one of Kurdish origin from Iraq.</p> <p>Out of the interviewed migrants, 12 arrived in Greece crossing the Evros border. The rest arrived by boat (five in Lesvos, one in Lakonia and one at the coast between Xanthi and Komotini). All migrants in detention centres reported long trip, months or even years in another country before entering Greece. All migrants have been arrested and had detention experience, while 3 of them have been hosted in a centre for minors.</p> <p>All migrants stated that they had limited information about their trip and about the destination country and the prerequisites to get legal papers.</p>
Total	66	

4. FIELD WORK

I. POLICY AND LEGAL FRAMEWORK⁴⁰

I.I International, EU, and national/local legislative framework on interception/reception/rescue at sea/green border

As discussed in detail by François Crépeau in his 2013 *Report of the Special Rapporteur on the human rights of migrants*, Greece is a signatory to core international legal frameworks on the protection of human rights of migrants, including international documents regulating the protection of refugees and prevention of trafficking of human beings. Greece is also a party to regional legal frameworks clarifying different aspects of the human rights of migrants: the **European Convention for the Protection of Human Rights and Fundamental Freedoms** and the **European Social Charter (Council of Europe)**; the **EU Acquis on migration and asylum** and the **Charter of Fundamental Rights (European Union)**, and other relevant EU directives.⁴¹ As the report further clarifies, international treaties ratified by Greece form part of Greek law according to the **Greek Constitution** (Art.28<p>1), which guarantees “full protection of life, honour and liberty, irrespective of nationality, race or language, religious or political beliefs for all persons living within the Greek territory (Art.5<p>2) and inviolability of personal liberty (Art.5<p>3).”⁴² It further postulates that “no person shall be arrested or imprisoned without a reasoned judicial warrant which must be served at the moment of arrest or detention pending trial, except when caught in the act of committing a crime (Art.6<p>1) and torture, any bodily maltreatment, impairment of health or the use of psychological violence, as well as any other offence against human dignity are prohibited and punished as provided by law (Art.7<p>2).”⁴³

Greece bears the responsibility for securing the rights and providing for the needs of asylum-seekers in the country, in line with the EU Regulation known as the **Dublin Regulation**,⁴⁴ which postulates that people in need of protection request it in the first Member State they physically enter or in the state responsible for their entry into the territory of the EU, Norway, Iceland, Liechtenstein, and Switzerland. With the increase of mixed migration flows to the EU through Greece, several EU Member States have stopped sending people back to Greece for the processing of their asylum application under the Dublin regulation due to the conditions surrounding the asylum process there. The Court of Justice of the European Union (CJEU) ruled in December 2011 regarding Greece that “Member States may not transfer asylum-seekers in the face of “substantial grounds” for believing there is a serious risk to their fundamental rights, and must either find another responsible state or process the asylum application themselves.”⁴⁵ At this point, the Dublin system has essentially ceased to operate with respect to Greece due to the particularly poor detention and living conditions, as well as deficiencies in the asylum procedure that do not ensure conformity to the Convention standards.⁴⁶

The Dublin Regulation is part of the Common European Asylum System (CEAS) developed after the ratification of the 1999 Amsterdam Treaty. CEAS has added a layer of enforceable EU law to Greece’s international obligations towards asylum-seekers and refugees. It has also established practical

⁴⁰ Information taken from input for Health MIPEX Strand Greece questionnaire.

⁴¹ UN General Assembly (2013) Report of the Special Rapporteur on the human rights of migrants, François Crépeau Mission to Greece* UN A/HRC/23/46/Add.4.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ See Regulation 2003/343/EC i.e. Dublin II Regulation and Regulation (EU) No 604/2013 i.e. Dublin III.

⁴⁵ Joined Cases C-411/10 (N.S.) and C-493/10 (M.E.), 21 December 2011.

⁴⁶ European Court of Human Rights (2014) Factsheets July 2014; www.echr.coe.int/Documents/FS_Dublin_ENG.pdf

mechanisms to assist Member States in implementing EU asylum policies. In this respect, Greece submitted an Action plan on Asylum and Migration Management to the European Commission in 2010, followed by a revised Action Plan in January 2013 with more specific engagements insofar as the issues of international protection, effective border management, migrant returns, and the role and functioning of the new asylum system law.

Law 3907/2011 from 26 January 2011 provides for the creation of an independent Asylum Service and Appeals Board, and the establishment of First Reception Service, aligning Greek legislation to the provisions of EU Directive 2008/115/EC of the European Parliament and of the Council of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals (EU Return Directive). In the spring of 2014, Greece adopted a new “Code for immigration and social integration and other provisions” (Law 4251/2014). This legislation came into effect on 1 June 2014 and incorporates all immigration relevant legislation, including pertinent EC Directives.

I.II Legislative and financial framework of open/closed centres

While the Ministry of Interior has overall responsibility for immigration issues,⁴⁷ Law 3907/2011 has given the jurisdiction for the set up and operation of the newly integrated asylum and migration management system to the Ministry of Public Order and Citizen Protection, in line with the revised Action Plan on Asylum and Migration Management (2013).

The new Asylum Service and Appeals Authority has been in operation since 7 June 2013, clarifying the roles of responsible asylum authorities in Greece. Access to the asylum procedure is currently provided by five Regional Asylum Offices (RAOs) – located in Attica, Alexandroupolis (including Komotini), Orestiada (inside Fylakio First Reception Centre),⁴⁸ Lesbos, and Rhodes.⁴⁹ Financial needs of the new Asylum Service are mainly covered by the State Budget (EUR 8.9M) and EU funds (EUR 1.5M). Although there is an overall improvement in the processing of asylum applications, only two of the RAOs are accessible by asylum-seekers that are not in detention: the Attica Rhodes ones. Consequently, the Attica RAO is currently in charge of registering the vast majority of asylum claims from migrants residing in Greece, which are impossible to handle effectively due to the sheer volume of applications. As a result, many asylum-seekers have to wait in a long queue and file multiple times in order to have their asylum application even registered. In the meanwhile, applicants do not have any non-refoulement guarantees, or protection against detention and subsequent removal. **Moreover, until they manage to successfully lodge their application, asylum-seekers are deprived of access to medical assistance and any other services provided to asylum-seekers.**⁵⁰

Developing of First Reception Service

The **First Reception Centre** in Fylakio, Evros (Greek–Turkish NE land border) has been fully operational since March 2013. Two additional centres with capacities of 180 and 120 places,

⁴⁷ See at:

<http://ec.europa.eu/immigration/tab1.do?searchFromTab1=true&searchByCountryCountryId=0&searchByIdFromMap=0&intCountryId=7&strIdSection=10&subSec=10&language=7&en&langDefault=&userLang=7&languageLocaleId=7>

⁴⁸ The asylum unit operating in the First Reception Centre (FRC) of Fylakio, which is not an open centre, also receives Asylum applications made only by its residents.

⁴⁹ For more information see at: www.ytp.gr/asylo.php?option=ozo_content&perform=view&id=3506&Itemid=465

⁵⁰ Submission of the Greek Council for Refugees to the Committee of Ministers of the Council of Europe in the case of *m.s.s. v. Belgium & Greece* (application no 30696/09); www.asylumineurope.org/news/27-05-2014/icj-and-ecre-highlight-problems-asylum-procedure-and-detention-conditions-greece-new

respectively, in Lesbos⁵¹ and Attica were to be operational in December 2014, however for the moment only the FRC in Evros region is fully functioning.⁵² Even though the FRC has been operating for more than a year, it is not fully operational in relation to its capacity mostly because of lack of personnel. Screening and identification services are provided by law enforcement officers, transferred from their regular posts to the centres, while the administrative and functional tasks of the centre are assigned to civil employees. Legal information regarding newcomers' rights and the asylum procedure as a whole is provided by UNHCR representatives. Health and psychosocial care, as well as interpretation services are provided by NGOs. Interpretation covers a vast range of languages; for a number of rare (limited use) languages, interpretation takes place through teleconference translation services. According to Law 3907/2011, third-country nationals are able to maintain contact with social agencies and organizations throughout the duration of the first reception procedures. According to the FRC interlocutors, the FRC distributes leaflets with information on NGOs that are registered according to the law (registration to the FRS Registry guarantees that an NGO is legally operating in Greece or in EU and complies with the qualification criteria that are set by Law 3907). Furthermore they reported access is allowed to all NGOs registered in compliance with the law and EU directives. UNHCR is also present in the centre, and provides information on the asylum procedure (but no legal aid). The stay of the newly arrived in the FRC cannot exceed 25 days. Once this period is over, non-vulnerable asylum-seekers are subject to transfer to detention centres due to delays in the examination of the asylum application within this period.⁵³

Two First Reception **Mobile Units** have been operational since June 2013, and are used (in cooperation with NGOs and the UNHCR) for the screening procedure of migrants without valid travel documents. Integral to these Mobile Units is an information group, staffed by UNHCR representatives, which provides third country nationals with information regarding their rights and the asylum procedure. **Health care and psychosocial care are also provided by NGOs.**

Age assessment is one of the most important tasks that first reception mechanisms address, as there are a great number of undocumented unaccompanied minors entering the country. On 29 October 2013 a Ministerial Decision regarding age assessment within the context of first reception services came into force, setting an age assessment protocol for the first time (Official Gazette B' 2745/ 29-10-2013). According to it, the determination of the age of a child is to be conducted by a team of medical doctors. Macroscopic characteristics of the child (such as physical appearance) constitute the first indicators of age assessment. If a decision cannot be made based on these characteristics, a psychologist and a social worker examine the cognitive, behavioural, and psychological development of the migrant. Only as a last resort, the Ministerial Decision states, is the examinee to be referred to a state medical institution for medical examinations by means of dental x-rays and x-rays of the left wrist. This is a positive development since until now, Asylum Service law enforcement officers resorted to medical age determining examinations at their discretion, and not as a matter of protocol. The most used method was dental x-rays, which as a stand-alone test has a considerable margin of error, rendering it unreliable.⁵⁴ Even though the identification of minors has been greatly improved in comparison to the past, cases where minors have been transferred to detention centres for adults

⁵¹ Moria Centre will be operational as a FRC in January 2015.

⁵² Moria Centre is operational since September 2013 at Lesbos Island as a HP Screening Centre.

⁵³ AIDA, Asylum Information Database. ICJ and ECRE highlight problems with asylum procedure and detention conditions in Greece in new submission to COE committee of ministers on m. s. case 27/05/14; See more at: www.asylumineurope.org/news/27-05-2014/icj-and-ecre-highlight-problems-asylum-procedure-and-detention-conditions-greece-new

⁵⁴ Age assessment and Legal representation of Unaccompanied Children, Greece. Available from www.asylumineurope.org/reports/country/greece/asylum-procedure/guarantees-vulnerable-groups-asylum-seekers/age-assessment

are still documented. As MSF stated in their recent report, *“the current practice of the police is to refer people claiming to be minors – in many cases after long delays – to local health facilities. However, the absence of a protocol and of medical staff with the right training and expertise renders this process highly problematic. In MSF’s experience, few of the young people referred for an age assessment by the police – after having already spent several months in detention – were declared minors. Most continued to be detained, even though many received inconclusive medical assessments (for example that their likely ‘bone age’ was found to be 18 years). In no case was the margin of error (ranging from two to five years, depending on the method of medical examination used) taken into account by the police, nor was the benefit of the doubt considered in favour of the minor”*.⁵⁵

Two **Screening Centres** (also operating as detention/pre-removal centres) in Chios and Samos have been re-furnished and in operation since April 2013. Their model is based on outsourcing services to NGOs, cooperating with International Organisations and with the existing Central First Reception Centre personnel. The screening centres have been established for recording and certifying the identity and origin of third-country nationals subject to first reception procedures, through specialized personnel.

Detention/pre-removal centres

The pre-removal centres, operating under the aegis of the Hellenic Police, constitute specialised facilities for detention of irregular migrants who are subject to removal. Following Presidential Decree 116/2012, the maximum period of administrative detention was extended from three to eighteen months, equating to the period allowed for detention under the EU Return Directive regulating conditions of removal of irregular migrants. More recently, the Ministry of Public Order and Citizen Protection adopted Opinion No. 44/2014 of the Legal Council of the State 20/03/2014, which led to indefinite detention of irregular migrants. The Greek Council for Refugees subsequently filed an appeal against the “endless detention duration.” The Court ruled on 23 May 2014 (Decision 2255/23.5.2014) that indefinite detention (in the form of compulsory stay in detention centre as defined by the State Legal Council Opinion 44/2014) is unlawful. As a consequence, an Afghan refugee, who had already been in detention for 18 months, was released.⁵⁶ Anecdotal information suggests that migrants who are at the end of their detention periods are being transferred between centres instead of being released.

Six **pre-removal centres** operate in Amygdaleza, Corinth, Paranesti, Xanthi, Komotini,⁵⁷ and Fylakio. In Ferres and Soufli in Evros, the border stations as well as several large police stations like Petrou Rali are used for pre-removal purposes. **Old and non-appropriate facilities** owing to poor conditions were **closed down** – (Venna, Elliniko (Old), Aspropyrgos, and Tycherio detention centres).

The official capacity of detention centres in Greece is reported to be 10,357. However, the actual number of people in detention up until 28 September 2013 is not known; the Minister of Public Order and Citizen Protection expressly stated that the number of third country nationals in detention throughout the country cannot be calculated due to the constant change in the number of detainees.⁵⁸ The Greek Council for Refugees and the Greek Ombudsman have reported overcrowding

⁵⁵ MSF report, *“Invisible Suffering Prolonged and systematic detention of migrants and asylum seekers in substandard conditions in Greece”*, April 2014.

⁵⁶ Infomobile, Lesvos: Voices from inside Moria – The new Pagani of Troika, 30 June 2014.

⁵⁷ Closed in November 2014; Xanti has been reported as about to close as well.

⁵⁸ Reply to the Parliamentary question on statistical information with regards to the capacity of detention centres posed by SYRIZA to the Ministry of Public Order and Citizen Protection, 28 September 2013.

in the Petrou Ralli, Amygdaleza, and Corinth⁵⁹ detention centres, as well as in the detention wings of various police stations. Detention of up to 18 months in police station cells designed for a maximum of a few days is a particular problem, especially given the overcrowded conditions. In practice, irregular migrants in Greece are detained when apprehended at the border or without proper documents on the territory. Individuals are initially held in police or border guards' stations, and in theory have to then be transferred to specific detention facilities if a return order is issued or if the person is being prosecuted for illegal entry. However, in practice people are held in police stations for the full duration of their detention. Asylum-seekers whose transfer to another Member State is pending under the Dublin Regulation are also reportedly being detained.

Healthcare services in FRCs and pre removal/detention centres are under the responsibility of the Ministry of Public Order and Citizen Protection. NaHOC, a structure within the MoH, is financed by HCDCP to provide health care services in some detention centres. Limited resources in terms of medicines and medical supplies, and lack of interpreters were reported to hinder their work as of the spring of 2014. Until September 2014, NaHOC was operational in Komotini, Corinth, Amygdaleza, and Petrou Rali.

Reception of vulnerable groups and unaccompanied minors

According to Article 1 of PD 220/2007,⁶⁰ "Adaptation of Greek legislation to the provisions of Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum-seekers in Member States (EE L 31/6.2.2003)," the executive responsibility for reception facilities lies with the MoH. As the responsible Directorate in the MoH for the operation of open reception facilities was moved to the Ministry of Labour, Social Security, and Welfare (L. 4052/2012), respective responsibilities including the management of ERF (European Refugee Fund) and related national budget were also transferred to the latter too. Managing NGOs' responsibilities for the day-to day operation of reception facilities are thus defined in the context of their respective agreement with the state authority.⁶¹ An amendment of Law 3907/2011 authorizes the First Reception Service to establish and operate open reception facilities for vulnerable groups and asylum-seekers; however none of the existing open accommodation centres are operated under the FRS.

There are fifteen centres for asylum-seekers and unaccompanied minors in operation, designed to accommodate altogether approximately 1,006 people: *"Agioli Anargiroi (70), Anogia (25), Arsis Refugees Shelter (12 families and 8 single parent families), Doctors of the World Athens (70), Makrinitza Volos Arsis (30), Mission Athens Archdiocese (20), Oreokastro Arsis (30), Red Cross Lavrio (320), Society of Minors Care Isavron (18), Praksis Athens Segi Program (65), Volos Agria (30), Hospitality Nostos (70), Future Nostos Moshato, Arsis Alexandropouli (22) and also apartments in Athens, Thessaloniki, and Lesvos"*.⁶² As mentioned previously, most of these centres are run by NGOs and funded by the European Refugee Fund and/or Norway/EEA grants. Two more centres suitable for accommodation of families seeking asylum have been identified (in Attica and Serres). Since both premises need large-scale refurbishment (estimated at around EUR 4,800,000), funding through the use of Structural Funds will be sought through the New Multiannual Financial Framework agreement (2014–2020) between Greece and the EU.

⁵⁹ The Greek Ombudsman, Field mission in the detention centres of Amygdaleza and Korinth and in the detention spaces of Petrou Ralli, 29 May 2013.

⁶⁰ PD 220/2007, "Adaptation of Greek legislation to the provisions of Council Directive 2003/9/EC of 27.

⁶¹ EMN Focussed Study 2013: *The Organisation of Reception Facilities for Asylum Seekers in different Member States*.

⁶² Aida. Asylum Information Database (2014). National Country report Greece; www.asylumineurope.org/files/report-download/aida_greece_second_update_revisedasylumservice_final_uploaded_0.pdf

According to the Asylum Service, all registered applicants are asked whether they are in need of housing accommodation. If so, The Asylum Service communicates the applicant's request for accommodation to the National Centre for Social Solidarity, the competent authority for the allocation of applicants to the existing reception centre/facilities. The Regional Asylum Office of Attica, which has registered by far the greatest number of applicants, has communicated 1,149 accommodation requests, which not only patently exceed available places, but which also add pressure on the already overburdened system of reception facilities, resulting in further delays in placement of applicants in reception facilities.⁶³ People who are not housed in accommodation centres also face serious obstacles in gaining access to health care and education services, among others. Renovating and increasing the capacity of accommodation facilities for asylum-seekers was foreseen in the 2010 and 2013 Action Plans on Asylum and Migration Management developed by the Greek government.

Regarding the allocation of specific categories of asylum-seekers to the appropriate reception facilities, PD 220/2207⁶⁴ includes clear provisions: responsible authorities and local self-administration agencies must provide for the special treatment of vulnerable asylum-seekers such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, and persons who have been subjected to torture, rape, or other serious forms of psychological, physical, or sexual violence (Article 17); special care should be taken for minors in general and unaccompanied minors in particular: access to rehabilitation services for minors who have been victims of any form of abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts, and ensure that appropriate mental health care and qualified counselling is provided when needed (article 18, paragraph 2). By virtue of article 19, paragraph 2 (a) and (b), authorities responsible for providing accommodation are to also ensure that unaccompanied minors are placed with adult relatives, with a foster-family, in accommodation centres with special provisions for minors, (d) or in other accommodation suitable for minors, and are protected from trafficking or exploitation. As far as possible, siblings must be kept together, taking into account the best interests of the minor concerned and, in particular, his or her age and degree of maturity. Likewise, there is a special provision for the victims of torture and violence: art. 20 par. 1 provides that responsible authorities shall ensure that, if necessary, persons who have been subjected to torture, rape, or other serious acts of violence receive the necessary treatment and/or counselling. In cases of asylum-seekers with a degree of disability of over 67 per cent, certified by an assessment of the relevant Health Committee, the Ministry for Health and Social Solidarity must provide them with a disability benefit for the duration of the examination of their asylum application and if appropriate accommodation is not feasible. This benefit must be paid by the competent services of the prefecture where the applicant resides. Prefectures are self-governing subunits of the Greek government, divided according to certain geographical boundaries, and there are 54 of them in the country.

I.III Entitlements to health care; health service provisions

The Greek National Health System (NHS) has "a mix of tax-based and insurance-based statutory financing," and as such is classified as "being in a transition phase from predominantly insurance-based (the Bismarck model) to being predominantly tax-based (the Beveridge model)."⁶⁵ The state budget funds "*rural health centres and rural clinic expenditures (which were established as part of the*

⁶³ EMN Focused Study 2013: *The Organisation of Reception Facilities for Asylum Seekers in different Member States*.

