large-scale supplementary immunization activities to vaccinate more than 1.3 million children against polio (and measles, mumps and rubella) in both government-controlled and contested areas. Further campaigns were needed to interrupt transmission in infected areas over the subsequent six months. Neighbouring countries, including Turkey, began planning and implementing supplementary immunization campaigns as part of a multicountry response to prevent the international spread of polio.

WHO recommends that all travellers to and from polio-infected areas be fully vaccinated against polio. Countries receiving travellers from polio-infected areas or accommodating people displaced by the conflict in the Syrian Arab Republic should identify anyone who is un- or underimmunized, or with unknown immunization status, and provide him/her with missing doses of polio vaccine according to the national schedule of the country of origin. High immunization coverage against polio across age groups and high-quality surveillance are essential factors for early alert and all-population protection against polio.

Fig. 2. Crowd at the refugee centre in Mineo, Sicily

© WHO/Matteo Dembech

Leadership and governance

Italy

Article 10 paragraphs 1–2 of the Italian Constitution state that the Italian legal system conforms to internationally recognized regulations on human rights and dignity. In addition, article 32 paragraph 1 states that Italy protects health as the fundamental right of the individual and as a collective interest, and guarantees free medical treatment to all indigents *(4)*.

Law no. 189 of 30 July 2002 *(5)*, also known as the Consolidated Italian Law on Immigration, approved a new set of rules for Italy in the field of immigration and asylum. Concerning asylum in particular, article 32 of this Law and the regulations of its implementation (Presidential Decree no. 303 of 16 September 2004) *(6)* established a new procedure for the examination of applications submitted by asylum seekers asking for recognition of refugee status based on the Geneva Convention *(7)*. The request for refugee status recognition must be submitted to border police

immediately upon arrival in Italy. If no border police are present at the arrival site, the request should be submitted to the relevant provincial police authority for the territory.

Italian law requires an identification procedure, in which the police take a photograph and fingerprints. An applicant must be identified before the asylum application is presented. In principle, an application should be examined within 30 days of submission, but delays of up to a year have been reported and the average time always exceeds 30 days. A territorial commission for the recognition of refugee status examines applications to submitted by the police authority. At the time of writing there were 10 territorial commissions of this type across Italy, but the Ministry of the Interior planned to increase the number to 16 to speed up the procedures.

On 23 October 2013 the European Parliament approved a bipartisan resolution on migrant flows that called for "modifying or revising laws that could impose sanctions on those who offer assistance at sea", thereby implicitly referring to the Consolidated Italian Law on Immigration *(5)*.

Besides refugee status, an international status of subsidiary protection is also applicable. A person eligible for subsidiary protection is a third country national or a stateless person who does not qualify as a refugee but in respect of whom substantial grounds have been shown for believing that the person concerned, if returned to his or her country of origin, or in the case of a stateless person to his or her country of former habitual residence, would face a real risk of suffering serious harm.

According to the Ministry of the Interior, 73% of the migrants who landed in Italy in 2013 came from countries affected by wars or dictatorships, and thus might have the right to be recognized as refugees. Of the 35 085 migrants arriving between 1 January and 10 October 2013, 9805 were from the Syrian Arab Republic (versus 582 in 2012), 8443 from Eritrea, 3140 from Somalia, 1058 from Mali and 879 from Afghanistan. Examining their ports of departure, 21 027 started their journey from Libya, 8159 from Egypt, 1825 from Turkey, 1650 from Greece and 1480 from the Syrian Arab Republic.

All the key components of leadership and governance in relation to national preparedness for and response to influxes of migrant populations come under the remit of the Ministry of the Interior. Within the Ministry of the Interior, the Department for Civil Liberties and Immigration is responsible for immigration and asylum policies and for assistance to immigrants and asylum seekers.

At the local level, the prefecture (territorial government office) located in each provincial capital is the territorial representative of the Ministry of the Interior, with the functions of a peripheral government office. The individual prefecture is responsible for all issues related to migration including overall coordination of preparedness for and response to mass arrivals in its territory.

The *questura* is the territorial state police office; it has provincial jurisdiction under the Ministry of the Interior. Its primary mission is to ensure law, order and public security in the province.

