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Healthcare access for refugees in Greece: challenges and opportunities

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Highlights:

- Influx of refugees into Europe highlights the need for health system preparedness
- Greece's economic crisis impacts its ability to respond to the health needs
- Predominantly Syrian, Iraqi and Afghani refugees in Greece present particular challenges
- Responding to refugee health needs encourages governments to consider universal healthcare access
- The Global Compact on Migration (2018) should benefit refugees and host communities

Key Messages

- The refugee and migrant health response in Greece has been impacted by Greece's economic crisis and pre-existing strains on its health system.
- The influx of predominantly Syrian, Iraqi and Afghani refugees led to challenges to providing socially and culturally appropriate healthcare.
- There are valuable lessons to learn from health system preparedness, responsiveness and capacity to manage the protracted phase of large influxes of refugees and migrants in the European context.

- Expanding healthcare coverage for both refugees and local populations could strengthen Greece's health system and support universal health coverage.

Abstract:

The arrival of more than one million refugees and migrants in Europe in 2015, most of whom transited through Greece, has placed significant strains on local health systems and demonstrated the need for preparedness to meet the immediate and longer-term health needs of arrivals in EU countries. Population movements will continue to occur and the need for cost effective, appropriate provision of both primary and secondary health services to meet these needs is key. The Global Compact on Migration was ratified in 2018 and forms an overarching, international agreement to address safe, orderly and regular migration which benefits refugees and migrants as well as host communities; however, it did not give due emphasis to health. In this manuscript, we explore the evolution of the health response for refugees in Greece over the last three years, the challenges faced at different times of the response and the efforts to integrate refugees into Greece's health system.

Background:

Current international conflicts, particularly those in the Middle and Near East have resulted in the largest population movements since World War II. The Syrian conflict alone has displaced 6.6 million people inside Syria and caused more than 5.6 million refugees, the majority of whom are hosted in countries neighbouring Syria.[1] The protracted nature of the conflict and the increasingly harsh conditions faced by refugees in neighbouring countries with poor labour prospects and poverty has led to

a significant increase in refugees taking perilous routes from Turkey to Greece, often paying thousands of dollars to smugglers to make the short journey by sea to arrive in Greece. Greece has been seen as a gateway to Europe, with the aim of reaching destination countries in Northern Europe and seeking asylum; as such, Greece was intended as a transit rather than destination country for many of the refugees. As a result, 2015 saw over one million arrivals to Europe by sea, 80% of them to Greece.[2]

The arrival of refugees and migrants, usually via the islands in Greece, has posed significant challenges for the Greek authorities, the UNHCR, international non-governmental organisations (iNGOs) and local NGOs (a number of which were formed in response to the crisis). Figure 1 shows the Eastern Mediterranean route taken by refugees to enter Greece. Up until 2015, after arrival on the islands, refugees either walked or were transported to First Reception Centres (FRCs) such as the one in Moria camp near Mytileni airport on Lesvos Island.[3] Refugees were registered by the UNHCR and those eligible for asylum were transported by ferry to mainland Greece. From there, they could continue their journey, often crossing the Former Yugoslav Republic of Macedonia (FYROM) border. At the FRCs, the initial medical screening and examination occurred alongside psychological assessment to identify particular vulnerability. FRC's were initially planned in 2010 and brought into Greek law in 2011.[3] The First FRC was opened in 2013 in Evros; however, for the purpose of this manuscript, the term FRC will refer to the 'hotspot' FRCs created by the European Commission in response to the 'exceptional migration flows' in 2015.[4,5] Located on five Aegean Islands, the initial centre was built on Lesvos in October 2015 followed by further ones in Chios, Samos, Leros then finally Kos in February - June 2016. FRC's were also intended to aid both Italy and Greece who were receiving

disproportionate flows of refugees at the time, to meet their obligations under EU law to swiftly identify, register, process and relocate refugees either through return operations or relocation in Europe.[6] The total capacity of all FRC's was initially planned to be 7,450 places, later revised to 5,576, yet the total capacity since conception has frequently been above this, approaching 11,000 people in December 2017 in Lesvos, of whom up to 30% are children.[7] In response to the lack of capacity in FRCs, closed or highly restrictive camp boundaries have been modified to include entire islands as areas of restriction with deportation orders pre-emptively arranged for each individual and placed on hold while the asylum process is completed.[4] This changing nature of population movement and restriction has implications for service provision and identification of medically high-risk individuals.