⁶⁴ PD 220/2007, "Adaptation of Greek legislation to the provisions of Council Directive 2003/9/EC of 27.

⁶⁵ Tragakes, E. and Polyzos, N. (1996). *Health Systems in Transition: Greece*. Regional Office for Europe; www.euro.who.int/__data/assets/pdf_file/0020/120278/E72454.pdf (11 June 2013)

NHS), salaries of personnel in public hospitals, subsidies of public hospitals (involving payments to hospitals over and above the per diem fees paid by the social insurance funds), subsidies of the social insurance funds, and subsidies of civil servant health insurance, capital investments, public health, medical education, etc.”⁶⁶ Thus, the services covered by the health system may be interpreted as providing universal coverage in terms of free health care for the insured. Private practice doctors and clinics are also available, while private health insurance is almost nonexistent. Out-of-pocket payments are especially prominent in the Greek health care system, covering fees for services in private hospitals, diagnostic centres, physicians and medication costs, as well “unofficial payments” to doctors in the public health-care system.⁶⁷

In the 2011 Greek budget, the health-care system was allocated EUR 6.1 billion, or 2.8 per cent of GDP.⁶⁸ In a World Health Organization ranking published in 2000, the Greek health-care system was ranked 14th in the world, ahead of countries such as Germany (25) and the United Kingdom (18), while also ranking 11th in performance on health level.⁶⁹ The financial crisis, however, has taken a toll on the health-care system, with public health expenditures steadily on the decline (by -13.4% in 2010 and a further -13.3% in 2011), a large proportion of the lower income population reporting unmet health needs,⁷⁰ and citizens being forced to contribute more towards the cost of their medications⁷¹. Austerity measures and the sharp rise in unemployment figures have resulted in a large number of citizens being excluded from the formerly universal health system; their choices are now down to a few Athens based NGOs which offer primary health-care services for free to vulnerable groups, including undocumented migrants.

Legally residing migrants

In principle, legally residing migrants are covered by the same system as nationals. This means that third country nationals have the same rights as nationals under their membership in the social insurance funds that provide health-care coverage for all categories of employees, including the self-employed.⁷² As previously explained, Law 4251/2014 (codifying migration and social inclusion legislation (Art. 21, par. 2), including the provisions of Legislative Decree No 57/1973 on social protection of people in need), also applies to third country nationals legally residing in Greece with the following caveat: migrants who apply for residence permit or for renewal of their residence permit need to provide proof of valid health-care insurance (under their social insurance fund or otherwise under private insurance) (Articles 6, 15). In addition, legally residing migrants renewing their residence permits on the grounds of dependent labour contracts need to prove that they have been employed for a minimum number of days during previous years. In a moment of economic crisis when many people are unemployed, this additional requirement makes challenging the renewal of residence permits for legally residing migrants who have lost their jobs and are living in precarious situations.

Furthermore, according to Ministerial Decision 139491/2006, third country nationals are – with some rare exceptions – excluded from applying for welfare/destitution card which allows individuals who are not covered by social insurance and have proof of low income to receive subsidized (free) health

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Ministry of Finance, 2011 Budget. Available from www.minfin.gr/budget/2011/proyp/index.html

⁶⁹ The World health report 2000: health systems: improving performance, WHO Library Cataloguing in Publication Data, World Health Organization 2000.

⁷⁰ OECD (2013), *Health at a Glance 2013: OECD Indicators*, OECD Publishing; http://dx.doi.org/10.1787/health_glance-2013-en

⁷¹ See at: www.cam.ac.uk/research/news/greece-austerity-takes-a-heavy-toll-on-public-health

⁷² The risk-sharing system for health care costs is based on compulsory insurance through membership with employment linked social insurance funds.

care. To apply for a welfare/destitution card, one of the following is required: a) a Greek identity card; b) an identity card issued to Albanian migrants (karta omogenous) of Greek origin; c) status as a national of a country signatory to the European Convention for Social and Medical Assistance, combined with permanent and legal residence in Greece. As an exception, some special categories of third country nationals have access to free hospitalization and medical care, such as: those residing in Greece with a residence permit on humanitarian grounds, foreign spouses or children of Greek or EU citizens, uninsured victims of trafficking, uninsured unmarried pregnant women and their children, children hosted in public or private law institutions/foundations, asylum-seekers, rejected asylum-seekers who reside on humanitarian grounds, and recognized refugees.

According to recent positive developments, with Ministerial Decision 1465 (3rd June 2014), uninsured legally residing third country nationals who cannot meet the requirements for welfare/destitution card (and are no longer covered by a public and/or private health insurance provider) can receive free hospital care based on a doctor's medical opinion and the decision of the responsible hospital committee. It should be noted though that this stipulates hospital care and not primary care. However, due to the economic restraints of the last two years, the health system now faces unprecedented crisis which has created additional public health issues as the country has to respond to epidemics of HIV/AIDS among IV Drug Users (IDUs), malaria and West Nile disease, and most recently rabies. As a result, the Greek state is unable to ensure any free health-care services to uninsured people – migrants representing a big part of this category.

Irregular migrants

Law 4251/2014 prohibits public servants and employees of public companies from providing services to third country nationals who have not entered and/or are not residing in the country legally. However, Paragraph 2 of the same law introduces some exceptions. One refers to the possibility of public health-care facilities providing health-care services to minors (under the age of 18), or in emergency cases. Article 26 of Law 4251/2014 (codifying migration and social inclusion legislation) [Previously Art. 84, par. 1 of L.3386/2005] states that: *"Public sector services including, local government, are prohibited from provide services to third country nationals who cannot prove their legal entry and stay in Greece."* Hospitals, clinics, and municipality social protection structures are exempted from this rule when third country nationals are admitted for medical emergencies, labor, or in the case of underage children. Moreover, according to paragraph 4 of Article 26 above (previously par. 4 of Art. 84, L.3386/2005), employees of the public sector who violate the provisions of paragraphs 1 and 2 can face disciplinary sanctions and will be punished according to the provisions of the penal code for breach of duty. Circular 45610, issued by the Minister of Health on 02/05/2012 to clarify access of non-nationals and the uninsured, specified that: *"The medical cases of undocumented migrants that can be accepted by public health care structures are those which are admitted as emergencies in the ER [Republic of Greece] and correspond to life-threatening, super urgent situations".*⁷³ The circular does not apply to **minors** for whom access to regular and emergency health care is in principle ensured. However, in practice children with undocumented status (or children whose parents have such status) are asked to pay to access non-emergency health care (including for vaccinations). Severe obstacles therefore remain for the access of children with undocumented status to the public health-care system. The circular also makes an indirect assumption that in the case of **emergency or infectious conditions**, health care will be provided for free; in all other cases the undocumented migrant will have to cover the cost of treatment as this is regulated by the Ministerial Decision in force. In practice, the definition of emergency is rarely applied literally by health-care professionals, who tend to also provide health care to undocumented migrants

⁷³ 45610/02-05-2012 Circular of MoH regarding the implementation of 139491/06 Common Ministerial Decision (GG 1747/B/30.11.06).

for non-life threatening conditions. However, destitute undocumented migrants' access to the health-care system is in practice limited, as they have to cover in full all incurred costs (e.g. diagnostic tests, treatment, and medication). Undocumented migrants are by definition not covered by any social insurance scheme.

In April 2012, the Minister of Health established a system of **infectious disease** control of undocumented migrants and asylum-seekers. Law 4070/2012 (Government Gazette (GG) 82/2012) included amendments to article 13 of the PD 114/2010, and article 76 of Law 3386/2005, which provide for compulsory health checks to which persons at high risk for communicable diseases may be subjected, namely – intravenous drug users (IDUs), sex workers, persons living in substandard conditions, and foreigners (depending on their country of origin). The legislation allows police detention of migrants for compulsory health checks. On the basis of nationality, appearance of poor health, being an IDU or accused of working as an illegal sex worker, the police can arrest people who allegedly represent a danger to public health. Persons who are infected with **HIV and other infectious diseases** and are in need of medical treatment are exempted of paying for care until their health stabilizes, provided that the appropriate treatment is available in their country of origin, in which case they are also entitled to temporary residence and employment permits (Law 2955/2001). HIV testing is not free of charge any more in public hospitals and screening centres, where it costs EUR 9. The need for anti-retroviral drugs is considered a life-threatening emergency; however undocumented migrants and uninsured people have no access to medication. About 16 per cent of people receiving antiretroviral therapy (ART) in Greece are migrants. Currently, every non-Greek national coming from a country where ART is unavailable has free access to health care and ART for humanitarian reasons.

Undocumented **pregnant women** may not be removed from the territory during their pregnancy or for six months after giving birth (Art. 79(1) of Law 3386/2005). This also holds true for undocumented migrants who cannot be deported for medical reasons, and who may benefit from a temporary residence permit (Art. 37(4) (a) of Law 2910/2001).

According to UNHCR et al. report, there is no public health structures specialized in working with, or assisting, **torture survivors**.⁷⁴ According to Greek law (PD 114, Articles 11, paragraph 13 and paragraph 14), if there are strong indications during the [eligibility] interview [at first instance] that the applicant has been subjected to torture, he/she has to be referred to a specialized medical centre, or either a doctor or a psychologist at a public hospital, who is then required to write a report on the existence or not of any injuries, maltreatment, or indications of torture. Medical and psychosocial support for asylum-seekers is also expressly provided for in the Greek Action Plan. Furthermore, Article 11, paragraph 2 of Law 3907 concerning screening centres states that: “the Head of the Centre of Unit shall, upon recommendation of the head of the medical screening and psychosocial support cell, refer persons belonging to vulnerable groups to the competent body of social support or protection. For the purposes of the present, vulnerable groups are: victims of torture, rape or other serious forms of psychological, physical or sexual violence.” Until now, law 3907 could not be applied yet, because there haven't been any such screening centres. In practice, referrals are done by NGOs working in the field or in reception centres to other NGOs specialized in documenting such needs. However, the medical reports of NGOs are not accepted as legal documents by Greek authorities, creating an absurd situation wherein torture survivors are unable to exercise their legal right to specialized care.

⁷⁴ UNHCR, France Terre d'Asile, Save the Children and PRAKSIS, Protection Children on the Move: Addressing protection needs through reception, counselling and referral and enhancing cooperation in Greece, Italy and France, July 2012.

International Health Regulation (IHR)/ Early Warning Response System (EWRS)

In order to increase health security and enhance preparedness, early detection, and response capacity at national/regional level to face threats to public health, WHO and MS developed the International Health Regulations (IHR) 2005 framework. It is a legally binding document that describes core capacities that need to be met at national level, and details a mechanism for information exchange and response collaboration under the umbrella of the WHO. According to Article 10, paragraph 12, of Presidential Decree 95/2000, the Department of Public Health, MoH is responsible for compliance with, and implementation of, the IHR's provisions. The revised IHR has been ratified by Law 3991/11 "*Ratification of the revised International Health Regulations (IHR) of the World Health Organization.*" The purpose and scope of these regulations are to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade (Article 2 of the IHR). Implementation of IHR core capacities was completed in 2012.

Enhancing the Early Warning System (EWS) reinforces health security. While IHR-2005 gives WHO a worldwide mandate, EWRS sets the notification regulation for EU countries (2119/98 and 2000/57). However, surveillance and alert networks developed by European and International organizations are not interconnected and none fulfill the need for enhanced health information exchange across the Mediterranean. EWRS communication and alerts dissemination is done through a secure website/platform with restricted access and in strong collaboration with the European Centre for Disease Prevention and Control (ECDC) and WHO. EWRS communication is handled by the HCDCP (Hellenic Centre for Diseases Control and Prevention) and National Health Operations Centre (NaHOC).

I.IV Discussion Section – I

Respect of international and European standards

It has been widely reported that the detention centres in Greece, including those for asylum-seekers, **fall short of international and European standards**. UNHCR has systematically documented this in field visits, and other reports on this subject are also available.⁷⁵ The Council of Europe Commissioner for Human Rights noted in his report on his visit to Greece that between 2009 and 2012, the European Court on Human Rights issued 11 judgments against Greece related to violation of Article 3 of the European Convention on Human Rights (prohibition of torture or inhuman or degrading treatment or punishment) with regards to migrants' detention conditions.⁷⁶ The Committee for the Prevention of Torture of the Council of Europe (CPT) noted in the report on their visit in 2011 that the design of detention centres in Greece does not respect CPT standards and has not respected them at least since 1997.⁷⁷ More recently, The European Court of Human Rights ruled that Greece was in violation of Article 3 of the European Convention of Human Rights (inhumane and degrading treatment) for detaining a Sudanese national for 15 days in 2 police stations under conditions of overcrowding, with

⁷⁵ United Nations High Commissioner for Refugees Office in Greece, Contribution to the dialogue on migration and asylum, May 2012; European Commission, Press Release, Statement of Cecilia Malmström, European Commissioner for Home Affairs, following the judgment of the European Court of Human Rights on the transfer of asylum seekers under the EU Dublin Regulation, Memo 11/35, Brussels, 21 January 2011. For an overview of European Court of Human Rights' judgments on detention conditions in Greece.

⁷⁶ Council of Europe: Commissioner for Human Rights, *Report by Nils Muižnieks Commissioner for Human Rights of the Council of Europe following his visit to Greece from 28 January to 1 February 2013*, 16 April 2013, CommDH(2013)6.

⁷⁷ CPT, Report to the Government of Greece on the visit to Greece carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 19 to 27 January 2011, CPT/Inf(2012)1, Strasbourg, 10 January 2012, par. 11.

no opportunity to walk outside, in cells that were devoid of natural light and lacked adjoining showers.⁷⁸

Although Greek law provides for proper conditions for persons deprived of liberty, the UN Working Group on Arbitrary Detention found in January 2013 that in practice in most detention facilities the conditions fall far below international human rights standards. It was specifically observed that **irregular migrants were mixed in with criminal detainees and that detention may take place for months in police holding cells and border guard stations** designed for a maximum stay of 24 hours. This constitutes a violation of article 31, Law 3907, which expressly prohibits the mixed detention of administrative with criminal law detainees and/or convicted persons. The Council of Europe's Human Rights Commissioner noted in his report following his visit in January/February 2013 that the lack of access to adequate health care in police run detention facilities was a significant issue.⁷⁹ He noted that even though the Ministry of Public Order is aware of it, **"a lack of funds hinders the implementation of any regular health-care programme"**.

Restrictive policy and legal framework as to entitlements to health services

In a context of prolonged economic crisis and increased mixed migration flows to Europe, the national legal and policy framework is becoming more and more restrictive to uninsured people, including irregular migrants (who have access to health care only in cases of emergencies), and vulnerable groups such as minors and pregnant women, whose numbers progressively increase. At the same time, even migrant groups (such as asylum-seekers) who are entitled to the same health care as Greek nationals face significant barriers in accessing asylum procedures and consecutively cannot benefit from their respective rights. Furthermore, access to health care for asylum-seekers is only granted during the time their claim is being processed. According to the Decision of the Director of the Asylum Service issued in May 2014, asylum-seekers from Albania, Bangladesh, Egypt, Georgia, and Pakistan are provided with an ID card valid for 45 days, while those of other nationalities receive an ID-card valid for four months. In the case of Syrian refugees, due to the ongoing civil war there, a six-month moratorium on return orders is in effect, with the possibility of subsequent six-month renewal periods until the Syrian crisis comes to an end. During these six-month suspension periods, there is no provision of rights in relation to housing, work, or health care. Therefore, these orders are in breach of Greece's international obligations, namely Article 3 ECHR, Article 3 of the UN Convention against Torture and Article 7 of ICCPR.⁸⁰

Vulnerability assessment and psychosocial support for vulnerable groups

According to the Greek law (Articles 17 and 20 of the Presidential Decree 220/2007 and Article 11 paragraph 2 of Law 3907) asylum authorities and local administrations have to provide special treatment for applicants from vulnerable groups such as disabled people, elderly persons, pregnant women, single parents with minor children and victims of torture, rape or other serious forms of psychological, physical or sexual violence. The authorities processing and analysis of asylum applications are required to ensure that persons who have been subjected to torture, rape, or other serious acts of violence are referred to a specialized unit, namely, one of the NGOs META-Action (META-DRASI in Greek), GCR, or BABEL – the last two working together as *Prometheus*, to receive

⁷⁸ European Court on Human Rights, *Horshill v. Greece*, (application no. 70427/11), 1 August 2013.

⁷⁹ Council of Europe: Commissioner for Human Rights, *Report by Nils Muižnieks Commissioner for Human Rights of the Council of Europe following his visit to Greece from 28 January to 1 February 2013*, 16 April 2013, CommDH(2013)6, para. 144.

⁸⁰ Aida. Asylum Information Database (2014). National Country report Greece. Available from www.asylumineurope.org/files/report-download/aida_greece_second_update_revisedasylumservice_final_uploaded_0.pdf

support and the necessary treatment for psychological and physical injuries caused by the aforementioned acts.⁸¹ Since October 2014, MSF (in partnership with Babel and GCR) has been providing medical rehabilitation to survivors of torture. Interviews with stakeholders suggest that, due to insufficient resources, very few cases are dealt with properly and in accordance with the law.

Case management, including age assessment of unaccompanied minors

The establishment of an age assessment procedure for young people in 2013 was a positive development, considering the high numbers of unaccompanied minors arriving to Greece. Even more imperative, however, is its thorough and responsible implementation, covering procedures and exams. Yet, according to respondents, most children whose age is debatable till do not go through an age assessment; some children even claim to be adults in order to be released faster from detention. This leads to many minors and even juveniles being treated like adults, either because they lie about their age or because they are registered as such. More recently, the European Court of Human Rights ruled in *House in v Greece*,⁸² a case concerning an unaccompanied minor from Afghanistan who was arrested and detained for illegal entry, that Greece violated his right to liberty due to his automatic detention for nearly 2 months in an adult detention centre.

A number of protocols and procedures have been developed in recent years – including age assessment, vulnerability assessment, and health screening models (to be discussed later in this report). However, interviews with stakeholders make it clear that due to the limited financial and/or human resources, in reality very few cases are dealt with properly and in accordance with the law. Proper implementation of national and European legal frameworks remains the biggest challenge of the new asylum and migration management system in Greece.

⁸¹ Article 20 PD 220/2007.

