

Malta: assessing health-system capacity to manage sudden, large influxes of migrants



Joint report on a mission of the Ministry for Energy and Health of Malta, the International Centre for Migration, Health and Development and the WHO Regional Office for Europe

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Abstract

The area of migration and health is one of the topics to which the WHO European health policy framework – Health 2020 – has drawn particular attention, along with other issues related to population vulnerability and human rights. Health 2020 provides a comprehensive framework, as well as values and approaches to action that are much needed in public health work in the field of migration and health. Thousands of migrants have arrived on Maltese shores, posing new challenges to the preparedness of the country's health system to manage a potential large influx of displaced populations and inspiring investment in emergency management and effective multisectoral coordination mechanisms. With this in mind, an assessment of Malta's health-system capacity to manage large influxes of migrants was jointly conducted by the country's Ministry for Energy and Health and WHO. Assessment activities were conducted within the framework of WHO's Public Health Aspects of Migration in Europe project, which supports the ongoing work of the WHO European Region to strengthen national and local capacities of Member States in order to address migrants' health needs, with a focus on public health. This report highlights the current Maltese capacity to manage this issue and suggests possible ways forward.

Keywords

DELIVERY OF HEALTH CARE - organization and administration
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Abbreviations

AFM	Armed Forces of Malta
AWAS	Agency for the Welfare of Asylum Seekers
BCP	border crossing points
CDC	United States Centers for Disease Control and Prevention
CPD	Civil Protection Department
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
DTaP-IPV-Hib	diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type b (vaccine)
dT-IPV	diphtheria, tetanus and inactivated poliomyelitis (vaccine)
ECDC	European Centre for Disease Prevention and Control
EU	European Union
EuroSur	European Border Surveillance System
Frontex	European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union
IAMSAR	International Aeronautical and Maritime Search and Rescue
IDCU	Infectious Disease Prevention and Control Unit
IHR	International Health Regulations
IMO	International Maritime Organization
ICMHD	International Centre for Migration, Health and Development
JRS	Jesuit Refugee Service
GP	general practitioner
MHAS	Ministry for Home Affairs and National Security
MIPEX	Migrant Integration Policy Index
MMR	measles, mumps and rubella
NGO	nongovernmental organization
PHAME	Public Health Aspects of Migration in Europe
PHC	primary health care
RCC	Rescue Co-ordination Centre
SAG	Special Assignment Group
SAR	search and rescue
SWOT	strengths, weaknesses, opportunities, threats
TB	tuberculosis
TESSy	The European Surveillance System
WGAD	United Nations Working Group on Arbitrary Detention

Executive summary

World Health Assembly resolution WHA61.17 on the health of migrants, approved in May 2008 – among other issues – requested the WHO Director-General to analyse the major challenges to health associated with migration and to explore policy options and approaches for improving the health of migrants.

To address these requests, the WHO Regional Office for Europe – through its European Office for Investment for Health and Development in Venice, Italy – manages the Public Health Aspects of Migration in Europe project. Within the framework of the project and because sudden, large influxes of migrants are taking place repeatedly in several countries of the WHO European Region, the WHO Regional Office for Europe developed a toolkit for assessing local health-system capacity to manage sudden, large influxes of migrants.

The toolkit was developed in collaboration with the International Centre for Migration, Health and Development, through a consultative process involving experts from various European countries during the first half of 2013. Malta was the third country to be assessed using the toolkit, after Italy and Portugal.

The mission took place on 25–29 November 2013 and the assessment team consisted of an expert from the European Centre for Disease Prevention and Control; one from the United States Centers for Disease Control and Prevention; one from the International Centre for Migration, Health and Development; one temporary WHO Migration Health Adviser, seconded by the Portuguese Ministry of Health and; and three WHO Regional Office for Europe experts.

In 2002 Malta started to become a recipient country for migrants from sub-Saharan Africa, particularly from Somalia. Although sudden, large influxes of irregular migrants had never happened previously, Malta is exposed to this type of migration event because of its geographical position and its vast search and rescue region of responsibility, which spans from Tunisia to Greece.

Undocumented migrants entering Maltese national territory are subject to administrative (as opposed to criminal) detention. However, the freedom of vulnerable individuals is restricted only until such time as the requisite medical clearance is obtained.

Emergency management structures are in place and are efficiently managed by high-profile professionals. However, there is little room to enlarge the present capacity to absorb any increase in workload, as a result of the very high bed occupancy rates in hospitals and the lack of available health workforce in Malta.

Owing to its innate limitations (in particular its small size), Malta may find difficulty in responding and sustaining a response to a sudden, large influx of migrants, and will probably require international assistance in the event that such an influx takes place. Furthermore, the situation would be worse if the general health of the arriving migrant population was poor, putting added strain on Malta's health system. The country has only limited capacity to deal with category IV and VI infectious diseases and, with the increasing number of undocumented migrants arriving to Malta's shores from various African regions, such a risk cannot be ruled out.

WHO can be instrumental in supporting the national health authorities to set up effective, sustainable and equitable mechanisms of preparedness and response to influxes of migrants and in advocating for the health rights of migrants arriving in Malta.

Introduction

The Republic of Malta is composed of a number of islands, the largest of which is Malta (followed by Gozo, Comino, and a number of smaller, uninhabited islets). The islands – located in the Mediterranean Sea, 80 km south of Sicily and 333 km north of Libya – have a population of around 450 000 people and a total area of 316 km², representing the highest population density among European Union (EU) countries. Malta became independent from the United Kingdom in 1964 and a republic in 1974, subsequently joining the EU in 2004.

In 2002 Malta started to become a recipient country for thousands of migrants from sub-Saharan Africa, particularly from Somalia. A significant factor influencing this dynamic is the increase in security at certain gateways to Europe that are generally utilized by migrants – specifically the border between Morocco and Spain to the west and the borders between Greece and its neighbouring countries to the east – which have resulted in migrants' routes being concentrated toward the centre of the Mediterranean region, and hence encouraging them to travel by sea, rather than land.

From 2002 to June 2013, 16 974 migrants arrived in Malta by sea, reaching a peak in 2008 of 2775 migrants arriving in 84 boats. In the first six months of 2013, 310 migrants landed on Malta, which seems to be an accidental destination for migrants departing by boat from the north African coast; the majority of these are believed to have been headed for Italy and have been intercepted en route. Accidental or not, considered in terms of its population, Malta proportionally receives the highest number of asylum applications in the world.