Two important changes to refugee policy occurred in March 2016 with significant implications for refugee flows and healthcare provision to refugees in Greece. On the 18th March 2016, the EU-Turkey deal was announced with the central premise that irregular refugees and migrants would be returned to Ankara if they had not made formal asylum applications in Turkey. For each refugee returned, the EU would resettle a Syrian refugee from Turkey who had qualified for asylum.[8] This led to a substantial decrease in the number of arrivals to Greece.[9] (see figure 2) Subsequent changes in EU funding strategies in August 2017 meant that the majority of EU funds, which had previously supported iNGOs, started to be channelled through Greek government services. This led to a number of large NGOs scaling back their projects or leaving Greece, with significant impact on health service provision for refugees. [10] Secondly, on 20th March 2016, several thousand people became stranded due to the closure of the FYROM border with Greece, creating informal settlements such as Idomeni and

EKO camps as a result. By May 2016, *informal* settlements were evacuated by Greek authorities and refugees were transported to formal camp settlements across Greece.[11] Figure 3 shows the location of these *formal* camps across mainland Greece and the islands.

In 2018, the Global Compact on Migration was ratified with the aim of supporting safe, orderly and regular migration with benefit to refugees and migrants as well as host communities. Though this could impact migration to Greece, 28 countries did not sign the final agreement which could lessen its impact. In addition, the Compact did not highlight health as a priority.[12]

It is against the background of these changes that we explore the provision of healthcare for refugees and how this has evolved, the challenges faced by the main stakeholders, potential solutions and a discussion of the integration of refugees into the Greek health system. In this text, we use the term refugees to refer to refugees, forced migrants and asylum seekers for ease of description. All authors have worked directly on the Greece refugee crisis at different times since December 2015.

Evolution of the health response and challenges faced

Between 2012 and 2015, a WHO Euro Office assessment was performed together with the Greek Ministry of Health and the affiliated KEELPNO (Hellenic Centre for Disease Control and Prevention), which assessed Greece's health system capacity to manage a large influx of refugees and migrants.[13] They made broad recommendations including the implementation of a multi-sectorial contingency plan

to deal with a sudden influx of a large number of refugees and migrants; the development of a national curriculum for cultural mediators and the harmonization of data collecting systems. It was noted that at that time, there was no comprehensive contingency plan to cope with a large influx of refugees and migrants and no standardized vaccination strategy for those in the FRCs. The lack of coordination predicted in this report was realised shortly after with an increase of monthly arrivals of refugees; this peaked at over 200,000 in October 2015.[14] (see figure 2) This was further demonstrated after the closure of FYROM border when up to 60,000 refugees remained in Greece.[14]

The rapid and substantial increase in refugee arrivals to Greece, particularly in 2015, combined with evolving health priorities at various parts of their journey and the nature of the changing situation have provided challenges to the formation of an effective health response which meets the needs of recipients.[15] It demonstrated a lack of preparedness within Greece's health system (which was already weakened by the economic crisis), responsiveness and resilience.[13] The complexities in the coordination between the Greek government/ NGO division of responsibility led to complex coordination of financial, logistic and political resource management in Greece from 2015 onwards. Key leadership positions and cluster groups (groups of humanitarian organisations which include NGOs and UN organisations who support the sectors of humanitarian e.g. health) were slow to be established and lacked clear communication and planning with participants. This was further complicated by inconsistent and bureaucratic government function, preventing adequate resource mobilisation on the ground and responsiveness for the benefit of communities in need.

The health response in Greece was also complicated by the wider economic and political situation in Greece in the preceding years.[15, 16] After significant economic recession and widespread unemployment, the relationship between Greece and the EU became strained and Greece required financial bailouts on several occasions to prevent bankruptcy.[17] During this period, austerity measures strained host community cohesion and reduced access to some healthcare services as employment-related health insurance rates fell.[18] The arrival of refugees exposed gaps in the already overwhelmed health system and led to a call for regional assistance for healthcare and humanitarian provision.