The *azienda sanitaria provinciale* (ASP) is the provincial health authority. This public body is responsible for provision of health services and management of health institutions in a given territory. The various ASPs and the structures (including hospitals and health centres) and services they manage constitute the national health system, which ensures universal health protection and medical assistance to all regularly resident citizens and foreigners.

Undocumented migrants from non-European-Union countries can gain access to all urgent medical care and to a wide range of health coverage through a "temporarily present foreigner" (STP) document. This provides a short-term but renewable anonymous code to all undocumented migrants once they access health services and receive health care under article 35 of the Consolidated Italian Law on Immigration *(5)*. Asylum seekers have the right to receive a national health system code and access to all national health services from the moment their application is submitted under article 42 of the Consolidated Italian Law on Immigration *(5)*.

Associations or cooperative societies that have won Ministry of the Interior tenders to deliver a basic package of health assistance within migrant centres provide primary health care in the centres (Fig. 3). Agreements with the Ministry of the Interior regulate their terms of reference and service provision.

Fig. 3. Migration centre in Lampedusa, Sicily

© WHO/Matteo Dembech

During influxes of migrants, ASP medical teams are responsible for initial medical triage at the point of entry. In the case of migrants arriving by sea, very preliminary medical triage is sometimes conducted on board the rescue boat when medical staff are present.

When a mass arrival of migrants overwhelms local capacity to respond, the regional authorities propose a state of emergency; this is approved and officially declared by the Council of Ministers and the prime minister or relevant minister. If a state of emergency is declared, the Department of Civil Protection takes over responsibility for coordinating the emergency response, with a clearly defined chain of command, contingency plans, response roles and responsibilities. Since 1982 this Department has been based in the offices of the Presidency of the Council of Ministers. It has a guiding role, in agreement with regional and local governments, in projects and activities for the prevention, forecasting and monitoring of risks and emergency intervention procedures.

In Italy, three types of government-run centres host migrants:

- centres for first aid and assistance (*centri di primo soccorso ed assistenza* or CPSAs) to provide initial accommodation for up to 48 or 72 hours after landing;
- open centres for asylum seekers (*centri assistenza richiedenti asilo* or CARAs) to accommodate migrants who have submitted a request for recognition of refugee status;
- centres for identification and expulsion (*centri di identificazione ed espulsione* or CIEs) for illegal migrants waiting to be moved back to their countries – these are "closed" centres and the people within them are not permitted to leave.

In addition, the System of Protection for Asylum Seekers and Refugees (SPRAR), established by Law no. 189 of 30 July 2002, is a network of local authorities with the objective of implementing reception and integration projects through hosting centres, funded by the available resources of the National Fund for Asylum Policies and Services. The Ministry of the Interior also contracts local authorities and third sector organizations to implement interventions, resulting in actions to ensure shelter, food, individual and sociocultural integration support, as well as legal counselling and accompanying health, social and linguistic measures.

SPRAR is characterized by the temporary nature of its scope, which should cover a period of six months according to the guidelines, with the possibility of an extension if the goal of socioeconomic and territorial integration has not been achieved. In 2010, 43% of the beneficiaries of SPRAR achieved these objectives. The statistics show that a majority of them were from Somalia, Eritrea, Afghanistan, Nigeria and Iraq.

The SPRAR network for the period 2011–2013 provided 151 local projects with 3000 places available for the entire three-year period. Significant enlargement is reportedly planned for 2014, increasing availability to 16 000 places.

The Central Directorate of the Civil Services for Immigration and Asylum – a division of the Ministry of the Interior's Department for Civil Liberties and Immigration – plans and sets up migrant centres. The relevant provincial prefecture manages the centres by means of financial agreements with associations or cooperative societies that have won tenders to provide services.

The standard services the centres must provide are:

- personal assistance (including clothing, bedding, personal hygiene, health and psychosocial care, translation and cultural mediation);
- food;
- environmental cleaning and hygiene;
- structural and infrastructural maintenance;
- legal support;
- administrative assistance to help asylum seekers and people eligible for subsidiary protection.

