

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



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Joint report on a mission of the Hungarian Ministry of Human Capacities and the WHO Regional Office for Europe



MINISTRY
OF HUMAN CAPACITIES

Abstract

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. Hungary has been significantly involved in a large flow of refugees, asylum seekers and migrants, the majority fleeing the Syrian Arab Republic, Afghanistan and Iraq. Hungary estimates that the 2015 refugee, asylum seeker and migrant population is almost 400 000, currently representing approximately 33% of the 1.2 million crossing the external borders of the European Union (EU) up to October 2015; at the time of this assessment, there were more than 360 000 migrants, among whom more than 170 000 applied for asylum. Furthermore, 80% of the arrivals in 2015 left within the first few days and an additional 10% left within two weeks for other EU destination countries, making Hungary both a large receiving and a transit country. This report reflects Hungary's situation of large influxes of refugees, asylum seekers and migrants that crossed the Hungarian border prior to the border access legislation of 16 October, even as the seasonal temperatures began to decline. In this context, the Hungarian Government, and specifically the State Secretariat for Health in the Ministry of Human Capacities, requested a WHO mission to support the health authorities in assessing the capacity of the Hungarian health system in managing large influxes of refugees, asylum seekers and migrants. The joint Ministry of Human Capacities–WHO assessment was consequently conducted from 12 to 16 October 2015 within the framework of the WHO Regional Office for Europe's Public Health Aspects of Migration in Europe (PHAME) project, with Hungarian representatives of governmental agencies, nongovernmental agencies and international organizations as active participants in the assessment process.

Keywords

DELIVERY OF HEALTH CARE – organization and administration

EMERGENCIES

EMIGRATION AND IMMIGRATION

HEALTH SERVICES NEEDS AND DEMAND

REFUGEES

TRANSIENTS AND MIGRANTS

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ISBN 978 92 890 5158 3

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Edited by Jane Ward

Publication designed and printed by: Copyfantasy

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Contents

Acknowledgments.....	iv
Contributors.....	v
Abbreviations.....	vi
Executive summary.....	vii
Introduction.....	1
<i>Scope of the mission.....</i>	<i>2</i>
<i>Method.....</i>	<i>3</i>
<i>Site selection.....</i>	<i>3</i>
<i>Participants.....</i>	<i>3</i>
Overall findings and recommendations.....	4
<i>Type of emergency.....</i>	<i>4</i>
<i>Public health risk assessment.....</i>	<i>4</i>
<i>Profile of refugees and migrants.....</i>	<i>4</i>
<i>Health profiles of the countries of origin.....</i>	<i>5</i>
<i>Journey-related health risks.....</i>	<i>5</i>
Leadership and governance.....	6
<i>Findings.....</i>	<i>6</i>
<i>Recommendations.....</i>	<i>9</i>
Health workforce.....	10
<i>Findings.....</i>	<i>10</i>
<i>Recommendations.....</i>	<i>10</i>
Medical products, vaccines and technology.....	11
<i>Findings.....</i>	<i>11</i>
<i>Recommendations.....</i>	<i>12</i>
Health information.....	12
<i>Findings.....</i>	<i>12</i>
<i>Recommendations.....</i>	<i>12</i>
Health financing.....	13
<i>Findings.....</i>	<i>13</i>
<i>Recommendation.....</i>	<i>14</i>
Service delivery.....	14
<i>Findings.....</i>	<i>14</i>
<i>Recommendations.....</i>	<i>18</i>
Conclusions.....	19
References.....	20
Annex 1. Glossary.....	22

Acknowledgments

The WHO Regional Office for Europe would like to express sincere appreciation to the Ministry for Human Capacities of Hungary, especially the State Secretariat for Health, for its commitment to improving the national health system in the area of migration health. Special thanks are also given to Dr Attila Beneda, Deputy State Secretary, Ms Krisztina Talas and Mr Gabor Csehi, senior advisors in the Ministry, and Dr Agnes Danielisz, Head of Department of Epidemiology Surveillance, National Public Health and Medical Officer Services. Thanks are also due to the staff of the WHO Country Office, Hungary, in particular Dr Zsófia Pusztai, Head, for their collaboration and technical support, as well as their active participation in the work of the team members during the mission. We are particularly grateful to all other stakeholders, leading experts, ministries, nongovernmental organizations (NGOs) and local experts for their dedicated contribution.

Appreciation for special support and active contribution also goes to the Ministry of Interior, Ministry of Human Capacities, Office of Immigration and Nationality, National Public Health and Medical Officer Service, Ministry of Foreign Affairs and Trade, National Police Headquarters, National Directorate General for Disaster Management, Ministry of the Interior, Ministry of Defence, Hungarian National Ambulance Emergency Service, the Hungarian Red Cross, Maltese Charity Service, Hungarian Interchurch Aid and the National Health Insurance Fund.

The staff of Bicske Reception Centre, Kiskunhalas Detention Centre, the Szeged Police Headquarters and staff of Szeged Hospital, the Roszke transit zone, Fót Child Protection Home and the Baptist Church temporary shelter home should receive a special mention for their work throughout the mission. We are also grateful to the High Commission for Immigration and Refugees, the International Organization for Migration, the United Nations Children's Fund, the International Labour Organization, the International Federation of Red Cross and several NGOs, for example the Menedék Association, Cordelia Foundation, African-Hungarian Union and Migration Aid.

The team of assessors – comprising members of the Department of Epidemiology Surveillance, National Public Health and Medical Officer Service, the Departments of International and EU Affairs and Health Policy, both within the Ministry of Human Capacities, and the WHO Regional Office for Europe – should also be thanked.

Contributors

Assessment team

Ministry of Human Capacities

- Dr Agnes Danielisz, Head of Department, National Public Health and Medical Officers' Service
- Ms Krisztina Talas, Senior Advisor, International Department, Ministry of Human Capacities
- Mr Gabor Csehi, Senior Advisor, Health Policy Department, Ministry of Human Capacities

WHO Regional Office for Europe

- Dr Santino Severoni, Coordinator, Public Health and Migration, WHO Regional Office for Europe
- Dr Nedret Emiroglu, Deputy Director, Division of Communicable Diseases, Health Security and Environment, WHO Regional Office for Europe
- Dr Erin Downey, Senior Expert on Preparedness and Emergency Response
- Ms Sara Barragán Montes, Technical Officer, Public Health and Migration, WHO Regional Office for Europe
- Ms Ina Parvanova, Regional Adviser, Communications, WHO Regional Office for Europe
- Dr Zsófia Pusztai, Head, WHO Country Office, Hungary

Abbreviations

EU	European Union
IOM	International Organization for Migration
NAS	National Ambulance Service
NDGDM	National Directorate General for Disaster Management
NGO	nongovernmental organization
NPHMOS	National Public Health and Medical Officer Service
OIN	Office of Immigration and Nationality
PHAME	Public Health Aspects of Migration in Europe
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund

Executive summary

Hungary's geopolitical status places it in a unique position for migration and it is on the route for the surge in refugees, asylum seekers and migrants¹ moving through Europe and other European Union (EU) Member States in 2015 from the east and south. Influxes of these populations in 2015 have surpassed all previous years such that the estimate exceeds the population counts for 9 out of 10 of the largest cities. Further, 90% of these populations consider Hungary as a transit country, staying from a few days to two weeks, as they strive to reach other EU countries.