The first responders to the islands and informal camps after the closure of the FYROM border were large iNGOs including Medecins Sans Frontieres (MSF). Alongside the traditional emergency actors were independent individuals, informal groups of healthcare and humanitarian volunteers and non-established small NGOs who often lacked prior experience of working in these settings. A delay in regulation and restriction of healthcare providers from government and iNGO leadership led to an uncoordinated and complex mix of services. This impacted the quantity, equity, quality and duplication of health services for the refugees. This often meant that SPHERE guidelines and comprehensive best practice guidelines were often overlooked.[19] The inconsistent regulation and standardisation of service provision continued after the closure of the informal refugee camps in May 2015 and the relocation of refugees to formal refugee camps (see figure 3) though KEELPNO and the Greek Ministry of Health were the overall coordinating body and their permissions were required for medical and non-medical providers to work in the formal refugee camps.

The lack of leadership and coordination was most exposed by the slow winterization program (preparedness for winter weather), particularly in December 2016 when heavy snowfall made already difficult living conditions more challenging. Petra camp, which housed 1500 Yazidi refugees who had fled ISIS attacks in Syria and Iraq and who resided in tents at the foot of Mount Olympus since the spring of 2016.[20] More than 54% of camp residents were children and faced harsh conditions with heavy snowfall. Camp residents were subsequently relocated to apartments, hotels and other camps as part of a program to provide shelter for 19,500 refugees and vulnerable asylum seekers which began in 2016. [21] The winterization program was hampered by limited coordination between actors, which could have ensured smooth relocation of refugees, or the use of common warehousing for winterization procurement needs which would have led to improved sharing of resources and reduced costs.[22]

Many NGOs (both small and established) found operating in Greece to be bureaucratic and expensive. This led to challenges in establishing and maintaining registration, opening bank accounts and maintaining the high per refugee cost of providing healthcare in Greece compared to non-EU countries or countries with lower costs of operating. Many of the larger iNGOs sought EU funding which was allocated in funding cycles so that services could be centralised and rationalised. In the summer of 2017, it was announced that EU funds would be channelled through government services making it increasingly challenging for NGOs in Greece to continue their work. This led many to restructure or pull out of Greece once their remaining funds were finished.[10]

The Greek Ministry of Health set up programs such as Philos (Emergency Health Response to Refugee Crisis), which were implemented by KEELPNO through the Asylum, Migration and Integration Fund from the EU.[23] Philos received 24 million Euros from the European Union and aimed to take a comprehensive approach to providing health services for refugees as well as strengthening the Greek health system to manage the increased demands particularly in secondary care.[23] Philos aimed to recruit health professionals and support staff, including drivers and translators to fulfil their commitments. Subsequently, health care services for refugees were increasingly streamlined with the relocation of migrant communities to urban centres, development of polyclinics and reduction in duplication of services between migrant and local host populations; the urbanization strategy began in late 2016. In July 2017, the ESTIA (Emergency Support to Integrate and Accommodation System) scheme commenced its program of providing refugees and their families with urban accommodation and cash assistance.[24] This European Commission funded scheme is administered by the UNHCR to support shelter for vulnerable asylum seekers and refugees; in April 2018, the European Commission pledged 180 million euros to continue this program and others which support migrant aid projects.[24]

Healthcare access for refugees in Greece

Greece is a signatory to the main human rights and legal frameworks pertaining to refugees and, in line with the Dublin Regulation, is responsible for providing for the needs of asylum seekers who apply in Greece.[25] In 2016, the majority of refugees arriving in Greece were from Syria (47%) followed by Afghanistan (24%) and Iraq (15%) with smaller percentages from Pakistan and Iran.[26] Healthcare priorities can

be understood in the context of each individual journey, typically focused on emergent and acute care in the days and weeks after arrival in Greece, transitioning to a dominant focus on mental health complaints and chronic conditions in the subsequent months and years. [15]

To transit through Greece and continue their journey, refugees needed to walk for hours in cold, damp conditions and sleep by roadsides or with minimum shelter. Healthcare access during these times was sparse.[27] After the closure of the FYROM border in March 2016, refugees in informal camps could access primary healthcare clinics provided by small or iNGOs. Referrals for secondary care were made into the Greek health system [28] but transport for both secondary or emergency care was expensive and had to be covered by the refugees themselves.