Nevertheless, the minimum requirements of the agreement between the Ministry of the Interior and the contracted parties are open to a certain amount of interpretation. The multi-agency Praesidium project, whose participants include the Italian Red Cross, International Organization for Migration, United Nations High Commission for Refugees and Save the Children, has established a monitoring body in an attempt to harmonize implementation.

According to article 403 of the Italian Civil Code *(8)*, unaccompanied children (aged up to 18 years) cannot be deported and must be accommodated in a safe place. The international NGO Save the Children, however, has expressed concerns over the non-standardized procedures used to determine the age of a child migrant and the poor protection measures adopted. Save the Children has therefore drafted a proposal for a law to protect unaccompanied migrant children. The proposal is likely to be accepted by the government.

Sicily

The Regional Government of Sicily, having responded to previous crises resulting from massive influxes of migrants, issued several legal directives aimed at assisting the immigrant population *(3)*. Nevertheless, Sicily has no regional laws regulating migration, as is the case in other Italian regions. In addition, no regional preparedness or response multisectoral plan is in place in case of sudden large numbers of people arriving from abroad.

In practice, the provincial prefectures are responsible for preparedness for and response to mass arrivals in their territories and have established their own procedures for such events. Of the five provinces visited during the mission, however, only the prefectures of Ragusa and Trapani had drafted an emergency plan of action to assist migrants landing in its territory *(9)*.

A formal interprovincial coordination mechanism is lacking at the local level, although the Central Directorate of the Civil Services for Immigration and Asylum in Rome conducts interprefecture coordination at the national level.

According to the Ministry of the Interior's website *(10)*, Sicily has the following government-run migrant centres:

- first aid and identification centre/CPSAs at Agrigento, Lampedusa (capacity 381) and Ragusa, Pozzallo (capacity 172);
- CARAs at Caltanissetta, Contrada Pian del Lago (capacity 96) and Trapani, Salina Grande (capacity 260);
- a first aid and identification centre/CARA at Caltanissetta, Contrada Pian del Lago (capacity 360);
- CIEs at Caltanissetta, Contrada Pian del Lago (capacity 96) and Trapani, Milo (capacity 204).

During the mission, however, the team was able to visit several additional migrant centres not listed on the website, including:

- the migrant centre in Mineo, Catania Province, which is considered the largest centre for asylum seekers in Europe, with a capacity of about 3000;
- the unofficial migrant centre in Porto Empedocle, Agrigento Province, which is not included as any of the existing types of centre recognized by the Ministry of the Interior;
- the migrant centre "Umberto I" in Siracusa, with a capacity of about 200.

Moreover, it appears that several other migrant centres are not listed on the Ministry of the Interior website or working with an unclear status (not defined as CPSA or CARA). Notifying the regional health authorities of new

migrant centres is not a consolidated procedure enabling automatic verification or support to secure adequate health standards or standard operating procedures.

CPSAs are supposed to host migrants for 48–72 hours, but it is not unusual for migrants to stay for weeks and even months. The same situation exists in CARAs, which should host asylum seekers for a maximum period of 30 days but in reality can host them for several months or even a year or more. The maximum length of stay in CIEs has been extended from 6 to 18 months. Long stays in the centres with uncertainty about the duration of the process for obtaining refugee status has created a tense situation in several centres in Sicily. Riots have been reported in various locations.

Two territorial commissions for the recognition of refugee status are based in Sicily. One is in Trapani, covering the provinces of Trapani, Agrigento, Palermo, Messina and Enna; the second is in Siracusa, covering the provinces of Siracusa, Ragusa, Caltanissetta and Catania. At the time of the mission a third commission was just being set up.

A memo sent by the Regional Department of Health to all ASP directors in 2012 clarified that asylum seekers have the right to receive a national health system code enabling them to access the full range of national health services. In several provinces, however, asylum seekers continue to receive only an STP code, which places some limitations on access to national health services.

Recommendations

1 Establish a regular multisectoral coordination mechanism involving the Ministry of the Interior and Ministry of Health, as well as civil protection, municipality and NGO representatives, at the regional, interprovincial, provincial and municipality levels.