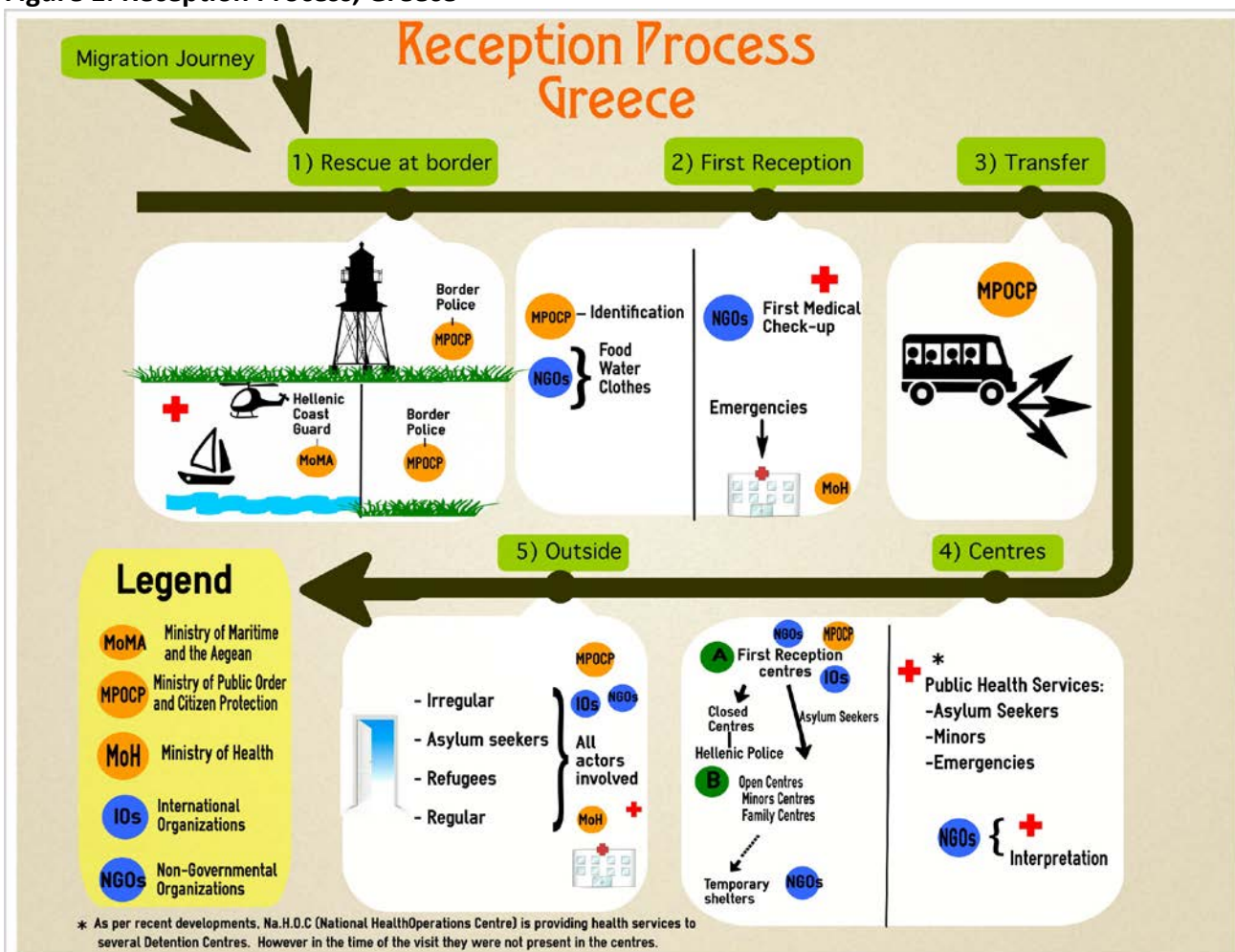
⁸² ECtHR, Application no. 71825/11, 24 October 2013.

II. PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

II.I Description of the reception process and coordination

The assessment covers all the phases of the reception process in Greece, divided as follows: rescue at border (sea or green border), first reception, transfer to relevant centres, and post-release.

Figure 1: Reception Process, Greece



Source: IOM Equi-Health project.

Rescue (at green border or at sea) and disembarkation

“The reception takes place where either the coast guards arrest migrants in the sea or police arrest them when they have already reached the shores. They arrest the migrants and send them to a FRC. The actors involved in the rescue are the border police”.

(CSO)

“During the reception process – If in the sea – migrants are being arrested by the coast guards and are being held during the administrative procedure. Sometimes they are medically checked, sometimes they are not”.

(CSO)

In line with their roles and responsibilities, the Hellenic Coast Guard and the Hellenic Police are the main actors in the reception process, while the police are also responsible for administrative

procedures. In respect to health, local health authorities, NGOs, and/or volunteers are counterparts who take care of arriving migrants, including by offering first aid when necessary. Medical emergency cases are transferred to the hospital.

“Until recently they were coming to the port, and a doctor and a nurse from MdM were going there to get first impression of their health status and distinguish vulnerable groups. My job was to inform them of their rights, i.e. what will happen from now on. Because of lack of space the coast guard was just keeping them in the port while waiting for their paper to come from the police. During this period the coast guard was trying to see if there were vulnerable groups such as mothers with small children or unaccompanied minors.”

(CSO)

“If the coast guards detect the migrants in the sea – we don’t exactly know what happens out there. Sometimes they are pushed back. Once they reach the shores they walk to the town, so they could get arrested and sent to the First Reception Centre.”

(CSO)

It is after the provision of first aid is completed that any personal data are recorded (name, age, nationality), and photos and fingerprints taken. Migrants are then transferred to an FRC. If the FRC is full, migrants are transferred to nearby detention centres.

“When they arrive from Turkey the coast guard brings them here. Most of the times they are just wet and scared and we try to do our best to help them, to provide them with the necessary medical assistance according to their needs and our capacity. If special medical tests are needed, doctors examine them. There are also people who are already in the police station, and they may have a medical situation. In that case they are brought to the hospital by a police car. These are not new arrivals but already in police custody”.

(HP)

First Reception Centre

By law, the maximum stay in FRCs is 25 days. During this period, migrants go through a screening and identification process, and apply for asylum. An NGO is responsible for the provision of health care and vulnerability screening in FRCs. Once the 25 days period is over, non-vulnerable asylum-seekers are subject to transfer to a detention centre, where they await their asylum application outcome.⁸³

“The police inform us about the migrants that have been detained and we inform about the possibilities we have to accept them. The migrants are brought here to be registered, for nationality identification. They get support from the social workers and psychologists, they are medically screened and they are told their obligations and rights in case they decide to apply for asylum in Greece”.

(LEO)

The roles and responsibilities of all health care and social support providers in FRCs are formalized by law, which defines the triage procedure and the services that are to be provided.⁸⁴ The same law also

⁸³ AIDA, Asylum Information Database. ICJ and ECRE highlight problems with asylum procedure and detention conditions in Greece in new submission to COE committee of ministers on M.S.S. case 27/05/14. See more at: www.asylumineurope.org/news/27-05-2014/icj-and-ecre-highlight-problems-asylum-procedure-and-detention-conditions-greece-new

⁸⁴ “Program of medical check and psychosocial support diagnosis and referral of incoming undocumented third-country nationals in the first reception structures” GG 2745 29/10/2013.

clarifies applicable age assessment procedures for minors' age determination. In 2013, the MoH developed guidelines for screening of new arrivals. After the initial examination is over and the clinical history is completed, migrants meet with a social worker who takes down their social history, and with a psychologist who does the psychological/vulnerability assessment.

“Our basic activities include medical and psychosocial support. We work in close collaboration with the doctor to manage crises and the social worker in psychosocial activities. The services are on daily basis and we always try to evaluate urgent situations. Depending on the flow of arrivals we may see from 1 to 30 people a day”.

(CSO)

According to interviewees, the job of the social worker and of the psychologist is determined by their “Professional ethics code” as specified by the relevant authorities.

“First we have the medical evaluation by the physician who takes a medical history. Afterwards the migrant talks with a psychologist and a social worker and they make notes of his/her requests. The social worker takes the social intake, and makes notes for issues such as legal (asylum) material assistance (e.g. basic needs etc...), he/she gives information about their rights, makes referrals for unaccompanied minors shelters, etc.”

(CSO)

Psychiatric cases were reported to be referred to the nearest mental health centre, according to the NGO representative at an FRC.

“All the psychosocial services are provided in the centre except of urgent psychiatric cases which are referred to the Centre of Mental Health in Orestiada”

(CSO)

Transfers, especially those of unaccompanied minors, from FRCs to detention centres and/or open shelters present a challenge, as most of the time they are done by police car, even if this is not a police responsibility.⁸⁵

“Who will transfer a person from Fylakio to Athens to a shelter? One was to be transferred; FRC didn't have money for transfer”⁸⁶

(CSO)

Detention centres

After the administrative/identification procedure, migrants who have arrived following the old procedure (before the establishment of the new Asylum Service and Appeals Authority on 7th June 2013) were either sent to detention centres or, due to lack of place, released with an order to leave the country within 30 days. Recently opened detention facilities are now used for overflow accommodation, as well as for housing of undocumented migrants who have been arrested by the police for lack of proper documents.

⁸⁵ Most of the times the transfer of Unaccompanied Minors is done by NGOs and with the coordination of the National Centre for Social Solidarity (www.ekka.org.gr/EKKA!show.action?lang=en). In exceptional cases when there are no CSO representatives available, the police is doing the transfer. For more information see: www.stegiplus.com/, www.metadrasi.org/content/unaccompanied_minors

⁸⁶ According to the FRC, transfers are not within the mandate of their Service.

“Migrants arrive here after their arrest and they remain until they are deported. Now the maximum period of detention is 18 months”.

(LEO)

“After 18 months if we were not able to deport them, they get a written order to leave the country in 15 days and they are released.... People from the Syrian Arab Republic⁸⁷ are granted with a 6 months period of legal staying in the country and they are set free”.

(LEO)

As described earlier, two medical NGOs provide health-care services to detained migrants. In practice, and considering the limited presence of health-care staff in detention centres, it is at the discretion of the law enforcement officers on duty to decide who is in need of medical care.

“The procedure is as follows: if someone needs a doctor, another migrant calls the guard on duty. He informs the officer on duty. If the migrant can be moved, he is taken to the examination room. Otherwise the doctor goes to the dorm. If there is no doctor at that time the migrant is been transferred to the nearest hospital with a police car or in extreme cases with an ambulance”.

(LEO)

Open centres for minors

As explained in the previous section, there are no more than fifteen centres⁸⁸ able to adequately accommodate minors and/or whole families in the whole country. In the context of economic crisis and limited funding, most of them face serious financial shortfalls (since they are primarily funded through the ERF programme), and so are constantly on the verge of ceasing operations. Even so, the major problem is that they are simply insufficient for the number of vulnerable population migrants who need accommodation, and who are forced to wait for months on end for a place.

“During the reception process the minors were kept longer at the police station until a special centre was found. That is the biggest problem because special shelters for minors are shutting down because of lack of funding”.

(CSO)

By law, minors cannot be detained, although in Fylakio Detention Centre unaccompanied minors were held in a detention cell while waiting for a UAM appropriate shelter to be found. According to the Commandant of Amygdaleza Detention Centre, a 40-person detention area for unaccompanied minors operates in a different area of the Centre as well.

The open centres admission process for minors includes medical screening.

“We have only undergone medical screening after one year in Athens. We needed medical papers for our referral to the minor centres. So, we were given by the UNHCR the names of hospitals where the doctors screened us – x-ray, TB and HIV tests. Otherwise, it would not be possible to be accepted

⁸⁷ Syrian citizens are released from detention after the identification procedure.

⁸⁸ AIDA, Asylum Information Database. National Country Report: Greece, 2013. Available from www.asylumineurope.org/files/report%20download/aida_greece_second_update_revisedasylumservice_final_upload_0.pdf

at the centre. At the centre we were not medically examined. At the minors' centre, there was a doctor and he was able to refer people to the hospital if needed.”⁸⁹

(Migrant)

NGO staff working in open centres for minors raised the issue of age assessment, which apparently is not always performed.

“The age assessment is not always carried out. We pick them up and carry them to our premises. If we do not help a child the police would leave him on the street, because they cannot arrest a child. The children are usually between 6 and 16 years old. The police call us because they know we'll take care of them. This means that the state doesn't do anything. The prosecutor's office is responsible for that but they do not do what they are supposed to. The so-called prosecutor's guardianship doesn't work. There isn't any structure to accommodate the minors. When we get the children from the street, a social worker does an interview. We make a social profile, and then a doctor does medical screening. We provide primary health care. When the first assessment is done and if the case is serious, we refer it to a hospital. We also provide health care on the street if it is a case of emergency. It's a matter of network and connections when it comes to referral to a hospital. You always have to have an interpreter with you. The child has to say a name and to be registered”.

(CSO)

Outside in the community

Migrants go to hospitals and other health-care facilities primarily after a doctor's referral, while health-care access remains a major challenge for the uninsured and undocumented. Most of the hospital based social workers interviewed noted that if all migrants are provided with legal documents and therefore have unimpeded access to the health-care system, many problems would be resolved.

II.II Public health in border communities

Migrant health poses a challenge to governments who are called upon to design policies that will improve the health status of migrants, help them avoid stigma and long term health and social costs, and at the same time allow them to integrate and contribute to the social and economic development of the community. The public debate on the relationship between migration and public health however, especially as presented in the media, ignores the broader context and focuses on the diseases those who enter and stay irregularly in the country may (or may not) carry.

“They sleep in the parks and wait to be arrested by the police, so they could get papers. The nationality is not known, they have no paper. Between them are people from ‘special services’ and they come to go to some places for ‘specific purposes’. Some of them can be a threat to the public security...I have no idea what sicknesses they could bring...Some of the local people are afraid of illnesses. Policemen and coast guards do not want to touch the migrants, do not want to have a physical contact with them”.

(CSO)

Most often, public concern is focused on how uncontrolled migration flows can threaten public health in the receiving country. Conversely, the question of whether the indigenous population's health

⁸⁹ They are talking about their entrance process to Agiasso centre for unaccompanied minors in Lesvos. Unfortunately the centre was shut down due lack of funding by the time of our visit. We've met them in the Non Formal Open Accommodation Centre of PIKPA.

problems may endanger the health of arriving migrants is often overlooked or ignored. Factors to consider as key parameters in the relationship between migration and public health include: the degree of accessibility to health care by the different groups of migrant and asylum-seekers (as mentioned earlier, irregular migrants have access only to emergency care until their state of health is stabilized (Law 3386/2005, Article 84)); information migrants may have on the health-care system, the general living conditions in receiving country, the conditions in detention centres and prisons; and, the general population's level of awareness on how to prevent and protect from infectious diseases. Although there is a widespread and irrational fear of diseases that migrants may be carriers of, a notion fueled by some media outlets' xenophobic attitude and tone, according to interviewed health professionals the public health in Greece is not endangered by migration as much as by other (such as the ongoing economic crisis and the near collapse of the public health-care system). Recent example of the role of media in providing misleading information on the public health risks related to migration was how in Amygdaleza detention centre a migrant was diagnosed with TB,⁹⁰ as well as that several prisoners and police officers in a police station in central Athens were infected with tuberculosis.⁹¹ The HCDCP denied the truth of these stories.

In their report entitled *Eleven Myths and Even More Truths*, the Rosa Luxemburg Stiftung Office in Greece stated that *"for at least twenty years, the migration issue in Greece is an issue which has been permanently coming to the forefront in different guises, taking up a central spot in public discussions. Those discussions are mostly dominated by distorted notions, while true facts are obscured, as migration is an issue that is instrumentalised by politics and exploited by the media. The actions of the main representatives of mass media and systematic interventions by the extreme right have led to the creation of social myths and at times even of situations of "moral panic", which make it more and more difficult to comprehend the phenomenon's complexity and of course address it in a sober manner"*.⁹²

In a joint press conference on Sunday, 1 April 2012,⁹³ Public Order and Citizen Protection Minister Michalis Chrysochoidis and Health Minister Andreas Loverdos described the problem posed by a burgeoning population of undocumented migrants in central Athens as "a ticking time bomb for public health," and named a number of infectious diseases migrants might suffer from such as tuberculosis, cholera, yellow fever, leprosy, syphilis, malaria, and diphtheria, all without presenting any relevant documentation. The HCDCP was supposed to start conducting checks on migrants with a focus on those living in cramped and unsanitary conditions in central Athens. After their common statement, the Health Regulation in conjunction with articles 58 and 59 of Law 4075/2012 *"introduced the health state of vulnerable persons as a self-sufficient reason for administrative detention and/or their deportation. One year later and after intense reactions from a wide spectrum of social and scientific private agencies and following the international outcry, Health Regulation GY/39A was repealed with the consent of the National Public Health Council. Nevertheless, on 26 June 2013, the day after the Minister of Health of the new government, Adonis Georgiades, assumed office, he brought the regulation back into force, simultaneously bringing back into the political agenda the rhetoric defining all migrants as public health 'time-bombs' that threaten the prosperity and well-being of Greek society"*.⁹⁴ On their part, HIV NGOs and LGBT and human rights initiatives chided the

⁹⁰ See at: "Tuberculosis outbreak at migrant detention center of Amygdaleza", *To Vima*. Available from www.tovima.gr/en/article/?aid=642094

⁹¹ See at: www.ekathimerini.com/4dcgi/_w_articles_wsite1_1_15/10/2014_543762

⁹² V. Papastergiou and E. Takou, *Eleven Myths and Even More Truths*, A publication by the Rosa Luxemburg Stiftung, Brussels Office – Office in Greece, Athens/Brussels, June 2014.

⁹³ See at: www.ekathimerini.com/4dcgi/_w_articles_wsite1_1_01/04/2012_435856

⁹⁴ V. Papastergiou and E. Takou, *Eleven Myths and Even More Truths*, A publication by the Rosa Luxemburg Stiftung,

new leadership in a joint statement, for ignoring the unanimous decision that prompted its repeal as well as the recent report by the Greek Ombudsman citing the provision's unconstitutionality. "We cannot allow the implementation of practices that lead our society to the Middle Ages," the statement by Positive Voice, Centre for Life and Praxis, among other groups, said.⁹⁵ In a press release MDM condemned the re-introduction of the Health Decree 39A by the Minister of Health as it "is offending basic human rights and human dignity. Also, under the wing of "protecting the community from contagious diseases" it is legalizing illness, poorness and addiction" while "victimisation and defilement of our fellow citizens is isolating us and reduces the chances of real medical care and transmission of diseases".⁹⁶

II.III Discussion Section – II

Sustainable funding of health care services

The main problems with the provision of health-care services to irregular migrants during the reception process are the sustainability of funding and the availability of health personnel and medical supplies. The latter affects exclusively border police, who do not usually have any kind of a medical background, yet need to find ways to provide basic health-care services to people in medical need.

"We treat migrants the same as Greeks, but we are the only hospital in Lesvos, and 4 health centres which will be closed by the end of the year due to the financial crisis".

(HP)

"There are no funds available for x-ray anymore. The current financial crisis affects our work in all possible ways. We can't hire people. We can't do x-ray. I was supposed to have 29 people staff, and we are two persons now apart from the police officers. We have the NGOs operating here because we cannot hire people".

(LEO)

On the different segments of the reception process

The quote below highlights some of main reception process challenges:

"When the rescue takes place at sea or close to the shore, the coast guards are responsible for arresting migrants and registering them. You may have people who were not arrested in sea suddenly appearing in a town in the island (Lesvos). No one can say where they came from and no one arrests them. The coast guards do not arrest them because they are not in the sea. The police insist that arresting migrants is a responsibility of the coast guards and they have to do the registration and bring them to the centres. We have cases of people begging to be arrested, because otherwise they cannot be registered, they cannot get to the FRC, and they cannot see a doctor. They wait until they get arrested. Sometimes for more than 10 days. The institutions avoid this responsibility because that means spending money on the food for the migrants. When we remind the authorities about their responsibilities, they respond that "we have another supervisor". There's a lack of will to solve the problems. And it is not a question of money anymore, because you have the

Brussels Office – Office in Greece, Athens/Brussels, June 2014.

⁹⁵ See at: www.hivjustice.net/news/greece-scientists-and-human-rights-campaigners-condemn-the-reinstatement-of-provision-39a-allowing-forced-hiv-testing-of-suspected-sex-workers-drug-users-and-undocumented-migrants/

⁹⁶ Médecin du Monde, Greece. Press release about the re-introduction of "The Sanitary Decree 39A" from the Minister of Health, July 2013. See at: <http://shar.es/1mGz9F> <http://shar.es/1mGz9F>

FRC and all you need is within it.⁹⁷ What the police and the coast guards have to do is to detain these people and bring them in to the FRC. But they don't. And the migrants cannot get in if not accompanied by the authorities".

(CSO)

- Besides funding shortages, which severely affect respective services functioning, better coordination between authorities, as well as a clear description of roles and responsibilities of each entity as to the registration of migrants is needed;
- The transfer of migrants between different centres seems to be problematic due to limited funding and staff shortages to handle the increased demand. At the same time, especially if health problems occur, the police must provide 2 officers to transport the person in question in the police car to the nearest hospital, without being trained and/or aware of the respective personal protective measures. Sometime private cars are also used for lack of other transportation means. Thus a clear procedure as to transportation of vulnerable groups and people with health needs to be put in place;
- Increased migration inflow and the lack of available places in the Greek reception system further complicate accommodation for new arrivals in respective facilities, and the asylum application procedure. According to NGOs, there are cases of migrants begging to be arrested and send to an FRC in order to be able to receive health-care treatment and social services support;
- Provisions of health and social services in centres is mainly provided by NGOs, who are in turn dependent on EU funding and thus with limited sustainability. Many of the NGO respondents shared their frustration that they are acting on behalf and instead of the Greek state, having to do everything with fewer resources;
- Access to services, in particular health care, for irregular migrants, recognized refugees, and asylum-seekers is limited by many factors. Besides the few NGO clinics, mainly located in Athens, where migrants and other vulnerable groups can find help for their health needs access to the public health-care system remains problematic other than in cases of emergency.