In addition, during the Libyan turmoil in 2011, Malta was faced with a large influx of almost 21 000 foreign workers that had been evacuated from Tunisia and Libya to Malta, in transit to their native countries.

The migration phenomenon is relatively new in Malta. This partially explains why the country – according to the Migrant Integration Policy Index (MIPEX)¹ – is behind most countries in terms of improving integration policy, despite offering integration-oriented programmes at accommodation centres. It should be pointed out, however, that the vast majority of undocumented migrants arriving in the country did not intend to land and seek protection in Malta, with the result that many are not interested in long-term integration in Malta.

World Health Assembly resolution WHA61.17 on the health of migrants, approved in May 2008, requested the WHO Director-General to analyse the major challenges to health associated with migration and to explore policy options and approaches for improving the health of migrants.

To address these requests, the WHO Regional Office for Europe's European Office for Investment for Health and Development manages the Public Health Aspects of Migration in Europe (PHAME) project. Within the framework of the project and because sudden, large influxes of migrants are taking place repeatedly in several countries of the WHO European Region, the WHO Regional Office for Europe developed a toolkit for assessing local health-system capacity to manage sudden, large influxes of migrants.

Malta was the third country (after Italy and Portugal) to be assessed using the toolkit, which was developed in collaboration with the International Centre for Migration, Health and Development (ICMHD) through a consultative process involving experts from various European countries during the first half of 2013.

The team of assessors – comprising three WHO Regional Office for Europe experts, one expert from the European Centre for Disease Prevention and Control (ECDC) and one from the United States Centers for Disease Control and Prevention (CDC) – participated in the assessment, together with one expert from the ICMHD and one temporary WHO migration health adviser seconded by the Portuguese Ministry of Health for the mission.

In March 2011 the WHO Regional Office for Europe conducted a rapid assessment mission to Malta in the context of the then ongoing crisis in Libya. The main objectives of the mission were: to look into the preparedness of the Maltese health system to cope with the public health consequences of a potential large influx of migrants and refugees; and to provide recommendations on how to improve cooperation and preparedness efforts.

¹ MIPEX is a reference guide to assess, compare and improve integration policy in all EU Member States. The British Council and the Migration Policy Group lead the MIPEX project. More information on Malta and other countries can be found at the MIPEX website (1).

Scope of the mission

The mission's aims were to:

- complete the assessment initiated by WHO Regional Office for Europe in 2011 of the Maltese health system preparedness for a sudden, large influx of migrants; and
- continue to test the toolkit for assessing local health-system capacity to manage sudden, large influxes of migrants.

Method

On-site visits and semi-structured interviews were carried out with key government officials, managers and health staff working in migrant centres. Whenever possible, migrants hosted in migrant centres were also interviewed. The assessment toolkit and consequently the interviews were based on the WHO health systems framework, which addresses six key functions: leadership and governance; health financing; health workforce; medical products, vaccines and technology; health information; and service delivery.

Site selection

Assessment locations and key informants were selected based on being sites of migrant centres and/or locations of migrant health services and/or institutions working in emergency management.

Overall findings and recommendations

Type of emergency

Since 2002, Malta has experienced a growing influx of migrants, predominantly departing from the Libyan coast. Although in absolute terms the number of migrants arriving in Malta has been rather modest so far, the overall impact in proportional terms – given the country's small size and high population density – has been significant.

Sudden, large influxes of migrants have been experienced previously in Malta.² However, the current situation is characterized by sporadic landings of tens (and occasionally hundreds) of migrants; this trend increases during the summer season and can usually be managed without declaring a state of national emergency. Notwithstanding, for Malta such arrivals are by no means insignificant. In fact, when considered in a per capita context, undocumented migration imposes a significant burden on Malta.

Owing to its geographical position and its huge search and rescue (SAR) region of responsibility (spanning from Tunisia to Greece), Malta is exposed to new influxes of migrants triggered by various political, social or economic events.

Public health risk assessment

The health risks of migrants stem from the health setting in the native country and the health conditions during their journey and settlement period. Such health risks are mostly related to unsafe travel arrangements, overcrowded conditions, and cultural barriers.

Vaccine-preventable diseases represent a health risk in people coming from countries in which immunization coverage is low. In addition, infectious diseases that are currently common in countries from which migrants originate pose a potential threat to population health in Malta.

Long and unsafe journeys in overcrowded boats expose migrants to physical and psychological trauma, risk of drowning, dehydration, unassisted childbirth, hypothermia, and infectious diseases.

Overcrowding in migrant centres can facilitate the transmission of various infectious diseases, including acute respiratory infections and diarrhoeal diseases. Crowded living conditions can also aid the transmission of HIV/AIDS, tuberculosis (TB) and skin infections, such as scabies.

² During the Libyan crisis in 2011, a large-scale evacuation plan was implemented to welcome and organize the departure of 21 000 foreign workers in transit from Libya to their native countries.

Although the majority of migrants are young people who are generally in good health at the moment of departure, some migrants are affected by chronic diseases and need continuity of care. The absence or interruption of treatment for chronic diseases could be life-threatening and represent a health risk.

The detention period in immigration centres can adversely affect the mental health of some people; however, it should be noted that vulnerable individuals are not detained between being visited for assessment and the outcome of the assessment.

Health risks are high in vulnerable groups of migrants, such as pregnant women and very young children. Staff working with migrants can be exposed to specific occupational health risks (2).

The general public may be impacted by specific infectious diseases if they are not identified prior to the migrants being discharged from detention centres (Fig. 1).

Fig. 1. Detention centre, Malta



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Leadership and governance

Findings

At global level, Malta is signatory to the United Nations Geneva Convention relating to the Status of Refugees of 1951 (entry into force in 1954), as well as the European Charter of Fundamental Rights of the European Union of 2000. Malta is not a State Party to the 1954 United Nations Convention relating to the Status of Stateless Persons, nor to the 1961 Convention on the Reduction of Statelessness (3).

At regional level the EU Asylum Acquis (4) sets out a number of important provisions on the reception and housing of asylum seekers and people enjoying international protection. It is important to note that these take the form of European Council directives, meaning that Member States of the EU, unless specifically exempted

from so doing, are bound to ensure that national legislation incorporates the requirements of the EU Asylum Acquis.

On 22 October 2013, the EU adopted Decision No. 1082/2013/EU (entry into force on 6 November 2013) on serious cross-border threats to health, with the aim of improving preparedness across the EU and strengthening capacity to coordinate response to health emergencies (5).

