ΜΕΤΑΠΤΥΧΙΑΚΟ ΠΡΟΓΡΑΜΜΑ ΣΠΟΥΔΩΝ:
«ΔΙΕΘΝΗΣ ΙΑΤΡΙΚΗ-ΔΙΑΧΕΙΡΙΣΗ ΚΡΙΣΕΩΝ ΥΓΕΙΑΣ»

ΕΘΝΙΚΟ ΚΑΙ ΚΑΠΟΔΙΣΤΡΙΑΚΟ ΠΑΝΕΠΙΣΤΗΜΙΟ ΑΘΗΝΩΝ
ΙΑΤΡΙΚΗ ΣΧΟΛΗ

ΔΙΠΛΩΜΑΤΙΚΗ ΕΡΓΑΣΙΑ

ΘΕΜΑ: REFLECTION ON HUMANITARIAN CRISIS MANAGEMENT- LEROS ISLAND CASE STUDY 2016

ΜΕΤΑΠΤ. ΦΟΙΤΗΤΡΙΑ: ΑΙΚΑΤΕΡΙΝΗ ΓΙΑΝΝΙΟΥ
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TOPIC: REFLECTION ON HUMANITARIAN CRISIS MANAGEMENT- LEROS ISLAND CASE STUDY 2016

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ΠΡΑΚΤΙΚΟ ΚΡΙΣΕΩΣ

ΤΗΣ ΣΥΝΕΔΡΙΑΣΗΣ ΤΗΣ ΤΡΙΜΕΛΟΥΣ ΕΞΕΤΑΣΤΙΚΗΣ ΕΠΙΤΡΟΠΗΣ ΓΙΑ ΤΗΝ ΑΞΙΟΛΟΓΗΣΗ ΤΗΣ ΔΙΠΛΩΜΑΤΙΚΗΣ ΕΡΓΑΣΙΑΣ

Τ… Μεταπτυχιακ….. Φοιτητ.. .....

Εξεταστική Επιτροπή

- ……., Επιβλέπων
- ……., Μέλος
- ……., Μέλος

Η Τριμελής Εξεταστική Επιτροπή η οποία ορίσθηκε από την ΓΣΕΣ της Ιατρικής Σχολής του Παν. Αθηνών Συνεδρίαση της …..ης ….. 20… για την αξιολόγηση και εξέταση τ…. υποψηφίου κ.. ……..……, συνεδρίαση σήμερα …/…./……..

Η Επιτροπή **διαπίστωσε** ότι η Διπλωματική Εργασία τ. Κ…
……. …Με τίτλο
……
……
…….
……, είναι πρωτότυπη, επιστημονικά και τεχνικά άρτια και η βιβλιογραφική πληροφορία ολοκληρωμένη και εμπεριστατωμένη.

Η εξεταστική επιτροπή αφού έλαβε υπ' όψιν το περιεχόμενο της εργασίας και τη συμβολή της στην επιστήμη, με ψήφους ……. προτείνει την απονομή στον παραπάνω Μεταπτυχιακό Φοιτητή την απονομή του Μεταπτυχιακού Διπλώματος Ειδίκευσης (Master's).

Στην ψηφοφορία για την βαθμολογία ο υποψήφιος έλαβε για τον βαθμό «ΑΡΙΣΤΑ» ψήφους ……., για τον βαθμό «ΛΙΑΝ ΚΑΛΩΣ» ψήφους ……, και για τον βαθμό «ΚΑΛΩΣ» ψήφους ……Κατά συνέπεια, απονέμεται ο βαθμός «(Άριστα, Λίαν Καλώς/Καλώς) & (Βαθμός)…….».

Τα Μέλη της Εξεταστικής Επιτροπής

- ……., Επιβλέπων (Υπογραφή)_____
- ……., Μέλος(Υπογραφή)_____
- ……., Μέλος (Υπογραφή)_____

ΠΙΝΑΚΑΣ ΠΕΡΙΕΧΟΜΕΝΩΝ

ΕΚΤΕΝΗ ΠΕΡΙΛΗΨΗ ΤΗΣ ΔΙΠΛΩΜΑΤΙΚΗΣ ΕΡΓΑΣΙΑΣ ΣΤΑ ΕΛΛΗΝΙΚΑ

Εισαγωγή: Η παρούσα διπλωματική εργασία έχει θέμα 'Σκέψεις πάνω στη διαχείριση της ανθρωπιστικής κρίσης- μελέτη περίπτωσης για το νησί της Λέρου για το 2016'. Τα τελευταία χρόνια η Ελλάδα και ειδικά τα ελληνικά νησιά του Αιγαίου υπέφεραν από την καταστροφική εισροή προσφύγων, θέτοντας σε κίνδυνο τους τοπικούς μηχανισμούς αντιμετώπισης συμβάντων. Καθώς η Ελλάδα βρισκόταν ανέκαθεν σε μια στρατηγικά σημαντική θέση στον ευρωπαϊκό και διεθνή χάρτη, συνδέοντας τρεις ηπείρους, τα νερά του Αιγαίου αποτέλεσαν δύσκολο πέρασμα για τα προσφυγικά ρεύματα.

Η περίπτωση μελέτης αφορά στη Λέρο, ένα νησί των Δωδεκανήσων, το οποίο έχει υποδεχτεί έναν τεράστιο αριθμό προσφύγων σε ένα σύντομο χρονικό διάστημα. Η Λέρος, όπως και πολλά άλλα ακριτικά μέρη της Ελλάδας, πάσχουν στον τομέα της Υγείας με έλλειψη υποδομών και εγκαταστάσεων και με επιδείνωση της ποιότητας της υγειονομικής περίθαλψης λόγω της οικονομικής κρίσης. Το επιπλέον φορτίο χιλιάδων προσφύγων προκάλεσε δυσφορία στο τοπικό σύστημα υγειονομικής περίθαλψης, στην τοπική κοινωνία της Λέρου, μα και στους ίδιους τους πρόσφυγες.

Η διπλωματική αυτή εργασία στοχεύει στην κριτική ανάλυση και παράθεση σκέψεων γύρω από τη διαχείριση της ανθρωπιστικής κρίσης στη Λέρο για το 2016. Μέσα από μια βιβλιογραφική ανασκόπηση θα γίνει προσπάθεια απάντησης του κύριου ερευνητικού ερωτήματος που είναι το εξής: ' κατά πόσον έχουμε καλύψει τις ιατρικές ανάγκες του εκτοπισμένου πληθυσμού σύμφωνα με τις υπάρχουσες κατευθυντήριες οδηγίες για ανθρωπιστικές κρίσεις'.

Επέλεξα το συγκεκριμένο θέμα λαμβάνοντας υπόψιν τη συνάφειά του ως προς το μεταπτυχιακό πρόγραμμα στη Διεθνή Ιατρική και Διαχείριση Κρίσεων Υγείας της Ιατρικής Σχολής του Εθνικού και Καποδιστριακού Πανεπιστημίου Αθηνών. Παράλληλα, το προνόμιο που είχα ως άμεσος παρατηρητής της κρίσης μέσα από τη συμμετοχή μου ως νοσηλεύτρια σε δυο διεθνείς Μη Κυβερνητικές Οργανώσεις διεθνούς εμβέλειας στον τομέα της παροχής υπηρεσιών υγείας μου επιτρέπει να εμπλουτίσω την έρευνά μου παραθέτοντας γεγονότα και πληροφορίες που έχω παρατηρήσει στο πεδίο και για τα οποία δεν έχει υπάρξει ακόμα κάποια δημοσίευση. Επιπλέον, πιστεύω πως το συγκεκριμένο θέμα είναι ένας αξιόλογος τρόπος για γνώση μέσα από την κριτική ανάλυση των γεγονότων σε συνδυασμό με την μελέτη των διεθνών οδηγιών.

Το μεταπτυχιακό πρόγραμμα στη Διεθνή Ιατρική και Διαχείριση Κρίσεων Υγείας της Ιατρικής Σχολής του Εθνικού και Καποδιστριακού Πανεπιστημίου Αθηνών προσεγγίζει θέματα σχετικά με τα προβλήματα υγείας των ευάλωτων ομάδων και των μειονοτήτων καθώς και θέματα ιατρικής καταστροφών και διαχείρισης κρίσεων υγείας.

Στη συγκεκριμένη μελέτη, η ευάλωτη ομάδα αφορά στους πρόσφυγες. Εν μέσω της οικονομικής κρίσης στην Ελλάδα, μια νέα κρίση ξεσπά με τη μορφή της αδυναμίας κάλυψης των βασικών αναγκών του προσφυγικού πληθυσμού στη χώρα. Σε γενικές γραμμές, ο κύριος στόχος της μελέτης αυτής είναι να προσδιοριστούν οι προκλήσεις που έπρεπε να υπερνικήσουμε στη διάρκεια της ανθρωπιστικής κρίσης μιλώντας πάντα για την περίπτωση της Λέρου. Παράλληλα, στόχος είναι η αναγνώριση των όσων μάθαμε από αυτή την κρίση για μελλοντική αναφορά. Τη μελέτη διευκολύνει ένα 'Δέντρο Προβλήματος', στο οποίο καθορίζεται το κύριο πρόβλημα και στην συνέχεια αναλύονται τα αίτια και τα αποτελέσματά

του. Το εργαλείο αυτό χρησιμοποιείται εκτενώς στη διαχείριση κρίσεων καθώς είναι αρκετά χρήσιμο.