⁹⁷ FRC interlocutors noted during discussions that there is political will to solve the problem as well as regular communications among the responsible authorities and CSOs.

III. MONITORING MIGRANT HEALTH

Although there are a number of studies on the topic of migration and health in Europe, the data is not extensive. First, subjects studied in some countries have not been studied in others; and second, data on health and disease are rarely categorized by "nationality" and/or "migrant" status. An overview of available data has been done within the framework of projects funded by the EU Public Health Programme 2003–2007.⁹⁸ According to the findings of one of the funded projects, most common indicators of migration status (if and where such were collected at all), were country of birth and/or citizenship (11 out of 27 EU MS).⁹⁹ The scarcity of migrant health data is also the case in Greece, where the national surveillance system collects predominantly epidemiological data, including data on HIV/AIDS therapy, as treatment is also subject to surveillance.¹⁰⁰

III.I Migrant health

Upholding *migrant health* is challenging, given the increased number of unaccompanied minors, pregnant women, babies, elderly, and disabled migrants arriving by sea. The long trip and the perilous migration conditions before and during the final transit of the sea border between Greece and Turkey (with no proper documents, transportation means, long walking distances for many hours or days, and feelings of helplessness at sea) have significant impact on both the mental and physical health of migrants arriving in Greece.

"I left Congo (DRC) in 2007. I went to Brazzaville. My father was close to the former president. One day he called my mum and said that I and my brother had to leave the country. We spent some time in a church too. Then I was 12, now I am 18. We left for Turkey after one year. In Turkey we stayed another 2 years. My brother worked in Istanbul to support us. Then I crossed the border at Evros with another 10 people. My brother drowned while crossing Evros. Our plan was to go to Thessaloniki".
(Migrant)

At arrival, the unfamiliar environment, the unknown language, the uncertainty about the future, and the lack of knowledge of procedures are some of the factors that aggravate migrants' health. Some of the newcomers do not know where exactly they are. In most cases, Greece was not intended as their final destination. They feel disappointed because they did not make it to the country where their relatives reside. Some demonstrate optimism and believe they have passed through the worst after crossing the border and/or being rescued/ detained by the police, as they see this as a chance to obtain documents and the possibility to start the asylum procedure and a new life in Europe.

"When I came to Greece I thought I will be granted with asylum because I was a PKK member and I was wanted in Turkey. Instead of this they gave me a paper to leave the country in 30 days. I managed to go via Italy to Holland where I spent 3 months. I apply for asylum and they found from my fingerprints that I was in Greece. Then they sent me back. When I'll be out of detention I will try to go again in Holland via Balkans". (Migrant)

⁹⁸ For a detailed overview of the project and available data please see: http://mighealth.net/index.php?title=Main_Page

⁹⁹ Signe Smith Nielsen, Allan Krasnik and Aldo Rosano (2009) Registry data for cross-country comparisons of migrants' healthcare utilization in the EU: a survey study of availability and content; www.biomedcentral.com/content/pdf/1472-6963-9-210.pdf

¹⁰⁰ For more information on the epidemiological surveillance work of HCDCP see at: www.keelpno.gr/Portals/0/Images/organogramma/FINAL_ORANOGRAMMA_ENGLISH.jpg

As previously described, hospitals, NGOs, and volunteers are the main actors engaged in providing initial health care for arriving migrants. They offer their medical services when there is an emergency or when the hospital doctor and/or the NGO believe specialized medical care is needed. The most frequently diagnosed medical conditions are fever, dermatological issues, infectious diseases such as scabies, parasitic infections, etc., and wounds sustained during the migration journey.¹⁰¹ There are generally fewer chronic diseases as migrants are relatively young. Cases of TB, HIV/AIDS, and other more complex infectious and chronic conditions are treated in Alexandroupolis, Thessaloniki, or Athens where more specialized treatment is available than at border and/or islands medical facilities.

As previously mentioned, during our field visits various regional health and civil protection authorities complained of medical staff and medical supply shortages brought on by the economic crisis. Medical facilities lack an adequate capacity to diagnose communicable diseases, and cannot guarantee necessary medications to migrants in need.

The findings of the mission of the ECDC to Greece, in collaboration with WHO and HCDCP, emphasize the relationship between the poor living conditions in Evros detention centres and the migrants' health problems. The key issues in all detention centres visited by the ECDC mission were substandard hygiene conditions, overcrowding, lack of personal hygiene facilities, lack of basic supplies, and lack of access to fresh air and physical exercise. The report further noted that severe overcrowding increases the risk of communicable diseases (such as diphtheria, tetanus, and polio), psychosocial distress, and the aggravation of traumatization; they can also cause potentially violent conflicts.¹⁰²

III.II Provision of health care and social services

As already explained, different health and social services are available to migrants in First Reception Centre (FRCs), detention centres, and outside of centres in the community.

First reception centres

At the time of our visit, the Evros FRC was staffed by health-care professionals from NGOs who provide primary health care.

According to the interviewed FRC health professionals, there are no standard operating procedures as to the exact roles and responsibilities of the institutions engaged with the reception of migrants from with respect to health. Law 3907/2011 clarifies the standard operating procedures which guide the FRC staff what to do in each case. In respect to health, the NGO working in a given FRC is supposed to do a triage procedure and fill a health card (box 1) prepared by the Ministry of Public Order and Citizen Protection with basic health and vaccination details. **Age assessment** is supposedly done on a regular basis, though FRC staff in fact acknowledged difficulties in accurately assessing the age of minors from Africa or Asia. Sometimes minors are sent to a hospital to have the assessment done, however respondents reported that hospital doctors also have difficulties in determining the age of migrants due to lack of experience with the people from Africa or Asia. According to FRC management, there are no reports on difficulties in determining the age of minors in Greece; age assessment is done by qualified professors at the University Hospital of Alexandroupolis, who are well versed in the procedure.

¹⁰¹ See also: MSF report: Migrants in detention – Lives on hold, 2009-10. Available from www.doctorswithoutborders.org/article/greece-lives-hold, MSF report: Emergency intervention in Evros, 2011. Available from www.msf.org/article/more-%2060-percent-medical-problems-faced-detained-migrants-evros-greececaused-inhumane-living, MSF report: Medical assistance to migrants and refugees in Greece, 2013, available from www.msf.org.uk/sites/uk/files/greece_refugees_2013.pdf

¹⁰² Mertens, E., et al.: Assessment of public health issues of migrants at the Greek-Turkish border, April 2011. Euro Surveill 17.

According to NGOs interviewed, the major obstacles to the provision of quality services to migrants are the bureaucracy, lack of knowledge, and limited funding. Time and again, interviewees pointed out how difficult it was to secure adequate accommodation solutions for **vulnerable groups**. **Interpretation services**, as mentioned previously, are provided by the NGO Metadrasi, which has some drawbacks, especially during health check-ups and in cases involving a psychologist:

“it is not always easy to persuade a person to speak about mental issues via an interpreter”.
(CSO)

Detention centres

Health care in detention centres is not part of the National Health System; so far it has been underwritten by EU funds i.e. the former European Return Fund and the new planned AMEF (Asylum and Immigration Fund), and international donors.¹⁰³ Subject to sufficient funding, in recent years, health care was provided by HCDCP or by medical NGOs (MSF, MDM or MEDical Intervention (Med IN)).

After the opening of additional detention centres in the Evros region in 2012, MSF and other NGOs transitioned to providing services under a situation of dire problems and extreme needs. MSF halted their work in the region after HCDCP began providing medical services to detainees in Evros and Rodopi regions in March 2013. As the HCDCP programme had ceased operations in April 2013 owing to a lack of funding, MSF and MED IN took over again. During the time of our visit, the team was informed that as of 1st of November 2013, NaHOC was expected to start providing services in the centres,¹⁰⁴ as per agreement between the Ministry of Public Order and Citizen Protection and the MoH (and funded by the ERF).¹⁰⁵

¹⁰³ For example MSF, who are present in DC since 2008.

¹⁰⁴ Experts noted during the national consultative committee meeting held in Athens in November 2014 that in November 2014 NaHOC have not started to provide health services in the centres, located in Evros and Rodopi regions yet.

¹⁰⁵ Since February 2014, the NaHOC has taken responsibility of the health care inside Amygdaleza detention centre.

Box 1: Health Card - First Reception Centre

ΕΛΛΗΝΙΚΗ ΔΗΜΟΚΡΑΤΙΑ Υπουργείο Δημόσιας Τάξης και Προστασίας του Πολίτη		Υπουργείο Παιδείας	
ΚΑΡΤΑ ΥΓΕΙΑΣ ΑΛΛΟΔΑΠΟΥ ΥΠΥ15			
ΑΡ. ΥΠΟΘΕΣΗΣ:		ΑΡ. ΦΑΚΕΛΟΥ:	
Τόπος:		Κέντρο Ταυτοποίησης ΕΛ.ΑΣ.	
Ημερ. Αφίξης:		Ημερομηνία	
Επώνυμο:		Όνομα:	
Όνομα Πατρός:		Αρ. Ιστορικού:	
Ημ. Γέννησης:		Εθνικότητα:	
Φύλο:		Γλώσσα:	
Καταγραφή ημερ/νία			
Χρόνιες Νοσοί		<input type="checkbox"/> Δυσβρίτης <input type="checkbox"/> Άσθμα <input type="checkbox"/> Επιληψία <input type="checkbox"/> Νεφροπάθεια <input type="checkbox"/> Καρδιοπάθεια/ΑΥ <input type="checkbox"/> Ψυχιατρικό <input type="checkbox"/> Κακοήθεια <input type="checkbox"/> Ειδικές λοιμώξεις <input type="checkbox"/> Αλλεργίες <input type="checkbox"/> Σχόλια:	
Φαρμακευτική αγωγή:			
Αναπηρίες		Εμβολιασμός:	
<input type="checkbox"/> Όραση <input type="checkbox"/> Άκοή <input type="checkbox"/> Κινητική <input type="checkbox"/> Ομιλία <input type="checkbox"/> Νοητική <input type="checkbox"/> Ακρωτηριασμός		<input type="checkbox"/> BCG <input type="checkbox"/> Τετάνου <input type="checkbox"/> Άλλο: <input type="checkbox"/> Δεν γνωρίζω	
Διατα Ελεύθερη			
Βρίφη Νήπια Ανήλικα		Θηλασμός:	
Υψος: Εκ. Βάρος: Χιλιόγρ. Σχόλια:			
Συννοδός:		Αρ. Παίδων:	
Αρ. Φακέλου:			
ΓΥΝΑΙΚΕΣ		Αρ. Εγκυμοσύνης:	
<input type="checkbox"/> Έγκυος <input type="checkbox"/> ΟΧΙ		<input type="checkbox"/> Αρ. Παίδων: <input type="checkbox"/> Γαλουχία: <input type="checkbox"/> ΟΧΙ	
Σχόλια:		Σχόλια:	
Σύντομο Ιστορικό, Παρούσα Κατάσταση:			
ΣΧΟΛΙΑ: Rx Θωρακός: ΝΑΙ Ευρήματα:			
Ευάλωτη ομάδα: ΟΧΙ			

HELLENIC REPUBLIC Ministry of Public Order and Citizen Protection		First Reception Centre	
HEALTH CARD			
Case Number:		File Number:	
Place: Samos-Screening Center		Date of arrival: Date	
Surname:		Name:	
Fathers name:		Registration number:	
Date of birth: Date		Nationality:	
Sex: Female		Language:	
Reg. date: Date			
Chronic Disease		<input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Epilepsy <input type="checkbox"/> Nephropathy <input type="checkbox"/> Heart Disease/HBP <input type="checkbox"/> Psychiatric <input type="checkbox"/> Malignancy <input type="checkbox"/> Specific infections <input type="checkbox"/> Allergies: Comments:	
Medication:			
Disabilities		Vaccination:	
<input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Speech <input type="checkbox"/> Mental <input type="checkbox"/> Amputation		<input type="checkbox"/> BCG <input type="checkbox"/> Tetanus <input type="checkbox"/> Other: <input type="checkbox"/> Unknown	
Diet Diabetes:			
Infants Minors		Breastfeeding:	
Height: cm. Weight: Kg.		Comment:	
Accompanying person:		File No:	
Surname:		Name:	
Women		Pregnant:	
No of pregnancies:		Children No:	
Breastfeeding:		Comment:	
Short history, Present situation:			
Comments:			
Chest X/R: NO Pathology:			
Vulnerability NO			

In 2013–14, MSF medical records on their work in detention settings provide an overview of the situation in place: *“the most common complaints were upper respiratory tract infections (24.7%); gastrointestinal disorders (14.7%); musculoskeletal problems (13.7%); skin diseases (8.5%); and dental problems (7.9%)”*.¹⁰⁶ *The recurrent scabies outbreaks observed in many detention facilities are indicative of the substandard conditions, as the spread of the disease is directly linked to poor sanitary conditions. During 2013 alone, MSF teams had to carry out two separate scabies control interventions in most of the detention facilities where they worked. In some detention facilities MSF also observed the unacceptable practice of distributing a single razor to be shared by more than one person, putting those in detention at risk of the transmitting infections such as HIV, hepatitis B and hepatitis C.”* MSF further highlighted the following problems in relation to medical care in detention facilities in the Greek islands and Northern Greece:¹⁰⁷ inability to continue current health interventions, lack of initial health screening for newcomer detainees, obstacles in the connection with public health authorities and transfer of responsibility to law enforcement officers for the evaluation of medical cases. As the majority of detainees migrants are not new arrivals, they have not passed through the new procedure ‘first reception centre’, which includes a medical assessment process. As a result of the absence of initial medical assessments, MSF teams have identified people in detention with serious chronic and communicable diseases, such as tuberculosis, some of whom had interrupted their treatment.¹⁰⁸

During the field work and respective visits to detention centres in November 2013, the team met and observed the work of professionals (programme coordinators, doctors, nurses, etc.) from the following organizations:

Table 6: NGO working in detention centres at the time of visit (November 2014)

Athens, Amygdaleza Detention centre	MED IN
Lesvos, Mytilini HP Screening centre (FRMU)	MDM/Doctors of the world
Orestiada, FRC Fylakio	MED IN
Orestiada, Fylakio Pre-removal DC	MSF
Xanthi DC	No health staff present

Usually there were one or two doctors, one or two nurses, a psychologist, and a social worker in each centre where an NGO operates. Most often services provided basic health care during business hours; there are no services afterhours in the centres. Police, in coordination with hospitals, assist migrants outside of regular business hours. Interpretation is also not secured for health assistance, as it is also linked to EU funding. Besides dealing with urgent problems of detained migrants and arranging visits to hospitals, police have to also follow up on prescribed treatments and distribute prescription drugs to migrants.

“I have a gall problem. And I had a crisis so we went to a doctor in Athens. The price was 65 euro, so they took my passport as a guarantee I will pay later. They gave me a photocopy and when I was arrested by the police I have shown the photocopy of my Bulgarian papers. But they keep me here. Often I have problems with the gall. I ask the policemen to bring me to a hospital, but they refuse. I stopped asking anymore. I stay with myself and the pain. I just wait for the pain to go away. A week after I came here, they sent me to a doctor. But it happened because I had pain. I was accompanied by guards. The doctor gave my medical file to the guard but I haven't seen this file since then.

¹⁰⁶ Statistics derived from 3,203 medical consultations which took place between October 2013 and March 2014.

¹⁰⁷ MSF, Letter to the Minister of Public Order and Citizen Protection dated 4 February 2013.

¹⁰⁸ MSF Report. Invisible Suffering. Prolonged and systematic detention of migrants and asylum-seekers in substandard conditions in Greece. MSF Operations in Immigration Detention Facilities In Greece 2008–2014.

And that was it. I didn't go to a doctor anymore. I need to undergo a surgery. But it won't happen here. If you need a doctor, you have to speak to the guards. They put you in a list, but what happens with this list I don't know".

(Migrant)

Following the initial hospital visit, the doctor is able to follow up on the migrant's condition if the person is still in the same centre. However, since there is no tracking system for medical patients, if the migrant is transferred to another facility, the entire process of going to the hospital and seeking treatment starts anew. Our team was informed that doctors are not permitted to enter inside the living area of centres, and that it is really difficult for them to evaluate health risks. Everything related to risk evaluation is done through interviews. For example, our team was told in both Amygdaleza and Orestiada DCs that migrants share razors but the doctors were not able to confirm this (as per MSF reports). There was also an outbreak of Hepatitis C in Orestiada due to sharing of razors.

NGO health services do not provide medical tests for HIV/AIDS, Hepatitis, Syphilis, or other infectious diseases, thus there is no information on any such medical conditions in a context of long detention periods and potentially risky behaviours. The tests can be done in the hospital but only when there is suspicion of a specific disease. The same is true for X-ray or any other specialized examination. Cooperation with hospitals has been reported as good until now, and they have provided free of charge health care, however financial constraints and reforms in the health-care system are threatening this fragile balance. No agreement was in place with hospitals or any public health service to provide medical aid reported at the time of our visit. Although vaccines and vaccination have on occasion been offered free of charge by HCDCP, this is not a regular service. NGOs do not provide vaccination. Sometimes vaccines are provided by hospitals; however, hospital workers reported difficulties in securing Tetanus vaccines and sera, when medically required. No agreement about the provision of vaccines and vaccination services was further reported to be in place between NGOs and the HCDCP. Migrant vaccination is not done on a regular basis. Interviewees also informed us that they were not aware of stool tests and/or any other medical tests being done for migrants identified as coming from countries with Polio outbreaks at the time of the visit.¹⁰⁹

According to the doctors we interviewed, when there are cases of **HIV**, patients are kept in the hospital for undetermined time but there have also been cases when a person living with HIV has been sent to the detention centre and the drugs were provided to the migrants in detention by hospitals. The doctors would prefer not to have such patients housed in the centres due to difficulties of providing drugs on time, while police officers are also reportedly uncomfortable with the idea. Overall, HPs reported that housing HIV positive migrants in detention centres or any other shelter is challenging due to stigma and discrimination. This is also an issue for migrant children living with HIV, and they consequently have to live in a hospital since they are not accepted in shelters for minors.

In terms of **health promotion**, either the doctor and/or the nurse on duty at the centre provide some general information to migrants, nothing about their health-care rights or psychosocial support. The information they provide and the time they spend with each migrant are not sufficient, and there are no leaflets or any other educational materials to tell migrants about communicable diseases, prevention, health promotion, and personal hygiene measures.

¹⁰⁹ HCDCP informed such was done after November 2013. Furthermore stool (faeces) tests are done regularly and that there has been a program on polio elimination running for more than 10 years. See at: www.keelpno.gr/Portals/0/%CE%91%CF%81%CF%87%CE%B5%CE%AF%CE%B1/%CE%94%CE%B7%CE%BC%CE%BF%CF%83%CE%B9%CE%B5%CF%8D%CF%83%CE%B5%CE%B9%CF%82/%CE%91%CE%BD%CE%B1%CE%BA%CE%BF%CE%B9%CE%BD%CF%8E%CF%83%CE%B5%CE%B9%CF%82/AFP%20POSTER%20PRESENTATION_v20%2005%202013_FI_NAL.pdf

During our field visits it became clear that it is very difficult to ensure long term treatment of **chronic conditions** such as diabetes, cancer, etc.; there is a lack of medication for cancer patients, but especially migrants. Migrants suffering from chronic diseases such as diabetes need special meals and insulin, but in detention centres it is difficult, if not impossible, to track and treat them properly. Disabled persons are also subject to inadequate care and accommodation.

Psychologists and social workers reported difficulties in providing **mental health-care services** in the centres because they did not have regular access to patients within the detention system, and because they could not ensure follow-ups, with further negative consequences for migrants.