In addition, the EU adopted the regulation on the European Border Surveillance System (EuroSur) in October 2013. The aim of EuroSur is to reinforce the control of the Schengen external borders. EuroSur establishes a mechanism for Member States' authorities carrying out border surveillance activities to share operational information and cooperate with each other and with the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union (Frontex) in order to reduce the loss of lives at sea and the number of undocumented migrants entering the EU undetected, and to increase internal security by preventing cross-border crimes (6).

The provisions and requirements of international and European laws have largely been incorporated in the principal legal instruments of Maltese legislation related to migration; namely, the Immigration Act (Chapter 217) (7) and the Refugee Act (Chapter 420) (8) of the Laws of Malta.

Malta has almost fully implemented the requirements of the International Health Regulations (IHR), but requested an extension in 2012 to finish developing its generic emergency preparedness and response plans and strengthen capacities at designated points of entry.

Malta's size and geographical isolation present a unique set of challenges for policy-makers seeking to ensure the adequate management of migrant influxes. Consequently, the Maltese Government has repeatedly called on the EU to implement a policy of "burden sharing" to assist Europe's border countries in bearing the brunt of undocumented migration.

Migration and asylum issues are the responsibility of the Ministry for Home Affairs and National Security (MHAS). Undocumented migration and border control are managed by the Police Immigration Office (Fig. 1). The Agency for the Welfare of Asylum Seekers (AWAS) is a body of the MHAS set up in 2009 to provide accommodation and other services to asylum seekers and protected individuals (see the Institutional Framework for Immigration Asylum in Annex 1).

Fig. 2. Police Immigration Office centre for identification



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The MHAS is also responsible for the Office of the Refugee Commissioner, and the Refugee Appeals Board, which are in charge of the determination of asylum applications and appeals, respectively.

Although Malta decriminalized illegal entry to the country in 2002, the country has adopted a restrictive interpretation of the 2003 European Council Directive laying down minimum standards for the reception of asylum seekers (9). In fact, migrants and asylum seekers entering the country illegally are subject to administrative detention.³ In the event that an asylum applicant's application is still pending at the 12th month, he or she is released from detention. It should be noted that most irregular migrants enter Malta without the correct documentation, which means that their identity and nationality also need to be ascertained as part of the process.

³ Detention is defined as "[r]estriction on freedom of movement, usually through enforced confinement, of an individual by government authorities. There are two types of detention. Criminal detention, having as a purpose punishment for the committed crime; and administrative detention, guaranteeing that another administrative measure (such as deportation or expulsion) can be implemented" (10). In the majority of the countries concerned, irregular migrants are subject to administrative detention, as they have violated immigration laws and regulations, which is not considered to be a crime.

Individuals who have entered the country illegally and without applying for asylum, or whose asylum application have been definitively rejected before the 12th month, may be detained for a maximum of 18 months with a view to returning them to their country of origin. However, it should be noted that detention for the purposes of return is subject to a review after three months. If there is no reasonable chance that the person in question will be returned, they are transferred to an open detention centre or into the community. After six months of detention for the purposes of removal, the initial review by the principal immigration officer is also reviewed by the immigration appeals board. Transfer from the detention centre is carried out if there are no reasonable prospects of return. It should be mentioned that practically all undocumented immigrants entering Malta apply for international protection, and Malta has a very high asylum recognition rate. This means that approximately 80% of asylum applicants are released from detention upon securing refugee status or subsidiary protection; that is, after a period of 4–5 months in detention. Moreover, asylum seekers and irregular migrants who are considered to be vulnerable are released from detention centres once the requisite medical clearance has been obtained (see the Migrant Influx Response Plan in Annex 2).

Malta has been criticized for its policy of detainment, among others by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the United Nations Working Group on Arbitrary Detention (WGAD). In particular, the WGAD claims that the initial mandatory detention of vulnerable undocumented non-citizens is contrary to international human rights laws and the 2008 European Commission Directive dealing with returning illegally staying third-country nationals (non-EU citizens) (11), which dictate that detention in such cases should only be used as a last resort.

After the maximum detention period of 18 months, migrants must be released, regardless of the status of their application (12). The vast majority (approximately 99%) of migrants entering the country illegally apply for asylum.

Maltese policy allows for the fast-track release of vulnerable groups, including families with children, the elderly, unaccompanied minors, pregnant and breastfeeding women, and people suffering from disabilities and/or serious physical or mental illness. However, in high-pressure situations owing to the sheer number of arrivals, migrants in those categories can be detained for several days in migrant detention centres before their vulnerability is assessed.

The MHAS operates two dedicated migrant detention facilities: the closed centres at Lyster and Safi barracks. Migrants granted “vulnerable persons” status or humanitarian protection, as well as asylum seekers who have been detained for 18 months, are moved to open migrant centres. Open centres are government owned and managed directly by the AWAS or subcontracted to nongovernmental organizations (NGOs). These centres are intended to function as transit institutions from detention to community.

The Maltese health care system is highly centralized and regulated (see the Ministry for Energy and Health organigram in Annex 3). Primary health care (PHC) is provided by public health services and by private general practitioners (GPs); these two systems function independently. The private sector accounts for about two thirds of the workload in PHC. Secondary and tertiary care are provided mostly by public hospitals.

A Migrant Health Unit was set up within the Primary Health Care Department in August 2008, aiming to facilitate migrant access to health care services, train health care professionals and students in cultural diversities, and train cultural mediators on health issues.

Health care is essentially free of charge at the point of delivery for all individuals residing in Malta who are covered by the Maltese social security legislation. According to the Refugees Act of 1 October 2001 (part 3, 10(1)) (8), asylum seekers are entitled to receive state-funded medical care and services. Subsidiary legislation states that, wherever possible, asylum seekers are expected to contribute to health care costs (13); however, where this is not possible, health care is free for asylum seekers.

In terms of emergency health management, a number of different contingency plans (for example, a Pandemic Preparedness Plan and the Mater Dei Hospital Critical Event Guide) and drafts are being developed in various areas of the health sector, focusing on different threats. However, an inclusive, all-hazard health emergency preparedness and response plan is missing from Malta’s contingency planning.

In case of an emergency resulting from a sudden influx of migrants that overwhelms the capacity of ordinary services (army, police and health system), the Civil Protection Department (CPD) would be called in to provide humanitarian and logistical assistance. A number of NGOs can also be called to provide support with specialized personnel.