Μέθοδος: Το ερευνητικό πρωτόκολλο έχει λάβει έγκριση από την επιστημονική επιτροπή του Μεταπτυχιακού Προγράμματος Διεθνούς Ιατρικής και Διαχείρισης Κρίσεων Υγείας του Πανεπιστημίου Αθηνών.

Η διπλωματική αυτή εργασία μελετά τον προσφυγικό πληθυσμό στη Λέρο κατά τη διάρκεια της περιόδου των αυξημένων ροών από την Τουρκία δια μέσου της θαλάσσης. Αυτός ο πληθυσμός περιγράφεται από την Ύπατη Αρμοστεία των Ηνωμένων Εθνών για τους Πρόσφυγες ως 'people of concern'. Ο αριθμός του πληθυσμού αυτού αυξανόταν διαρκώς τόσο λόγω της μαζικής έλευσης των προσφύγων όσο και λόγω της συσσώρευσής τους στο νησί λόγω διαφόρων περιορισμών.

Ο πληθυσμός-στόχος άγγιξε τα υψηλότερα νούμερα τον Οκτώβριο του 2015. Οι κυριότερες εθνικότητες των προσφυγικών αυτών ροών ήταν οι Σύριοι, Αφγανοί και Ιρακινοί. Υπήρχαν, επίσης, αρκετοί Πακιστανοί, Αλγερινοί, Κούρδοι, ελάχιστοι Ιρανοί και Λιβανέζοι.

Η εργασία αποτελείται από μια εισαγωγή, το κύριο μέρος και τα συμπεράσματα. Επίσης, περιλαμβάνονται μια περίληψη στα αγγλικά και μια εκτενής στα ελληνικά. Στην εισαγωγή υπάρχουν κεφάλαια που υπενθυμίζουν στον αναγνώστη την πολιτική σκηνή πίσω από τον πόλεμο στη Συρία και την επακόλουθη προσφυγική κρίση στο νησί της Λέρου. Επιπρόσθετα, υπογραμμίζω τους λόγους για τους οποίους επέλεξα το συγκεκριμένο θέμα προς μελέτη, τις επιδιώξεις μου, τη συνάφεια του θέματος με το μεταπτυχιακό πρόγραμμα, τη μεθολογία, τα ερευνητικά ερωτήματα και τη δομή της.

Το κύριο μέρος περιλαμβάνει ένα γενικό και ένα ειδικό μέρος που επικεντρώνεται στην μελέτη της παρούσας περίπτωσης. Η εργασία κλείνει με προτάσεις και συμπεράσματα.

Η βιβλιογραφική ανασκόπηση διεξήχθη με τη χρήση μηχανών αναζήτησης όπως της Lancet, Google Scholar, Google και λοιπές. Έχω χρησιμοποιήσει την εφαρμογή Mendeley για την προσθήκη και οργάνωση της βιβλιογραφίας. Επιπλέον, έχει γίνει παράθεση προσωπικών εμπειριών και γνώσεων από το πεδίο. Η αναζήτηση έχει γίνει με λέξεις-κλειδιά όπως «μεταναστευτικό Λέρος», «αξιολόγηση στην ανθρωπιστική βοήθεια», «προβλήματα υγείας προσφύγων».

Σκοπός: Σκοπός της παρούσας διπλωματικής εργασίας είναι η ενίσχυση της μάθησης μέσω του προβληματισμού και της μετάδοσης των εμπειριών μου από το πεδίο ως παρακαταθήκη για το μέλλον.

Αποτελέσματα: Η εργασία αυτή αποτελεί μια ποιοτική έρευνα και τα αποτελέσματά της δεν είναι μετρήσιμα. Για τις ανάγκες της διπλωματικής αυτής εργασίας δημιουργήθηκε ένα «δέντρο προβλημάτων», το οποίο και στη συνέχεια αναπτύχθηκε. Ως κύριο πρόβλημα ορίζονται οι «ακάλυπτες ανάγκες υγείας» του πληθυσμού. Τα αίτια του προβλήματος αυτού είναι η έλλειψη χρημάτων, η έλλειψη διερμηνέων, η μη κάλυψη των βασικών αναγκών όπως για παράδειγμα η πρόσβαση σε ζεστό νερό και θέρμανση, η απώλεια των φαρμάκων στη θάλασσα, ο θάνατος αγαπημένων ανθρώπων, η έλλειψη ιατρικού προσωπικού, η έλλειψη σε διαγνωστικό εξοπλισμό, η ελλιπής πληροφόρηση των ασθενών, η στέρηση του δικαιώματός τους στη συνέχιση του ταξιδιού τους και η μη πρόσβαση σε δωρεάν φάρμακα. Τα προαναφερθέντα οδήγησαν σε μια σειρά γεγονότων επιβαρύνοντας την ήδη βεβαρυμμένη

υγεία πολλών προσφύγων. Παράλληλα, προέκυψαν επιπλοκές σε κάποιους ασθενείς οδηγώντας σε ανώφελες εισαγωγές στο τμήμα επειγόντων, σε αύξηση των επιπέδων στρες τόσο των ασθενών όσο και του προσωπικού του νοσοκομείου οδηγώντας σε επαγγελματική εξουθένωση. Επιπρόσθετα, αυξήθηκαν τα ιατρικά λάθη και οι διακομιδές και οι παραπομπές σε άλλα νοσοκομεία της χώρας όπως και οι αεροδιακομιδές.

Οι προκλήσεις που είχαμε να αντιμετωπίσουμε ήταν κυρίως το μέγεθος του πληθυσμού-στόχου. Η μαζική εισροή προσφύγων σε σύντομο χρονικό διάστημα σε ένα μικρό νησί χωρίς τις απαραίτητες εγκαταστάσεις για την υποστήριξή τους ήταν μια από τις μεγαλύτερες προκλήσεις. Ο αριθμός των προσφύγων αυξανόταν καθημερινά μέσω των αφίξεων εξ θαλάσσης. Αυτή η τάση προειδοποιούσε για επιπρόσθετες κρίσεις όπως για παράδειγμα τα ναυάγια. Ο αριθμός των προσφύγων στο νησί επηρεάστηκε και από άλλους παράγοντες, όπως η ευρωπαϊκή πολιτική, οι καιρικές συνθήκες, η οικονομική δυνατότητα των προσφύγων και άλλα.

Ο χρόνος ήταν επίσης ένας κρίσιμος παράγοντας στην αντιμετώπιση της προσφυγικής κρίσης στην αντιμετώπισή της. Ο χρόνος ήταν εξίσου σημαντικός και για τους ίδιους τους πρόσφυγες μιας και το πολιτικό παρασκήνιο γύρω από το κλείσιμο των ευρωπαϊκών συνόρων άλλαζε καθημερινά.

Ακόμη, οι καιρικές συνθήκες που επικρατούσαν στο νησί δυσχέραιναν τις συνθήκες διαβίωσης των προσφύγων. Λαμβάνοντας υπόψη το γεγονός πως οι πρόσφυγες ζούσαν μέσα σε υπαίθριες τέντες εν μέσω χειμώνα και με ελάχιστα μέσα για θέρμανση, αυτό οδηγούσε σε αύξηση των αναπνευστικών λοιμώξεων και ιδιαίτερα στις ευπαθείς ομάδες, όπως τα μικρά παιδιά και τους ηλικιωμένους.

Σημαντικό είναι πως η έλλειψη υποδομών και εγκαταστάσεων για τη φιλοξενία του προσφυγικού πληθυσμού στο νησί ήταν επίσης σημαντικό τροχοπέδη. Στην πραγματικότητα, το κύριο έργο στην παροχή καταλυμάτων, στην πρόσβαση πόσιμου και ζεστού νερού οφείλεται στην παρουσία των Μη Κυβερνητικών Οργανώσεων.

Όντας επαγγελματίας υγείας στο πεδίο εν μέσω προσφυγικής κρίσης και παράλληλα, ως φοιτήτρια στο μεταπτυχιακό πρόγραμμα «Διεθνής Ιατρική και Διαχείριση Κρίσεων Υγείας», είχα τη δυνατότητα να αντιληφθώ με επιστημονικό υπόβαθρο τις προκλήσεις που έπρεπε να ξεπεραστούν.

Συζήτηση: Μέσα από αυτή τη μελέτη παρατηρώ πως ακόμα και σε περιόδους όπου οι άνθρωποι αντιμετωπίζουν δυσκολίες στην προσωπική τους ζωή ή και συλλογικά, υπάρχει η ανάγκη για προσφορά σε όσους έχουν ανάγκη. Ο εθελοντισμός παίζει σημαντικό ρόλο στην αντιμετώπιση καταστροφών και οι εθελοντές είναι πραγματικά αναγκαίοι. Είναι αισιόδοξο πως ο εθελοντισμός συμβάλει ενεργά στη διατήρηση της ομοιόστασης εν μέσω κρίσης.