“There are a lot of health problems faced during the care of migrants. Mental health is the main priority and they need special care and doctors are not trained for but a psychologist or a social worker helps them. There were migrants kept for more than a year in detention centres and most of the time they live in very crowded conditions, there is no music, books or any other activity such as language course apart of walking within the centre that they may perform. There are scarce TVs or radios. There are interpreters when there are health problems but often not always on time and not every time. A psychiatrist can visit the centre or the migrant is sent to the hospital. But there is not any mental health prevention plan related to different activities the migrants may perform in such centres. There are many difficulties to follow and care for psychiatric and epileptic cases and they are kept most of the times in detention centres but commanders are sometimes scared of them and try to deport such cases. There were cases where minors were kept with adults with psychiatric conditions. MSF has been trying to organize such care and protocols and help the police but still there are difficulties.”

(Team member and Expert opinion)

Indeed, mental health problems are root causes for **riots and attempted suicides**. There have been cases of migrants attempting to injure one another. Cases of migrants’ mistreatment by police are difficult to prove, and so doctors/psychologists try to mediate such discussions. The doctors would like to be able to perform some basic tests on site. At the same time, NGOs report accidents/injuries happening in detention centres, usually during riots and/or clashes between migrants and the police. Riots are often a violent reaction to the uncertainty in detention; usually they break out because of prolonged stay or continuous lack of hot water or heating. It is difficult to obtain accurate information about police brutality, and most detention centre NGO staff, as well as the migrants themselves, are in fact reluctant to discuss this issue.

“They do not have any rights, health-care rights included.”

(CSO)

As far as **sexual activities**, doctors informed our team they do not ask about the sexual preferences, orientations, and behaviors of migrants. Typically, the subject is taboo even with the migrants themselves; at the centres, condom distribution is not allowed.

There are a lot of complaints and problems related to **dental care**, which difficult to organize. The visiting team was informed by MSF of a good practice in one of the detention centres, where a dentist association had agreed to provide pro bono treatment and screenings, however not surprisingly the demand was greater than their capacity to treat patients.

Our team did not meet any non-NGO social workers at the detention centres. At the same time, interviewees from the police force shared plans for hiring 50 psychologists, 50 interpreters, and 50

social workers to work under the supervision of the police system.¹¹⁰ Of course, any such programme would need substantive financial support.

The reality is that Greece's islands and other border regions have witnessed an unprecedented tidal wave of migrants, asylum-seekers, unaccompanied minors, pregnant women, victims of trafficking, and other vulnerable groups. Even though first line staff is not trained on recognizing or treating the special needs of migrants, due to the constant influx, they have gained certain skills and practices which they apply daily in trying to manage the increasing mixed migration flows.

In hospitals/outside centres

In hospitals, in addition to the chronic budgetary shortages, the lack of enough qualified interpreters is a common problem, and it directly impedes doctors' efforts to compile accurate medical histories of the patients they are treating. NGO Metadrasi could be called to interpret, when available. Cultural mediators are not available in hospital settings, and doctors reportedly share their frustration with not having information of the cultural background of their patients. Further issues, reported by all health-care staff, included dealing with migrants with mental health problems, and difficulties in completing long treatments in cases of severe infections.

"Now with people from Asia or North Africa there is unfortunately immense loneliness. Concerning psychological problems, I have never seen them ask for support from a psychologist. I think that the staff probably underestimates this need."

(HP)

Box 2: Good practice, Work of Médecins du Monde

What's the role of MdM? After the migrants are brought to the FRC, they give their names, they give fingerprints, and they're registered. At that point we get in with a doctor, psychologist and social worker to do a medical screening and fill all the forms, to do referral to hospital if needed, screening of vulnerable groups also. At same time UNHCR provide information on their rights, obligations according to the laws, asylum services (*legal information*).

We have five open polyclinics in Athens, Thessaloniki, Chania, Perama and Patras. We work in a detention centre in Corinth and also in the HP temporary screening centre in Moria Lesvos as part of the FRMU and in the HP registration screening in Chios. We have in every centre two doctors, two nurses, one social worker, one psychologist, one field coordinator and one interpreter. Clinics and open polyclinics – similar number of practitioners. We also rely on 600–800 volunteers (*medical personnel*).

Follow-up? Depends on our capacity. When the migrants are released from the centres in the islands, we advise them to get in touch with MdM in Athens (if they go to Athens) or to get in touch with our volunteers in the regions they go. In most of the cases, the migrants go to the hospitals where our doctors work. The follow-up is linked to the clinics throughout Greece.

Health information. We provide information on HIV, hepatitis. We try to detect vaccination records, to assess levels of knowledge about HIV, pregnancy. We do that in the centres.

Last year we provided medical services to 50,000 patients and 60 per cent of them were migrants.

¹¹⁰ IOM was informed that 70 health professionals were hired by NaHOC through the HCDCP after November 2014.

III.III Data collection

All NGOs (and previously, the HCDCP) offering services in the FRCs/detention centres collect locally migrant health data locally. In every centre, where present, doctors and nurses try to organize the patient files, register medical services provided, and report data to the authorities. According to governmental interlocutors, some NGOs working in the centres have refused to share patients' medical files, perhaps due to fears that any such would not be treated with due respect for patient privacy. However, this is not productive or effective when it comes to continuous course of treatment and/or when people are transferred between institutions. Usually all data are recorded in a local form of database. Different NGOs have different databases, which follow different templates, and are not interconnected. They record mainly demographic and health data for monitoring purposes (See Box 1). In principle, data isn't aggregated, analysed, or shared with external stakeholders; it is kept locally (either in paper or electronic format). MSF uses the aggregated data for their public reports and for advocacy (i.e. Impact of detention on health report), but also they share this data with the authorities regularly and try to meet with them for discussions at least once per month.¹¹¹ NGOs further informed us they do not share any information outside the centres and all information related to the health of migrants is kept at the level of different centres and/or NGOs, so they are not allowed to exchange information when migrants change centres. In cases where there is an absolute need for information sharing, it is done by phone.

With respect to hospitals, an interviewee from the admission and emergency department of Mytilini hospital in Lesvos confirmed all health data are registered in the common registry for admissions and emergency of the hospital; doctors prefer to keep only personal data related to health care. The files are kept in the hospital and if a migrant wants to know more about his/her medical condition, that information is provided; information and files can be further accessed by medical doctors or health care workers working for NGOs. Data on TB and other infectious diseases subject to surveillance and reporting is collected at every hospital and then shared with HCDCP, which further aggregates the information.¹¹² At the same time, there is no computerized or web based hospital or emergency registry where medical data can be obtained in real time and shared with interested health professionals. In principle, when migrants leave the hospital, it is exceedingly difficult to track them or to refer them out, since there are no referral services for migrants.

The Law for Protection of Individuals with regard to the Processing of Personal Data (2472/1997), the Law for Protection of Personal Data and Privacy in the electronic telecommunications sector, and amendment of Law 2472/1997 (Law 3471/2006)¹¹³ are the standards on data storage and transfer; however, they are practically inapplicable in detention centres since there are no health workers permanently posted there.




A standard protocol for medical screening, psychosocial diagnosis, support, and referral of undocumented third country nationals in FRCs is supposed to be followed, per the recent Ministerial Decision *Programme of medical control, psychosocial diagnosis, support and referral of third country nationals entering without legal documents first reception facilities* (Official Gazette B' 2745/29-10-2013). Below are reproduced copies of the HCDCP forms for migrants' medical screening in detention, as codified by the aforementioned law.

¹¹¹ MSF, Providing medical assistance to immigrants and refugees in Greece. Results from intervention of MSF in immigration detention centres. January–April 2013. Available from http://issuu.com/msfgreece/docs/2013_wrd_report_gr_664bbc66933e7e?e=1561839/3562383#search




¹¹² See at: www.keelpno.gr/en-us/epidemiologicalstatisticaldata.aspx

¹¹³ Hellenic Data Protection Authority portal. Available from www.dpa.gr/portal/page?_pageid=33,43560&_dad=portal&_schema=PORTAL (accessed 23 February 2014).

Box 3: HCDCP Medical card

<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;">  <p>ΚΕΝΤΡΟ ΕΛΕΓΧΟΥ & ΠΡΟΛΗΨΗΣ ΝΟΣΗΜΑΤΩΝ (ΚΕ.ΕΛ.Π.ΝΟ.)</p> <p>ΥΠΟΥΡΓΕΙΟ ΥΓΕΙΑΣ & ΚΟΙΝΩΝΙΚΗΣ ΑΛΛΗΛΕΓΥΗΣ</p> </div> <div style="text-align: center;">  </div> <div style="text-align: center;">  <p>4η ΔΥΠΕ ΜΑΚΕΔΟΝΙΑΣ ΘΡΑΚΗΣ</p> </div> </div> <div style="margin-top: 20px;"> <p style="color: red; font-weight: bold; text-align: center;">MEDICAL CARD / ΙΑΤΡΙΚΗ ΚΑΡΤΑ</p> <p style="text-align: center;">ΟΝΟΜΑ / NAME:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p style="text-align: center;">ΕΠΩΝΥΜΟ / LAST NAME:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p style="text-align: center;">Α. ΜΗΤΡΩΟΥ / CODE NR:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p style="text-align: center;">ΦΥΛΟ/ GENDER:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p style="text-align: center;">ΕΚΔΟΘΗΚΕ /ISSUED ON:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> </div>	<p style="text-align: center;">ΟΝΟΜΑ / NAME:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p style="text-align: center;">ΕΠΩΝΥΜΟ / LAST NAME:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p style="text-align: center;">ΗΜ/ΝΙΑ ΓΕΝΝΗΣΗΣ / BIRTH DATE:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p style="text-align: center;">ΧΩΡΑ ΠΡΟΕΛΕΥΣΗΣ/COUNTRY OF ORIGIN:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="margin-top: 20px;"> <p style="color: red; text-align: center; font-weight: bold;">VACCINATIONS / ΕΜΒΟΛΙΑΣΜΟΙ</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 15%;">Date/ Ημερομηνία</th> <th style="width: 25%;">Nature of vaccin / Εμβόλιο</th> <th style="width: 25%;">Dose / Δόση</th> <th style="width: 35%;">Υπογραφή ιατρού / doc- tor's signature</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> </div>	Date/ Ημερομηνία	Nature of vaccin / Εμβόλιο	Dose / Δόση	Υπογραφή ιατρού / doc- tor's signature																																								
Date/ Ημερομηνία	Nature of vaccin / Εμβόλιο	Dose / Δόση	Υπογραφή ιατρού / doc- tor's signature																																										

Box 4: Medical History Form. Implementation of actions for the medical and psychosocial needs of undocumented third countries nationals who may need international protection. Evros Region. HCDCP.

ΥΛΟΠΟΙΗΣΗ ΔΡΑΣΕΩΝ ΙΑΤΡΙΚΩΝ & ΨΥΧΟΚΟΙΝΩΝΙΚΩΝ ΑΝΑΓΚΩΝ ΑΛΛΟΔΑΠΩΝ ΥΠΗΚΩΝ ΤΡΙΤΩΝ ΧΩΡΩΝ ΧΩΡΙΣ ΝΟΜΙΜΟΠΟΙΗΤΙΚΑ ΕΓΓΡΑΦΑ ΠΟΥ ΕΝΔΕΧΟΜΕΝΩΣ ΧΡΗΣΟΥΝ ΔΙΕΘΝΟΥΣ ΠΡΟΣΤΑΣΙΑΣ ΣΤΗΝ ΠΕΡΙΟΧΗ ΤΟΥ ΕΒΡΟΥ

ΙΑΤΡΙΚΟ ΙΣΤΟΡΙΚΟ

• Στοιχεία

Όνομα	Επώνυμο	Χώρα Προέλευσης
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Φύλο	Ηλικία	Ημερομ. Αφίξης
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Ημερομ. Αναχώρησης		
<input style="width: 90%;" type="text"/>		

Ιατρείο:

• Ατομικό ιστορικό εξεταζόμενου/ης

<p>ΝΑΙ ΟΧΙ</p> <p><input type="checkbox"/> Ασθμα</p> <p><input type="checkbox"/> HIV+</p> <p><input type="checkbox"/> Ανεμοβλογιά</p> <p><input type="checkbox"/> ΑΕΕ</p>	<p>ΝΑΙ ΟΧΙ</p> <p><input type="checkbox"/> Υπέρταση</p> <p><input type="checkbox"/> Φυμητιωση</p> <p><input type="checkbox"/> Καρκίνος</p> <p><input type="checkbox"/> Ηπατίτιδα</p>	<p>ΝΑΙ ΟΧΙ</p> <p><input type="checkbox"/> Διαβήτης</p> <p><input type="checkbox"/> Καρδιολογικό</p> <p><input type="checkbox"/> Σπασμοί</p> <p><input type="checkbox"/> ΣΜΝ</p>
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• Οικογενειακό Ιστορικό

<p>ΝΑΙ ΟΧΙ</p> <p><input type="checkbox"/> Ασθμα</p> <p><input type="checkbox"/> Καρκίνος</p> <p><input type="checkbox"/> Διαβήτης</p>	<p>ΝΑΙ ΟΧΙ</p> <p><input type="checkbox"/> Υπέρταση</p> <p><input type="checkbox"/> ΑΕΕ</p> <p><input type="checkbox"/> Φυμητιωση</p>	<p>ΝΑΙ ΟΧΙ</p> <p><input type="checkbox"/> Καρδιολογικό</p> <p><input type="checkbox"/> Άλλο</p>
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Σχόλια:

Μόνο Γυναίκες: ☐
Εγκυμοσύνες: ☐
Τώρα Εγκυος: ☐

ΙΑΤΡΙΚΟ ΙΣΤΟΡΙΚΟ

• Ιατρικό πρόβλημα υγείας τώρα:

	Ηλικία Έναρξης	Φάρμακα

Αξιολόγηση Πόνου: ☐ Πόνος Τώρα: ☐ ΝΑΙ ΟΧΙ

Χαρακτήρας Πόνου: ☐ Περιγραφή:

Διάρκεια Πόνου: ☐

• Ψυχική Υγεία, Προβλήματα χρήσης

<p><input type="checkbox"/> Επισοδια μανίας</p> <p><input type="checkbox"/> Ψυχιατρική νοσηλεία</p> <p><input type="checkbox"/> Χρήση Αλκοόλ/Ουσιών</p>	<p><input type="checkbox"/> Χρήση βίας</p> <p><input type="checkbox"/> Απόπειρες αυτοκτ.</p> <p><input type="checkbox"/> Αγχώδης Συνδρομή</p>	<p><input type="checkbox"/> Ψυχοτρόπα</p> <p><input type="checkbox"/> Κατάθλιψη</p> <p><input type="checkbox"/> Ψύχωση</p>
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☐ Θεραπεία απεξάρτησης

☐ Σεξουαλική ή φυσική κακοποίηση

Σχόλια:

• Προβλήματα ψυχικής υγείας τώρα

☐ Ναι ☐ Όχι

Εάν ναι, περιγραφή προβλήματος:

• Οδοντιατρικά προβλήματα

☐ Ναι ☐ Όχι

Εάν ναι, περιγραφή προβλήματος:

• Ζωτικά Σημεία

Θ.	Πίεση	Αναπνοές
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

1

2

MSF distribute a personal health-care booklet for migrants to carry with them, so as to facilitate proper diagnosis and treatment, given the general difficulty in obtaining/transferring medical records. This is helpful when migrants are transferred to another facility, but even so, medical tests done in hospitals are sometimes misplaced and not included in the booklets.

In Greece, hospitals do not have centralized databases for patients' medical histories. However, patients can request to review their individual files. The question then is whether patients are aware of their rights, especially in the case of migrants who might not be at all familiar with the health-care system. Interviewed health professionals often stressed the need to have a centralized online health records system to not only store patients' medical histories, but also monitor, exchange, and analyse relevant health data.

Detention centre social workers record social/demographic data of vulnerable group migrants, as well as requests concerning legal issues, special needs such as non-food items (NFIs), clothes, etc. If and when needed, social workers refer migrants to other services and organizations. Psychologists collect data concerning traumatic experiences like physical and psychological abuse, loss of family members or close friends, etc. History of substance abuse such as alcohol or drugs is also recorded. Data is collected electronically and on paper;¹¹⁴ all information collected is private and confidential, and is therefore not shared

Detention centre police staff is responsible for the collection of administrative data including demographics, personal data, family history, etc. for the purposes of police and identification proceedings. In some cases the police also collect health data due to lack of medical staff; this includes information on treatment and/or medical tests done, although police in some of the centres have in the past refused to collect health data, stating they did not feel comfortable doing so. Police officers stated they try not to disclose any of the information collected, as per national data protection laws, except for demographic purposes (when they share with the justice authorities (Prosecutor's Office) and FRONTEX, who then upload it and make it available on the national police site astynomia.gr). Interviewed law enforcement officers recommended that stricter data management systems be put in place, in line with the national data protection law.

III.IV Discussion Section – III

Health data collection and storage

A well-protected web based system can help monitor migrants' health and provide information for timely follow-ups and treatment. Furthermore, a medical data sharing system which guarantees confidentiality and privacy and potentially minimize duplication of efforts, medical tests, etc. A common database to be accessed by all personnel or another mechanism of medical information exchange between medical personnel can be of vital importance.

Lack of routine surveillance system

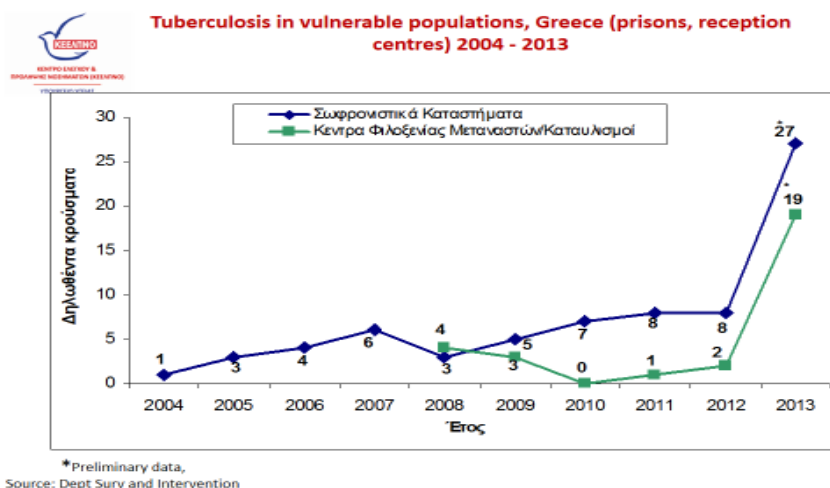
The mission team found neither a system of routine medical surveillance (regular disease reporting or syndromic surveillance), nor a protocol for regular epidemiological analysis in any of the visited centres.

One area of particular concern for the health authorities is TB among migrants, and especially drug resistant and MDR TB (multidrug resistant TB). Indications of higher incidence and prevalence of specific infections among migrants in detention centres can be seen in the following graph from HCDCP, comparing data on the number of tuberculosis cases in prisons (blue line) and in detention centres (green line).¹¹⁵ One possible explanation of the increase in detected TB cases could be the increase of migrants being arrested after August 2012 when Xenios Zeus operation started. HCDCP considers that the reintroduction/reemergence of diseases is possibly related to larger vulnerable populations and 'super spreading' environments, i.e. irregular migrants minorities, prisons, at first reception/pre-removal detention centres, given that migrants are detained for longer periods of time.

¹¹⁴ See attached social and psychological history form.

¹¹⁵ Personal communication with the epidemiological department of HCDCP 2014.

Figure 1: Tuberculosis in vulnerable populations, Greece 2004–2013



Source: HCDCP, Department of Epidemiological Surveillance and Intervention.

Under the auspices of the Greek Presidency, a meeting entitled *Public Health Benefits of Screening for Infectious Diseases among Newly Arrived Migrants to the EU/EEA* took place in March 2014. ECDC and HCDCP experts exchanged experiences and discussed the public health benefits of screening practices in the various EU Member States. Some of their conclusions were:¹¹⁶

- Screening of migrant populations can be a valuable practice if it is based on scientific evidence. However, practices vary significantly between Member States and there is no agreement on a list of common diseases to screen, although tuberculosis is considered a high risk agent by all;
- Screening should have a comprehensive approach and should not be restricted only to infectious diseases. Screening should also be to the benefit of both the individual and the community, and most importantly it should be connected to a treatment option for the particular diseases/conditions;
- Migrants are a diverse population, and appropriate risk assessment for each group is needed before specific screening policies can be adopted;
- More scientific evidence is needed to make policy decisions for appropriate migrant screening. Sharing of data was advocated, as well as continuous evaluation of the existing screening programmes and collation of cost-effectiveness data, when and where available;
- Public health professionals and the health-care sector in general should promote and advocate the benefits of non-discriminatory screening and close the gap with other involved stakeholders and specialties (e.g. ministries of interior, law enforcement, border control, etc.).