2 Define a regional multisectoral contingency plan for responding to mass arrivals of migrants, including a clear chain of command with roles and responsibilities outlined from regional to municipal levels (an incident command system).

3 Map all existing migrant centres and clarify the legal and administrative status of all structures accepting migrants.

4 Define a regional migrant settlement plan, identifying and mapping possible locations and buildings that could be used as additional migrant centres to decongest existing centres and to be ready to address new migrant influxes.

5 Reduce the length of stay in migrant centres in accordance with existing legislation. Set up additional territorial commissions for the recognition of refugee status.

6 Disseminate information about the rights of asylum seekers to full access to the national health system according to the Administrative Decree 2183/2012 *(11)*.

Health workforce

According to Ministry of the Interior Directive 3154/ D.C.S. 11.6 of 27 November 2002 *(12)*, associations or cooperative societies that have won Ministry of the Interior tenders are responsible for providing:

- primary health care within centres, including initial medical examinations;
- health staff including cultural mediators;
- medicines and basic equipment;
- referrals and retention of individual medical cards.

Contracts define the type of health care that should be provided, but identification of competencies and consequent recruitment of medical staff is open to interpretation. It is therefore left entirely to the contractors, as are working shifts and surge mechanisms in the case of mass arrivals. This creates some discrepancies and nonhomogeneous approaches; for instance, nurses are not always included in the medical teams.

During influxes of migrants, ASP medical teams are responsible for initial medical triage at the landing point (Fig. 4),

but here competencies, team composition and surge mechanisms are not standardized. In the case of migrants arriving by sea, very preliminary medical triage is sometimes conducted on board the rescue boat, but medical staff are not always present on the boats.

Fig. 4. Triage on the shore of Lampedusa, Sicily

© WHO/Matteo Dembech

Occupational health for health staff working in the migrant centres visited during the mission appears to be properly addressed. A standardized approach is lacking, however, so different protection measures are adopted by the various centres.

Medical staff of the national health system dealing with emergencies are offered regular opportunities to attend training and refresher courses. Nevertheless, the curricula focus mainly on lifesaving interventions and resuscitation practices and do not cover specific migration health topics.

Cultural mediators support the work of the health staff in every centre visited during the mission, but are not always present during initial triage at the landing site.

Recommendations

1 Define and promote standard competencies, workforce composition, surge mechanisms and occupational health measures for health staff working in migrant centres and/or implementing rescue and triage activities.

2 Design and implement regular training and refresher courses on migrant health for health staff working with migrants.

3 Systematically include trained medical doctors or nurses in any rescue boats.

4 Systematically include nurses and cultural mediators in any medical team working with migrants.

Medical products, vaccines and technology

Associations or cooperative societies that have won Ministry of the Interior tenders for managing migrant centres provide medicines and basic medical equipment (Fig. 5). They have established agreements with pharmacies or wholesalers for the regular supply of medicines included in the Italian National Formulary. The system has enough stock to cover an increased demand caused by a sudden massive influx of migrants, as demonstrated during the 2011 emergency in Lampedusa, when no shortage of medicines was reported.

Fig. 5. Medical equipment in the migrant centre at Pozzallo, Sicily

© WHO/Matteo Dembech

Medicines are not usually given directly to migrants but are instead administrated in the presence of the health staff of the centre. Treatments for a few days are only given directly if migrants are to be transferred to other institutions.

Staff of the national health system administer vaccines within the migrant centres or in referral health-system institutions. Vaccine stocks and cold chain equipment are reported to be sufficient.

The Ministry of Health's National Department for Communication and Prevention issued a protocol for the immunization of migrants during the 2011 emergency in Lampedusa *(13)*. The protocol recommends administration of the following vaccines to all migrant children with incomplete documentation on their immunization status: measles, mumps and rubella; polio; *Haemophilus influenzae* type b; hepatitis B; and diphtheria, tetanus and pertussis. According to the same protocol, adults should receive only tetanus prophylaxis in the case of wounds. The mission team found, however, that the protocol was not implemented in all centres visited.

A system enabling migrants to keep track of vaccines and/or medical products received is in place in certain centres but is not coordinated or standardized at the national or regional levels.