The CPD falls under the responsibility of the MHAS. The department forms part of a European-wide mechanism for civil protection, which was formed to ensure a common response to emergencies by all EU Member States. The CPD is responsible for the maintenance of a national system of prevention, preparedness and response to any disaster that could affect the Maltese community. However, the existing National Disaster Contingency Plan was written in 1995 and was under revision at the time of writing. Simulation exercises are regularly conducted by CPD, but their focus is mostly airplane crash scenarios.

A site has been identified for the Maltese operations centre for the CPD in the former Malta Police Corps Special Assignment Group (SAG) complex at Ta' Kandja. Unfortunately, it was not possible to visit it during the mission, owing to timing constraints.

The primary responsibility for the coordination of SAR activities lies with the Armed Forces of Malta (AFM). To this end, the AFM operate the Malta Rescue Co-ordination Centre (RCC), which is internationally recognized as the SAR point of contact in Malta.

During the evacuation of 21 000 foreign workers in 2011, an emergency interministerial coordination mechanism was set up under the responsibility of the Ministry of Foreign Affairs. According to the health needs assessment conducted by the WHO Regional Office for Europe, all the key elements to cope with the consequences of an influx of displaced population were addressed effectively in the multisectoral preparedness and response planning process set up in Malta during that event (14).

During the present mission, it was possible to receive a presentation of the details of the 2011 emergency operation, confirming the effectiveness of the system set up on that occasion. However, that coordination mechanism has since been dismantled (after the crisis) and there is only scant documentation of the experience.

In 2012 the Maltese Ministry for Energy and Health initiated the development of a national health system strategy for 2013–2020 in order to meet the many challenges facing the health system in Malta. These challenges include an ageing population, growing burden of noncommunicable and chronic diseases, and environmental changes.

Recommendations

- 1 The MHAS should consider introducing alternatives to detention in line with the latest European Council Directive 2003/9/EC (9) laying down minimum standards for the reception of asylum seekers, while pursuing detention when necessary in accordance with the criteria set out in the same legislation.
- 2 The Ministry for Energy and Health (Superintendence of Public Health, Primary Health Care Department, Mount Carmel Psychiatric Hospital) should advocate for health with the MHAS to reduce the length of the detention period because prolonged detainment of asylum seekers could:
 - have a serious negative impact on their health status and create administrative and logistic bottlenecks in the event of sudden, large influxes of migrants.
- 3 The national CPD should promote the inclusion of sudden, large influxes of migrants into the possible scenarios considered in the new all-hazard National Disaster Contingency Plan.
- 4 The Ministry for Energy and Health (Superintendence of Public Health, Primary Health Care Department, Mater Dei Hospital) should task its working group for developing an integrated public health emergency preparedness plan (to respond to large influxes of migrants) with drawing up priority response scenarios based on risk/impact assessment, including operational guidance for all levels of the administration. The plan should clearly indicate the essential core support functions, the basic support infrastructure, and essential capacities. A plan for revising and testing the response capabilities of the main (Mater Dei) and other hospitals should be included. This work should be carried out in collaboration with and with reference to the overarching National Disaster Contingency Plan by the CPD. In developing the plan, the working group should also consider the requirements of the EU legislation in force (Decision 1082/2013/EU (5)) and the full implementation of IHR capacities.
- 5 The Ministry for Energy and Health should consider including migrant health in the national health system strategy for 2013–2020.

Health workforce, medical products, vaccines and technology

Findings

The total number of physicians listed in the registers of the Medical Council in 2012 was 2074, equivalent to 349 per 100 000 population. There were 7.1 nurses and midwives per 1000 people in 2011 (15). Even though there has been a significant increase (more than 30%) in the uptake of the nursing profession since the mid-2000s, recruitment of qualified nurses from overseas continues, in order to address staff shortages in the field. Data on the number of cultural mediators working in the health system are not available. The general impression, however, is that there are very few. The Primary Health Care Department, along with the various activities of the Migrant Health Unit, has established a cultural mediation services point of contact at the health centre in Floriana, including training sessions for cultural mediators. However, there was only one cultural mediator still working in that health centre at the time of the mission. Cultural mediators tend to be selected and trained within the migrant community; however, they are among the first to be resettled in other countries, partly owing to their high level of education. The Primary Health Care Department has recently applied for EU funding to continue the cultural mediator project.

The main hospital in Malta (Mater Dei) has a hospital emergency response plan, which has been used to manage the previous and current migrant influx events. The implementation of the Influenza Pandemic Preparedness Plan, developed in line with WHO recommendations, promoted the adoption of human resources surge mechanisms. The system was tested during the H1N1 pandemic, with good outcomes and lessons learned as a basis for responding to other types of emergencies.

However, outside the Mater Dei Hospital, there is no formal mechanism for increasing human resources for health, but an informal surge mechanism exists, based on personal knowledge of people and institutions. With this in mind, professionals encountered during the mission stated repeatedly that Malta is a small country where people know each other and it is therefore relatively easy for health managers to call on additional health staff for extra duties in case of an emergency. However, international experience shows that if such arrangements are not formalized in a clear incident command system, chains of command based only on unwritten personal arrangements may be chaotic, resulting in delays and/or unnecessary overlap.

The WHO Regional Office for Europe assessment conducted in 2011 identified the limited number of nurses and certain medical specialists, along with the lack of surge capacity as critical bottlenecks in the Maltese health system, making it impossible to cope with a substantial extra patient load for an extended period. As a result, a sudden, large influx of migrants would require the mobilization of international support. The present assessment confirms these findings.

The CPD has 130 staff and 60 volunteers, and more volunteers are being called for. The AFM have made a major investment in the training of personnel. All SAR training has been modelled on the United States Coast Guard methodology. Procedures have recently been further updated in order to reflect the standards outlined in the International Maritime Organization (IMO) International Aeronautical and Maritime SAR (IAMSAR) manual.

Malta is almost entirely reliant on importing medicines and vaccines from overseas. Medical products, vaccines, cold chain supplies and modern medical technologies are widely available. The Central Procurement and Supply Unit of the Ministry for Energy and Health has stock for three months, and Mater Dei Hospital has stock for three years. Rapid stock mobilization mechanisms are in place and most medicines are free of charge at the point of use.

The public health policy in Malta stipulates that migrants should be vaccinated as soon as possible upon arrival in the country and before they are allowed to leave the detention centers. The transport of vaccines follows standard procedures to ensure the cold chain is maintained. Vaccines are administered as detailed in the list below.