This situation changed in May 2016, when these informal camps were forcibly evicted and refugees were sheltered in formal refugee camps across Greece.[29] (see figure 3) These took many forms but were often far from main urban centres with poor transport links. Each camp was intended to shelter around 600 refugees but often sheltered more.[30] The Ministry of Health worked with NGO providers to deliver primary health care at these sites. Secondary care referrals were made into the Greek health system where necessary, however they often incurred high costs either for the NGO provider or for individual patients as the costs of transport, medications and potentially subsequent specialist care had to be met. Once in hospital, language was an additional key constraint. For reasons of miscommunication, refugees could miss appointments or were unable to communicate effectively with the care providers. Some NGOs attempted to provide a cultural mediator service in hospital facilities

during working hours however this was not always effective or sufficient.[13] The Philos program sought to address this however they were often unable to recruit and retain sufficient mediators and translators.[23]

Some refugees found the focus on primary healthcare rather than direct access to specialist secondary consultations frustrating; this was compounded by the restricted ability to communicate with health providers and understand the system. These frustrations often reflected the difference in health system expectations between country of origin and country of residence. For example, Syria's health system before the conflict consisted of a mix of public and private healthcare provisions with a heavy reliance on direct specialist consultations.[31] This led to confusion and exasperation particularly among Syrian refugees who were used to accessing specialist services readily in Syria rather than accessing primary healthcare first. Similar issues were present in FRCs on the Islands where NGO-led healthcare was often underfunded and insufficiently equipped to manage chronic and complex health conditions including mental illness.[32]

Integration of refugees into the Greek health system

By the end of January 2019, it is estimated that 26,452 accommodation places have been created for refugees and asylum seekers in urban settings, mainly through the ESTIA program.[24] As of December 2018, there are 71,200 refugees in Greece (56,600 on the mainland and 14,600 on the islands) meaning that the majority of refugees still remain in camps.[33] Healthcare for the two populations differs with integration into the Greek health system more likely for those who are urbanized. Table

1 summarizes some of the challenges that the integration of refugees into the Greek health system raises.

The Philos program which aims to strengthen the Greek health system to support both refugees and host populations has met with partial success due to challenges in recruitment and programming. This has been compounded by Greece's on-going economic crisis which has led to struggles to provide healthcare for its local population and affected its health system. It has led to an exodus of Greek healthcare workers and insufficient resources in health facilities alongside an increase in out of pocket expenditure for Greek citizens.[10] However, as of April 2016, access to healthcare is no longer linked to employment-based health insurance, a move that provides benefit not only for refugees but also uninsured local populations.[34] As such, investing in healthcare provisions for the refugee population and in Greece's heath system can also support healthcare for host populations including vulnerable populations by broadening healthcare access. To access healthcare, a social security number is now required which is intended to equalise access and remove barriers to care. Unfortunately, the recognition and implementation of these changing regulations has been inconsistent and slow, as has the provision of social security paperwork to members of the population.[13] As a result, access pathways to healthcare services continue to separate health provision for refugees and migrants from that of the host populations in spite of political commitment to integrate from both the Greek government and UNHCR.[35]

Healthcare integration for refugees in Greece is further complicated by the variation in health system structure between countries of origin, destination (Greece) and

providers of healthcare (often from Europe and/or the USA). The concept of general practice or family medicine as a cornerstone of community-based care was common in proposals and programs from iNGO's providing care at the start of the refugee influx in Greece and continues to be prioritised in EU and international funding models.[23] However, outside of the refugee context in Greece, primary care is often privatised and/or hospital based and very distinct from the general practice model in other countries in Europe though new policies on primary healthcare in Greece are being initiated in cooperation with the WHO.[36,37] As a result, transitioning from NGO to government run services has political, cultural, financial and logistical implications that affect both the host and refugee populations.

The transition from NGO to government led health services has been completed in some regions and is yet to commence in others.[38] In areas where primary healthcare for refugees is being adequately covered by the Greek health system, there remains a lack of tailored services that take into account culture and language barriers; this includes refugees in urban centres. Service provision is further complicated by inconsistent organisational structures, where a number of ministries share responsibility for the healthcare of refugees; these could be streamlined to reduce variation in government bodies responsible for the provision of healthcare across different locations. For example, the Ministry of Migration Policy is responsible for the health of refugees in Reception Centres on the islands rather than bodies that sit under the Ministry of Health. Relevant legislation and regulation remains regionally diverse and is most pronounced when considering the mainland centres and those on outlying Islands.[38]