Recommendations

1 Promote the adoption of essential medicines lists and therapeutic protocols.

2 Promote and monitor the implementation of the Ministry of Health protocol for immunization adopted during the 2011 emergency in Lampedusa.

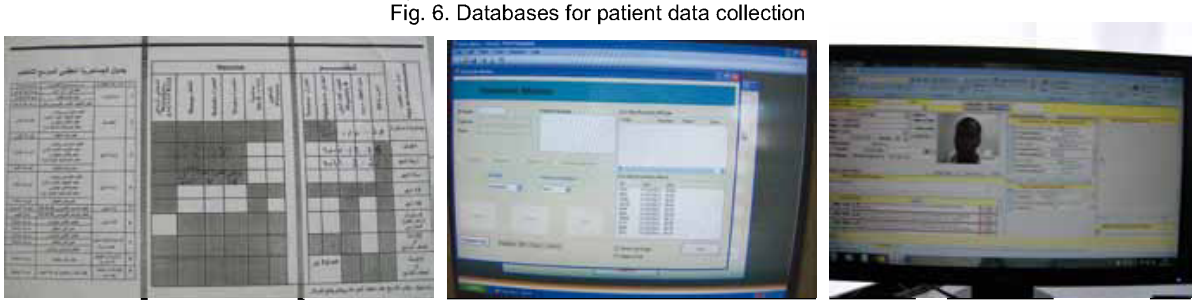
Health information

While overall responsibility for managing migrant influxes lies with the Ministry of the Interior, the Ministry of Health retains important public and individual health responsibilities for migrant and host communities. Effective coordination and information exchange are therefore essential. In Sicily the regional and provincial departments of health and provincial prefectures cooperate to assist migrants, but several gaps exist in the information flow between and within those entities. The Regional Department of Health, for instance, does not have a full map of all migrant

centres on the island because neither the prefectures nor the ASP have provided it with the information. Health teams working in migrant centres are not always informed in a timely manner of migrant arrivals and departures in order better to prepare related health activities.

The migrant centres visited during the mission do not collect or retain health records in a homogeneous and comparable manner. Electronic databases exist in many centres, but they use different programs and the systems cannot communicate with each other (Fig. 6). It is therefore difficult to gain a current and comprehensive picture of the health status of the migrants hosted in all centres.[1]

Fig. 6. Databases for patient data collection



© *WHO/Matteo Dembech*

During the 2011 emergency in Lampedusa the Ministry of Health, in collaboration with the National Institute of Health, adopted a syndromic surveillance system to monitor the health status of the migrants landing on the coastlines of the island *(13)*. The system was later extended to all migrant centres of Italy. It is still active, although the number of reporting sites dropped from 139 in April 2011 to 14 in June 2013. Of the eight reporting sites identified for Sicily, only five reported during the month of June 2013 *(14)*. Other sites in Sicily never activated the system and have thus never reported as part of the network.

Several health staff working in migrant centres expressed the need to clarify various aspects of the syndromic surveillance system to the mission team. Indeed, there are discrepancies in the way data are collected. For instance, each patient should be assigned to only one main condition to avoid double counting. In addition, according to WHO guidelines *(15)*, where possible the number of new visits should be indicated separately from the total number of patient visits on tally sheets and registers to facilitate estimation of proportional morbidity and the overall workload of health facilities. This is not happening in all migrant centres and patients can be counted several times for the same disease.

Regular communication to the public is an essential component of any emergency operation, but a public communication strategy for cases of mass arrivals has not been drafted at either the regional or provincial level. In fact, rumours about migrants carrying various communicable diseases have been widely present in the local media, creating unjustified social alarm and stigma. In June 2013, for example, a local newspaper reported that 40 000 people were at risk of tuberculosis because of the influx of migrants.

Health promotion messages in various languages were present in all centres visited by the mission team.

Recommendations

1 Improve the flow of information between the regional and provincial representatives of the Ministry of the Interior and Ministry of Health, defining focal points, reporting lines and regular information exchange mechanisms.

2 Adopt a regional migration health card, possibly integrating modern technology into the storage and transfer of medical records.