- Adolescents >10 years of age receive one dose of diphtheria, tetanus and inactivated poliomyelitis (dT-IPV) and measles, mumps and rubella (MMR).
- Children >2 to <10 years old receive one dose of the so-called 5-in-1 diphtheria, tetanus, pertussis, poliomyelitis and *Haemophilus influenzae* type b (DTaP-IPV-Hib) and two doses of MMR (the latter, two months apart).
- Children <2 years of age receive full vaccination according to the Maltese national schedule.
- Adults receive one dose of dT-IPV.

Given the vaccine requirement specifications, the Superintendent of Public Health, in cooperation with the Parliamentary Secretary of the Ministry for Energy and Health, can fast-track the procurement procedures.

Recommendations

- 1 The Ministry for Energy and Health (Superintendence of Public Health, Primary Health Care Department, Mater Dei Hospital) should:
 - finalize standard operating procedures for emergencies, distribute them and ensure relevant training is provided;
 - ensure adequate capacity to test and evaluate the response to emergencies of national relevance, supported by a plan for simulation exercises involving all relevant sectors, detailing various responsibilities for providing an integrated response among them (epidemiology, laboratory, environmental health, food and animal health, health care);
 - include cultural mediation and health management of a sudden, large influx of migrants in health staff training;
 - define policies for accepting international medical teams in case of a sudden, large influx of migrants.
- 2 The Ministry for Energy and Health and the MHAS should jointly develop and implement a national training course on cultural mediation resulting in the award of an internationally recognized certificate.

Health information

Findings

The Department of Health Information and Research maintains a registry (births, deaths, hospital admissions) capturing data from public and private institutions. Mortality data are gathered bi-weekly, while hospitalizations are recorded on a case-by-case basis in an information technology system with unique identifiers (for example, the national identification number or foreign citizen number given by the hospital). Anonymous case-based data – with all details, including nationality – are sent to the Department of Health Information and Research, while data relating to communicable diseases are codified and entered into The European Surveillance System (TESSy).⁴ The data can be disaggregated for analysis, including by country of origin.

The Infectious Disease Prevention and Control Unit (IDCU) within the Department of Health Promotion and Disease Prevention Directorate is responsible for the notification, investigation and control of infectious diseases in Malta. Data are available from this unit on infectious diseases in migrants. The main infectious diseases encountered are TB, HIV, scabies and chicken pox.

The need to establish a syndromic surveillance system during major migrant influxes has been discussed in the past (14) but has not yet been addressed in Malta.

Multilingual health information and promotion materials have been produced and disseminated by the Migrant Health Unit.

There is no defined health risk public communication strategy. This is to be included in the country's generic emergency preparedness and response planning.

Recommendations

- 1 The Superintendence of Public Health should promote syndromic surveillance training to health staff working in key public health institutions, including those belonging to other ministries involved in the management of national emergency operations.
- 2 The Ministry for Energy and Health should define a health risk public communication strategy.

⁴ TESSy is the ECDC's flexible metadata-driven system for collection, validation, cleaning, analysis and dissemination of public health data.

Health financing

Findings

Total expenditure for health was 8.7% of Malta's gross domestic product in 2011 (16), which was in line with the EU average.

Ministry for Energy and Health contingency funds are very limited. However, the Ministry of Finance has the ability to mobilize funds quickly for the Ministry for Energy and Health in order to cover expenditures during emergency operations, as was the case during the evacuation emergency in 2011 and during the H1N1 pandemic.

Service delivery

Findings

Malta currently has a total of 1833 hospital beds. Mater Dei Hospital is the main acute general hospital in Malta, with a total of 825 beds and a bed occupancy rate of close to 100%. However, the hospital layout is flexible and can be rapidly reorganized (triage, isolation, intensive therapy unit, recovery areas), as proven during the H1N1 pandemic and the evacuation crisis in 2011. The hospital has limited capacity to deal with category IV infectious diseases, as there are no high-security isolation areas and only limited diagnostic facilities are available to provide care in such cases.

Public PHC is offered in eight health centres and 42 clinics. They are staffed by GPs, consultants, dentists, paramedics and nurses providing a variety of specialist health care services, including immunization, paediatric care and maternity care. The Primary Health Care Department's Migrant Health Unit is situated at the Floriana Health Centre and helps migrants to access the health system and to integrate into Maltese society.

In terms of mental health, three national health service units offer treatment for psychiatric patients. The largest is Mount Carmel Psychiatric Hospital, with 569 beds. Smaller units exist within the two general hospitals: Mater Dei Hospital (on the main island of Malta) and Gozo General Hospital. Undocumented migrants with mental health disorders in detention centres are referred to the Mount Carmel Psychiatric Hospital. There is no cultural mediator among the Mount Carmel Psychiatric Hospital staff.

The mental health of migrants in detention centres is of particular concern. Depression and psychosomatic syndromes are very common. A study published in 2010 confirmed that the incidence of psychosis among undocumented immigrants was very high, compared with that of the general Maltese population (17).

Detention capacity in the MHAS's two dedicated migrant detention facilities (closed centres at Lyster and Safi barracks) continually fluctuates according to seasonal arrivals. An estimate of a total capacity of 1000 migrants could be calculated based on past statistics. However, previous large migrant influxes have already overstretched the absorption capacity of the detention centres, creating massive overcrowding. It is worth mentioning that overcrowding does not only occur in closed centres: such difficulties are invariably also encountered in open accommodation settings.

The day-to-day management of the immigration detention facilities is carried out by the Detention Service, a government body under the authority of the MHAS.

The private consortium Medicare Services Ltd supplies the MHAS with personnel, including physicians and nurses, to run PHC medical clinics in the detention centres from Monday to Friday (09:00 to 14:00). Medicare Services Ltd health staff comprise five GPs and two nurses, with limited surge capacity. There is no cultural mediator among the detention centre staff, but the NGO Jesuit Refugee Service (JRS) provides migrants in detention with legal assistance and social work services (including health care and psychological support). The JRS team includes lawyers, social workers, a nurse, cultural mediators, outreach workers and administrative staff, plus a number of regular volunteers.

Certain nongovernmental and international observers have criticized conditions at administrative detention centres in Malta, including the United Nations WGAD (18), Doctors without Borders, Amnesty International and Human Rights Watch.