Οι προτάσεις μου μέσα από τις εμπειρίες μα και την έρευνά μου αφορούν στην αξιοποίηση στο έπακρο των εμπειριών των ανθρώπων που έχουν συνδράμει εθελοντικά στην αντιμετώπιση κρίσεων. Οι άνθρωποι είναι η κινητήριος δύναμη για να πάμε ένα βήμα παραπέρα.

Η επικοινωνία είναι το κλειδί σε κάθε επιτυχία, πόσο μάλλον στην διαχείριση καταστροφών. Είναι σημαντικό να επωφεληθούμε από τις πιο πρόσφατες τεχνολογίες και να τις εφαρμόσουμε στην πράξη, στο πεδίο. Υπάρχουν διάφορες εφαρμογές που μπορούν να

εφαρμόζονται με επιτυχία στο πεδίο, μία εξ αυτών είναι η τηλεϊατρική. Η τηλεϊατρική είναι ένα εξαιρετικό εργαλείο όταν οι μεγάλες αποστάσεις είναι μια από τις προκλήσεις που έχουμε να αντιμετωπίσουμε. Με τη βοήθεια της σύγχρονης Τηλεϊατρικής ο ασθενής μπορεί να εξεταστεί εικονικά από έναν γιατρό ή επαγγελματία υγείας, να λάβουν διάγνωση, θεραπεία και παρακολούθηση της πορείας της υγείας τους. Η Τηλεϊατρική πραγματικά μπορεί να κάνει τη διαφορά στον τρόπο με τον οποίο αντιμετωπίζουμε τους πρόσφυγες, ειδικά σε χώρους με ελάχιστες εγκαταστάσεις, εξοπλισμό και προσωπικό.

Πιστεύω ακόμη πως κάθε χώρα οφείλει να είναι προετοιμασμένη για κάθε ενδεχόμενο καταστροφής. Οι κυβερνήσεις των χωρών θα έπρεπε να έχουν ενσωματώσει στις νομοθεσίες τους τα Ελάχιστα Πρότυπα σε περιπτώσεις καταστροφών και να προσαρμοστούν αναλόγως. Πρέπει πάντα να υπάρχει ένα σχέδιο διάσωσης διαθέσιμο σε περίπτωση καταστροφής και όλοι οι εμπλεκόμενοι να ενημερώνονται και να συμμορφώνονται με τα πρότυπα. Τα πρότυπα πρέπει να είναι απλά ένας οδηγός αναφοράς και καλό θα ήταν να υπάρχει ένα συμβούλιο αποκλειστικά για τη διαχείριση κρίσεων και καταστροφών, έστω και αν η πιθανότητα καταστροφής είναι μικρή. Τελευταία οι καταστροφές είναι όλο και συχνότερες με τη μορφή των τρομοκρατικών επιθέσεων αλλά και λόγω της κλιματικής αλλαγής. Επομένως, είναι απαραίτητο να υπάρχει διαθέσιμο ένα σχέδιο ετοιμότητας ανά πάσα στιγμή.

Η συνεχιζόμενη εξέλιξη και η εκπαίδευση είναι πολύ σημαντικοί τομείς και η διαχείριση καταστροφών είναι ένας τομέας στον οποίο το μέλλον πρέπει να μας βρει καλύτερους. Η συνεχιζόμενη μάθηση πρέπει να στοχεύει στην απόκτηση περισσοτέρων δεξιοτήτων και γνώσεων σε θέματα που σχετίζονται για παράδειγμα με τον έλεγχο λοιμώξεων σε περιβάλλοντα ελαχίστων πόρων, με την προαγωγή της υγείας, την ψυχική υγεία και το τραύμα, τη διατροφή, το θηλασμό και άλλα.

Τέλος, δεν θα πρέπει να παραλείψω τη σπουδαιότητα της δυναμικής της παρακίνησης. Είναι η εσωτερική δύναμη που ωθεί τους ανθρώπους να γίνουν καλύτεροι και πιο χρήσιμοι στην κοινωνία. Ανθρώπους που έχουν επενδύσει πραγματικό χρόνο από τη ζωή τους για την προσφορά και τον εθελοντισμό στο πεδίο, τους χρειαζόμαστε να μιλήσουν ανοιχτά για τις εμπειρίες τους και να τις μοιραστούς δημόσια. Χρειάζεται προώθηση της δουλειάς των εθελοντών και καλό θα ήταν οι διεθνείς οργανισμοί να συνεργαστούν μαζί με εθελοντές και να συμβάλλουν στην αναθεώρηση και ανάπτυξη πρακτικών που εφαρμόζονται στην διαχείριση καταστροφών.

Συμπεράσματα: Σε αυτή τη διπλωματική εργασία προσπάθησα να απαντήσω στο αμφιλεγόμενο ερώτημα σχετικά με το κατά πόσο καλύψαμε τις ανάγκες των προσφύγων σχετικά με την υγεία. Οι προκλήσεις που έπρεπε να ξεπεράσουμε κατονομάστηκαν μέσα σε αυτή την έρευνα και διαγραμματικά φαίνονται μέσα από το «Δέντρο Προβλήματος». Το μέγεθος του πληθυσμού-στόχου, οι καιρικές συνθήκες, η ξαφνική εμφάνιση των αφίξεων διαμέσου θαλάσσης, οι περιορισμένες εγκαταστάσεις υγειονομικής περίθαλψης είναι μερικές μόνο από τις προκλήσεις που αντιμετωπίσαμε.

Για να έχει η απάντησή μου βάση στο ερευνητικό ερώτημα πραγματοποίησα μία βιβλιογραφική ανασκόπηση σε δημοσιεύσεις που τόνιζαν τη σπουδαιότητα της αξιολόγησης των προγραμμάτων ανθρωπιστικής βοήθειας. Επιπλέον, η ανασκόπηση συμπεριέλαβε τα κύρια πρότυπα που θα έπρεπε να χρησιμοποιούνται σε περιπτώσεις καταστροφών.

Η παράθεση των προσωπικών μου εμπειριών από το πεδίο έγινε στην προσπάθεια καταγραφής των δράσεών μας για μελλοντική αναφορά, καθώς δεν υπάρχει διαθέσιμη βιβλιογραφία σχετικά με την ανθρωπιστική κρίση στην Λέρο.

Κλείνοντας, υποστηρίζω το γεγονός πως όλοι μαζί δώσαμε τον καλύτερό μας εαυτό εκείνη τη χρονική στιγμή και με τα υπάρχοντα μέσα. Ωστόσο, πιστεύω πως υπάρχει περιθώριο για βελτίωση.

ABSTRACT

Introduction: in this thesis the research question being presented is ‘have we met the medical needs of displaced people following existing guidelines in responding to humanitarian crises’, the reasons for selecting this topic, the available literature regarding program evaluation in humanitarian assistance, the international guidelines and reflection on the management in this case study.

Purpose: the purpose of this dissertation is to enforce learning via reflection and to leave these experiences as a consignment for the future.

Methods: a literature review has been conducted using Scholar, Lancet, Google and other search engines in addition to personal experiences in the field.

Results: this thesis is a qualitive research and the outcomes from this are not measurable.

Conclusions: in conclusion, working in the field during this crisis I recognize that everyone had been working driven from their passion to support and assist the people in need. The existing guidelines had been followed wherever possible taking into account the location and the time of the crisis.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Μεταναστευτικό Λέρος, προσφυγικό, evaluation in humanitarian assistance, refugees in Greece, UNHCR data.

ΑΦΙΕΡΩΣΗ

Αφιερώνεται σε όλα παιδιά που «χάθηκαν»..

ΕΥΧΑΡΙΣΤΙΕΣ

Ευχαριστώ το Θεό.

Ευχαριστώ την οικογένειά μου.

INTRODUCTION

In the past years Greece and especially the Greeks islands of the Aegean suffered a devastating influx of refugees that inflected the local coping mechanisms. As Greece has always been in the most strategically important position connecting three continents (Europe, Asia and Africa) the Mediterranean Sea and the Aegean waters became significant rough 'pathways' for the displaced people coming from the Middle East, Asia and Africa.

Leros is one of the Dodecanese islands which has been critically affected in the past few years by the massive numbers of refugees. As Leros had already been facing abandonment in the healthcare facilities due to the financial crisis of the country, the extra load of thousands of displaced people caused distress to the healthcare system, the local community and the refugees themselves.

This thesis is a reflection on the humanitarian crisis' management in Leros island for the year 2016. The aim is to review any literature available in order to answer the main question 'have we met the medical needs of the displaced people following existing guidelines in responding to humanitarian crises'?

The reasons for reflecting on this subject are the relevance with the postgraduate Master's course in International Medicine and Health Crisis Management, the privilege of witnessing the crisis while working for two internationally known Non-Governmental Organizations in the healthcare services, which allows me to add facts I have seen in practice in the field for which no literature has yet to be published. Additionally, I strongly believe the subject is a great way to learn via reflection.