Estimates indicate that almost 400 000 irregular² migrants entered Hungary in the first eight months of 2015, with 161 000 claiming asylum. By comparison, 2157 claimed asylum in 2012.

Several unique challenges arise in managing public health responses for both the general population and the refugees, asylum seekers and migrants, including how to provide basic health care to a sudden large influx of people. The height of the population surge was in July and August 2015; however, legislative changes in border access with Serbia and Croatia slowed the migrant movement dramatically in September and October. Consequently, the assessment described here took place as Hungary was beginning to recover from its heightened response but also when personnel were beginning to assess the effectiveness of practices.

The Hungarian Government requested the WHO Regional Office for Europe, in collaboration with the State Secretariat for Health at the Hungarian Ministry of Human Capacities, to apply the Public Health Aspects of Migration in Europe (PHAME) toolkit to examine the situation in Hungary in terms of its capacity to respond in the acute phase to the public health needs and challenges of large influxes of refugees, asylum seekers and migrants. The mission took place on 12–16 October 2015 with site visits and semi-structured interviews with key government officials, and representatives from nongovernmental organizations (NGOs), international organizations, health facilities, and transit, reception, and detention centres, in addition to other relevant stakeholders. The assessment reflects Hungary's situation of large and continuing influxes of refugees, asylum seekers and migrants at the Hungarian border prior to 16 October's border access legislation.

The two aims of the assessment, as they pertain to responding to large influxes of refugees, asylum seekers and migrants, were to:

- support health authorities and partners in identifying gaps, building on existing capacities and developing informed health interventions; and
- promote intersectoral collaboration in the development and implementation of a health sector response.

This population, mainly transiting through Hungary, created a number of public health challenges, such as identifying unique health needs of a new subpopulations quickly (e.g. vulnerable populations and chronic and infectious disease concerns), having sufficient time to provide care,

1 United Nations High Commissioner for Refugees (UNHCR) first applied the term “refugees, asylum seekers and migrants” to the case of the large influxes of people legitimately recognized as exposed to risk for their life through war, prosecution or violence in the Balkan crisis of the early 1990s.

2 An irregular migrant is defined by movement that takes place outside the regulatory norms of the sending, transit and receiving countries or as the universally accepted definition of irregular migration. From the perspective of destination countries, it is entry, stay or work in a country without the necessary authorization or documents required under immigration regulations. From the perspective of the sending country, the irregularity is, for example, seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfill the administrative requirements for leaving the country (see the Glossary).

documenting health care services provided and tracking individuals for appropriate follow-up. Recent legislative changes have provided more interministerial response authority and have further strengthened the Office of Immigration and Nationality (OIN) and the National Police as having the lead role in the 2015 response aspects of the access to health at borders, transit zones, camps and centres.

Although Hungary had been operating in heightened response to surges of refugees, asylum seekers and migrants for all of 2015, it had not activated its national emergency operations plan. The strategies used by the Hungarian responders have highlighted both best practices that could be included in the all-hazards national plan and areas where improvement would be helpful.

- The National Police, Hungarian Defence Force and the National Ambulance Service (NAS) provided examples of good practice in their changing responses during the crisis, such as implementing measures for registering, processing and documenting individuals; providing mobile health units (small buses); and responding rapidly to need in disparate non-standard locations.
- Developing national communications strategies that effectively and rapidly extend from the national level to the local level would facilitate situational awareness for system responders, as well as for the migrant and resident populations.
- Strategies should take into account the support that NGOs can provide for responders and populations in need.
- Contingency plan development should include a robust medical response capability and incorporate awareness of the psychosocial aspects of a crisis on all those involved – migrants, health workers and other responders.
- Although there is no direct evidence of any association between migration and spread of infectious diseases, health security in terms of the potential risks of infectious diseases in any large influx of people is a concern for many. Evidence-based public health educational material on communicable and noncommunicable diseases should be provided to the public, responders and refugees, asylum seekers and migrants.
- Strategies for vulnerable populations such as children and unaccompanied minors need special planning in terms of their protection and health needs.

Effective communication is key to ensuring response effectiveness. Interministerial communication is in place, although:

- translators and cultural mediators are needed to help health workers to give effective care; and
- public messaging and interaction with the media would help to disseminate pertinent information on response activities, potential impacts on resident populations and to ease potential fears through education.

Introduction

Hungary is located in central Europe and has about 10 million inhabitants, some 2.1 million of whom live in the country's capital Budapest. National borders are shared with seven countries: Slovakia, Ukraine, Romania, Serbia, Croatia, Slovenia and Austria. Hungary has been a Member State of the EU since May 2004.

Hungary's special characteristics are rooted in its history of fluid borders, as well as the strong migratory tendencies of those with Hungarian ancestry who are citizens of neighbouring countries (1). In recent years, the number of irregular migrants crossing the Hungarian eastern–southeastern borders with countries in the Schengen zone has increased dramatically and in January 2015 was as high as 20 000. The western Balkan route has two main migratory flows: (i) from the western Balkan countries themselves, and (ii) mainly Asian migrants who originally entered the EU through the Bulgarian–Turkish or Greek–Turkish land or sea borders and then proceeded, through the western Balkans, into Hungary (2).

For many of the current refugees and migrants, Hungary is one of the first EU Member States encountered after Greece, and the country has become a massive transit country within this European migration crisis. Furthermore, 80% of the arrivals in 2015 left within the first few days and an additional 10% left within two weeks for other EU destination countries, making Hungary both a large receiving and a transit country (3). Its geopolitical position within the migration crisis has uniquely stressed its health-system capacity to manage the large influx of refugees, asylum seekers and migrants, which did not slow even with falling seasonal temperatures.