During the mission, it was possible to visit the Lyster Barracks Detention Centre and interview several migrants, managers of the centre and the medical team working in the centre's clinic. The centre has an ideal maximum capacity of 370. At the time of assessment, 139 migrants were detained (including 40 women); however, during summer months the centre could be overcrowded, housing even as many as 1000 undocumented migrants. The detained migrants interviewed complained about the length of the detention process, lack of privacy and space, and limited access to outdoor areas (one hour per day) (Fig. 3). These migrants confirmed concerns about their mental health status. According to the medical staff working in the detention centre, gastritis, depression and anxiety are the most frequent reasons for medical consultations. Managers of the detention centre expressed their concerns about the overcrowded conditions during the peak of the migration season (summer). The Lyster Barracks Detention Centre is equipped with an X-ray unit and an isolation room (provided with EU funds) (Fig. 4). The unit is intended to facilitate the TB screening by X-ray systematically performed for all irregular migrants arriving in Malta.

Fig. 3 Migrants during the daily outdoor hour at a detention centre in Malta



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Fig. 4. Isolation room at Lyster Detention Centre



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Once released from the detention centres, migrants are accommodated in open migrant centres. At the time of writing approximately 1600 people were hosted in 11 open centres. The capacity can be stretched to 3000 (19), but in the event of a very large influx, standards would inevitably lower. The capacity estimate by the Maltese authorities in order to be able to continue to provide high-quality service indicates that the number of migrants should not exceed 1000. Open centres are administrated by the AWAS in the majority of cases, or subcontracted to an NGO. A variety of services are offered to asylum seekers, including additional help for individuals identified as being vulnerable, and providing information programmes on employment, housing,

health, welfare and education (Fig. 5). Migrants in open centres can usually access the public health care system free of charge. Interpreters are usually identified within the migrant community, to assist with language difficulties, but professional cultural mediators are missing from the migrant centres (Fig. 6).

Fig. 5. Free time and language classes at open detention centres in Malta



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Fig. 6. Rooms in open migrant centres



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During the mission, it was possible to visit the Marsa and the Dar il-Liedna open centres. The Marsa centre is managed by the NGO Foundation for Shelter and Support to Migrants. It has a total capacity of maximum 500, but it has been overcrowded with up to 1000 people, with negative consequences in terms of the already basic living conditions. At the time of the visit, approximately 400 migrants were being hosted in the centre. Almost 70 people – including 25 full-time on-site staff – make up the centre's staff. As it is an open centre, no medical services are provided, although the NGO is raising funds to recruit a physician. According to the centre management staff, mental health problems are the most frequent reasons for requesting medical assistance at the centre. The Dar il-Liedna open centre accommodates families and unaccompanied minors. It has capacity for about 60 people, with very limited possibility to expand. The AWAS runs the Dar il-Liedna centre with five staff.

Recommendations

1 The MHAS should:

- recruit cultural mediator staff in all offices dealing with migrants at the harbour, in the detention centres and open centres, in health care and administrative institutions;
- improve living conditions in detention centres, including privacy, outdoor access, and psychosocial support;
- identify sites that can be used as temporary shelters in case of sudden, large influxes of migrants.

2 The Superintendence of Public Health should design and conduct a comprehensive research study on the mental health of migrants living in detention and open centres.

Conclusions

Malta's migrant reception system needs to be integrated by means of a plan addressing the country's response to sudden, large influxes of migrants. Although the system has recently coped with the arrival of hundreds of migrants, such influx rates are particularly significant for Malta, considering the per capita context. A sudden, large influx of migrants would therefore create additional health risks and logistical challenges (see the migrant influx response strengths, weaknesses, opportunities and threats (SWOT) analysis in Annex 4; annex 5 comprises a glossary.).

The forthcoming revision of the National Disaster Contingency Plan is an opportunity to develop an all-hazard approach based on risk assessment, which would include sudden, large influxes of migrants in the possible scenarios.

Emergency management structures are in place. However, there is little room to enlarge the present capacity to absorb any increase in workload, as a result of the very high bed occupancy rates in hospitals and the lack of available health workforce in the country.

To date, Malta has managed to provide a high standard of care at primary and secondary levels to migrants requiring health care services, despite stretched resources. However, the country is not adequately prepared to respond to a sudden, large influx of migrants and is likely to require international assistance should such an event materialize.

Malta would also require urgent assistance if a category VI infectious disease case were to be diagnosed among the migrant population on arrival. Financial assistance is required to set up a high-security isolation area within the only state hospital (Mater Dei).

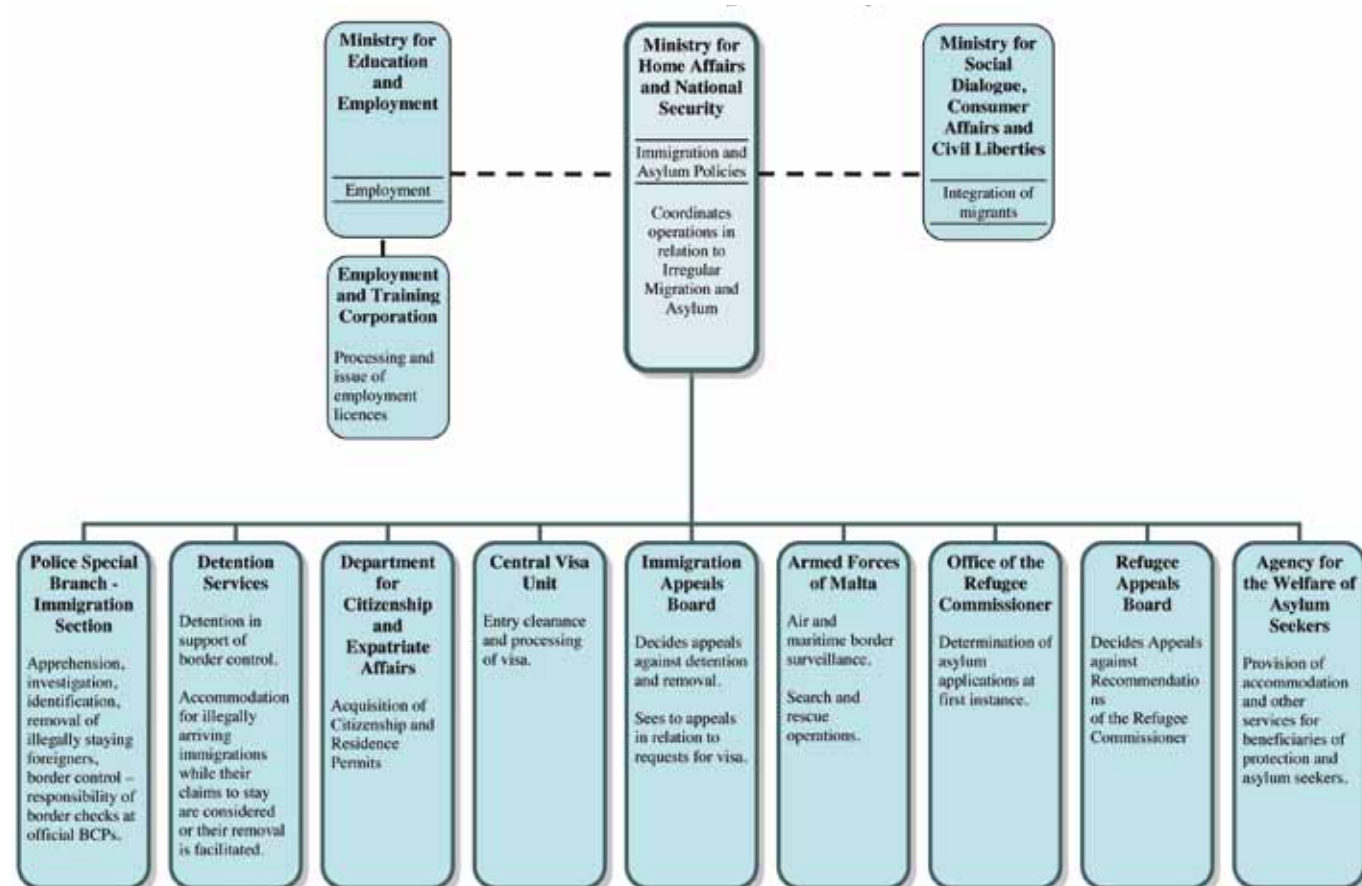
WHO can be instrumental in supporting the national health authorities to set up effective, sustainable and equitable mechanisms of preparedness and response to influxes of migrants and in advocating for the health rights of migrants arriving in Malta.