Structural barriers

An important observation made by one of the nurses interviewed is that currently every health issue of migrants is treated in hospitals, even though most of them could be treated by primary health-care providers instead, which would be both more efficient and more affordable; The trouble is that there is no primary care service for migrants outside of what NGOs in reception and detention centres provide. Some NGOs are attempting to do so on the outside (of centres), but since such activities are technically unofficial (and sometimes performed clandestinely literally through the backdoors of cafes, etc., the quality of such medical services cannot be guaranteed).

¹¹⁶ Informal Meeting of Health Ministers 28–29 April 2014, Athens, Greece Migration and Public Health Discussion Paper.

Coordination and clear distribution of tasks around the reception process at local level

Despite the fact that a protocol from the MoH is in place, there is adequate health screenings of new arrivals are lacking; various obstacles to more active cooperation between public health and law enforcement authorities results in back and forth transfer of responsibilities, without much getting done. At the same time, local hospitals are unable to keep up with the demand, as they are in fact the only officially sanctioned health-care service available to migrants. Doctors there reported difficulties obtaining accurate and timely medical information on migrants from NGOs and other previous care providers.

IV. MIGRANT-SENSITIVE HEALTH SYSTEM

The assessment team visited one First Reception Centre, one First Screening Centre, and three detention centres in order to observe the conditions for third country nationals. Authorization to enter was requested and granted prior to the visits. The following overview of the living conditions in the centres, as we observed them in November 2013, is arranged according to the order of our visits.

IV.I Infrastructure and physical conditions

Amygdaleza detention centre

The centre in Amygdaleza, northwest of Athens, was built with EU funding,¹¹⁷ and opened in April 2012 with a reported capacity of more than 1,600. In a November 2012 press release, the Greek Government refers to UNHCR characterising “the facilities [of the Amygdaleza Detention Centre] exemplary as regards accommodation and security.” In reality, UNHCR’s assessment of the centre was that it was in better condition than others in Greece, a comparative estimate that hardly qualifies as “exemplary”.¹¹⁸

The centre is located near the Greek Police Academy, about 10 km from Athens and 3 km from the town of Acharnae. The nearest hospital is 4 km away in an area called Olympic village. The facility has a triple fence topped with barbed wire and the yard is covered with big gravel.

“The biggest problem with the infrastructure is – I believe – the large stones on the ground. During a riot last August against the extension of detention from 12 to 18 months, the migrants used the stones and we had injuries among police officers”

(LEO)

Migrants live in two-bedroom, two-bathroom prefab residences, with four beds per room. Police and administrative staff of the centre have their offices also located in similar facilities.

Hot water was reported to be available at all times, and rooms cleaned daily by cleaning staff. Disinfection, disinfestations, and rat extermination were also reported to be regularly performed as well. Meals are provided by a catering company three times per day. The detainees are allowed two walks daily, every morning and every evening. According to the commandant of the centre, detainees are allowed visits by relatives and friends but, according to NGO sources, visitors are only allowed to communicate with inmates through a barrier fence, and only for a few minutes at a time.

¹¹⁷ Answer given by Ms Malmström on behalf of the Commission, Parliamentary questions, 30 August 2012. Available from www.europarl.europa.eu/sides/getAllAnswers.do?reference=E-2012-006104&language=FR

¹¹⁸ Press release of UNHCR Greece (in Greek). Available from www.unhcr.gr/nea/artikel/e85872903d1e467c5bbc0251d9071f54/epifylaxeis-tis-ypa.html

At the time of the visit, migrant health care and psychosocial support was provided by the NGO MEDical Intervention, and doctors were only available during weekdays; in cases of emergency migrants were transferred to the nearest hospital accompanied by law enforcement officers.

“At times inmates simulate illness in order to be sent to a hospital, which complicates the treatment for those who are actually ill”
(Migrant)

Since February 2014, the NaHOC has taken over health care inside Amygdaleza.¹¹⁹

Moria screening/detention centre, Lesvos¹²⁰

Moria opened on 25 September 2013, and has room for 98 persons. It is located just outside the village of Moria, 6 km from the town of Mytilini, and 11 km from the nearest hospital.

The structure of the facility is similar to the Amygdaleza detention centre: prefab residences surrounded by a triple fence topped with barbed wire and a gravel courtyard. Each prefab has three separate dormitories with 14 beds in total, and one shared toilet and shower. Detainees have access to hot water, bar soap, paper towels, and toilet paper. Ventilation is done through windows. There is an air-conditioning system for both heating and cooling. Each person is issued a blanket and bed sheets at arrival. Clothes and sanitary pads are provided by the NGOs working onsite. Cleaning staff cleans the rooms daily. Disinfection, disinfestations, and rat extermination are reported to be regularly carried out. Drinking water is available at all times, meals are provided by a catering company three times per day. Migrants are allowed to request special culturally and religiously sensitive diets, but they cannot prepare their own food onsite. Migrants are required to preserve a daily programme of attending roll call and dining at specified times.

The yard is very small and crowded. People do not have possibility for sport activities, although they are free to practice their particular religion and so prayer carpets are provided. Although the visiting team was not officially allowed to talk with migrants, we had the opportunity to ask them a few questions, under police supervision.

At the time of our visit, health care and psychosocial support was provided by the Médecins du Monde NGO. The existing health-care facility, located in a container similar to the ones migrants live in, was staffed by a doctor and a nurse. There was no possibility to quarantine and observe persons displaying symptoms of infectious disease on site. Such situations were dealt with by referring the patients to the hospital in Mytilene. Sick migrants can remain at the infirmary or in a segregated room if needed. Metadrasi NGO staff provided interpretation services, and there was also an UNHCR office with two staffers, and an Asylum Service office staffed by three people who inform migrants about the administrative and legal measures and procedures pertinent to their cases. Information sheets about centre's regulations and procedures are available in multiple languages.

The maximum period of stay in the centre was reported to be 30 days.

¹¹⁹ Amigdaleza: *“When the Great Wolves eat the Light”* Published on 10 June 2014. Available from <http://infomobile.w2eu.net/2014/06/10/amigdaleza-when-the-great-wolves-eat-the-light/>

¹²⁰ At the time of the field visit Moria centre was a screening centre. In reports Moria centre is also referred as registration centre. The term used in this report is screening centre. According to the First Reception Service, Moria is expected to be functional as a FRC in January 2015.

Box 5: Good practice: PIKPA open centre

It is worth noting that the PIKPA open centre in Lesvos is run by a consortium of volunteers and NGOs called The Village of All Together.¹²¹ After negotiations with the municipality, the group was granted permission to run a migrant reception centre at the disused PIKPA (Patriotic Institution of Social Protection and Restoration) camp. The area was leased for free by the municipality and the camp was run exclusively by volunteers. Lesvos' civil society had thus created a strong alternative proven to work – an open reception centre for migrants in an environment which respects human life and dignity. Unfortunately, in April 2013 the project had to be discontinued due to lack of funding. Nevertheless, it remains a good practice to follow as an alternative to prison style detention of undocumented migrants.

“There’s no strict organization within our team. We rely on personal connections and we try to react if we get a phone call that someone is in need of help. If we are told that there are 10 migrants lying in the park, we go there and we help them. The police appreciate what we do because we do their job. They call us to take care about the migrants. The law says that if you provide unauthorized services for migrants you break the law; you’re something like a smuggler. But they let us help them, because otherwise they would have to do it. So “The village of all together” breaks the law, but the police don’t mind. I cook at home and bring food to migrants...At PIKPA we provide information on how to apply for asylum, what kind of papers they need and how long they could stay in the country legally after registration. When we need interpretation we call the NGO “Metadrasi” to provide interpretation”.

(CSO)

“The old open centre in PIKPA was a very nice place and could easily accommodate migrants. The space is open, you don’t have the feeling of detention, the environment is nice, and they can have a room and a kitchen. They can live for a time as human beings. The point is that someone has to coordinate this officially. For example, imagine that the smugglers find out that there are potential customers who are not supervised by anyone, or any right-wing supporters that can attack them. They must feel safe. You cannot get a migrant who has just come into the country, without knowing the language and just leave him there alone. I have discussed this many times with the police and the coast guard, especially when we have new arrivals and they are forced to stay in the port in the cold and rain. Why they don’t just take them to PIKPA? Their problem is who will take the responsibility. Coast Guard points to the municipality, the municipality says I cannot take it and the migrants are just sitting in the port getting wet. I think we need to see the bigger picture and not to use the fact that they are not obliged by any law as an excuse”.

(CSO)

¹²¹ More info: Oi Polloi, “The village of all together: Everyone should enjoy the right to life”. Available from <http://oipolloi.co/?p=267>

Fylakio First Reception Centre (FRC)



Source: IOM Equi-Health Project.

Fylakio FRC is the first of its kind opened in Greece, but it was not yet fully operational at the time of our visit. The centre is located 35 km from the Turkish border, 15 km from the Bulgarian border, 20 km from the town Orestiada, and 1 km from the village Fylakio. It opened in March 2013 with a 240 bed capacity.

As the other two facilities, the Fylakio FRC features prefab residences surrounded by a fence, with similar occupancy and set-up as the previously described living spaces – there are relatively new and clean dorm style rooms, hobby room for watching TV, and a separate room for prayer. Upon admission, migrants receive a blanket and bedsheets, clothes, and sanitary pads; facilities are cleaned and disinfected on a regular basis, and migrants can wash their clothes on their own. An outside catering company provides centre residents with three times a day.

During a one-hour tour of the facility, our team observed relatively good living conditions for new arrivals. In terms of communication with the outside world, mobile phones were allowed, and most migrants used them to communicate with their families, in addition to the public phones for both outgoing and incoming calls.

Health care and psychosocial support is provided by the NGO MED IN, while in case of mental disorder emergencies, migrants are transferred to the nearest mental health-care facility.

“The main problem is interpretation. It is very important to be able to communicate with these people. I personally know that many psychiatrists in hospitals refused to see migrants because of the communication problems. I think if there is something that we should definitely provide to these people is their human right to be able to explain how they feel and we should be able to understand”.
(FRC staff)

The centre’s health-care facility is staffed by a doctor and a nurse, although it does not have any quarantine capacity, and in infectious disease cases, patients are transferred to the hospital in Didymoteicho (40 km away, 45 min. by car). The nearest emergency service and outpatient facility is in Dikaion (15 km far, 10 min. by car). Sick migrants can remain at the infirmary or in a separate room if needed. Staff of the NGO Metadrasi provides interpretation. There is also an UNHCR office providing legal information, as well as informational hand-outs on the asylum application process available in multiple languages.

“The MedIn NGO is responsible for providing doctors and social workers. The UNHCR is also responsible for legal information. We are working on the establishment of an Asylum Service and

First Reception Service in accordance to law 3907... We have regular meetings with the head of the nearest hospital in Didimotiko. We request from the hospital authorities to provide medical examinations of the migrants. We also organize meetings with the prosecutor who's responsible for the cases of unaccompanied minors; we have meetings with the mayor of Orestiada and the mayor of Didimotiko. We need prosecutor's permission to refer the minors to guest houses all over Greece or to include minor in a voluntary return programme".

(FRC staff)

The health-care facility and offices are located in containers similar to those where migrants live. The maximum period of stay in the centre is 25 days. If there are no available places, migrants are sent to the detention centre next door (see below) until room frees up at the FRC.

During our visit, there was a case of an asylum-seeker who had just been granted refugee status. This refugee was initially at the FRC but he was transferred to the detention centre after 25 days, while his application was pending. He was suffering from mental health issues and severe trauma, according to the psychologist at the centre. Despite of his health status, he had been detained and housed in inadequate living conditions, resulting in further deterioration of his health.

Both in Moria Screening Centre and Fylakio FRC the ground is covered with gravel and rubble. As mentioned before, during rioting in Amygdaleza detention centre, gravel rocks were used as weapons against law enforcement officers, causing injuries to both police and migrants.

Fylakio detention centre, Evros

The Fylakio detention centre is just next to the First Reception Centre. It is the oldest detention centre in Greece, and its infrastructure has not been updated. It was built in the 80s as a clothes factory, and subsequently remained empty and disused for many years. The capacity of the centre is 374 people, and the maximum detention period is 18 months. There are approximately 50 employees in total.

"What struck me at the Fylakio detention centre was that they had built a tall wall at least 3.5 meters high and at the top of it they had put a barbed wire like they were trying to forbid even the wind to pass through. Like they were not even allowed to breath"

(CSO)

Migrants live noisy, dirty, and overcrowded cubicles/cells filled with unhealthy odours, and to use sanitary facilities which fall far below the minimum hygiene standards and often even lack hot water. Each cubicle/cell accommodates 50–60 migrants who are locked inside for approximately 18–19 hours a day. The facility fails to provide basic privacy; Blankets are provided but bedsheets are not; Clothes hang from the bars through which detainees receive meals. Male cells are separate from the women's. There was also a cell with four minors in the corridor going towards the women cell, waiting for a place in a shelter for unaccompanied minors. Among the women, there was a 17 year old girl from Afghanistan and a 78 years old woman from the Islamic Republic of Iran. There were also women from Vietnam, China, and Ethiopia. The girl from Afghanistan was offered to go to the FRC, but she said that she did not want to be separated from her brother (housed in the male wing). Another Afghan woman, aged 22, reported she was suffering from gynecological problems but could not communicate with the doctors due to lack of interpretation. One of the Vietnamese women called a person from her mobile phone and one of our colleagues spoke with him in English. He confirmed that an interpreter was on his way to the centre from Athens. These women's cell was cleaner and more organized than the others.

There was a small exercise yard where migrants could walk or play sports during their recreation time (5–6 hours per day), but since it was rather small, migrants are usually divided in two groups during yard time. A catering company provides meals three times per day.

The visiting team was informed by the detention centre commandant that a comprehensive health care and psychosocial support programme had previously been running for some time, funded by the Ministry of Citizen Protection and the Hellenic Centre for Diseases Control and Prevention (HCDCP). However, it had now been discontinued due to lack of funding. At the time of the visit, health care was being provided by MSF. As witnessed by MSF teams on the ground, *“the immigration detention practice and conditions in Greece not only constitute a violation of national, European and international standard, but also directly harm people’s health and undermine their dignity. Having witnessed the unnecessary suffering and harm which detention inflicts on migrants and asylum-seekers, MSF is compelled to denounce the current widespread practice of prolonged and repeated detentions in Greece, which in the two years since the launch of ‘Operation Xenios Zeus’ has proliferated and affected tens of thousands of people”*.¹²²

We were also informed that the very small infirmary lacks a number of essential medicines. Only a small exam room is available, so to quarantine and observe persons displaying symptoms of infectious disease on site is not possible. Such situations are dealt with by referring the persons to the hospital, following the same procedure as in FRC.

According to the CoE representative on our team, *“the facility is overcrowded; inmates are not adequately provided with information about reasons for detention or about their legal situation; they do not have access to a lawyer (free of charge); the accommodations are not in a clean condition; inmates hang card boxes around their beds in order to create privacy; toilets are not appropriately separated from the cells; there is a bad smell in the whole facility; the inmates are anxious, noisy and aggressive because of the bad conditions under which they are detained.”*

There was a container with donated clothes for the migrants in the yard, and the facility commander had given migrants permission to carry and use mobile phones so they could communicate with their families; however, this option is only available to those who can afford to supply a cell phone and buy airtime on their own.

The situation for the centre staff is difficult as well. There is no health prevention at all. If anything happens to them health-wise, they have to seek out medical care. During our visit, a young officer approached members of the team and asked them to do something on behalf of the detainees. When asked about his own needs, he said:

“At least I’m free. I can go to my doctor if something happens. But what about them? Who cares about them?”

(LEO)

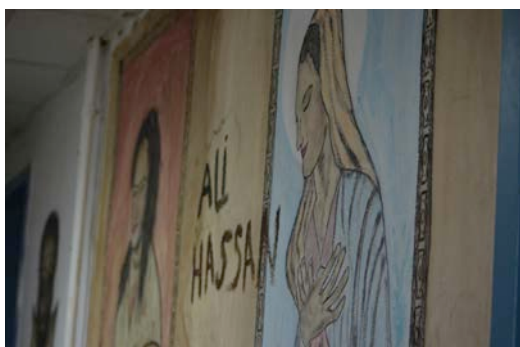
Xanthi detention centre

This centre, located on the grounds of the former police academy just 2 km from Xanthi, has been in operation since August 2012. It has 150 employees, and a 480 bed total capacity, although at the time of our visit 492 migrants were housed there. The average time spent in the centre was reported to

¹²² MSF Greece report, “Invisible Suffering Prolonged and systematic detention of migrants and asylum seekers in substandard conditions in Greece”, April 2014.

be eight and the maximum 18 months, and in 2012, approximately 1,225 migrants total were accommodated there, all of them male.

The centre has two buildings for the migrants and one for the administration, as well as a small courtyard. The buildings and yard are all narrowly surrounded by a tall wire hedge, each. Each building has two floors with eight-man, bunk bed rooms, and a minimum sleeping area of 3 m² per person. There are shared toilets and showers on each floor (28 toilets and 28 showers total). Hot water is available only during the winter when the central heating system is running. Rooms are cleaned everyday by cleaning staff but migrants are also able to clean their rooms themselves, if/when they want. Windows open for ventilation, while detainees have also decorated the room walls with their own paintings.



Meals are provided by a catering company three times per day, and the allocated budget for food is about five Euros per migrant per day. The migrants are able to request a special diet, according to their dietary requirements and cultural and religious eating customs. According to the centre commander, detainees may choose their own meal programme every week from a preselected menu. In special cases (like religious holidays), detainees are allowed to prepare their meals themselves using the facilities of the police academy. Although migrants' chief grievances were about the length of detention and the asylum application process, most of them also complaint about the food:

"The food here is very, very bad. We have only pasta and again pasta. No fruits, no vitamins, and no access to hot water."

(Migrant)

There are special rooms for educational programmes and for individual prayer. At the time of our visit, English lessons were being offered to detainees by a volunteer detainee English teacher from Afghanistan.

The centre has a medical room and a pharmacy, but no permanent health-care staff. Patients are referred to the Xanthi general hospital (500 meters away), which is convenient for all involved, especially law enforcement officer (who are required to accompany migrants). The police director has organized a network of pharmacy owners and employees to collect medicines from private pharmacies for the detainees. Law enforcement officers are responsible for the recording, safekeeping, and distribution of medicines due to lack of health professionals inside the detention centre.

Problems are also observed in other centres without permanent medical staff, as exemplified by the quote below:

“We had a problem with a migrant. He had an acute low back pain and had to be transferred to a hospital. The hospital gave him a treatment with injections. In the absence of health professionals the director had to do the injections to the migrant”.

(LEO)

According to national interlocutors, in November 2013 NaHOC has hired 130 psychologists, social workers and interpreters to work in detention centres with 6 month contracts, with renewal dependable on EU funding. People started work in January 2014 and their contracts expired in June 2014. Since then the staff waits for a renewal. In April 2014, there were 60 doctors hired to work in detention centres with 8 months contract. The problem is that they started late April and since June they have to work without interpreters, psychologists and social workers.

IV.II Occupational health of staff

Health and social workers

There is no data collection on occupational health of staff working with migrants despite the fact that it is not only needed, but also required by law¹²³ (law 1568/1985). **All doctors** interviewed stated that the working environment, the working conditions, the facilities, and the daily struggle to get by with their salaries under the current financial crisis were simply exhausting them. It should be noted that the average salary of public hospital doctors in Greece is very low according to the average doctor's salaries in the private sector. There is no additional incentive to work with migrants or vulnerable groups like Roma, and thus critical health-care positions often cannot be filled.