Hungary estimates that the 2015 refugee, asylum seeker and migrant population (see glossary in Annex 1) is almost 400 000, currently representing approximately 33% of the 1.2 million crossing the EU's external borders up to October 2015 (4). In October, the OIN reported that it registered 176 315 asylum seekers in Hungary. The five most common nationalities were Syrian (37%), Afghan (26%), Kosovan (14%), Pakistani (8%) and Iraqi (5%) (3).

Hungary's green border (the border section between border crossing points) with Serbia was closed on 15 September (5) (Fig. 1), prior to the PHAME assessment, and on 16 October, the day following the completion of the PHAME assessment, the green border with Croatia was closed (6).

By 3 October 2015, the estimated number of refugees, asylum seekers and migrants entering Hungary was over 300 000, and 161 000 had claimed asylum in the first eight months of 2015. The OIN estimated that two thirds of those seeking asylum were from Afghanistan, Iraq and the Syrian Arab Republic and entered the country irregularly (7). By comparison, the total number of refugees, asylum seekers and migrants in 2014 (42 777) was 13 times the combined number for 2008–2013 (8). At the height of the 2015 influx (approximately July and August), the Hungarian authorities were struggling to register all the arrivals and provide basic services such as first physical examination and first aid and medical care at reception centres, which were collectively serving 4500 people – double their intended capacity (9).

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.

Fig 1. Fence at the border between Serbia and Hungary



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

In October 2015, the WHO Regional Office for Europe conducted a rapid assessment mission to Hungary in the context of the ongoing migration crisis in Europe at the request of the Hungarian Government. The main objectives of the mission were to examine the preparedness of the Hungarian health system to cope with the public health consequences of a potential large influx of refugees, asylum seekers and migrants and to provide recommendations on how to improve cooperation and preparedness efforts.

The team of assessors comprised WHO Regional Office for Europe experts on public health and migration, communicable diseases, health security and environment, and communications, together with the Hungarian Ministry of Human Capacities, the National Public Health and Medical Officers' Service (NPHMOS) and representatives of the WHO Country Office, Hungary.

Scope of the mission

The mission's aims were to:

- support health authorities and partners to identify gaps, build on existing capacities, and develop informed health interventions for arrivals of large groups of refugees, asylum seekers and migrants; and
- promote intersectoral collaboration in the development and implementation of a health sector response to the arrival of large groups of refugees and migrants.

Method

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

Site selection

Assessment locations and key informants were selected based on being sites of possible refugee, asylum seeker and migrant influxes and/or locations of migrant centres and/or institutions working in emergency management. The assessment team visited several sites that provided insight into the frontline operational responses for different subpopulations of the migration influx and their unique health needs:

- Bicske Open Centre
- Fót Child Protection Home
- Family Home of Baptist Church
- Kiskunhalas Detention Centre
- Röszke Transit Zone and Szeged Police Headquarters
- health facilities.

Participants

In addition to the assessment team, several governmental entities participated in the site visits and discussions, providing the team with an understanding of Hungary's leadership and governance structure specifically as they related to large influxes of refugees, asylum seekers and migrants. NGOs and international organizations also participated, providing the team with an understanding of collaborating and coordinating entities that added to Hungary's surge capacity to address large influxes of these populations. Participants included:

- **government:** Ministry of Human Capacities, Ministry of Interior, Ministry of Foreign Affairs and Trade, Ministry of Defence, Office of Immigration and Nationality, National Police Headquarters, National Directorate General for Disaster Management (NDGDM), National Public Health and Medical Officer Service, National Ambulance Service, National Health Insurance Fund;
- **NGOs:** Charity Services, Cordelia Foundation, Hungarian Red Cross, Maltese Charity Service, Hungarian Interchurch Aid, Menedék Association, African-Hungarian Union, Migration Aid; and
- **international organizations:** United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM), United Nations Children's Fund (UNICEF), International Labour Organization, International Federation of the Red Cross, United Nations Food and Agriculture Organization.

Overall findings and recommendations

Type of emergency

Throughout 2015, Hungary faced a large influx of refugees, asylum seekers and migrants, mostly because of its geopolitical location on their journey across Europe. Although Hungary had not declared a national emergency during this migration crisis, it had activated a national plan to deal with the migrant influx. Border access policies have affected the flow of irregular migrants into Hungary and, by extension, the population surge pressures on its health system.

Hungary faces several unique challenges while managing its response to the public health aspects of refugees, asylum seekers and migrants:

- current 2015 irregular migrant estimates surpass the population counts of nine out of 10 of Hungary's largest cities (city size range, 116 000–204 000);
- approximately 90% of refugees, asylum seekers and migrants see Hungary as a transit country, staying from a few days to two weeks, as they strive to reach other EU countries; and
- large population movement presents several public health challenges, such as identifying unique health needs of subpopulations requiring specific health interventions (e.g. chronic and infectious diseases), having enough time to provide care, being able to consistently document health care services provided, and tracking subpopulations for appropriate follow-up as needed.

The population spikes of July and August and the reductions in September and October (after closure of the green borders with Serbia and Croatia) created a period of rapid change in Hungary's national response strategy for the public health aspects of managing a large influx of refugees, asylum seekers and migrants. Within this context, the PHAME assessment took place in a post-acute phase and conducted interviews during 12–16 October 2015.

Public health risk assessment

Although there is no direct evidence of any association between migration and spread of infectious diseases, the potential risks of infectious diseases are often discussed in the context of “health security” and potential risks to local populations. The Government set up an ad hoc security committee to address refugee and migrant health. According to Hungarian Law, all irregular migrants entering a centre should be screened, but in practice only a few people are because they leave the centre (within a few hours to a few days) to continue their journey beyond Hungary to other EU countries. Some health workers noted that even those potentially needing borderline emergency care for a chronic disease were resistant to spending the time to get the services, again in favour of leaving as quickly as possible.

Profile of refugees and migrants

From 1 January to 12 October 2015, there were 176 315 claiming asylum, the five most common nationalities were Syrian (37%), Afghan (26%), Kosovan (14%), Pakistani (8%) and Iraqi (5%) (3). For approximately a year, the Afghan and Kosovar applicants have been increasing.

In early 2015, most migrants were men under the age of 20 years (70–80%). Over the year, the socioeconomic status shifted to include poorer, more vulnerable populations and greater numbers of women and children. The age range for single males expanded to include both younger (more unaccompanied minors and children separated from their families) and older males. In addition, there was an increasing number of migrants with special health needs.

Health and medical needs of refugees, asylum seekers and migrants have primarily been those of middle-income countries, with a health profile generally similar to that of the host population. With reduction in socioeconomic status of the population arriving, the propensity for more exacerbated chronic disease conditions may arise. Respiratory illnesses are expected to increase in the winter months as respiratory syncytial virus and seasonal influenza become widespread in the Region.