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Annex 1. Institutional Framework for Immigration and Asylum

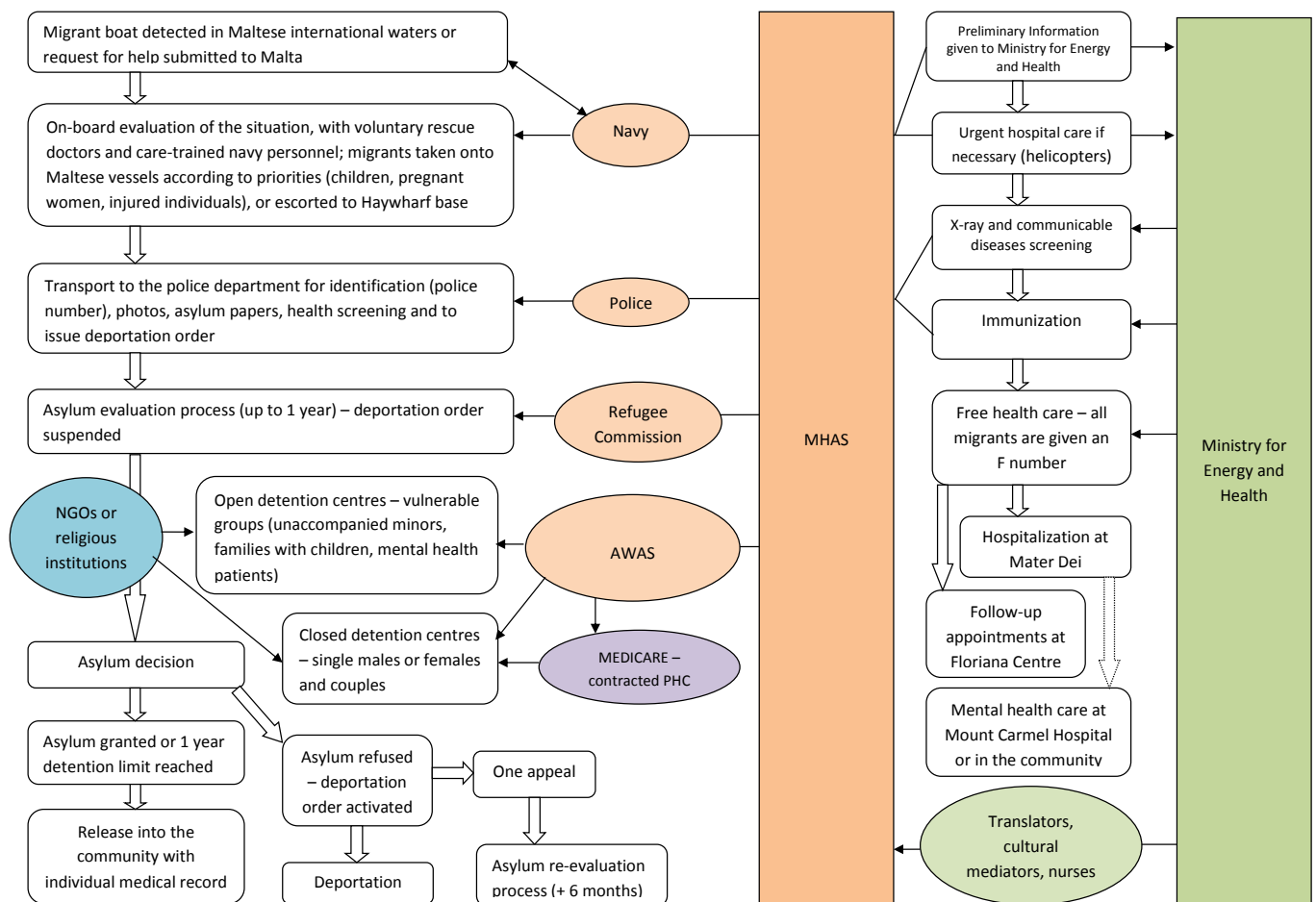


This institutional chart provides an indicative overview of the asylum and migration system in Malta. It should not be taken as fully representative - as at April 2013.