The postgraduate Master course in International Medicine and Health Crisis Management of the Athens University School of Medicine approaches issues concerning health related problems of vulnerable groups and ethnic minorities as well as issues of disaster medicine and crisis management. In this case study, the vulnerable groups are the refugees. A new dimension is now added to the existing economic crisis already present in the form of the incapacity of meeting essential health needs of the refugees. The overall purpose of this study is to identify the challenges we had to overcome during the humanitarian crisis in Leros' case, and to point out the learning outcomes for future reference. In order to do the above, I have made a problem tree; a problem tree lays out the core problems as well as their causes and outcomes and it's a helpful tool in management (Tree, 1993).

THE HISTORY BEHIND THE SYRIAN WAR

In December 2010 in Tunisia a revolutionary wave of demonstrations, protests, riots and civil wars started the so-called Arab Spring (Wikipedia, n.d.). Following Arab Spring, a wider wave of protests against Assad's government in Syria fired an armed conflict that finally led to the beginning of the civil war. In the war that started in 2011 the participants were the Syrian government, the Syrian opposition, the Rojava and the Islamic State of Iraq (ISIS). (*(35) Syria's war: Who is fighting and why - YouTube*, 2017)

The first shots in the war are fired in March 2011 by Syrian dictator Bashar al-Assad against peaceful Arab Spring demonstrators. The protests grew rapidly and in July 2011 Syrian troops (the Free Syrian Army) join the conflict. The conflict was then the great opportunity for extremists (Jihadists) around the region to join the rebels. Following this, Assad released jihadists prisoners to tinge the rebellion with extremism to make it harder for foreign backers to support them. At the same time Syrian Kurdish groups seceded from Assad's rule in the north of Syria. At the end of the summer 2011, Iran intervenes on Assad's behalf. At the same time, Arab states of the Persian Gulf began to send money and weapons to the rebels. Hezbollah, then, reinforced Iran's fight alongside Assad. This move made Gulf States send even more resources to the rebel opposing Assad. By 2013, the Middle East is divided between Sunni powers supporting the rebels and Shias supporting Assad. (*(35) Syria's war: Who is fighting and why - YouTube*, 2017)

That April, Obama's administration, horrified by Assad's atrocities signs a secret order authorizing the CIA to train and equip Syrian rebels. At the same time, US urges Arab Gulf States to stop funding extremists with no result. In August Assad uses chemical weapons spreading death among civilians. The US backs down under a Russia-brokered deal, but the incident establishes Syria as a great-powers dispute between America and Russia. (*(35) Syria's war: Who is fighting and why - YouTube*, 2017)

In February 2014 al-Qaeda affiliate, based mostly in Iraq, breaks away from the group over internal disagreements. The group calls itself the Islamic State of Iraq and Syria (ISIS) and it becomes al-Qaeda's enemy. ISIS mostly fights not Assad, but the other rebels and the Kurds, carving out a mini-state it calls its Caliphate. In September, one year after the US almost bombed Assad, it begins bombing ISIS. In August, Turkey bombs Kurdish groups in Iraq and in Turkey, even as the Kurds fight ISIS in Syria, but doesn't bomb ISIS. This got to a core problem: the US sees ISIS as its main enemy, but the US's allies like Turkey and a lot of other Middle East States have other priorities.(*(35) Syria's war: Who is fighting and why - YouTube*, 2017)

In September, Russia intervenes on behalf of Assad, sending a few dozen military aircraft to a long-held Russian base in the country. At the end of 2014 ISIS claimed a territory size of Great Britain and a population of 11 million people. (*(35) Syria's war: Who is fighting and why - YouTube*, 2017).

BRIEF DESCRIPTION OF CRISIS IN LEROS ISLAND

Going back in 2015 Europe experienced a high influx of migrants, the highest since the Second World War. Most of the refugees came from Syria, the world's top source of refugees. UNHCR announced that approximately 850 000 refugees entered Greece in 2015 (UNHCR Data Portal-Greece, 2015) and according to the UN's International Migration Report for 2015 nearly two thirds of all international migrants live in Europe (76 million), with Germany hosting the majority of them around 12 million (United Nations, Department of Economic and Social Affairs, 2016).

Leros is part of the Dodecanese islands located in South Aegean and only 7 naval miles from the Turkish coast. Despite the fact that Greek islands had always been a passage for illegal migration, during the last years this passage became particularly important. In summer 2015, Leros' coasts and streets were flooded by people of all ages, especially Syrians. Almost all of them had been rescued by the Greek coastguard or got transferred from Farmakonisi, a military island 12 naval miles from Leros, where most of the refugees landed following their dangerous boat trip from Turkey (*Φαρμακονήσι - Βικιπαίδεια*, n.d.).

The unexpected influx of refugees in Leros Island had been an unprecedented challenge for the local civilians and management. Leros is a small island of approximately 9.000 inhabitants, where 2.500 refugees alone had arrived within 3 weeks. The numbers of refugees were constantly increasing, with around 5.000 refugees on the island in the winter of 2015 for several weeks, as many European countries had denied entrance to the refugees (Εργασία et al., n.d.). The figures started to change in the beginning of 2016, mainly due to European borders' closure.

METHODOLOGY

Approval: The study protocol has been approved by the committee of the M.Sc International Medicine and Health Crisis Management, University of Athens.

Participants: This thesis studies the refugee population in Leros island during the high peak influx season*. This population is described by the UNHCR as People of Concern. The number of this population varied daily as refugees continued to enter via the sea routes; additionally, refugees continued to depart via public sea lines to the mainland approximately three times a week. The population of the study reached the highest numbers in October 2015. The most common nationalities of these sea arrivals were Syrian, Afghans and Iraqi refugees. There were also several Pakistanis, Algerians, Palestinians, Kurds and very few Iranians and Lebanese.

Design: The thesis consists of an Introduction, the Main part and the Conclusion; The thesis has two abstracts, one in English and an extended one in Greek. In the Introduction there are chapters that give the reader a quick reminder of the political scene in Syria and the following migration crisis on the Greek island of Leros. I also explain the reasons for choosing this case study and what I am aiming for, its relevance to the MSc, the methodology, the research questions and its structure; the main part includes a general part of the literature review and a specific part which focuses on the case study. The thesis closes with the outcomes and suggestions.

Materials: I have used the Mendeley application in order to add citations and bibliography in this thesis. I have also used the Google and the Scholar Google search engines.

Procedure: Search by using key words such as ‘μεταναστευτικό Λέρος’, ‘evaluation’, ‘humanitarian aid’, ‘Leros crisis’, ‘migration’, ‘evaluation in humanitarian assistance’, ‘refugee health problems’.

LITERATURE REVIEW

Many will agree with the fact that interventions in responding to humanitarian crises need to be evaluated (Banatvala & Zwi, 2000). The Code of Conduct, the Sphere Project, the Active Learning Network for Accountability and Performance in Humanitarian Action, the Humanitarian Accountability Partnership International, the Quality Project and the People in Aid were established by different actors in an effort of a generalized improvement of the humanitarian assistance (Roberts & Hofmann, 2004)(Ersel, 2015). There is an extra difficulty when it comes to evaluating programs in settings where there is already a local mechanism (Roberts & Hofmann, 2004), something that we can see in our case study.

Με σχόλια [KG1]: Programs need to be evaluated

The Sphere Project as mentioned above was created in 1997 based on two main principles; the first principle says that anyone who suffers from a crisis has the right to receive assistance and to live with dignity and the second principle that anything possible should be done to alleviate any suffering(Project, 2018). This consists of a Humanitarian Charter and the Minimum Standards (Project, 2018). The Minimum Standards by Sphere related with the health needs/problems the refugees had been facing in this case study will be discussed following in this dissertation.

Με σχόλια [KG2]: The sphere

For a fact, the Sphere Standards need to be in place from the beginning to the closure of a program cycle (Project, 2018). Following the Standards' routes, the success of the program is most likely granted. At the initiation of a crisis, the Sphere Standards can guide as to identifying acute needs and plan activities based on those needs (Project, 2018). Additionally, the Sphere Standards can support the strategic development and construction of the program in the best possible way (Project, 2018). However, the Sphere Standards have a realistic point of view and suggest that in case standards cannot be met for any reason action still needs to be taken by working in collaboration with other stakeholders and by finding ways to eliminate any harm (Project, 2018).

The Code of Conduct set by the International Federation of Red Cross and Red Crescent Societies and the International Committee of the Red Cross seeks independence, effectiveness and impact in responding to disasters (Project, 2018). The Code of Conduct has 10 Core Principles:

Με σχόλια [KG3]: Code of conduct

1. The humanitarian imperative comes first.
2. Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone.
3. Aid will not be used to further a particular political or religious standpoint.
4. We shall endeavour not to act as instruments of government foreign policy.
5. We shall respect culture and custom.

6. We shall attempt to build disaster response on local capacities.
7. Ways shall be found to involve programme beneficiaries in the management of relief aid.
8. Relied aid must strive to reduce future vulnerabilities to disaster as well as meeting basic needs.
9. We hold ourselves accountable to both those we seek to assist and those from whom we accept resources.
10. In our information, publicity and advertising activities, we shall recognise disaster victims as dignified human beings, not hopeless objects (Project, 2018).