Hungarian Red Cross statistics for medical help, including screening and treatment, in reception facilities covered general medical examinations for 27 435 people in the first eight months of the year, with 2208 treated. The most frequent health problems reported were tonsillitis, bronchitis, laryngitis, pneumonia, scabies, lice, gastroenterological diseases, gynaecological issues, flu, HIV infection, hepatitis C, dental issues, skin conditions and allergic conditions (10).

Health profiles of the countries of origin

Most refugees, asylum seekers and migrants arriving in Europe have travelled from Middle Eastern countries where vaccines are widely accepted and coverage has been historically high. Those most at risk of acquiring vaccine-preventable diseases are young children who were not vaccinated during civil unrest and conflict. Among the host population, there will also be many individuals who have not been vaccinated for a variety of reasons, although in Hungary the vaccination coverage is among the highest in Europe and there has been no measles outbreak since the mid-1990s. Recent outbreaks of measles in many countries of the Region have highlighted adolescents and young adults as susceptible to the disease. Most outbreaks of vaccine-preventable diseases such as measles, rubella and pertussis continue to occur in the Region independent of large population movement.

Journey-related health risks

National policies are playing an important role in predicting the migration routes and subsequent pressures on national health systems. The eastern Mediterranean route (the passage long used by migrants crossing through Turkey to the EU) has grown ever-more crowded with the deteriorating situation in the Syrian Arab Republic since 2011. These routes have also been merging with an East African migratory route south of the Mediterranean basin – a route long used by people fleeing conflict in Somalia, the Democratic Republic of the Congo and South Sudan.

Frequently reported health risks associated with the migration journey includes physical exhaustion, lack of nutrition, dehydration, physical trauma, thrombosis, diabetes and pregnancy-related problems) (10). For particularly vulnerable populations (e.g. women, children and unaccompanied minors), risks of human trafficking exist.

Accommodation during the migration and at emergency shelters was often crowded and lacked adequate eating and sleeping areas, clean water, sanitation and hygiene resources, and medical services. All may lead to exacerbation of chronic and noncommunicable diseases and the risk of

spread of infectious disease. Children are particularly prone to acute conditions such as respiratory diseases, diarrhoea and skin infections. Finally, the temporary nature of the transit locations, the urge to quickly leave and continue their journey, and seasonal cold temperatures all contribute to refugees, asylum seekers and migrants moving through a challenging public health context in an exhausted and compromised physical state of health.

Leadership and governance

Findings

The Hungarian Ministry of Human Capacities contains the State Secretariat for Healthcare and other ministries that interface to serve the Hungarian population and extend from the national level to the regional, county, subregional, submunicipal and private sectors where applicable. The objectives of the health system are either set explicitly in various laws, regulations and policy documents or set implicitly by the actions taken by the government. They mostly revolve around the protection and promotion of patient rights, the assurance of equal access to services for equal need, the provision of evidence-based effective services and the achievement of system efficiency (11). Overall, the administrative structures of the health system are aligned as they pertain to assessing the system's capacity to manage a sudden large influx of refugees, asylum seekers and migrants.

The Ministry of Interior and, when a disaster is declared, the NDGDM lead the response to an emergency. Hungary has a national plan to respond to disasters and emergencies and some components of interministerial plans have developed specific contingencies to respond to large influxes of refugees, asylum seekers and migrants. Throughout 2015, the national plan was not formally activated and the NDGDM acted in a supportive role to the police. As such, during this large-scale migration influx, Hungary has showed capacity to manage the overall response to a surge of an estimated 200 000 individuals, with no deaths or major diseases for refugees, asylum seekers migrants, staff or local populations reported. Coordination mechanism at the ministerial level for the current crisis among relevant sectors and stakeholders are in place.

The Ministry of the Interior and the OIN reported that over 350 000 irregular migrants had entered the country by mid October 2015. A humanitarian disaster was not declared because the health sector was able to cope with the current situation. If there is a formal disaster emergency declaration, the country can ask for support through the North Atlantic Treaty Organization representative and through the United Nations and the EU's Civil Protection Mechanism. In September 2015, Hungary activated the Civil Protection Mechanism for the provision of tents, containers and other items.

The NDGDM, within the Ministry of the Interior, is responsible for protecting the lives and the property of the population living in Hungary, insuring the safe operation of the national economy and protecting the elements of the critical infrastructure. As an important public safety task, the NDGDM is a law-enforcement body with a national competence (e.g. all-hazards planning). NDGDM's main mission is preventing disasters as an authority, carrying out rescue operations in civil emergencies, organizing and controlling protection activities, eliminating the negative consequences of emergencies, and performing reconstruction and rehabilitation. Although the NDGDM has not been formally activated during the 2015 influx of refugees, asylum seekers and migrants, it has engaged in a coordinated heightened response capacity with the other ministries and the police.

The Hungarian Police is the main (and largest) state law-enforcement agency in Hungary (Fig. 2). It carries nearly all general police duties such as criminal investigation, patrol activity, traffic policing and border control. It is led by the National Police Commissioner under the control of the Minister of Interior. The body is divided into county police departments, which are also divided into regional and town departments. During the 2015 influx of refugees, asylum seekers and migrants, Hungary's emergency response was augmented by the legislation assigning to the police the lead role in implementation of operational aspects of providing access to health when individuals arrived at the border transit zones. Here the military augments police activities by protecting the border with fences and providing some medical care for the police, if needed. The police are responsible for providing health care at the immigration detention centres and OIN is responsible for all other health care at open reception centres and asylum centres.

Fig. 2. Stakeholder meeting with the Hungarian Police at the Kiskunhalas Detention Centre



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On 21 September 2015, the Hungarian Parliament adopted further amendments to the Police Act and the Act on National Defence. These extended the powers of the police in situations of “crisis caused by mass immigration” to block roads, ban or restrain the operation of public institutions, shut down areas and buildings and restrain or ban the entering and leaving of such places (12).

As a result, the police created their own health posts near transit zones to cope with the needs of the increased number of irregular migrants and the increased fear among the population and the professionals that the migration impacted. Initially they had a contingency plan, with localized elements and some delineation of a clear division of responsibilities, but this plan had to be adjusted to address issues never before encountered in terms of the capacity challenges of such a large influx of people. The police currently collaborate closely with hospitals near the borders, where refugees, asylum seekers and migrants are taken for emergency care.