“What creates insecurity is the current situation in Greece. Most of my colleagues have a fear for tomorrow. Although our work is absorbing, in our free time we will discuss with a colleague, we will hear something about someone who lost his job and this will reproduce anxiety. We hear on TV the minister or whoever saying something and we get frustrated. Then you have to return to your work and be 100 per cent engaged to your duty. Work comes first, concerns are for later”.

(HP)

Similarly, **nursing staff** reported being exhausted and understaffed for the amount of work they are doing. They are all afraid for their health as they feel they are in danger of being infected. They all use masks because they are scared, and some reported taking additional prophylactic measures, such as HBV vaccines. One of the recommendations is that all those working in hospitals should be vaccinated (and/or informed of any such programmes available for the staff) and reminded of the occupational health risks and protection measures at work.

“Nurses all wear constantly masks. I tell them that not all potential patients have tuberculosis but they are afraid. I believe that the nurse is more likely to get TB on the bus coming to work rather than from the patient he is treating and in familiar surroundings. They also worry about getting pierced (from an infected needle). They feel they work in an unhealthy environment. Safety in the workplace is a matter of psychology. The place here probably increases rather than reduces the nurses' insecurity. They don't feel protected, safe. It is a generalized fear, that we are not safe. Yet they overcome their fear daily. They also often suffer from burnout syndrome. Of course no one just decides to leave her job because of the economic need. The socioeconomic status of nurses is not high class; they come mainly from poor families. They don't have a lot of options. A nurse will never see a psychologist in his workplace. Mental health is a taboo. Nurses with mental illness are often

¹²³ Law 1568/1985, "Health and safety of workers". Available from www.ypakp.gr/uploads/docs/721.pdf

taken care of by the nursing service that protect them, give them less stressful assignments and generally manage it internally”.

(HP)

“We (the nurses) are at the front line. It is normal to have cases of burnout syndrome. It is not just the amount of work but also the conditions. If I could change something I’d hire more staff”.

(HP)

While nurses generally like their jobs, their workplace conditions and relatively low salaries make them feel that there is little respect for their work.

“The biggest incentive for a nurse is gaining recognition as a professional in his/hers workplace and as a person in society, something that he/she doesn’t get. The biggest problem for nurses is being unappreciated”.

(HP)

As to **NGO** interviewees, most are young people with great interest in what they do, but they are also overwhelmed by the problems faced by migrants. Because of the increasing number of migrants in need of immediate help, the efforts and working hours invested in overcoming administrative obstacles, NGO staff frequently deal with disappointment, anxiety, and distress. Some of them reported being unpaid for periods of up to 10 months. This patently leads to additional stress, occupational insecurity, and overall burn-out.

All respondents, social workers, and psychologists reported to be in good physical health.

Law enforcement officers

Detention centre working conditions for law enforcement officers are strenuous and demanding, both physically and mentally (long shifts, stressful environment, risk of injury, etc.). The risk of burn-out is very high.

“The actual work hours are not measurable. The official time is 8 hours a day, 5 days a week, but such is the nature of the work that we always exceed the standard working schedule”.

(LEO)

None of the law enforcement officers interviewed indicated particular health concerns, although they had not been vaccinated or trained on self-protection measures.

“There is no vaccination programme. I personally have not been vaccinated and so far I have not encountered any health problems. I know that some of my colleagues, particularly if they have young children, get vaccines for influenza or hepatitis but there is no specific vaccination programme for the staff”.

(LEO)

Concerning the distribution of LEOs’ daily duties in detention centres where all detainees are men, staff members’ gender is taken into consideration.

“Women colleagues do almost every thing we do. The only difference is that they are not placed in the wings because the officer in charge may need to enter inside. Since the prisoners are all men, we choose to place only male officers in the wings”.

(LEO)

Officers at times feel threatened, e.g. when they have to deal with riot situations, but to their credit they also try to understand the migrants' point of view.

"We must not forget that the people held here are, above all, human beings. In some incidents, policemen wanted to file charges against some migrants because they, for example, verbally attacked them, insulted them etc... When they come to me I try to explain that, although it is their right to do that, they should think about how difficult it is to live under such circumstances. I always say to the younger guys 'If they put us in there, how long do you think we would last?' Or I tell them 'Do you know what journey these people have done to arrive here? You think that you control them? They are smarter and more resourceful than you. They are here for their survival and you should respect them for that'. I always try to be conciliatory".

(LEO)

Generally, all personnel working with migrants in detention centres experience elevated levels of stress and burn-out. All reported that they do not sleep well and often they feel depressed, which they characterize as an inevitable part of their job. Most of them undergo periodical medical check-ups, but this is based on their personal initiative rather than on any professional protocol or procedure.

None of those interviewed reported having received any specific training on migration health and/or intercultural mediation. Language and cultural barriers pose further difficulties to staff we met during. FRC managers informed us they had trained their staff in intercultural issues, as well as developed a booklet on intercultural issues; interpreters are also available in the areas operated by the asylum services. Most health professionals and law enforcement officers have not received special training on migrant health, intercultural communication, or human rights/legal aspects of migration, but stated they would like to, if trained in a participative way.

In general, the assessment team observations were that NGO staff was better informed than LEO when it came to health care and self-care issues, though they also reported to need more training and information on cultural issues and self-protection measures.

IV.III Health knowledge, attitudes, and practices

Communication barriers

As previously discussed, the most significant communication difficulties stem from the lack of interpreters and cultural mediators in hospitals and/or other health-care facilities. In order to facilitate communication between migrants and social services, NGOs offering medical services (MDM, MED IN, PRAKSIS) ask assistance from family members, friends or the embassies of the migrants' countries of origin. Difficulties in communicating clearly and effectively with detainees can have a number of negative consequences, not the least of which is possible aggressiveness towards hospital or FRC/detention centre staff.

"I believe that our body language also does not help, we do not give him the time, the way we stand as we speak, half inside and half outside (the room) with high protection masks on, always pressed by time, thinking about giving the right treatment and protecting the clinic community from active tuberculosis. All this does not help the migrant. Often migrants leave before the end of their treatment and I think partly due to us forgetting to inform them that they do not owe money to the hospital. Often a migrant may sneak out. Is it because he is afraid? Or is it because he has obligations? A month is a long time to stay in the hospital, combine that with us not reassuring

migrants that they do not have to pay... I don't know if the doctors do inform them, but we don't".

(HP)

Social workers and psychologists working in the centres experience difficulties when communicating with migrants who can't speak Greek and who are from cultural and religious backgrounds different from their own. This process is time-consuming and brings additional pressure to an already demanding and pressed for time work environment. In 2011 and 2012, an EU funded pilot project using 70 cultural mediators in 21 selected hospitals in Athens and Thessaloniki was conducted by the National School of Public Health and Diastasis-Educational and Support Services Company.¹²⁴ Health professionals claim that the project was very helpful and time saving, however due to lack of funding it was terminated.

"Although intercultural mediators existed for some time, doctors only used them for filling in the medical history and nurses not at all. I think that must have been a project that's finished because there used to be brochures at the entrance on how to find them and I don't see them anymore. Now they really could help with psychological counselling and more besides. Immigrant patients in hospitals do not understand the seriousness of the situation and that they should take their pills. It's the communication manner between immigrant and nurse, both speaking half English-half Greek and the nurse pressuring him to take the pills immediately. The immigrant feels threatened, inspected, as if the nurse is a cop, feels that he has done something wrong to the host society. Because I have a relative education I have identified the problem, as being that Greek nurses don't have the proper training on different cultures and multiculturalism, I do not know if the doctors have any. Unfortunately we do not spend the necessary time and language does not help".

(HP)

"Since we are talking about migrants, I believe the issue of language is an important barrier that even the doctors cannot overcome, which is why the institution of cultural mediators must become permanent. When doctors and nurses cannot communicate verbally, they start using sudden gestures towards the immigrant, acting like a cop. "Get in your chamber, wear the mask, why did you get out, did I not tell you not to go out?" If somebody speaks their language, there can be a relationship of trust. They are afraid of us, they think that we are with the police and that we would give them to the police, which no-one would ever do. It's not our job to do that. We become cynical and act horribly because of the situation in our work and everything we face there".

"It would be most helpful to have interpreters in the hospital on a permanent basis - or for the centre referring the patient to the hospital to send an interpreter with him. I think coming from the same place is even more important than speaking the same language, being familiar with the patient's culture".

(HP)

The communication problem was also mentioned by the psychologist at the First Reception Centre, mainly because it is sometimes challenging to persuade a migrant to speak about mental health issues via an interpreter.

"The main problem is interpretation. We need to be able to understand that this person needs us immediately and with specific issues".

(CSO)

¹²⁴ See at: http://ec.europa.eu/ews/UDRW/images/items/itpr_30873_634774185.pdf

Another important issue not to disregard is the availability of information materials in multiple languages which clarify the specificities of certain diseases and subsequent treatment (for example TB care), so that migrants know what the treatment is, how it is organized and what the potential consequences for discontinuing it prematurely are.

“...the Greek nurse has too many problems to solve daily and not enough time, has severe cases to handle, do not forget tuberculosis is a disease that needs a physician and a nurse immediately available, needs to be urgently diagnosed and treated. As a result, these people who are alone feel even lonelier because of the behavior of health professionals. The doctor will make the diagnosis, give the treatment and he’s finished, the nurse will tell them take these pills and that’s it. Since they often do not realize that they must necessarily take the pills, because of language barriers, my instruction is that they need to take the pills in the presence of the nurse. No one of course ever sat down to explain what is happening. They do not realize the seriousness of the disease and those under anti-TB treatment cannot understand the instructions. These instructions should exist in different languages according to the population that we see in the hospital.¹²⁵ This will be helpful not only for the patient but also for the staff, because even if the doctor is fluent in English, the migrant often isn’t”.

(HP)

The right to health and other legal mechanisms

Despite the fact that health professionals interviewed are not aware of the International and EU legislation and/or even of national legislation regarding migrants’ rights to health, they agree that migrants have right to health and would like to see this right, which is provided in national legislation, getting applied in practice.

“I do not know which migrants have access to the health system under the law and which don’t. I know that they all come here and we accept everybody. We deal with migrants in the same way as the Greeks. If they need to stay in hospital, we take care to provide them with the necessities. Often they need to stay for 6, 7 or 8 hours for observation. In these cases, because we know they have no money, we make sure they are provided with food. Also, if we see that they need clothes, we go to social services and ask for some (to give away)”.

(HP)

“When they arrive at our clinic, all patients are already hospitalized. I don’t have the experience of the emergency room, the nursing staff is not responsible for checking these people’s papers or how they got to the emergency. I think they arrive accompanied by friends from the same country. Their health is in poor condition and are forced to seek health services. Most patients hospitalized in our department, the pulmonary clinic, have tuberculosis and arrive to us in very poor condition. They are wasted to the point of cachexia. When we see a migrant patient, we are sure he has tuberculosis”.

(HP)

Although health-care services in FRCs/detention centres at the moment are the responsibility of the Ministry of Public Order and Citizen Protection, health-care professionals believe the MoH to be the institution responsible for health-care services and related expenditures for migrants

¹²⁵ The Anti-tuberculosis Division of the Hospital Sotiria informed us that they have informational leaflets on TB in different languages, see more at: www.tbcenter.gr/english-2/

Law enforcement officers acknowledged that undocumented migrants should have access to asylum procedures and entitlement to health care, but that because of their high numbers in the country, this is not possible.

"The problem is that there are too many of them and it is therefore impossible to look at each case individually. I'm sure many of the people here should get asylum, but when you have 100-200 entering from the border every day, how can you handle it? Most people do want to leave. Go to other countries. But you cannot open the door for them and tell them "bon voyage." Unfortunately, they must endure this situation here".

(LEO)

The **DUBLIN III regulation** is uniformly considered to be unfair for both migrants and the receiving country.

"All Europe has to share the responsibility. Many of the migrants anyways go to Western Europe illegally. Not all countries apply Dublin II for people coming from Greece because it's known they are coming from Greece".

(CSO)

Interviewed law enforcement officers, although they were not aware of the law, stated that migrants held in detention have as much right to health care as anyone else. According to them, migrants even have priority in access to hospital services, because they are under police escort.

"They have the right to health just like everybody else. Speaking from my own experience, anytime we escorted someone to the hospital, he had the same treatment Greeks have, sometimes even better because as inmates they had priority".

(LEO)

"I do not know much about migrant health policies. I know that in our area they do not have to pay and that all migrants are admitted in emergencies, but anyone uninsured, Greek or migrant will have to pay for the overall medical expenses."

(HP)

All interviewed social workers and psychologists agree that migrants have a **right to health**. Social workers in hospitals suggest that migrants should have unlimited access to health-care services, their legal status notwithstanding. However, the majority of social workers and/or psychologists are not aware of the conventions and/or EU legislation related to migrants' rights to health. Most interviewed HPs, law enforcement officers, and social workers are not familiar with the **European and/or national legislation** on the right to health, and are unable to make any specific suggestions and/or describe contradictions between the international, national, and regional legislations. For the same reasons, it is difficult for most of respondents to identify gaps in the policy and legal framework related to the reception process of migrants. The vast majority believes that migrants' health is an absolute responsibility of the MoH. At the same time, all respondents agree that the current economic crisis has negatively affected the policy and the legal framework regarding migrants, and especially their access to health care.

"I believe that the financial crisis has led policymakers to deal with migration as if it is of minor importance. In my opinion they are not interested because they are just third country nationals. They say 'their countries have to take care of them, we have enough problems we do not need more'.

They see it as a problem. I have heard things in stakeholders meetings that made me so angry...”
(CSO)

“The crisis has affected everyone. Especially those people (migrants) who are the last in line. It has clearly played a role in how we work now, what we can offer to them”. (LEO)

The interviewed doctors and nurses (working in the NHS or for NGOs) claim that no information exists for health workers on **IHR, EWRS**, or the new draft legislation on serious cross border health threats. They had never received any training related to IHR/EWRS and/or crisis management. Despite the absence of capacity building on management of emergencies according to IHR or through EWRS, interviewees stated they knew of their legal obligation to report cases of infectious disease to the HCDCP. On the other hand, programmes related to infectious diseases do not always take in consideration migrant health.

Training needs

Most health professionals and law enforcement officers have not received special training on emergencies, migrant health, public health, or legal issues regarding human rights or migration issues, yet they express desire to learn and be trained in a participative way.

“The biggest problem of all is funding. Not just for infrastructures but also for training. We need education. Education for everybody here - we need to know exactly what we can and should do”.
(LEO)

NGO professionals are, on the whole, better trained in migration and intercultural issues than NHS employees. However, most of the training seminars and various courses take place in Athens, and so workers in other regions generally expressed an interest in having more opportunities for continuing education and training in their own regions.

“We are unable to attend training outside of the island. I have attended seminars as a student in Italy because I was interested in the subject of migration and of course what has been done in Lesvos, by UNHCR, Amnesty International etc. But we need more specific training here, to find the solutions where the problem is”.
(CSO)

“Concerning our education, it is all about cost. We cannot go somewhere else, outside of the hospital to be trained in migration issues. If something is to happen is better to be here”.
(HP)

IV.IV Discussion Section – IV

Provision of appropriate health services

Every centre should employ at least one qualified general medical practitioner. There needs to be an immediate referral system in place for emergency cases. Dental services should be available on request for detention centres. Good practices implemented in some centres (i.e. collaboration with local dental associations, etc.) should be considered and implemented. Doctors should be required to perform follow-ups, always with the patient’s consent. Migrants in detention should have access to their medical files and doctor-patient confidentiality should be respected.

Living conditions in detention centres

Most of the detention centres we visited had problems with heating and hot water, and the detainees complained about insufficient amount and poor quality of food, lack of soap and other hygiene products, as well as insufficient clothing, shoes, and blankets. While there have been many reports of severe overcrowding in the past, at the time of the visit, the situation in the detention facilities seemed to have improved, with the notable exception of the Fylakio detention centre. Commonly reported problems include lack of ventilation, limited sanitation, extreme room temperatures, and poor hygiene. Inadequate access to functioning latrines was cited especially in Fylakio Detention Centre, with dozens or even hundreds of detainees having to share a single toilet with no privacy. Detention in unsuitable places such as police and border guard stations should end immediately, as should prolonged and unjustified detentions. If administrative detention is inevitable, migrants must not be held in overcrowded places in inhumane and degrading conditions. Detainees should have access to legal help and the option to challenge their detention in court. Unaccompanied minors or children separated from their families should not be kept in regular detention centres until their referral to adequate centres for accommodation of children, but instead need to be housed in more appropriate facilities, such as short term centres for families and children.

Occupational health of staff

Both psycho-emotional and physical stress should be addressed. All interviewees in public hospitals referred to feelings of insecurity for the future because of the financial crisis. They also felt stress related symptoms (psychosomatic) and burnout. Detention centre employees experience elevated job stress and stress-related health concerns. Some of them were particularly worried about hygiene and the possibility of contracting a contagious disease from the detainees. They all referred to physical weakening as a result of exposure to constant stress and excessive job demands. However, any such observations are based on anecdotal information as there are no studies on this topic in Greece. Law enforcement officers feel they are at a high risk of physical injury as well. In terms of health promotion and prevention programmes, interviewees from different institutions informed us they were not aware of any extra vaccination programmes (for Hepatitis B or others) offered as part of their occupational health care package plan besides the obligatory vaccines in the national health programme. At the same time, FRC interlocutors told us that additional vaccination is available for free if and when requested through local public health-care centres. HCDCP advised that there is a national programme for vaccination of health workers in every hospital in Greece. NGO staff was mostly disappointed by the overall situation regarding migrant health, and they were also facing anxiety and distress because their work depends on EU funding, leading to increased job insecurity and a volatile work atmosphere, job satisfaction, and motivation.

Training opportunities and needs

Psychological support for staff working with migrants is urgently needed. A comprehensive training programme would also have a positive spillover effect on migrants' health and wellbeing. Though most of the staff working with migrants possessed the necessary professional skills to effectively carry out their tasks, based on their extensive exposure to high migration inflow, health-care professionals and law enforcement officers expressed their need for more training on topics such as intercultural competencies, foreign languages, first aid, infection diseases, human rights, safety and security in the work place. In addition, they would like to be trained on global migration patterns, public health implications of migration, as well as self-protection and occupational health issues, sensitization to physical and mental health issues of vulnerable persons, such as victims of human trafficking, smuggled migrants, and unaccompanied minors.

5. CONCLUSIONS AND RECOMMENDATIONS

V.I Conclusions

Mindful of the sovereign rights and national security concerns which accompany our actions, the International Organization for Migration (IOM) feels it is the collective responsibility of states, institutions, and organizations alike to respond to the challenges about migration and health as described in this report in a humane, effective, and sustainable way. The first priority is to save lives and uphold human rights, including the right to health.¹²⁶ Second, cooperation and dialogue within the EU and with migrants' countries of origin and transit is essential. Because some EU countries are undoubtedly under heavy pressure due to the large number of arrivals and asylum requests they receive, the concept of 'responsibility sharing' needs to move from idea to action at all levels of international cooperation. Family reunification, adequate integration measures, relocation within the EU, and resettlement from third countries are efficient means to share responsibility and provide safe avenues for those seeking international protection within the EU.

Recent history of Greece as a reception country combined with increased migration flows and economic crisis possibly explain much of the current Greek difficulties related to the situation of migrants. There have been improvements in the government's efforts to manage irregular migration, including the development of a new reception system, as well as the steps taken to streamline and shorten the asylum application process. Still, many challenges remain, especially in relation to provision of health care and social services. The system as it is now promotes a separation of health care for undocumented migrants from that for the rest of the population. Although this has offered a temporary solution, efforts should be focused on giving the national health-care system the human and material resources to provide services that meet the current and future needs of both groups in an equal and equitable manner.

Greece undoubtedly faces challenges in managing the continuing migrant arrivals. While in theory irregular migrants are transferred from police/border guard stations to specialised detention facilities within a few days after being arrested, detention facilities are often operating at or beyond full capacity, resulting in many migrants being held in police/border guard stations for extended periods of time. There is lack of continuity in health care in FRCs and detention centres, and some provided services are entirely EU funding dependent. Existing medical/nursing staffing levels are inadequate, and syndromic surveillance protocols are not in place either in detention centres or in FRCs. Diseases that cause severe morbidity (e.g. tuberculosis), diseases that might cause epidemics, and deaths from unexplained causes should be subjected to more thorough surveillance. Health-care workers in each centre should be responsible for applying surveillance protocols and daily reporting of suspicious cases, in addition to administering vaccinations to residents.