3 Revise and promote the syndromic surveillance system.

4 Define and promote a regional risk information and communication strategy (including press releases, talking points and spokespeople).

[1] One interesting model is used in the CARA in Mineo: each guest receives an electronic badge in which, among other comprehensive information, health records are stored. Using a password, authorized health staff can download personal health records from the badge to any computer connected to the local network set up in the centre.

Health financing

It was not possible to collect precise information about the availability of funds to cover preparedness and response activities in cases of mass arrivals. According to the sparse information collected, regional and provincial institutions do not have contingency funds. Moreover, it seems that the central government has not yet reimbursed funds disbursed by regional health authorities during the 2011 emergency in Lampedusa. In 2011, medical evacuation expenditure amounted to €5 million due to increased services for the migration emergencies *(2)*. A cost estimate of the ongoing response operations is not available.

Recommendation

1 Conduct an analysis of the costs to the regional health system of the ongoing response.

Service delivery

Health

In the case of migrants arriving by sea, very preliminary medical triage is sometimes conducted on board the rescue boat by medical staff of the navy or of the Order of Malta, but medical staff are not always present on the boats. Urgent cases are evacuated from the rescue boat to the nearest health institution by helicopter.

ASP medical teams are responsible for initial medical triage at the landing point (Fig. 7).

Fig. 7. Medical team at the shore conducting triage

© WHO/Matteo Dembech

The scope of the triage is to:

- identify urgent cases that must be referred to hospitals;
- certify the absence of infectious diseases that contraindicate transfer to a migrant centre.

Cases of scabies are transferred to separate isolation rooms in the migrant centre. Cases of suspected tuberculosis are usually moved to the nearest hospital.

During the 2011 emergency in Lampedusa, NGOs and Red Cross medical teams also provided triage at landing sites. No standardized triage system was in place during that crisis, however, and none has yet been implemented.

Associations or cooperative societies managing the migrant centres are responsible for providing:

- primary health care within centres, including initial medical examinations on arrival;
- health staff including cultural mediators;
- medicines and basic equipment;
- referrals and retention of individual medical cards.

Nevertheless, primary health care in migrant centre Umberto I in Siracusa is provided by EMERGENCY, an Italian NGO; ASP staff provide primary health care in the centre at Porto Empedocle, Agrigento and in the CPSA in Pozzallo, Ragusa; and the Italian Red Cross is responsible for primary health care in the CARA in Mineo, Catania.

Environment

Water and sanitation systems are connected to the public system in all centres visited by the mission team except in Mineo and Trapani, where there are dedicated water pump stations and sewage treatment systems. Drinking-water is distributed in plastic bottles.

The water supply and sanitation system in Lampedusa, however, is unusual and in need of particular attention. The absence of spring sources of potable water on the island obliges the local administration to provide water for the population in tankers from Sicily or by local desalination. Treatment and storage of the water remain risky processes. The CPSA in Lampedusa receives water from a desalination plant and from the municipal network.

Since the 2011 crisis the authorities in Lampedusa have initiated work to upgrade wastewater treatment: the new plant will be completed in 2015. Until that time, all wastewater generated on the island is discharged, without prior treatment, directly into the sea through 800 metres of pipes *(2)*.

Numbers of toilets and showers in the migrant centres match minimum standards for the capacity originally planned, but the centres are often overcrowded and greatly exceed their capacity for weeks and even months at a time. In such cases, water and sanitation systems, individual space and overall hygiene conditions become inadequate.

All the centres visited during the mission have a public system for the collection of medical and non-medical waste. Disinfestation, however, is not regularly conducted in all the centres visited.

Migrants are accommodated in a variety of buildings: residential cottages (Mineo), containers and restored barracks (Caltanissetta), former schools (Siracusa and Trapani), prefabricated buildings (Porto Empedocle and Lampedusa) and warehouses (Pozzallo) (Fig. 8).