National plans include coordination with NGOs, such as the Maltese Charity Service, the African-Hungarian Union and the Hungarian Red Cross, to augment ministry border capacity by providing

health and medical services such as mobile health offices, volunteer doctors, paramedics and nurses, and basic first aid services. Other supportive services are provided, including distribution of food and water, clothing, blankets/insulation foils and hygiene items. Some NGOs (e.g. Cordelia Foundation, Hungarian Red Cross and Interchurch Aid) also provide psychosocial support. The Menedék Association, responsible for promoting the social integration of foreign citizens migrating into Hungary, has expanded to the provision of cultural mediation to facilitate access to health care for refugees, asylum seekers and migrants.

The Government closed the green borders with Serbia and Croatia, initiating the same border policing method for both border sections (Fig. 3). Transportation to the Hungarian–Slovenian border for the refugees and migrants who were unable to cross the Hungarian–Croatian border was effective as of 16 October (13). This legislation eased the refugee and migrant influx into Hungary via these two countries and shifted population pressure points to the shared border with Slovenia.

Fig. 3. Closed border between Hungary and Serbia



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Within the Ministry of Human Capacities, Hungary assigns overall responsibility for social welfare and health care provision to central government, but other actors also take part in decisions related to the organization and functioning of the health system.

The OIN administers duties related to asylum, citizenship and foreigners (13). This includes:

- migration to Hungary;
- residence and settlement permits;
- citizenship applications;
- asylum applications, ensuring reception conditions and facilities, integration of those granted international protection, implementation of Dublin III Regulations;

- proceeding against “illegal migrants”, including detention and deportation; and
- tasks stemming from Schengen obligations.

The OIN and police operate centres for refugees, asylum seekers and migrants including open reception centres for asylum seekers and beneficiaries entitled to international protection, detention centres and guarded living quarters. OIN runs reception centres (Bicske, Debrecen, Nagyfa and Vámosszabadi), some intended for short-term stays and others intended for long-term stays, and closed asylum detention centres (Békéscsaba, Debrecen and Nyírbátor). The Police run immigration detention facilities (e.g. in Kiskunhalas and Nyírbátor). The Ministry of Human Capacities (the General Directorate for Social Affairs and Child Protection) runs facilities specific for unaccompanied minors. These are monitored by the Public Health and Epidemiological Service of the police. The Ministry of Interior exercises supervisory control over the OIN and the police.

The OIN is also responsible for making age-definition tests for unaccompanied minors without identity documents; however, the Ministry of Human Capacity is responsible for the care of migrant children and unaccompanied minors. According to Act LXXX of 2007 on Asylum (Act on Asylum), those eligible for preferential treatment includes unaccompanied minors or vulnerable persons such as minors in general and single parents with minor children, where among other rights, the best interest of child must be taken into consideration during the asylum and immigration procedure. Child protection laws ensure unaccompanied minors get care of the same quality as that for Hungarian citizens but appropriately takes into account unique differences in religious and cultural habits of migrant children.

Three key NGOs participated in the interministerial discussions: the Hungarian Red Cross, the Hungarian Interchurch Aid and the Maltese Charity Service. These NGOs and several others (e.g. Charity Services, Cordelia Foundation, Menedék Association, African-Hungarian Union, Migration Aid) collaborated closely with the Government to provide a number of key activities in support of the health services at local level to supplement capacity to manage the sudden large influx of refugees, asylum seekers and migrants; for provision of mobile ambulances, medical staff and volunteers; and for activities such as coordinating food and water, supplies, medications, transport, family reunification and temporary shelter. Other NGOs were active but had a less organized linkage with service providers and so were less aware of national initiatives where their services could be offered in support.

Recommendations

- All-hazard, generic plans should be developed to include contingencies for migrant surges and corresponding health-system response planning. Lessons learnt and best practices should be incorporated into the contingency plan.
- Developing procedures to foster greater coordination among the relevant ministries and the NGO community would enhance the capacity to respond to a large influx of migrants.
- Communications strategies should be improved to help refugees, asylum seekers and migrants, as well as the resident population, to understand the processes in place.
- Currently the centralized information system is effective but increased awareness at local level would be a benefit.

Health workforce

Findings

Like many countries, the Hungarian health care system has suffered from workforce migration and ageing. The large migration influx has been characterized as an elevated state of response but not as an activated disaster response. The health care workforce in health facilities reported an increased work load in response to the growing crisis that was described as longer work days and more work days, but there was not a staffing shortage. Although health care workers were overstretched during the response, they showed flexibility and surge capacity during 2015 as the influx increased (Fig. 4).

Fig. 4. Health facilities of Bicske Open Centre



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Health care workers did not consider that they needed additional training beyond their traditional skills but, particularly in refugee reception centres, the need for additional resources such as translators was emphasized.

NGOs, such as the Hungarian Red Cross, have a valuable supportive role but rely heavily upon the volunteer community to provide assistance.

Recommendations

- Update emergency response plans to reflect the increased demands on both the health care and non-health care workforce and include plans for staff secondment to needed locations.
- Develop policy directives to support the health services and workforce to accommodate specific needs (e.g. translators) during a large influx of refugees, asylum seekers and migrants.

- Promoting and incorporation best practices, such as those by the Menedék Association and Pecs University, for capacity building on cultural mediation for the health and medical workforce, and other responders.

Medical products, vaccines and technology

Findings

The NPHMOS, through the National Institute for Epidemiology, plans, directs and coordinates the compulsory immunization programme and supplies the vaccines through its regional and subregional offices; family doctors and the school health services carry out the vaccinations. The district mother and child services provide pre- and postnatal care, as well as prevention and health education for families and schools, and is coordinated and supervised by senior nurses from the NPHMOS. Pharmacies in Hungary are authorized by the NPHMOS, are issued a licence by the National Institute of Pharmacy and Nutrition and are run under the personal responsibility of the pharmacist. In principle, every physician and dentist is entitled to prescribe pharmaceuticals. The cost of selected pharmaceuticals is covered by the health insurance scheme, but the type and extent of Hungary reimbursement varies. Virtually 100% coverage against childhood diseases exists (11).

Vaccines were available at reception centres for children but providers were challenged to run an effective programme because of issues of consent and the desire of migrants to leave quickly.

Shortages of medical products were not reported and there was a clear understanding of the supply chain and ordering process (Fig. 5).

Fig. 5. Medical post at the border between Hungary and Serbia



Recommendations

- Update and refine migration contingency plans for best practices in vaccinating migrating children, given lessons learnt and difficulty of the timeframe for treatment.
- Develop communication strategies for refugee, asylum seeker and migrant vaccine awareness, health promotion and disease prevention.

Health information

Findings

Health care data registries are held within the State Secretariat for Health. The Ministry of Human Capacities currently records the number of treatments provided for refugees, asylum seekers and migrants according to their migration status. Data collection on infectious diseases and epidemics is regulated by the ministerial decree on the procedure of reporting communicable diseases.