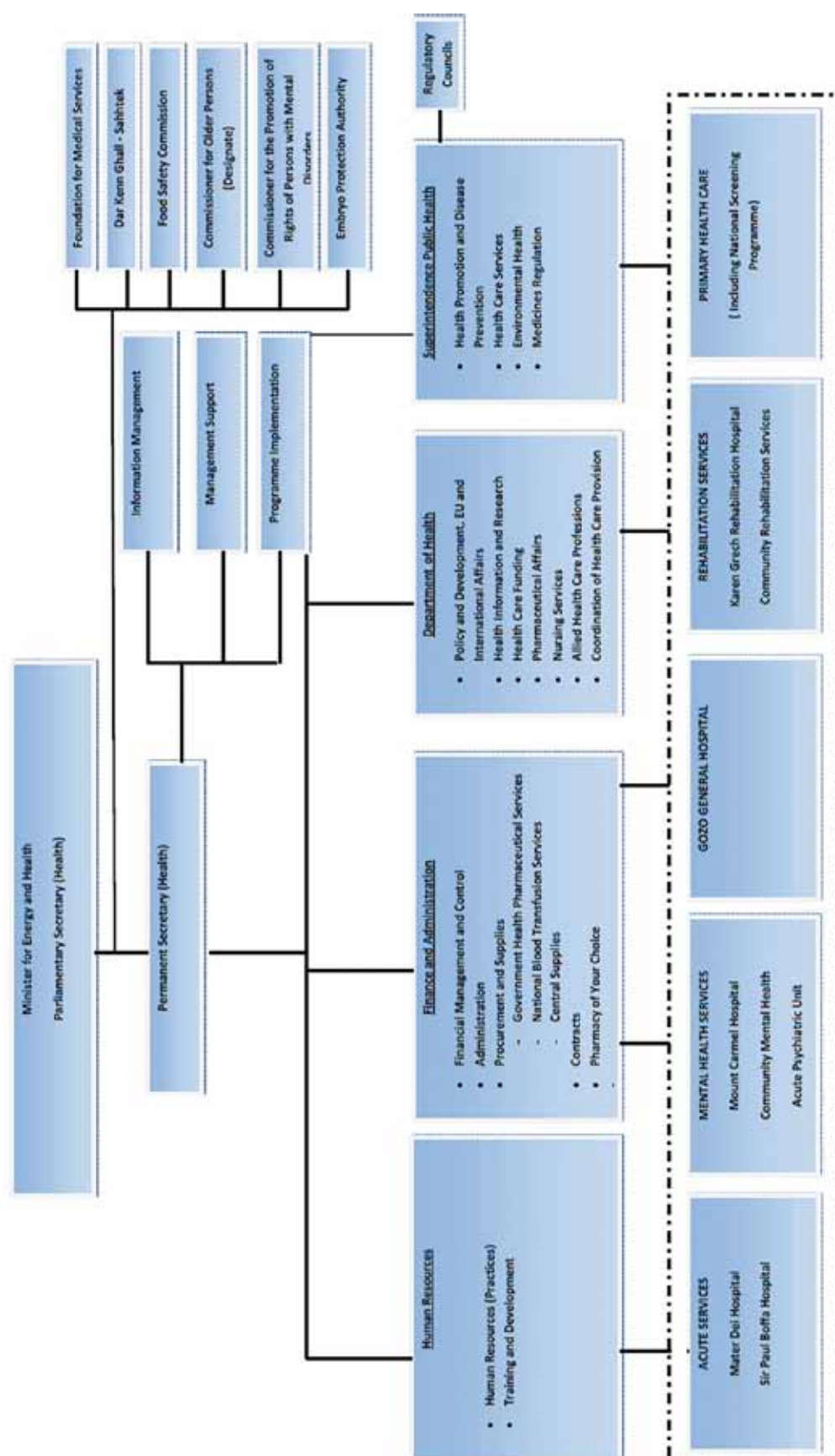
Notes. This institutional chart provides an indicative overview of the asylum and migration system in Malta (in April 2013). It should not be taken as fully representative. BCP: border crossing point.

Source: extracted (with permission) directly from the European Commission and EMN factsheet (20).

Annex 2. Migrant Influx Response Plan



Annex 3. The Ministry for Energy and Health organigram



Source: extracted (with permission) from the Ministry for Energy and Health website (21).

Annex 4. Migrant influx response SWOT analysis

STRENGTHS	WEAKNESSES
• Malta is a small island with only one harbor for entry • Distances between MHAS institutions and health facilities are only short • The country's migration response team comprises a small, permanent group of people within institutions (everybody is already known to each other) • Malta is not a 1st choice destination for illegal migrants (most are en route to other destinations) • Cultural mediation has been introduced at PHC level • Health care is free for everyone at the point of use	• Ministerial and interministerial migrant process flow rules are not clearly defined • No database interface exists between ministries and within the Ministry for Energy and Health (migrant medical records circulate on paper) • Disaggregated data on migrants and their health are scarce (resulting in difficulties producing accurate reports) • The Ministry for Energy and Health budget does not include the migrant burden • Migrant mental health care referral processes are not clear • There are limitations in dealing with category IV infectious diseases in Malta
• WHO Regional Office for Europe's Malta assessment could enhance horizontal dialogue between ministries • Experiences from countries previously assessed could be shared with Malta • Contacts could be developed for future visits/training among European countries • Awareness should be raised of the need to develop a health information strategy • The possibility of a large influx of migrants should be included as an emergency event in the CPD preparedness plan (under revision) • Malta could accomplish its Health 2020 strategic goals	• A trend is emerging of increased illegal migration from Africa to Europe • The Maltese health care system is under pressure (limited human and financial resources) • MHAS facilities are under pressure • The possibility has been suggested that there is increasing xenophobia within the country • Negative international media news has a major impact on Malta's key economic sector (tourism) • Category IV infectious diseases represent a significant threat
OPPORTUNITIES	THREATS

Annex 5. Glossary

Displaced population

Persons who have fled their country due to persecution, generalized violence, armed conflict situations or other man-made disasters. These individuals often flee en masse (10, 22).

Migrant

The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of “personal convenience” and without intervention of an external compelling factor. This term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their families (10, 22).

Refugee

A person, who “owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (Convention relating to the Status of Refugees, Art. 1A (2), 1951, as modified by the 1967 Protocol) (10, 22).

WHO toolkit for assessing local health-system capacity to manage sudden, large influxes of migrants

The WHO toolkit for assessing local health-system capacity to manage sudden, large influxes of migrants has been developed for assessing the capacity of local health systems to prepare and respond to emergencies resulting from large influxes of migrants. The toolkit comprises assessment forms with instructions for preparedness and response. It also includes a glossary of the key terms used in the document; the procedures for and recommendations on using the toolkit; and a list of possible sources of information required for the assessments (22). The assessment forms are organized into sections according to the six functions (building blocks) of the WHO health systems framework.

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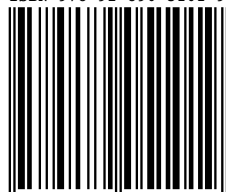
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