Fig. 8. Improvised shelter

© WHO/Matteo Dembech

Associations or cooperative societies managing the migrant centres are responsible for providing food, environmental cleaning and hygiene, and structural and infrastructural maintenance. Catering services provide food in the centres visited during the mission except in Mineo and Lampedusa, where food is prepared in the centres' kitchens. Food for children, and that meeting special nutritional and cultural requirements is available. Individual hygienic kits are distributed, but daily new arrivals to already overcrowded environments with overused facilities create substantial managerial difficulties. These result in the poor hygienic conditions observed, to different degrees, in all centres visited during the mission.

Not all the centres visited seemed to have satisfactory safety standards. The mission team did not include a building code expert, but an engineer from the regional civil protection authority encountered in the migrant centre at Porto Empedocle reported that the centre does not meet minimum acceptable levels of overall fire safety. This situation has been reported to the Prefecture of Agrigento.

In addition, the centre in Porto Empedocle is located less than 100 metres from a sewage treatment plant. This is in contravention of Annex 4 point 1.2 of the Resolution of the Interministerial Committee for the Protection of Waters Against Pollution and Law no. 319 of 10 May 1976 *(16)*, which state that the minimum distance of sewage treatment plants from inhabited buildings should be 100 metres.

The situation in those centres not listed as official migrant centres is of particular concern. Local health authorities are not systematically informed about their opening, and thus cannot perform the necessary hygiene and safety inspections.

Recommendations

1 Establish and maintain homogeneous minimum standards of living conditions in accordance with the Sphere Handbook *(18)* in all types of migrant centres, according to the right to life with dignity set out in the Universal Declaration of Human Rights *(18)*.

2 Certify the adequacy (including capacity, furniture, safety, hygienic conditions, proper water and sanitation systems, heating and cooling systems, and safe structure and infrastructure) of any site chosen as a migrant centre before using it.

3 Share information between the Ministry of the Interior and Ministry of Health on existing official and non-official migrant centres and future settlement plans.

4 Systematically monitor agreements with entities managing migrant centres.

Testing the draft assessment toolkit

The toolkit was not employed as a questionnaire asking for "yes" or "no" answers because of the complexity of the context; rather, it was used as standard structure to follow during the interviews.

The toolkit addresses all major issues related to preparedness for and response to influxes of migrants, although some questions are redundant.

Using the six key functions of the WHO health-system framework as a structure represents an effective method for assessing preparedness for and response to influxes of migrants. The format should be adapted, however, to the different levels of the health system.

Recommendations

1 Eliminate redundant questions.

2 Regroup the questions according to the level of the health system assessed, creating different questions to ask at national, regional, subregional and local levels.

3 Add specific forms for assessing living conditions in migrant centres.

Conclusions

The health preparedness and response system for influxes of migrants in Sicily requires improvement in some aspects of overall management related to governance, health coordination and information management. Experienced human resources for health, tools and equipment are present. The lack of specific regional legislation and the absence of a mechanism for regular coordination and exchange of information between and within the Ministry of the Interior and Ministry of Health at regional, subregional and local levels, however, result in disparate and sometime inconsistent approaches.

WHO can have an important technical advisory role supporting regional authorities in setting up sustainable, efficient and effective regional mechanisms of preparedness for and response to influxes of migrants. This would also reduce repeated calls for a state of emergency and the consequent vertical, expensive and ad hoc interventions of the national civil protection authorities for events that could be managed at the regional level.