Health care service providers are required to report 72 communicable diseases. The central database of infected patients includes communicable diseases among migrants and records the country of origin of the patient. Within the group of foreign-born infected patients, migrants are identified by specific data such as special social security number and the location where the case was reported, usually a reception centre operated by OIN.

The Office of the Chief Medical Officer of the NPHMOS determined that a large population influx can significantly increase the risk of introducing an eliminated or locally absent communicable diseases and is a risk factor for epidemiological stability. However it did not consider that the influx of refugees, asylum seekers and migrants implied an epidemiological threat but it did involve an epidemiological risk. Disease risk increases in crowded places without appropriate levels of hygiene and two key epidemiological events related to the migration influx were reported: gastroenteritis at the Debrecen reception centre and undetermined symptoms including diarrhoea and vomiting at Budapest Nyugati Station. Both events were responded to by the health services as appropriate to the severity of infection.

Vaccination records are stored onsite in hard copy and can be provided to the individual or to the individual's family to keep before they leave the centres. Information is available to distant health providers but there is no clear system of intercountry communication of such health data.

Health information is collected at various locations, including health centres, hospitals and reception centres. Given the different types of facility, the different geographic locations and the surge in patients, transferring this information to central collection systems can be challenging.

Recommendations

- Strengthen national health information systems to more effectively interface with local health systems in regard to collection of epidemiological data on refugees, asylum seekers and migrants.
- Apply knowledge gained via health information to develop health-promotion materials for health staff, citizens and non-citizens.

Health financing

Findings

Public expenditure on health is financed mainly through a combination of contributions and general tax revenue transfers to the health insurance scheme. Participation in the health insurance scheme is compulsory for all citizens living in Hungary. Based on the current legal framework, coverage should theoretically be 100%, but the health insurance status of approximately 4% of the population was unclear in 2009 (11). The benefits package is comprehensive but not exhaustive.

In case of illness, applicants for asylum are entitled to certain, defined health care services free of charge. Such services include general practitioner care, outpatient specialist care and inpatient care for urgent medical care, as well as age-related mandatory vaccination. Persons eligible for preferential treatment, such as minors or disabled people, are entitled to a wider circle of services, including rehabilitation, psychological and psychotherapeutic treatment (14). Given the transient nature of refugees, asylum seekers and migrants, it is often challenging for health care workers to provide the needed care at the points of access.

Refugees, asylum seekers and migrants benefit from the Hungarian national health system in a structured way with four tiers depending upon whether they are new arrivals or moving into the asylum system. However, one NGO, the Baptist Church Family Home, reported that even those migrants granted asylum by the Government are struggling in some cases with access to a social security number and access to the necessary care in case of need. One potential cause of the problem is that the providers and the National Health Insurance Fund have difficulty in interpreting and implementing the legislation on the rights and obligations of beneficiaries of international protection.

1. Every person residing in Hungary, including irregular migrants and asylum seekers, has the right to emergency health care, as regulated by Decree No. 52/2006 (XII.28) by the Ministry of Health on Emergency Health Care Services. Examples of services include:
 - major trauma and wounds, including primary wound treatment, body cavity injury, open fractures, amputations;
 - maternity needs;
 - serious infectious diseases; and
 - attempted or intended suicide, acute psychological disorders.
2. Registered asylum seekers are covered during the 90 days of the asylum process for emergency care, transportation, secondary and tertiary care (both in- and outpatient) and pharmaceutical drugs. Screening and medical treatment (e.g. respiratory infections, gastrointestinal infections, gynaecological problems, scabies, lice, tuberculosis, syphilis, HIV, hepatitis B and C, dental problems, skin conditions, allergic conditions) are available to registered asylum seekers.
3. If international protection is granted (i.e. for refugees and beneficiaries of subsidiary protection), the OIN provides and pays for primary care, in- and outpatient care and pharmaceuticals for those people in need for the first year (ambulance use is covered by the state budget).
4. At the end of the first year, a social security number is provided and in principle access to health care services occurs as for any citizen.

Additional financial resources are provided by NGOs under their relief plans, for example financial resources for the Hungarian Red Cross are provided by the International Federation of Red Cross

and Red Crescent Societies. The Hungarian Red Cross designs and implements its relief plan, but funding for components of that plan are usually obtained through an emergency appeal by the Hungarian Government, specifically the Ministry of Human Capacities, as was the case for this migration crisis. The Hungarian Red Cross has directed funding toward hiring interpreters and volunteers who speak some of the languages of origin for the migrants. They have also provided a handbook in different languages.

Recommendation

- Identify financial implications for an extended elevated response rather than activation of the complete national disaster strategy.

Service delivery

Findings

At the national level of the Hungarian health system, service delivery contains four key service segments: the NAS; national institutes; medical universities; and clinical departments, specialty hospitals and polyclinics. These segments interface with the ministries and central government in financing and public health sectors. All but the NAS has regional, subregional and private sector counterparts performing similar health services.

Public health services in Hungary fall within the remit of the central government, in particular the Ministry of Human Capacities, which provides these services through the NPHMOS, which is responsible for public health; social medicine and health administration; supervision of health service delivery; monitoring and evaluation of sanitary conditions; epidemiological issues and changes in population health status; and health promotion and prevention. Municipalities are responsible for primary health care, including family doctor services (through family physicians and family paediatricians), dental care, out-of-hours surgery services, mother and child health, nurse services and school health services.

In January 2015 there were five open reception centres for refugees, asylum seekers and migrants and two specifically for unaccompanied children; however, during the year Hungary responded to changing needs, including detention centres, after the closure of the green border (over 600 people have been arrested crossing the closed border and 70 detained) (Fig. 6). Some reception centres are intended for a limited stay (e.g. Nagyfa), others for longer stay or specifically for children (e.g. Fót). Individual facilities all have health services that include general practitioner and some provide psychological and post-traumatic stress disorder aid. Two facilities had paediatricians and nursing services. General services provided in reception facilities include hygiene items, toiletries and recreational activities (e.g., sports gym, library, free wifi) and specific activities for children. Families are not separated during the asylum procedure (15).

Fót is an open centre for unaccompanied minor asylum seekers and is one of seven child protection centres in Hungary. Fót has a contingency plan in place, including scenarios for a surge of unaccompanied minors (up to 1000) should a national catastrophe occur. The contingency plan includes it serving as a regional centre, given its capacity to house minors.