Mainstreaming health services for both host and refugee populations is intended to improve access to the health system for all as it allows staff to be more efficiently mobilised for both populations resulting in reduced tensions and competition among host and refugee populations.[39] One the main objectives of the Philos program was to increase staffing to meet the healthcare needs of refugees, including translators in public hospitals, increased epidemiological surveillance and provision of primary care facilities in the remaining refugee camps.[30] This was with the aim that all healthcare provision for refugees both in camps and in urban centres will be led by the government through KEELPNO. However, the program has been challenged by difficulties in the recruitment of sufficient specialised staff, particularly to the islands where refugees continue to arrive resulting in staff shortages and has meant some primary healthcare services on the islands continue to be provided by NGOs. The shortage of staff and services has impacted health screening for communicable diseases, mental healthcare and care for refugees with particular vulnerabilities such as sexual and gender based violence (SGBV) [40] and victims of torture.[41] Innovative recruitment methods, introducing limited registration for refugee healthcare workers or removal of legal barriers to allow specialist staff from outside of Greece or from among the refugee populations to work within their field represent some of the ways in which staffing constraints may be lessened; this could be applicable for translators, cultural mediators and other healthcare workers.

Conclusion

The rapid and large influx of refugees and migrants into Greece which escalated in 2015 has posed significant challenges to healthcare provision and demonstrated the

need for preparedness to meet the immediate and longer-term health needs of arrivals into EU countries. Population movements will continue to occur, especially as a result of protracted situations of conflict and violence and the need for cost effective, appropriate provision of both primary and secondary health services to meet these needs is key. Additionally, expanding healthcare coverage for both refugees and local populations could strengthen Greece's healthcare system, supporting universal health coverage.

The Global Compact on Migration was ratified in 2018 and is to form an overarching, international agreement to address safe, orderly and regular migration which benefits refugees and migrants as well as host communities; this could have important implications for migration in Europe. However, the scarce mention of health in the Compact misses an opportunity to re-enforce the concept of health as a human right as enshrined in international law.[12] The experience in Greece has demonstrated the need for preparedness, responsiveness and resilience across Europe's health systems to respond effectively to large scale population movements as has occurred in Greece. Improved coordination between national agencies such as KEELPNO and international agencies, streamlining of health services, providing a cultural mediator service are some of the potential solutions for future responses in similar settings.

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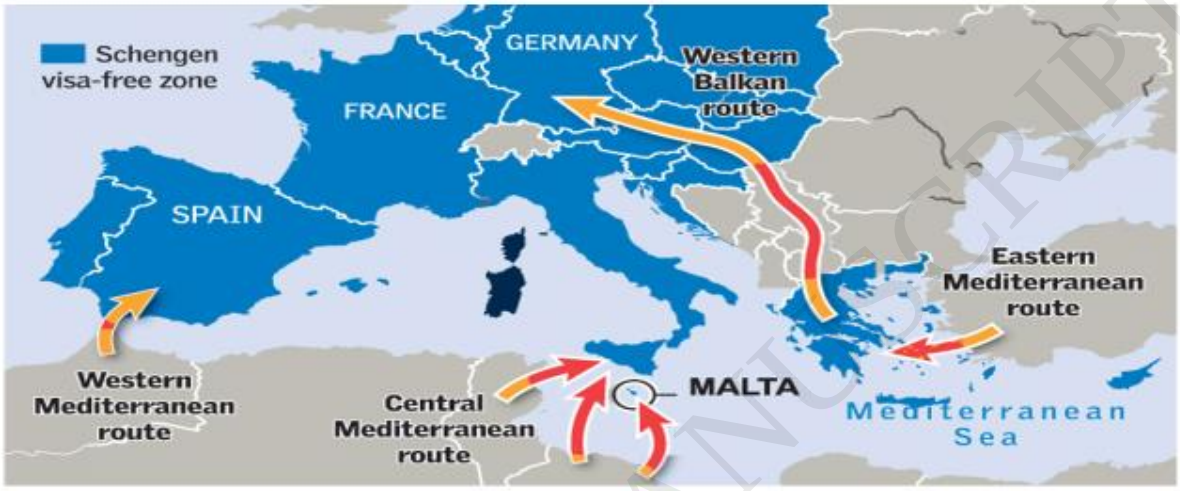
Figure 1: This figure shows the Eastern Mediterranean route taken by refugees to enter Greece with the aim of reaching northern Europe. Under the EU-Turkey detail (March 2016), it was agreed that refugees would be returned from Turkey to Greece; in return, Turkey received refugee-aid and the promise that the EU would resettle a Syrian refugee from a Turkish refugee camp for every refugee returned to Greece.