References

1. Toolkit for assessing health-system capacity for crisis management. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0008/157886/e96187.pdf, accessed 13 January 2014).
2. Second assessment of migrant health needs in Lampedusa and Linosa, Italy. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0010/184465/e96796.pdf, accessed 14 January 2014).
3. Increased influx of migrants in Lampedusa, Italy. Copenhagen: WHO Regional Office for Europe; 2011 (http://www.euro.who.int/__data/assets/pdf_file/0004/182137/e96761.pdf, accessed 14 January 2014).
4. Constitution of the Italian Republic. Rome: Senato della Repubblica; 1947.
5. Legge 30 luglio 2002, n.189. Modifica alla normativa in materia di immigrazione e di asilo [Law of 30 July 2002, No. 189. Changes in the legislation on immigration and asylum]. Rome: Parliament of the Republic of Italy; 2014 (http://www.parlamento.it/parlam/leggi/02189l.htm, accessed 19 August 2014).
6. Italy: Decree of the President of the Republic No. 303 of 2004, regulations related to the procedures for the recognition of refugee status. National Legislative Bodies; 2014 (http://refworld.org/country,,,DECREEES,ITA,4562d8b62,47c6c5b12,0.html, accessed 20 August 2014).
7. The Geneva Conventions of 12 August 1949. Geneva: International Commitee of the Red Cross; 1995 (http://www.icrc.org/eng/resources/documents/publication/p0173.htm, accessed 26 August 2014).
8. Italian Civil Code translated in English. Milan: Wolters Kluwer Italia; 2014 (http://www.altalex.eu/content/italian-civil-code-translated-english, accessed 20 August 2014).
9. Piano provinciale di soccorso e assistenza in emergenza sbarchi [Provincial plan for rescue and assistance to migrants landing in Ragusa province]. Ragusa: Prefettura – Ufficio Territoriale del Governo di Ragusa; 2010 (in Italian).
10. I centri dell'immigrazione [The immigration centres] [website]. Rome: Ministry of the Interior; 2013 (http://www.interno.gov.it/mininterno/export/sites/default/it/temi/immigrazione/sottotema006.html (in Italian), accessed 14 January 2014).
11. Administrative Decree 2183/2012. Palermo: Sicily region (https://pti.regione.sicilia.it/portal/page/portal/PIR_PORTALE/PIR_LaStrutturaRegionale/PIR_AssessoratoSalute/PIR_Decreti/PIR_Decreti2012/Linee%guida%20stranieri%2017-10-2012.pdf, accessed 18 August 2014).
12. Linee guida e convenzioni tipo per la gestione di Centri di permanenza e di centri di identificazione [Guidelines and conventions for managing prevention and identifications centres]. Prot. 3154/D.C.S./11.6. Rome: Ministry of the Interior; 27 November 2002.
13. Protocollo operativo per la sorveglianza sindromica e la profilassi immunitaria in relazione alla emergenza immigrati dall'Africa settentrionale [Operational protocol for syndromic surveillance and prophylactic immunity in relation to emergency immigrants from North Africa]. Rome: Ministry of Health; 2011 (http://www.salute.gov.it/imgs/C_17_newsAree_1478_listaFile_itemName_1_file.pdf (in Italian), accessed 14 January 2014).

14. Sorveglianza sindromica: popolazione immigrate [Syndromic surveillance: immigrant population] [website]. Rome: National Centre for Epidemiology, Surveillance and Health Promotion; 2013 (http://www.epicentro.iss.it/focus/sorveglianza/immigrati.asp (in Italian), accessed 14 January 2014).

15. Outbreak surveillance and response in humanitarian emergencies: WHO guidelines for EWARN implementation. Geneva: World Health Organization; 2012 (http://www.who.int/diseasecontrol_emergencies/publications/who_hse_epr_dce_2012.1/en, accessed 14 January 2014).

16. Sustainable Water Management through Common Responsability enhancement in Mediterranean River Basins [website]. (http://www.waterincore.eu/deliverables/03_01_03_en.pdf, accessed 20 August 2014).

17. Sphere handbook: humanitarian charter and minimum standards in humanitarian response. Geneva: Sphere; 2011.

18. Universal Declaration of Human Rights. New York: United Nations; 1948.

Annex 1. Glossary

Displaced population
People who have fled their country due to persecution, generalized violence, armed conflict situations or other man-made disasters. These individuals often flee en masse *(1)*.

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 *(1)*.

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) *(1)*.

WHO toolkit for assessing local health-system capacity to manage sudden massive influxes of migrants
This WHO toolkit has been developed for assessing the capacity of local health systems to prepare for and respond to emergencies caused by large influxes of migrants. It comprises assessment forms with instructions for completion to evaluate preparedness and response. It includes a glossary of the key terms used in the document; procedures for and recommendations on using the toolkit; and a list of possible sources of information required for the assessment. The assessment forms are sectioned according to the six functions of the WHO health-system framework.

Reference

1. Toolkit for assessing health-system capacity for crisis management. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/_data/assets/pdf_file/0008/157886/e96187.pdf, accessed 13 January 2014).