Fig. 6. Bicske Open Centre



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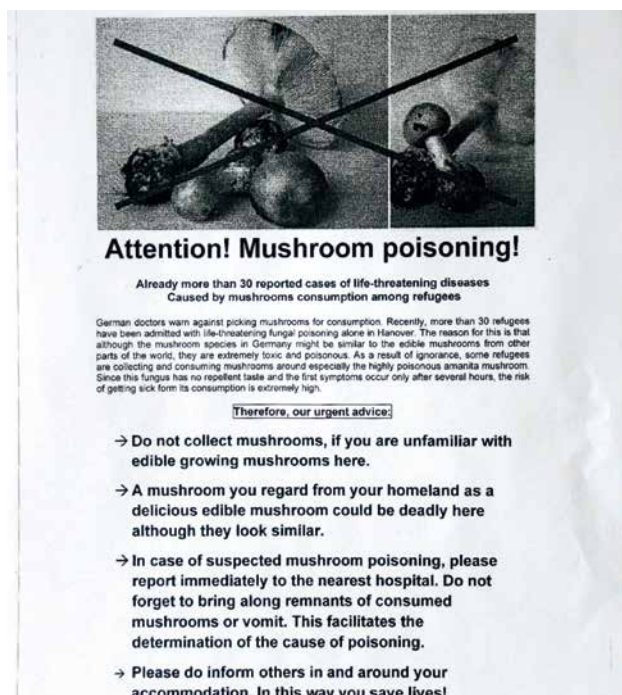
The General Director characterized unaccompanied minors as prior to and following the 15 September legislation. Prior to the legislation, 95% of the minors were aged 16–18 years. Following the 15 September legislation, the average age was 15 years. Prior to the legislation, a backlog of placing minors with guardians existed and minors frequently were not placed for several months. This delay was exacerbated by the transient nature of the minors, who frequently left Fót in pursuit of migration to other EU countries (security measures existed but only minors under 14 years of age needed permission to leave the premises). Following the 15 September legislation, the child protection authority and the child protection guardian system were reinforced and a deadline of eight days for assigning the guardian was introduced in the amendment of the Act on Asylum; as from 1 August, the child protection authority can assign a guardian in several days.

The assessment team visited a number of locations (e.g. health facilities, reception and detention centres, temporary family home, and child protection institute) and talked to staff. From a communication and education perspective regarding infectious and noncommunicable diseases, some places had flyers and posters and included infection control and chronic disease prevention behaviours among the refugees, asylum seekers and migrants (Fig. 7). While this was considered routine in several health facilities, in others educational material was available if requested. Health promotion materials were not provided across institutions in a systematic manner, and only print material was used (videos and interactive media could be helpful in this setting).

The general medical examinations of asylum seekers is mandated by OIN and performed by general practitioners (usually on a contractual basis). These general medical examinations, also referred to as screenings, are distinguished from epidemiological screenings that are performed by the public health authorities, per Section 63 of Government Decree No. 301/2007 (XI.9). (Between January and September 2015, 1392 migrants were screened, and an additional 20 migrants were screened in October prior to the border access legislation.) The outputs of the epidemiological

screening are collected in aggregate form (not personalized), and in some cases samples may undergo further laboratory testing. On the basis of this epidemiological screening, the local public health authority (the public health unit of the municipal office) may take additional epidemiological measures, but they do not initiate further medical examinations and these data are not forwarded to NPHMOS. In summary, the Office of the Chief Medical Officer of the NPHMOS, the public health authorities of the county government offices, and the Public Health and Epidemiological Service of the police closely cooperate to provide general medical screening and epidemiological screening when needed.

Fig. 7. Mushroom poisoning prevention flyer at Bicske Open Centre



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Screening and treatment are conducted in all reception facilities and in October 2015 general medical screening had occurred for 27 435 people; however, with most refugees, asylum seekers and migrants remaining at the reception centres for 24 hours or less, achieving screening and any treatment was challenging, particularly as many individuals are unwilling to take part. While the following services were made available for refugees, asylum seekers and migrants, and many used them, the inherent nature of this moving population did not fully stress health service delivery:

- first medical screening: in the registration centre operated by the police;
- primary care by the OIN;
- secondary care and inpatient care by local health care providers;
- necessary medication, bandages, certain medical devices; emergency dental care, prenatal and maternity care; and
- patient transport in certain cases if state of health means transport cannot be solved otherwise.

The process that asylum seekers and irregular migrants pass through upon entry (e.g. checking of clothing, fingerprinting, registration of details) can be stressful and the stress can be accentuated

by communication challenges of language and culture. Although families are not separated, health or other reasons can lead to separation of a family member. Many families are anxious to leave health care facilities and reception centres to continue their journey regardless of any deteriorating health conditions.

Szeged's police registration centre has responded to increasing needs close to the border by providing health care services to individual irregular migrants and families using mobile health clinics (small buses). Common health problems found include allergies and injuries resulting in between 5 and 10 referrals to hospitals per week. They have built a "bathing container" for scabies treatment that provides a highly efficient means to quickly treat infected individuals (Fig. 8). Refugees, asylum seekers and migrants usually stay in the centre for 24 hours for registration purposes but they can also stay for an additional 12 hours when needed. The police also provide some supplies (e.g. nappies, food, water, hygiene products). Transport to the border with Austria is provided to facilitate the journey. Their doctors and volunteers speak several languages.

Fig. 8. Bathing container at the Szede's police registration centre



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The Hungarian Defence Force, at the request of the OIN, provides medical services such as transit first aid stations for refugees, asylum seekers and migrants (Fig. 9). Further they provide first health screening and first medical aid in transit zones, including for OIN staff, the police and the Hungarian Defence Force as needed.

The NAS has a strong, centralized coordinated response system with 20 dispatch centres and a central dispatch centre in Budapest. They have 561 basic life support ambulance units, 180 ambulance life support units and seven helicopters. NAS performs approximately 1.1 million tasks per year. Refugees, asylum seekers and migrants have needed primary ambulance services at public places or at reception facilities. About 30% of these were males younger than 18 years. Spikes in ambulance calls occurred in August and early September, corresponding to the influx

of migrants. When convoy transport was set up, the NAS organized emergency care on the route as well as at roadside stopping places, ensuring extra health service capacities were available.

Fig. 9. Medical doctor of the Hungarian Defence Force working at the border between Hungary and Serbia



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NAS had plans in place and an alert methodology for activation. While these were not formally activated, the NAS reported that it had developed increased capacity specifically for the migration crisis, providing emergency medical care, medical transport to hospitals and advice to response authorities. Daily reports are provided to the Ministry of Human Capacities, the Ministry of the Interior (Central Operative Group), the NAS General Director and the NAS Director of Operations. Throughout 2015, NAS was repeatedly scaling up and down its response efforts in addition to shifting the areas where it was providing services.