Source: Quatro Strategies: http://www.quatrostrategies.com/2016/03/06/latest-info-graphics-on-syria-and-migrant-crisis/

Figure 1: This figure shows the Eastern Mediterranean route taken by refugees to enter Greece with the aim of reaching northern Europe. Under the EU-Turkey detail (March 2016), it was agreed that refugees would be returned from Turkey to Greece; in return, Turkey received refugee-aid and the promise that the EU would resettle a Syrian refugee from a Turkish refugee camp for every refugee returned to Greece.

Figure 2: This figure shows the number of refugees arriving each month with arrows showing key dates and events relevant to the health response for refugees in Greece. In May 2016, 'informal' camps like Idomeni and EKO were closed and refugees were moved to 'formal' camps across mainland Greece. NGO – non-governmental organization.
https://data2.unhcr.org/en/situations/mediterranean/location/5179

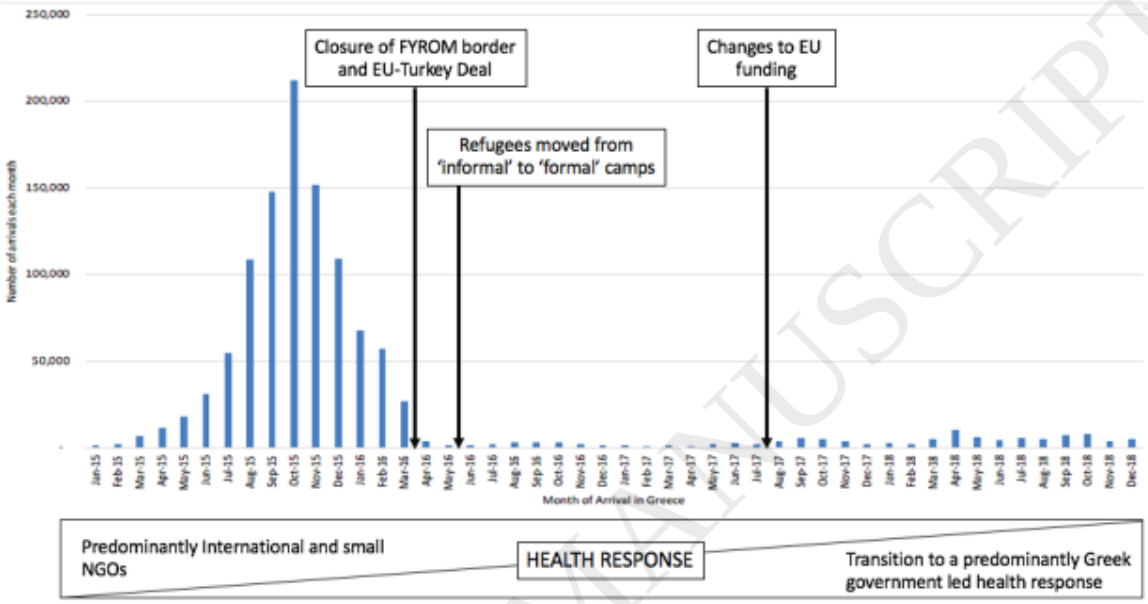


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Figure 3: This map shows the location of refugee camps on mainland Greece and on the Greek islands on 13th September 2017 when there were 54 'formal' camps; numbers represent the number of camps at that location. Since 2016, some refugees have been moved from refugee camps to urban and peri-urban accommodation under an urbanization program. Primary healthcare is provide by non-governmental organisations alongside the government in the refugee camps with secondary care referrals into the Greek health system. For urban refugees, healthcare is accessed through local Greek healthcare providers. Source: Ministry of Health- National Health Operations Center http://geochoros.survey.ntua.gr/ekepy/

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Table 1 summarizes some the challenges faced by refugees in accessing healthcare in Greece and potential solutions.