Going through the available literature, we see different approaches in evaluating programs. In the paper of Les Roberts & Charles-Antoine Hofmann a main question is being set and they offer two different ways to give an answer (Roberts & Hofmann, 2004); they suggest a comparison with a control group that didn't receive aid or to compare the 'before/after' the intervention (Roberts & Hofmann, 2004). Surveillance systems can become useful tools in collecting data in a systematic way and can be used to give us an image of the general population's health status (Roberts & Hofmann, 2004). The correct information collected at the right time seems to increase effectiveness of humanitarian interventions in public health in crises (Checchi et al., 2017). The Inter-agency Health Evaluations in Humanitarian Crises Initiative proposes the establishment of reviewing the health programs between agencies (Roberts & Hofmann, 2004).

The conclusions in the paper of Roberts & Hofmann and other papers (Blanchet et al., 2017)(Checchi et al., 2017) are that there is not enough data available regarding the health impact of humanitarian aid as epidemiological tools are not being used frequently, there isn't skilled personnel in the field and there's the need for training and motivation (Roberts & Hofmann, 2004).

According to the *guidelines for implementing interagency health and nutrition evaluations in humanitarian crises* the geographic area and the population we target should be identified (UNHCR, 2007). For this project the geographic area is generally called 'Leros island' for the needs of the media, however, the target group which is the refugees have been divided depending on where they lived; the camp and the Artemis villa. the target population consisted of refugees of all ages and all statuses.

In the *guidelines for implementing interagency health and nutrition evaluations in humanitarian crises* it is stressed that analyzing aspects of health and nutrition outcomes, performance of health and nutrition services, health and nutrition sector policy and strategic planning, risks and the humanitarian context should be described (UNHCR, 2007). Health and nutrition outcomes include mortality, morbidity and malnutrition rates; it is important to define

Με σχόλια [KG4]: Approaches in evaluation

Με σχόλια [KG5]: Conclusions

Με σχόλια [KG6]: Identification of the target group

Με σχόλια [KG7]: All aspect should be described

once again the geographic area as the mortality rate in the sea is high whereas on land there were no deaths recorded. On the other hand, morbidity rates had been high.

An interesting finding in the available literature is the proposition of setting up a dedicated interagency service for public health information and epidemiology (Checchi et al., 2017).

Με σχόλια [KG8]: propositions

In his paper *the humanitarian system is not just broke, but broken: recommendations for future humanitarian action* Prof Spiegel recommends four sets of actions in order to improve humanitarian responses in future crises; 1. Centrality of protection, 2. Integration of the affected population into the national health systems, 3. Transfigure leadership and coordination, 4. Intervene more efficiently, effectively and in a sustainable way (Spiegel, 2017).

Με σχόλια [KG9]: how to act in the future

Professor O'Keede and J.Rose agree that the core sectors in humanitarian assistance should include health, nutrition, water, sanitation, hygiene, and shelter; also they underline the importance of working with the affected populations in order to achieve development (Rose & O'Keefe, 2016).

According to the Sphere Project everyone has the right to water and sanitation (Project, 2018). Humans suffering from a disaster have more chances of developing an illness related to poor sanitation, which could also lead to death (Project, 2018). Therefore, public health is strongly connected with the WASH activities (Project, 2018). As described in the Sphere Project the most important actions should be the hygiene promotion, the establishment of safe drinking water sources, the accommodation of sanitation facilities and the limitation of environmental health risks (Project, 2018). Last but not least, it is important to mention that the community engagement in the implementation of any action is essential (Project, 2018).

THE PROBLEM TREE

It is unquestionable that war can cause a chain of dreadful situations; violence, displacement, abuse, poverty, famine, worsening of health and death (VanRooyen et al., 2005). The problem which is being investigated in this case study is the Unmet Medical Needs. A problem tree has been created to allow the reader to visualise the causes of the core problem and its effects. The target group which is under the microscope for the needs of this dissertation is the displaced population in Leros island. This group consists of mainly Syrian and Afghan families, young Pakistani men, Eritrean refugees and unaccompanied minors and ethnic minorities such as Kurdish (Hodes et al., 2018). The children, the women, the elderly, the sick and the single-parent families suffered the most in this crisis (Al Gasser et al., 2004).

The medical problems and the medical needs could be categorised in three groups; the first group consists of the medical problems that pre-existed, for example people with diabetes or heart problems which were present even before the journey to Greece. The second group includes the medical problems which occurred as a result of this dangerous voyage, such as burns, fractures, loss of family members in the sea. The third group of needs is a result of the unsatisfied basic human needs, for instance lack of space and limited hygiene. In this thesis it is important to explain the rationale behind the reason these needs were unmet, not to explain why the needs existed.

The lack of Doctors

The main cause of the central problem was the lack of doctors; the healthcare facilities had been employing either newly qualified doctors with limited experience or there were only a few specialised doctors. The hospital of Leros had a 24h cover emergency department for the whole island and the refugees; the emergency department was mainly staffed with newly qualified doctors with an interest in psychiatry and there were only two clinical bays in the emergency room. The hospital had also been very supportive with the following specialties: paediatrics, obstetrics, gynaecology, pathology, orthopaedics, cardiology and surgery. However, most of the patients had several visits to the emergency department, which had a negative impact on the hospital's workload. There were quite a few neurological/neurosurgical cases which could not be dealt with at the hospital of Leros and had to be transferred to another island or to the mainland. Additionally, there was a case of an extremely unstable patient with type 1 diabetes which could not be observed by any of the hospital doctors, therefore, NGOs contacted a private endocrinologist who had been looking after the patient for free. Other private doctors on the island agreed to provide healthcare services to the refugees for free as an act of humanitarianism, but not all of them.

The lack of diagnostic equipment.

The hospital of Leros is equipped with very basic diagnostic equipment such as X-ray scanner, a sonographer, a basic operating room and a mobile ventilator. Therefore, CT/MRI scans could not be performed there; in addition, there was no critical care unit nor any paediatric surgeon available, therefore children with congenital heart or neurological abnormalities could not be examined nor operated on there and had to be sent to specialised centres, a procedure that usually took several months and a lot of effort from every stakeholder (hospital, NGOs, patients, donors).

No access to free medication. There were several other issues with healthcare especially when it came to medication prescribing and dispense. According to the healthcare regulations regarding medication dispense, patients need to be insured in the national system and medications need to be prescribed under specific regulations (*Πρόσβαση των Ανασφάλιστων στο Δημόσιο Σύστημα Υγείας - Ανάπτυξη Μονάδων Υγείας - Υπουργείο Υγείας*, n.d.). Refugees without a legal right to stay in Greece couldn't meet the essential criteria in order to get part of that register, therefore they had to pay 100% of the product's price; however, things changed later on, as UNHCR was claiming that refugees could register and have access to free medication. The lack of relevant information resulted in misunderstandings and furious patients.

Loss of medication in the sea. Another issue the stakeholders had to face was the fact that refugees had lost their medication along with all their belongings in the sea. It was quite easy to replace products commonly found in the market such as ibuprofen or paracetamol. However, several refugees had been receiving specific treatment back in their countries for serious conditions and unfortunately, they had lost any proof of the name or the brand name was in Arabic, which made it impossible to identify the active ingredient. In these cases, patients had to be sent to specialised doctors whenever possible in order to diagnose the condition and get a prescription. In addition, some medication was dispensed in another form back in their countries and was not dispensed in the same form in the Greek pharmaceutical market. Therefore, when patients didn't know the name of the drug they had been receiving their description of what they had to take didn't match that of which European doctors were familiar with creating more uncertainties in regards to what patients should be receiving and impacting their health.

Lack of interpreters. As patients needed to be able to verbally express their needs, the role of the interpreters was more than necessary. The available interpreters on the island were very few; the Arabic speakers almost always had the opportunity to speak via an Arabic- Greek or

Arabic- English interpreter. On the other hand, Farsi interpreters weren't present all times, Kurdish interpreters were not available for a face-to-face service and the same goes for other languages such as Urdu, Pashto, Eritrean languages etc. The hospital had no interpretation services on site, and after a certain stage the patients were denied healthcare services if the patients were not accompanied by an interpreter. Without interpreters, the level of communication between patient and medical staff was minimum, disappointment and anger were constantly present and the co-operation between the hospital and the NGOs was becoming very challenging.

Uncovered basic needs. There is a very tight connection between the coverage of the basic needs as per Maslow and the mental health and wellbeing (Acton & Malathum, 2000). The crisis in Leros had several phases whereby no bibliography is available; during the initial phase refugees had to sleep in the streets. Even after the initial response to the crisis when some tents were offered to the most vulnerable groups, hundreds of displaced people continued sleeping overnight in the streets without the basics. The access to water and sanitation are critical in a disaster; their lack could lead to water-related diseases and to the transmission of faeco-oral diseases (Ersel, 2015). The WASH facilities initially were very few and couldn't satisfy the needs of the thousands of refugees. Therefore, refugees and especially little children began developing upper and lower respiratory tract infections, urine infections, constipation, skin conditions and muosceletical problems (Pavli & Maltezou, 2017).

Mental instability. Not only during the initial phase of the crisis did problems occur due to the lack of shelter and WASH but also after a year or so, refugees living in houses or camps began suffering from various mental disorders, such as insomnia, suicidal thoughts, anxiety, depression. The reasons varied. Thousands of these displaced people had lost a loved one during the war, or the journey, others had just been informed that their family had been killed back home and all their hopes disappeared. Others had their asylum application denied and had attempted suicide several times. This stressful situation of being in a foreign country, without any money, without their families and having no means to leave Greece fired up lots of anxiety and extreme unsocial behaviour.