Culturally sensitive communication and the need for cultural mediators were repeatedly mentioned as crucial by responders who had direct interaction with refugees, asylum seekers and migrants. Many NGOs provide support in this area both at reception centres and in hospitals. It was found that English was often used as a bridging language. Again in service delivery, effective and culturally sensitive crisis communication was emphasized.

Recommendations

- Develop and distribute health promotion/disease-prevention education materials unilaterally among health service and reception facilities.
- Develop contingency plans that include health-system/hospital-based scenarios for an influx of patients and longer durations of hospital stay.
- Document best practices (e.g. lessons learnt, case studies, policy briefs) and share among other applicable response entities.
- Develop best practice strategies for scaling up and scaling down the two front-line operational responses (police and the NAS) and incorporate these into contingency plans.

- Develop strategies to collect health data for refugees, asylum seekers and migrants that could be supportive for their care in other countries.
- Incorporate risk-communication strategies at intersectoral and interministerial levels to enhance county and national level communication.
- Consideration should be given as to how procedures at reception and detention centres can sometimes negatively affect health status of refugees, asylum seekers and migrants and to improve communication about such procedures.

Conclusions

Hungary's national response plan has been operating and adapting to large influxes of refugees, asylum seekers and migrants since 2014 when inflows began to exceed the combined figures for several previous years. Although the Hungarian Government did not have a specific contingency plan at the height of the migration crisis in July and August 2015, the national plan was adapted to address some specific aspects of the challenges arising, for example legislation identifying the National Police as the lead for the border health service. Other agencies such as the Hungarian Defence Force and NAS adapted quickly to provide transit first aid stations and medical transport services at very varied and changing locations.

However, additional contingency planning for managing a sudden surge in the influx of these populations, which may happen again, is needed.

- Medical response plans should be created/refined to maximize the effectiveness of the health care workforce, including managing staffing demands of greater intensity and duration; providing support information for staff, service users and the general population (e.g. leaflets/posters); and provision of better cultural mediation/language support in the field.
- More effective integration and utilization of NGOs would help to support services.
- Developing forums for sharing information within the country at the interagency level would enable expertise to be shared across agencies.

NPHMOS determined that the unprecedented migration flow did not imply an epidemic threat but did involve an epidemic risk given the rapid increase in population and the stresses on the migrant population. WHO recommends developing and applying national guidelines for the application of general infection prevention and control measures to all populations, during both crisis and non-crisis times, for example provision of information on hand washing, respiratory hygiene and cough etiquette.

While Hungary has a national health strategy that includes vaccination for all children, regardless of their legal status, the rate of transit seen during the summer surge, in addition to the reluctance for the migrant population to utilize health services or slow their journey, made it difficult to implement this policy. A national strategy will need to be determined regarding the practicality of attempting a vaccination campaign. In this effort, WHO in coordination with UNHCR, UNICEF and IOM can provide recommendations, given migration characteristics and evidence-based immunization recommendations for the country of origin (16).

Concerns about communicable diseases indicate that public health education and guidelines would serve the host population, including health workers, by addressing misconceptions

regarding communicable diseases. WHO has developed educational evidence-based material on communicable and noncommunicable diseases that is available for all countries needed assistance in this technical area.

The Hungarian Government responded quickly to the crisis by putting in place specific interministerial communication and collaboration. However, additional communication strategies for migration contingency planning would enhance communication between central government and local agencies; between agencies in different regions; for health workforce interactions with refugees, asylum seekers and migrants; and for the health and response sector with the media, including training on how and when to brief the media. Crisis communication training at all levels would improve coordination and collaboration. Specific training in how to interface with the media is paramount: for public messaging in all areas of pertinent information on response activities, its potential impact on resident population, and to ease potential fears through education.

There may be value in a WHO-sponsored interactive forum where responders in Member States can learn from those in other countries who have faced similar problems. The WHO Regional Office for Europe is ready to support the country to implement recommendations provided here and as requested.

Hungary's unique geopolitical context of global population pressures is significant; the current migration crisis in Europe will continue to present countrywide capacity challenges. Hungary has national surge plans and, despite not having countrywide formalized contingency plans for the large influxes of refugees, asylum seekers and migrants, has managed the health care aspects for their populations to date, including for its local population and the migrating population arriving to its country.

Many health system lessons have been discussed specific to the six areas of the WHO health systems framework: leadership and governance; health financing; health workforce; medical products, vaccines and technology; health information; and service delivery. The WHO Regional Office for Europe is ready to support the country to implement recommendations provided herein and as requested.

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Annex 1. Glossary

These entries are based on the UNHCR Glossary.¹

Asylum seeker	An asylum seeker is someone who says he or she is a refugee and seeks international protection from persecution or serious harm in his or her home country. Every refugee is initially an asylum seeker, but not every asylum seeker will ultimately be recognized as a refugee. While they are waiting for their claim to be accepted or rejected, they are called asylum seekers. The term asylum seeker does not suggest whether someone is a refugee or not, it simply describes the fact that the person has applied for asylum.
Irregular migrant	An irregular migrant is someone who enters a country in a way not in line with administrative requirements (e.g. without a valid visa and/or travel documents) or someone who enters legally but continues to stay longer than permitted. From the perspective of destination countries, it is entry, stay or work in a country without the necessary authorization or documents required under immigration regulations. From the perspective of the sending country, the irregularity is, for example, seen where a person crosses an international boundary without fulfilling the administrative requirements for leaving the country. Asylum seekers are entitled to stay in a country until their asylum claim is decided; therefore, they cannot have an illegal status even though they may have entered in an irregular way.
Migrant	Any person who chooses to move not because of a direct threat of persecution or death but mainly to improve their lives by finding work, or in some cases for education, family reunion or other reasons.
Refugee	According to the 1951 Refugee Convention, ² a refugee is a person who is outside the country of his or her nationality and is unable or unwilling to take up the protection of that country because of a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion or membership of a particular social group in case of return. People fleeing conflicts or generalized violence are also generally considered as refugees, although sometimes under legal mechanisms other than the 1951 Convention.

¹ UNHCR. Glossary. Budapest: United Nations High Commissioner for Refugees Regional Representation for Central Europe; 2015 (<http://www.unhcr-centraleurope.org/pdf/resources/evaluation-and-research/glossary.html>, accessed 10 May 2016).

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**World Health Organization
Regional Office for Europe**

UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00
Fax: +45 45 33 70 01
Email: eucontact@who.int
Website: www.euro.who.int