Challenge	Explanation	Potential way forward
Cultural and Linguistic and expectations of healthcare	The majority of refugees in Greece were Arabic speaking (Syrian, Iraqi) though there were significant proportions of Kurds (predominantly Kumanji speakers), Afghanis and Yazidis. Other dominant language groups from African nations became more common from 2017 onwards. Many refugees travel from countries that had strong or strengthening health systems before the collapse of their health systems. In the Greek refugee setting, this became relevant and was highlighted in focus group discussions where cultural differences and health seeking behaviour varied across communities. These were in contrast to the style and standard of care from 'single point of entry' systems common in Europe.	1. Engage refugees and refugee community leaders in health decision-making, engagement and employment opportunities to provide capacity building to enhance their input into service provision. 2. Include training and capacity building for the host community before international recruitment to ensure greater sustainability. *3.* Recruit volunteers with linguistic and cultural backgrounds to align with both the migrant and host populations and ensure appropriate training and capacity building pre-deployment. *4.* Hold focus groups with a focus on health promotion and understanding the structure of the Greek health system could explore the realities of healthcare delivery in Europe and manage expectations.
Navigation of the Greek health system	The Greek health system is a complex mix of public and private services. Most Greek patients contribute out of pocket payments where social insurance or publically funded services are unavailable. Primary health care, diagnostic technologies and pharmaceuticals are predominantly private. Since May 2010 the Greek economy has received "bail out" payments from the IMF (International Monetary Fund) and Eurozone. The economic recession in Greece is improving; however chronic neglect of the financial, structural and service delivery aspects of the health system have reduced the reach and accessibility of secondary and tertiary services.	Investing in the health system in urban centres to support healthcare provision for refugees and local populations or improving links between primary healthcare in the refugee camps and the formal secondary healthcare system are potential ways to reduce costs and support healthcare access. This would need to be with an increase in staff including translators and cultural mediators. The introduction of the Philos program in conjunction with the Ministry of Health (funded to 24 million Euros) was tasked to with this however has met with challenges in recruitment of sufficient numbers of sufficiently trained staff.
Logistics and referral mechanisms	Host and refugee community integration and equitable access to services is complicated by camp locations in unpopulated/industrial areas removed from general infrastructure including public transportation. The location and changing locations of the camps made operational logistics costly and inefficient for providers leading to ad hoc planning, inefficient staffing and costly medication management.	Government procured medical supplies available at discounted prices for medical providers could reduce duplication and ensure that all medical supplies are within EU regulations and Greek law. Further improvements to cost and availability of public transport networks could reduce tensions and perceived barriers to accessing healthcare.

	Attempts to create comprehensive referral pathways including transport by NGO's early in the response were hindered by inconsistent government policy on transportation of refugee patients. This ad hoc referral system was redeveloped in each new camp as populations and providers shifted. The assumption that healthcare providers (and their budget) extended to transport to and from secondary care providers and emergency care locations was problematic.	Clarification on human trafficking definitions and transportation permission for designated providers of care would have significantly improved access to secondary and tertiary services.
Lack of continuity among providers	Services were highly variable across locations. When formal camps were established, each had an allocated service provider for primary healthcare services and a wide variety of additional services based on individual interest and capacity. When refugees were moved with no warning to other formal camps the continuity of care was lost and service provision may be less comprehensive. Where possible, handheld health passports reduced the need to repeat initial diagnosis and treatment plans however these were usually in English, not necessarily readable by the secondary and tertiary hospitals or patients themselves.	Nationwide handheld health passports should be administered to each individual engaged in the protection system, including a statement of rights of access/ reflection of service access agreements from government and UN bodies. Implementation of a UN card was discussed but never rolled out due to complexities of the system. However, a recognised handheld health passport could enable clear, standardised documentation. Translation would still remain an issue but communication between providers would have been streamlined and trusted.
Gaps in specialist provision	Each health NGO arranged their own local referral pathways based on need and at times, involved privately funded services to bridge gaps within the public healthcare sector and/or religious and cultural barriers from host country medical providers. Camps that were closer to larger cities, for example Thessaloniki, benefitted from increased service options. Seasonal barriers to care also prevented trust in and utilisation of specialist services outside of emergencies e.g. services are severely restricted in Greece during August.	Urbanisation of migrants has reduced the disparities on the mainland; however, issues still persist in regional areas and outlying islands. Clearer guidelines on universal service delivery in each camp or urban primary healthcare clinics along with coordinated mapping of secondary tertiary services from the start of the formal camps is needed. Stronger coordination between all health actors, government and UN with a clear mapping process is essential before formal camps are opened or refugees relocated.