EU border closure. Very few refugees wanted to stay and live in Greece, a country with an unstable economy. Everyone wanted to move with their families to countries like Germany, Sweden, England, Austria, Finland, where there was a better perspective for the refugees. Unfortunately, the announcement of the closure of the borders to those countries created generalised panic and distress. The anxiety was even greater for those refugees where members

of their families had already been accepted in other European countries. Therefore, the political decisions really had a major impact on the refugees' mental health.

No money. It is well understood how money can affect our quality of health and wellbeing. Little or no money could prevent refugees from having access to medication and healthy foods, crucial factors especially for chronic patients with diabetes, hypertension, high cholesterol etc. Additionally, without money, refugees could not carry on with their journey to their destination, which resulted in depression, anxiety and suicidal thoughts. A few cases of theft had also been reported as well as minor injuries due to aggressive behaviour. Many refugees had reported abuse by the smugglers to the medical teams; there was another case of a very old Afghani woman travelling with a few other members of her family in which she reported that her daughters were not allowed to enter the boat as they didn't have enough money; she had no news from them since.

Wrong diagnoses. All the above were identified as the most important causes of the refugees' recent medical problems or the unmet medical needs. The results affected every stakeholder in diverse ways. The refugees' health deteriorated firstly, because of lack of doctors or due to wrong diagnoses and secondly, because they were left without the necessary treatment for their conditions. Complications also occurred as conditions were left untreated for a considerable time.

Hospital staff 'burnout'. The hospital staff got 'burned out' due to the huge workload and the difficult circumstances under which they had to work daily with limited support; not only did they have to constantly care for refugees with minor illnesses, but also they had to face victims of shipwrecks and their mourning families. It is important to stress that the hospital staff had no psychological support from the ministry of health in order to overcome these difficulties. Additionally, the hospital staff received no training on how to appropriately communicate with these delicate groups of displaced people.

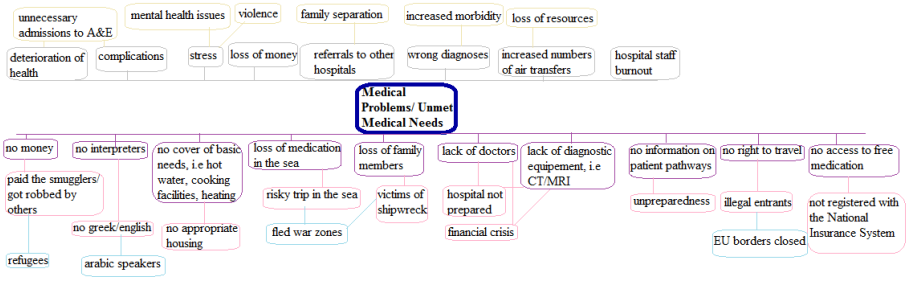
Referrals to other hospitals. The number of referrals to other hospitals like Kalymnos', Rhodes', Crete's and Athens' was significant as Leros' hospital was unable to provide the necessary healthcare for specific cases, mainly due to the lack of appropriate diagnostic equipment and relevant medical specialties. There were also MEDEVAC transfers due to emergencies following accidents.

Unnecessary admissions to A&E. The only ambulance on the island covering 9000 citizens in addition with the refugees had been receiving several calls daily through the ambulance service to collect refugees attempting suicide or even faintings and other injuries. The A&E had also been offering healthcare services 24/7 to refugees, who had been queuing almost daily

for minor illnesses. As A&E has only 2 bays, there had to be a triage of the cases to be examined first; triaging was causing great distress not only to refugees but to the locals, as there were also critical cases that had to be seen without any delay.

Mental issues. The medical staff working in the hospital and the other supplementary medical teams on the island had to deal with mental health issues daily. Taking into consideration the population's background it is well known that a considerable number of refugees had been imprisoned and/or tortured by the ISIS or the Syrian army; others had been victims of torture by the Taliban soldiers and others had been raped and traumatised during their journey (Bowles, 2005) (*The Rise of the Taliban in Afghanistan: Mass Mobilization, Civil War, and ... - N. Nojumi - Βιβλία Google*, n.d.). Additionally, other refugees developed mental health problems following traumatic experiences while crossing the Aegean Sea, especially those who had lost their loved ones in shipwrecks (Blitz et al., 2017).

Distress. Mainly due to EU regulations for various reasons in each case, families got separated or could not be reunited. Refugees were mostly up-to-date with recent politics as these would affect their future plans. In cases where decisions made by the governments were opposed to their will, as expected, people became stressed, upset and difficult to communicate with. As a result, protests had been ongoing on several occasions, where people got injured due to violent behaviour.



The Challenges

The size of the population. The massive influx of refugees in a short period of time on a small island without facilities to support the refugees was one of the greatest challenges in this case study. The number of the refugees we had to support had been growing daily with new arrivals. This included the possibility of having to be additionally prepared for disasters such as shipwrecks. The number of refugees staying on the island was also affected by many other factors such as Europe's politics, weather conditions, refugees' financial capacity, etc.

Timing. Timing was also crucial trying to cope with the increasingly high influx of the refugees as human resources and equipment were pretty much at the same levels during all times. For the refugees, time was as important as entering EU borders. As political decisions were to determine refugees' future, people were rushing to enter the Greek borders at any cost, rushing to register, and finally rushing to get their precious ticket to the mainland. Along with them, we all had to work fast in order to help them move on, as well as to decompress the pressure the island was facing day-by-day.

The weather conditions. In winter, humidity on the islands increase the sense of cold, but apart from that, rough winter weather resulted in two major shipwrecks (*Νέο διπλό ναυάγιο με 43 νεκρούς και πολλούς αγνοούμενους πρόσφυγες σε Καλόλιμνο και Φαρμακονήσι - Ειδήσεις - νέα - To Βήμα Online*, n.d.); the victims included children. Living conditions were poor taking into account the fact that refugees had to sleep in tents without heating during the winter months; the rainy and cold weather affected the population's health causing mainly airway infections. Last but not least, the bad weather was one important factor for delaying departures from the island to the mainland, as ferries would cancel or delay their schedule.

Lack of facilities. Another challenge for dealing with this major crisis was the lack of facilities. As Leros is a small island with only a few thousand residents, there were not enough public shelters for the homeless in case of emergency. As a matter of fact, refugees were left to sleep in the streets during the initial phase of the crisis and later on in tents around the port area. In addition, an abandoned public building was utilized in order to house a medical clinic in use by the Doctors Without Borders, a boutique with clothing and other items for hygiene purposes was run by an NGO with Dutch volunteers; the other rooms were used by refugees as a shelter. WASH facilities were very poor in the beginning, however, Doctors Without Borders completed their plan and set toilets, showers and tank with drinkable water in place. Unfortunately, refugees were left with cold water to shower with even during the cold months.

Working as a healthcare professional with an NGO during the initial phase of the crisis and at the same time studying for my Master's course in International Medicine and Humanitarian Crisis Management benefited me in pinpointing the challenges we had to overcome.

Implementation of the Sphere Minimum Standards on the field

As described previously in the Problem Tree section the lack of appropriate housing and facilities can lead to problems and could create health concerns. The Sphere Project has published a series of standards in an effort to ensure human dignity at all times during a crisis. Outlined, the Sphere Standards implemented in this case scenario are being presented.

Hygiene Promotion Standard 1.1

'People are aware of key public health r+isks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them' (Project, 2018).

As a member of the medical team of Doctors Without Borders (MSF Belgium) I was selected to be part of the Health Promotion Team; the team consisted of the Lead health Promoter, one Arabic interpreter and one Farsi interpreter and me, a nurse. The plan was for me to get trained by the Health Promoter on how to communicate with the displaced population, pass on the message of the importance of keeping a good personal and community hygiene with the assistance of the interpreters.

Our activities in the refugee camp had included visiting the tents one-by-one and reminding people of the importance of good hand hygiene mainly when using the WASH facilities and while handling food. Also, we had been reminding people to visit the clinic if anyone was not feeling well. Apart from that we had been stressing the importance of maintaining their tents and keeping the camp area clean. Lastly, we had to enforce the use of showers; this proved to be a hard task unfortunately, as the running water was cold and as expected, people were not happy with this situation. Luckily, the problem of cold running water had finally been resolved after several weeks.

Besides human contact and the verbal communication of the information regarding personal hygiene, the health promotion activities included posters visualizing the useful information in Arabic and Farsi. At the end of the induction in the team, I was able to communicate with the refugee population on my own with the interpreters or even when there was a heavy workload the interpreters could take over and work solely with the refugees on this matter.

It is necessary to add the feedback we had been receiving from the refugees through this contact. The feedback was a great way to improve our activities and see the results of our work.

Hygiene Promotion Standard 1.2

'Appropriate items to support hygiene, health, dignity and well-being are available and used by the affected people' (Project, 2018).