Living conditions within the specialised centres are generally unacceptable. The assessment team noted poor detention conditions and the failure of the Greek authorities to address known deficiencies in the facilities housing undocumented migrants. The Greek Government filed a report to the Committee of Ministers (23/11/2012), stressing that contracts had been signed with cleaning companies, physicians, psychologists, interpreters, and social workers. According to observations and discussions with stakeholders, planned reforms remain weakly implemented in practice, hampered by budgetary cuts and deficient administration of available funds.

¹²⁶ International Migration, Health and Human Rights, IOM/WHO/OHCHR; http://publications.iom.int/bookstore/index.php?main_page=popup_image&plD=976&zenid=8igbf19ipge04pmj5ne28ij9c6

Findings from the assessment have shown degrading physical and mental health of migrants due to the long duration of reception process. Long stays in the centres, most often much longer than the maximum permitted under the law, and severe overcrowding conditions are just some of the main causes of the worsening migrant health and consequent increase in health-care needs.

V.II Recommendations

Our recommendations based on the assessment carried out in Greece at the end of 2013, and were further revised during National Consultative Committee (NCC) meeting in Greece in November 2014, are as follows:

I. Policy and Legal Framework

EU level

- In line with the EP resolution in response to the Mediterranean Sea tragedies,¹²⁷ expand and promote existing EU legislation and procedures allowing safe entry into the EU.
- Develop common and concerted EU operational responses for addressing root causes of forced and irregular migration.
- Dublin Regulation was devised to prevent ‘asylum shopping’, however it has increased the pressure on border Member States, as well as led migrants to remain in irregular status while trying to reach the country of actual destination where they intend to apply for asylum. Discuss/address burden sharing among EU MS, including the cost of health-care provision to migrants, covering not only the initial phase of application processing, but all the way to resettlement.
- Reception conditions and procedures should fully respect migrants’ dignity and fundamental rights. To complement the Council Directive 2003/9/EC on Minimum standards on the reception of applicants for asylum in Member States, it is recommended to develop more specific indications as to provisions of health care and minimum standards (such as type and number of personnel required and ratio of medical staff to migrants) to be applied during the reception process.
- Develop specific EU Guidelines, taking into consideration the best interests of children, ensuring prompt access to a fair and timely asylum procedure. As indicated by the previous EC Commissioner for Home Affairs Cecilia Malmström: "the rights of the child must always come first. We need clearer and more predictable EU asylum rules for unaccompanied minors."
- Align procedures and protocols for assessment of vulnerabilities and timely provision of protection of vulnerable groups.

National level

- Ensure compliance with National, European, and International legislation on the right to health.

¹²⁷ European Parliament resolution on migratory flows in the Mediterranean, with particular attention to the tragic events off Lampedusa (B7-0476/2013).

- Ensure appropriate vulnerability screening and referral for treatment of vulnerable groups (disabled, elderly persons, pregnant women, single parents, victims of torture, rape, or other forms of violence) within the legal framework. The responsibility to identify and refer to relevant authorities potential vulnerable people early in the reception process and/or held in detention should be delegated to one specific, qualified, and unbiased actor.
- Develop a comprehensive approach as to age assessment of UAMs, taking under advisement social, psychological, and educational aspects in the assessment.
- Increase the capacity and establish new open centres/centres for unaccompanied minors and other vulnerable groups, and ensure sustainability by allocating sufficient EU funding.
- Expedite the administrative procedures required for asylum-seekers and irregular migrants and end indefinite detention.
- Detention of unaccompanied minors and other vulnerable groups, when otherwise unavoidable, should take place in dedicated and specially adapted facilities.
- Promote integration policy and measures with targeted interventions focused on migrants and national population to promote a two-way process. Examples could be language classes and cultural awareness/diversity training for the public/community.

II. Partnerships, networks and multi-country frameworks

EU level

- Promote policies that uphold migrant health by strengthening transnational/cross border networks/bilateral agreements.
- Sponsor dialogues, exchanges of practices, and effective cooperation and solidarity at regional, European, and global levels.
- Facilitate accessibility of the solidarity/social cohesion, Asylum, Migration, and Integration Fund (AMIF) funds for social and health service provision for local and regional stakeholders working in the migration field.
- Make EU funding conditional on periodic evaluation by national and international monitoring bodies, including those working for the prevention of torture and ill-treatment.

National level

- Ensure respect of human rights throughout the reception system, which has to be responsive and adaptable to migration flux/numbers based on the recognition that migration is a steady phenomenon and that hasty, emergency mode responses are best avoided.
- Integrate health policy in detention/reception with national health policy.
- Establish a structured response, involving multiple sectors and levels, during the entire reception process by developing shared/horizontal protocols outlining specific agency roles and responsibilities.

- Establish a network for the exchange of information and good practices between all structures and services working with migrants.
- Establish cooperation with the local departments of Public Health and Social Care which until now have not been involved in issues concerning migrants.
- Encourage cooperation with private doctors such as dentists and dermatologists, so that regular check-ups of the migrant population living in detention centres can be done in a timely and professional manner.
- Work with local communities where there are plans for new migrant reception centres by providing information and discussing/assuaging possible fears and resentment towards migrants.
- Promote a constructive discourse and reporting on migration and public health as important in fostering social integration, while at the same time addressing misperceptions in the community. Malpractices and miscommunication lead to fears of infection epidemics both among local authorities and the public. In this respect, the socially responsible collaboration with the media is crucial, as is promoting the positive contribution that migrants make to the community.

III. Monitoring migrant health

- Implement guidelines for border management, detention, and reception centres with special emphasis on securing a positive public health perspective.
- Develop a systematic and comprehensive health assessment, data collection (for communicable and non-communicable diseases), and referral mechanism.
- Ensure continuity of health care.
- Include psycho-social support for migrants in detention and reception settings.
- Promote disaggregated data based on migrants' status to anticipate needs and analyse health-care service utilization outside centres.
- Provide migrants with access to their medical histories and files.
- Appropriate share of health-related data locally, nationally, and at EU level. This would mean setting up an information system able to better encourage a more global take on responsibility and a better continuity of migrant health care.

IV. Migrant-sensitive health system

- Reinforce the health and social support systems, including interpretation, cultural mediation, and psychosocial assistance by adequately trained staff throughout the reception process (in the centres and also within the national health system). It is strongly advised to develop

standardized procedures in order to guarantee the presence of competent/fully trained interpreters and cultural mediators during all the phases of the reception system.

- Ensure humane treatment and conditions in reception facilities (both short-term and long term) in line with international, CoE, and EU recommendations. Alternatives to detention should be sought.
- Provide information to migrants about their entitlements to health care according to their legal status, at all stages of the reception process and beyond.
- Improve living conditions and foster migrants' subsequent integration in the community; promote low or no cost activities: washing machines, sport facilities, visits of friends and family, sport activities, cultural activities, training courses, media in multiple languages, Wi-Fi.
- Continuous training for health-care professionals, law enforcement officers, and coast guard officers on the broad range of topics identified by respondents - inter-cultural competencies, foreign languages, first aid, tropical diseases, human rights, safety and security in the work place, etc.
- Special attention should be paid to occupational health of staff, including topics such as vaccinations, information on possible risks at work, self-protection measures, and hygiene measures.
- Psychological support for detention and processing centre staff should be given high priority.
- Professionals working with migrants should be provided with organizational support on the part of institutions as much as on the part of their supervisors.
- In the community: foster effective provision of quality health care to irregular migrants (especially women, children, and unaccompanied minors), facilitated by interpreters and cultural mediators.

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ANNEXES

ANNEX I. Open/closed centre checklist



1 a. Name of the centre:	Fylakio	Moria	Xanthi
b. Type of centre (short term, long term, open, etc.)	Detention centre for migrants, long term	Temporary Screening Centre	Detention centre, long term
c. Under whose authority is the centre?	Ministry of Citizen Protection	Ministry of Civil protection, Police	Ministry of Public Order and Citizen Protection
d. Under whose management is the centre?	Papagregoriou Superintendent George V.	Papazoglou Konstantinos FRMU acting Head	Konstantinos Hatzistamatis, Police Major
e. Type of the staff	Police and civilian staff	Police and civilian staff	Police and civilian staff (1 administrator, 1 cleaning lady)
2. Total number of employees at the centre:	50	11 persons from police, 9 from First Reception Mobile Unit (2 from UNHCR, 4 from Metadrasi, 2 from FRS, 5 MdM), 3 from Asylum Department	150
3. Short description of the centre's environment:	20 km from Orestiada, 1 km from the village Fylakio, 35 km from the Greek/Turkish border and 15 km from the Greek/Bulgarian border.	Outdoor space, 1 km from village Moria and 6 km from Mytilini town	2 km from Xanthi
4. How many stayed in the centre last year?	No data available	The centre opened on the 25 of September 2013	Approximately 1,225 people

5. What is the average time spent at the centre?	18 months	10 days	8 months
6. What is the maximum time that a migrant can spend at the centre?	18 months	1 month	15 months
7. What is the maximum capacity of the site?	374	98	480
8. What measures are taken when the available premises are insufficient?	They are referred to other centres	There was not such case	Not happened yet. The transfers are made after consultation so they have never being overcrowded.
9 Is any pre-screening done for identification of most vulnerable groups of migrants before admission to the centre?	No	Yes	Yes before entering the centre. If someone declares to be a minor or that belongs to another vulnerable group we deal with this case individually.
a. Who is responsible for this pre-screening of migrants?		The port authorities	
b. What is the training of people doing the pre-screening?			
10. Are then migrants separated by:			
a. Gender?	Yes	Yes	There are only men
b. Family status?	No	Yes	Yes
c. Age? (Unaccompanied minors from adults)	Minors are referred to special centres ¹²⁸	FRMU is responsible for id vulnerable persons. Once they identify someone as a minor they refer him/her to EKKA to be placed to a special centre for UAMs	Yes
d. Vulnerability? (i.e. pregnant, elderly, etc.)	No	Yes	No
e. Nationality?	No	Yes	No
f. Religion?	No	No	No
g. Healthy and ill?	Yes, there is a recovery room	No, ill people stay at the sanitarium if needed but they are not in quarantine	No
h. Suspected contagious and non-contagious persons?	Yes, there is a recovery room		No, there is no recovery room at the centre. All health issues are being handled to the hospital.

¹²⁸ The team visiting facilities observed minors d hosted in Fylakio Detention centre.

ANNEX II. Institutions contacted during the field visit (alphabetical order)

AGALIA

Charity of Mytilene founded in 2009 which provides food and clothing to migrants.

THE “AGHIA SOPHIA” CHILDREN’S HOSPITAL

Founded in 1896 and became operational in 1901. With seven hundred and fifty (750) beds, it is the largest children’s hospital in Greece and one of the largest children’s hospitals in Europe. It welcomes children up to the age of 14 and older children under special circumstances.

The Hospital has a department for every medical specialty, both in pathology and surgery fields. There are one hundred and ten (110) intensive care beds for children and newborns as well as specialised departments, including the Bone Marrow Transplant Unit, the Haematology and Oncology Departments, the Paediatric Cardiology Department, the Haemodynamic Laboratory, the Pediatric Cardiac Surgery Departments and the Neuromuscular Disorders Unit. There is also a range of laboratories, some of which are unique and highly specialized. Within the Hospital premises the Institute for Child Health also operates.

ARSIS NGO

ARSIS – Association for the Social Support of Youth is a Non-Governmental Organization, specializing in the social support of youth that are in difficulty or danger and in the advocacy of their rights. ARSIS was established in 1992 and since then it operates in Athens, Thessaloniki, Volos, Alexandroupoli, Kozani and Tirana. ARSIS offers its services to young individuals who live under conditions of poverty, neglect, victimization, conflict, disapproval, exploitation, isolation, racism or they are having problems with the law, they are institutionalized, have dropped out of school, they don’t have family or a place to live. It provides services such as psycho-social support, preparation for employment, legal support, educational support, temporary housing and food services for young people without home or in major difficulty, social and recreational mobilisation. ARSIS operates a shelter for unaccompanied migrant minors in Alexandroupoli. (www.arsis.gr)

GENERAL HOSPITAL FOR CHEST DISEASES “SOTIRIA”. TBC CLINIC /OUTPATIENT CLINIC

One clinic out of the 12 pulmonological departments of the 800 bed general public teaching hospital which also has two pathology departments, two surgery departments, a psychiatric clinic, a department for allergies and two thoracic surgery departments. The hospital is on duty every day. The hospital was founded on 1902 in order to fight tuberculosis. The TB clinic takes care of 4–5,000 TB patients per year. There is also an MDR TB department (8 beds). In the department work 3 doctors.

ILIAKTIDA

“Iliaktida” is a non-profit organization, which was created because of the needs of the local community of Mytilene-Lesvos, with the aim of obviating social exclusion through labour employment, and individualized counselling of people with disabilities and vulnerable groups. “Iliaktida” and other local NGOs are united in an alliance called “The village altogether” trying to help migrants. They provide food and clothes “The village altogether” runs a shelter (open centre) using a building of the municipality of Mytilene. (www.iliaktida-amea.gr)

MEDECINS DU MONDE (MdM)

MdM - Greece was established in 1990 and they constitute a Greek Organisation which follows its own path based to the particularities of Greece, maintaining its economic and administrative

independence. At the same time, however, they remain part of the International Net of MdM. Doctors, sanitary personnel, administrative staff and logisticians offer their services voluntarily.

MdM - Greece, maintaining their autonomy, both operational and financial, organise, staff and finance missions through the Greek department. MdM is responsible for providing medical and psychosocial assistance in the Temporary Screening Centre in Lesbos as part of the First Reception Mobile Unit. (www.mdmgreece.gr)

MEDECINS SANS FRONTIERES (MSF)

Doctors without Borders/Médecins Sans Frontières (MSF) is an international medical humanitarian organization created by doctors and journalists in France in 1971. MSF provides independent, impartial assistance in more than 60 countries to people whose survival is threatened by violence, neglect, or catastrophe, primarily due to armed conflict, epidemics, and malnutrition, exclusion from health care or natural disasters. MSF provides independent, impartial assistance to those most in need. MSF also reserves the right to speak out to bring attention to neglected crises, challenge inadequacies or abuse of the aid system, and to advocate for improved medical treatments and protocols. MSF provides medical assistance and psychosocial support in different detention Centres (e.g. Detention Centre in Fylakion Evros). (www.msf.gr)

MEDICAL INTERVENTION

Medical Intervention is a Greek medical relief organization founded in Athens on 8 March 2004 and is an NGO. The goal of medical intervention is to assist populations in crisis abroad and within the country and the implementation of effective programmes for every socially excluded group.

Medical Intervention is responsible for providing medical assistance and psychosocial support in FRC in Fylakion Evros and in Detention Centre in Amygdaleza. (www.medin.gr)

METADRASI

Non-Governmental Organization “METAction” was founded in December 2009, primarily, in order to promote a rational system of managing migration flows with respect for human rights, and international and national legislation, for the development of actions concerning the reception and integration of migrants and refugees in Greece, as well as actions for their voluntary return and reintegration in their countries of origin.

The METAdrasi has been active since 2010 in training interpreters adopting a system of evaluation and certification which aims at efficient and more accurate interpretation. The interpreters provide interpretation either physically (in places outside of Athens are dispatched interpreters) or remotely via teleconference system to Competent Authorities Asylum (Police Divisions and Sub-Divisions and Secondary Appeals Committees), international and European organizations, to NGOs, to government and non-government agencies and hospitals in the following languages and dialects: English, Albanian, Amharic, Arabic, Aramaic, Vervineia, French (French - Creole), Georgian, Spanish, Chinese, Kinyarwanda, Kurdish (Kermentzi, Sorana, Bandini), Lingala, Moldavian, Bengali, Dari, Ukrainian, Urdu, Punjabi, Salted, Russian, Sinhala, Somali, Swahili, Turkish, Farsi, Hindi. Metadrasi provides its services in Detention and First Receipt centres (Amygdaleza, Lesbos, Evros). (www.metadrasi.org)

PRAKSIS

PRAKSIS is an independent NGO, which has as its main goal the creation, application and implementation of humanitarian and medical action. PRAKSIS, activates all across Greece and especially in the two major urban centres of Athens and Thessaloniki, the island of Lesbos and in the

area of Patras. Simultaneously, volunteers of PRAKSIS are located and activated in different parts of Greece.

The Programmes of PRAKSIS, based on the two polyclinics in Athens and Thessaloniki, offer direct and free medical and pharmaceutical health care, psychological support, social support (related support services), legal assistance, housing and employment counseling in every socially excluded group such as: street children, economic migrants, asylum-seekers/refugees, homeless people, drug users, gypsies, victims of trafficking, ex-prisoners, people who have no access to public health services, social or legal support. (www.praksis.gr)

SMA, SOCIETY FOR THE CARE OF MINORS

The Institution was established in 1924 with the name "Protection of women and children in detention". It was an initiative of the National Council of Greek Women, with the first major donor being Emmanuel Benakis. In 1972 the Association changed its name to the current "Society for the Care of Minors" while accordingly adjusting its purpose and services provided. Over time the work and activities of the Society have been adjusted in order to meet specific social needs with specialized, up-to-date and quality services which respect human rights and provide a family type environment. To date over 2,500 young people of different nationalities and social needs have passed through the centre.

VOSTANEION GENERAL HOSPITAL OF MYTILENE, LESVOS

The hospital was first founded in 1692 while the one in 1858. It has 250 beds and departments for most medical specialties in pathology and surgery fields including a psychiatric department.

THE UNIVERSITY GENERAL HOSPITAL OF ALEXANDROUPOLIS was first founded in 1939 and transferred in December 2002 in Dragana area, 6 km from the city of Alexandroupolis. With 673 beds is the largest hospital of the area. The hospital has departments form every medical specialty in pathology and surgery fields.

The university pathology department serves more than 1,000 patients per year. The clinic visited by the researchers has a staff of 15 doctors including those under training.

Monitoring Migrant Health	Policy and Legal Frameworks
<p>Assess with multi-stakeholder perspective how health of migrants is determined from the borders onwards; the accessibility to health and support services; the quality of care and of data collection analysis, storage and dissemination; health status perception and knowledge of the epidemiological situation.</p> <p>The IOM assessment focuses as well on routine information gathered from the borders on data collection, processing, analysis, dissemination, storage.</p>	<p>Information collected under this section is related to policies, laws and legal frameworks concerning health rights of migrants, taking into consideration how they are implemented, monitored and evaluated. A special focus is also devoted to division of responsibilities and roles as well as financing aspects.</p> <p>Assess the adoption and implementation of relevant international standards and policies on the protection of migrants and the right to health in national law and practice, the development and implementation of national health policies that incorporate a public health approach to the health of migrants and promote equal access to health services for migrants, regardless of their status.</p>
Migrant-sensitive health systems	Partnerships, networks and multi-country frameworks
<p>Assess existing health and support services preparedness for diversity, human resources, infrastructures including physical and living conditions, hygiene and safety, referral institutions; and occupational health of staff working at the borders and in open/closed centres, including health concerns, work conditions, perceived health risks, health knowledge, attitude and practices.</p> <p>Also, the information collected under this section aims at understanding the quality of health services provided to migrants and collect information inter alia, in the migrant sensitive health system component (routinely available medicines, equipment, vaccines, PEP kits, etc., as well as PPE).</p> <p>Workforce issues are included in several components of the IOM assessment (types and numbers, preparedness of staff). The IOM focus is on personnel working from the borders on and in related communities/settings with specific focus on cultural competency and also on their occupational health.</p>	<p>Information collected under this section looks at partnership in the area of migration and health among various stakeholders.</p> <p>The IOM assessment focuses on institutional cooperation between actors involved in the migration management process in the country, with special focus on the referral mechanisms in place, personnel management, partnerships, network and multi-country framework, exchange of good practices.</p> <p>Links to EWR, IHR as well as information of critical events, incl. emergency situations and issues of public health concern, public health promotion and prevention campaigns are also included.</p>

Source: IOM Equi-Health.