On their arrival to the island, the displaced people had already been given blankets, energy bars and water, either on the rescue boats or at the Farmakonisi or even at the port of Leros soon

after disembarkation. Volunteers had been distributing kits with personal hygiene items individually to the refugees.

On top of that, a group of Dutch volunteers along with local volunteers created a 'boutique', a room in the abandoned building where the clinic was co-located, with clothing and shoes for all ages, more items for personal and menstrual hygiene as well as baby care items. It was literally a 'shop' where anyone could enter following the queue and could get anything up to 5 items per person; that was a measure in order to ensure that everyone could get at least another pair of shoes and clothes as many refugees had ripped or wet clothing.

At the hand washing station soap bars had been placed, however, these had been removed by people on several occasions. The toilets and showers had been regularly cleaned by a dedicated person hired by the municipality, nevertheless, people were complaining of the cold water, and mothers had to wash their babies with cold water in winter time, as there was not always hot water available.

In addition, there were no laundry facilities, but despite that, women washed their family's clothes by hand with cold water and allowed them to dry under the sun.

Volunteers had been helping mothers with babies and young children by distributing powdered milk and warm water. They would go around the camp and check for babies and toddlers and they would try to accommodate their needs whenever possible.

Hygiene Promotion Standard 1.3

Menstrual Hygiene Management and Incontinence

'Women and girls of menstruating age, and males and females with incontinence, have access to hygiene products and WASH facilities that support their dignity and well-being' (Project, 2018).

The clinic and the 'boutique' were places where women and girls could get their menstrual hygiene supplies. There had been no requests for incontinence products.

The Sphere Standard suggests as minimum supplies 1. absorbent cotton material, disposable pads (15/month), or reusable sanitary pads, 2.underwear and 3.extra soap (Project, 2018). In practice the disposable pads had only been available and distributed.

Water Supply Standard 2.1

Access and water quantity

'People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking and domestic needs' (Project, 2018).

The Sphere Standards proposes 1. 15 litres per person per day minimum, 2. Determine quantity based on context and phase of response (Project, 2018). In our case there was a water station in place with a refillable water tank; the water had been under quality checks regularly.

Water Supply Standard 2.2

Water Quality

'Water is palatable and of sufficient quality for drinking and cooking, and for personal and domestic hygiene, without causing a risk to health' (Project, 2018).

The water tank was being refilled regularly by a private water supplier as the island hasn't got a drinkable water network established to provide houses and businesses with fresh drinking water. Even though the water was drinkable, many refugees suffered from dehydration and urine track infections; patients had been complaining of the taste of the water. Refugees had been struggling with the drinking water as it had a weird taste. Patients had been reassured that the drinking water provided was safe to drink and had gone through quality and safety tests regularly and on top of that, the medical team had been drinking water from the same tank as a way to enforce reassurance on this matter. In Addition, each patient had been given one bottle of water 1.5 litter following their visit to the clinic in order to fight dehydration.

Excreta Management Standard 3.1

Environment free from human excreta

'All excreta is safely contained on-site to avoid contamination of the natural, living, learning, working and communal environments' (Project, 2018).

The Sphere Standards' indicators for the excreta management suggest that there are no human faeces anywhere the people are and that all excreta containment facilities are located within a safe distance from any water source (Project, 2018). If we imagine that the refugee camp in this case has the shape of a rectangle, the toilets and the showers had been placed at the top right edge of the rectangle. The distance from the toilets to the closest tent was around 10 meters and from the water tank the distance was around 5 meters.

Excreta Management Standard 3.2

Access to and use of toilets

'People have adequate, appropriate and acceptable toilets to allow rapid, safe and secure access at all times' (Project, 2018).

The key indicators for this Sphere Standard sets a ratio of shared toilets at least 1 per 20 people (Project, 2018); as we understand, for a refugee camp in a limited space the number of 50 toilets for 1000 people or more sounds surreal. In addition, the Sphere Standards propose

minimum distance between tents and shared toilets are maximum 50 meters (Project, 2018); this target had been luckily achieved.

Excreta Management Standard 3.3

Management and maintenance of excreta collection, transport, disposal and treatment

'Excreta management facilities, infrastructure and systems are safely managed and maintained to ensure service provision and minimum impact on the surrounding environment' (Project, 2018).

The Sphere Standard indicator is that all human excreta is disposed safely in respect to public health and the environment (Project, 2018).

Vector Control Standard 4.1

Vector Control at Settlement Level

'People live in an environment where vector breeding and feeding sites are targeted to reduce the risks of vector-related problems' (Project, 2018).

Vector Control Standard 4.2

Household and Personal Actions to Control Vectors

'*All affected people have the knowledge and means to protect themselves and their families from vectors that can cause a significant risk to health or well-being'* (Project, 2018).

Regarding Sphere Standards for Vector Control there had been no incidents or complaints and as far as the medical team was aware any actions on this matter had been handled by the municipality as per their protocols.

Solid Waste Management Standard 5.1

Environment free from solid waste

'Solid waste is safely contained to avoid pollution of the natural, living, learning, working and communal environments' (Project, 2018).

All the solid waste had been handled by assigned personnel and had been transferred to an area outside the designated refugee camp, but in close distance. The municipality had been handling the waste and would transfer it to the rubbish dump of the island.

Solid Waste Management Standard 5.2

Household and personal actions to safely manage solid waste

'People can safely collect and potentially treat solid waste in their households' (Project, 2018).

The refugee camp in this case scenario had several points for solid waste containers; in addition, every tent had its own bag for waste disposal. Moreover, part of the Health Promotion was to inform and reinforce people to safely dispose of their waste and to keep their tents free from rubbish.

Solid Waste Management Standard 5.3

Solid waste management systems at community level

'Designated public collection points do not overflow with waste, and final treatment or disposal of waste is safe and secure' (Project, 2018).

As mentioned above, designated personnel by the municipality was responsible for the waste management in the refugee camp; the personnel had been present daily in order to ensure safe management of the trash.

Standard 6

WASH in healthcare setting

'All healthcare settings maintain minimum WASH infection prevention and control standards, including in disease outbreaks' (Project, 2018).

In this case scenario there had been no outbreaks reported. However, the medical team had been working in an unhealthy environment with limited access to running water; there had been no running water in the clinic. The medical team had been using a room in an abandoned building where there was no ventilation, only a small opening in the wall which was an entry point for dust and rain. There were no toilets available for the medical team, nor designated toilets for the patients. The cleaning material available were the basics. The use of the personal protective equipment was minimum.

Food Security and Nutrition Assessments Standard 1.1

Food security assessment

'Where people are at risk of food insecurity, assessments are conducted to determine the degree and extent of food insecurity, identify those most affected and define the most appropriate response' (Project, 2018).

Food Security and Nutrition Assessments Standards 1.2

Nutrition assessment

'Nutrition assessments use accepted methods to identify the type, degree and extent of undernutrition, those most at risk and the appropriate response' (Project, 2018).

Food Security Standard 5

General food security

'People receive food assistance that ensures their survival, upholds their dignity, prevents the erosion of their assets and builds resilience' (Project, 2018).

Food Assistance Standard 6.1

General nutrition requirements

'The basic nutritional needs of the affected people, including the most vulnerable, are met' (Project, 2018).

Food Assistance Standard 6.2

Food quality, appropriateness and acceptability

'The food items provided are of appropriate quality, are acceptable and can be used efficiently and effectively' (Project, 2018).

Food Assistance Standard 6.3

Targeting, distribution and delivery

'Food assistance targeting and distribution is responsive, timely, transparent and safe' (Project, 2018).

Food Assistance Standard 6.4

Food use

'Storage, preparation and consumption of food is safe and appropriate at both household and community levels' (Project, 2018).

At the initial stage of the crisis the food had been distributed by volunteers and the army. As far as we were aware, the food items consisted of poultry, beef, fish, vegetables, rice, pasta, bread and fruit; the pork had been excluded as it is known that muslims are not allowed to consume pork as per their religion (*Why Pork is Forbidden in Islam (All parts) - The Religion of Islam*, n.d.).

Every Sunday, volunteers would take over food production and distribution. The rest of the days the army in collaboration with local restaurants had been offering the food, which was the same regardless of the nutritional needs that different individuals could have had. The meals were based on a 2000 kcal per person per day.

At the initial stage of the crisis in this case management there was no actor dedicated to nutrition assessment and diet planning; every issue that could lead to any kind of health problems would fall under the medical team's umbrella. There was only one major concern of a child's severe malnutrition. There had also been reported refugees with a significant loss of weight during their voyage from their homelands. The greatest concern however, had to do with the nutritional management of patients with diet-related health problems such as diabetes and hypertension. All the meals had been prepared with the addition of salt and all the meals had been served with a type of carbohydrate (white bread, plain rice, plain spaghetti, potatoes, etc). The medical team had raised these concerns in their meetings with the project's leader

and came up with a temporary solution; in collaboration with a local fast food restaurant the medical team was providing each diabetic patient with a coupon so they could get a wholewheat pitta bread with a chicken souvlaki and vegetables per day.

As for the children, volunteers had been split into shifts ensuring there was warm water and milk formulas day and night by visiting each tent where children were. There was a case of a toddler which was found to be underweight, due to its' mother's misconception of right feeding. The on-site pediatrician went through a thorough physical examination of the child and an intense training with the mother on how to feed her child.

Health Systems Standard 1.1

Health service delivery

'People have access to integrated quality healthcare that is safe, effective and patient-centred' (Project, 2018).

Healthcare Systems Standard 1.2

Healthcare workforce

'People have access to healthcare workers with adequate skills at all levels of healthcare' (Project, 2018).

Health systems standard 1.3

Essential medicines and medical devices

'People have access to essential medicines and medical devices that are safe, effective and of assured quality' (Project, 2018).

Health systems standard 1.4

Health financing

'People have access to free priority healthcare for the duration of the crisis' (Project, 2018).

Health systems standard 1.5

Health information

'Healthcare is guided by evidence through the collection, analysis and use of relevant public health data'(Project, 2018).

The Problem Tree briefly outlines the core issues related with the available healthcare system on the island of Leros at the time of the crisis; collapsing healthcare facilities located in an Italian building (*Κρατικό Θεραπευτήριο Λέρου – Νοσοκομείο Λέρου*, n.d.)(*Κρατικό Νοσοκομείο Λέρου*, n.d.), a general hospital which had been downgraded due to the country's financial crisis (*ΥΓΕΙΑ | ΡΙΖΟΣΠΑΣΤΗΣ*, n.d.) left with very few specialized doctors and staffing levels down to 1/3 of the required number to cover its needs (*ΥΓΕΙΑ | ΡΙΖΟΣΠΑΣΤΗΣ*, n.d.). Despite this unfortunate situation, the hospital's staff went the extra mile for the refugees, especially the

midwives in the maternity ward; the staff had always been very prompt and kind with the refugees. The 'Doctors Without Borders' on the field and the hospital of Leros managed to cooperate in a way that the majority of the patients with no life-threatening issues had been receiving assistance in the refugee camp and the more serious cases had been referred to the hospital for further management; in this way, the hospital survived from a complete collapse due to the patients' overflow. Nevertheless, there had been many times when the hospital staff had struggled a lot with the workload pressure and even more so with the cases where there was no interpreter present.

The most common analgetics, antibiotics, antihypertensive, antidiabetic medication etc could be provided by the 'Doctors Without Borders' for free. Occasionally, the hospital staff would provide patients with the needed medications off the record. However, there were times when patients needed to take special drugs; for instance, antiepileptic medication in which case, the 'Doctors Without Borders' would buy these from a local pharmacy and provide it to the patient.

Communicable Diseases Standard 2.1.1

Prevention

'People have access to healthcare and information to prevent communicable diseases' (Project, 2018).

Communicable Diseases Standard 2.1.2

Surveillance, outbreak detection and early response

'Surveillance and reporting systems provide early outbreak detection and early response' (Project, 2018).

Communicable Diseases Standard 2.1.3

Diagnosis and case management

'People have access to effective diagnosis and treatment for infectious diseases that contribute most significantly to morbidity and mortality' (Project, 2018).

Communicable Diseases Standard 2.1.4

Outbreak preparedness and response

'Outbreaks are adequately prepared for and controlled in a timely and effective manner' (Project, 2018).

Part of the Health Promotion was to inform the refugees on how to prevent communicable diseases such as the flu, scabies, etc.

'Doctors Without Borders' medical team had already a surveillance and report protocol in place and in communication with the national KEELPNO (centre for controlling communicable diseases) all the cases of communicable diseases were being reported and followed up on, ie

scabies. The protocols for diagnosis and treatment were most of the times available on site. However, there had been several misses, as the doctors on the field were unexperienced and there weren't available diagnostic tests.

Child Health Standard 2.2.1

Childhood vaccine-preventable diseases

'Children aged six months to 15 years have immunity against disease and access to routine Expanded Programme on Immunization services during crises' (Project, 2018).

The vaccination program commenced almost a year after the initiation of the crisis (2016).

Child Health Standard 2.2.2

Management of newborn and childhood illness

'Children have access to priority healthcare that addresses the major causes of newborn and childhood morbidity and mortality' (Project, 2018).

There were several cases of children with serious illnesses such as hydrocephalus, seizures, heart problems etc which on the one hand, couldn't be dealt with at Leros' hospital and on the other hand these cases couldn't be released nor could they be referred to the specialist children's hospital in Athens, unless of course the case was a matter of life or death. Most of the times, patients and their families had to wait for several weeks until their paperwork would allow them to be released to the mainland.

Sexual and Reproductive Health Standard 2.3.1

Reproductive, maternal and newborn healthcare

'People have access to healthcare and family planning that prevents excessive maternal and newborn morbidity and mortality' (Project, 2018).

Sexual and Reproductive Health Standard 2.3.2

Sexual violence and clinical management of rape

'People have access to healthcare that is safe and responds to the needs of survivors of sexual violence' (Project, 2018).

In the refugee camp apart from the medical team there had always been a psychologist present. There were no incidents of rape reported in the refugee camp, neither had refugees reported rape in previous refugee camps in Turkey by that time. However, there had been several incidents of domestic violence. These cases had been referred to the Protection Officer in the UNHCR for further assistance.

Sexual and Reproductive Health Standard 2.3.3

HIV

'People have access to healthcare that prevents transmission and reduces morbidity and mortality due to HIV' (Project, 2018).

There had been no HIV patients reported in the clinic, nevertheless, we can't be sure there had been zero cases.

Injury and Trauma Care Standard 2.4

Injury and trauma care

'People have access to safe and effective trauma care during crises to prevent avoidable mortality, morbidity, suffering and disability' (Project, 2018).

As all the refugees would come to Leros island via the sea, many shipwrecks had occurred by that time. The medical team and other volunteer groups had always been on call in case they had to urgently provide healthcare to the injured. The Leros hospital was equipped with one ambulance for the whole island, which made things even harder in emergencies like shipwrecks with many casualties.

Mental Health Standard 2.5

Mental health care

'People of all ages have access to healthcare that addresses mental health conditions and associated impaired functioning' (Project, 2018).

Leros is known worldwide for its psychiatric hospital, therefore most of the doctors were psychiatrists.

Non-communicable Diseases Standard 2.6

Care of non-communicable diseases

'People have access to preventive programmes, diagnostics and essential therapies for acute complications and long-term management of non-communicable diseases' (Project, 2018).

The non-communicable diseases in the population we study were the ones which are related to middle age such as diabetes, hypertension, etc but also mental conditions like PTS following traumatic events. As described previously, despite the limited means available in the healthcare everyone tried their best to support the people in need.

Suggestions

In times when people face difficulties in their personal lives it is promising to see them willing to help others in need. Volunteering plays a major role in disaster management and volunteers are needed indeed. We need to make the most of our previous experiences and along with the practices we have learned to make a step further in becoming 'citius, altius, fortius'.

Communication is the key to every success, so it is in disaster management. We need to take advantage of the latest technology and apply this in the field. Applications such as telemedicine are great tools when distance is an obstacle. Doctors could virtually examine patients on the field and offer diagnosis, treatment plan and follow-up. Telemedicine could make a difference in how we treat refugees especially in settings with minimum facilities, equipment and staff.

Additionally, countries around the globe need to be prepared in case of emergency. Governments need to incorporate within their legislations the Minimum Standards in case of disasters and adapt them accordingly. There always needs to be a plan in place in case a disaster occurs and every stakeholder needs to be informed and compliant with the Standards. The Standards is just a guide for reference and there should be a council dedicated in disaster management continuously working on the subject even if the possibility of a disaster is small; moreover, disasters lately have a new shape due to terror attacks and climate change, therefore, it is crucial to have a preparedness plan available at any time.

Continuous development and education are so important, as Solon the Athenian said 'you live and learn', disaster management is another field we need to become better in the future. The continuous development should aim for the acquisition of more skills and knowledge in relevant sub-topics such as infection control management for the healthcare professionals in settings with limited resources, health promotion, management of psychological trauma in patients, nutrition for different health statuses, breastfeeding, etc.

Motivation is the force that makes people better, so we need motivated people who have spent significant time from their lives volunteering in the fields to speak to the public, share their experiences, promote their work and cooperate with international organizations in developing the practices we implement in disaster management.

Conclusion

In this thesis I tried to answer a controversial question regarding the refugees' health needs and how well we performed in the field. There had been several challenges and we had to fight against factors such as the size of the population, the weather conditions, the sudden onset of the arrivals by the sea, the limited healthcare facilities and many more. In order to give an answer, I conducted a literature review on papers stressing the importance of the evaluation of programs in humanitarian aid and outlining the core minimum standards which should be implemented in case of disasters. I also added my personal experiences from the field in an effort to have our actions written for future reference, since there is no literature available referring to the refugee crisis on Leros island. In conclusion, all together we performed in the best possible way at that time, but for sure we could do much better. How do we know we did well? The people in need were there to say 'thank you'.

BIBLIOGRAPHY

(35) Syria's war: Who is fighting and why - YouTube. (2017). https://www.youtube.com/watch?v=JFpanWNgfQY

Acton, G. J., & Malathum, P. (2000). Basic need status and health-promoting self-care behavior in adults. *Western Journal of Nursing Research*, *22*(7), 796–811. https://doi.org/10.1177/01939450022044764

Al Gasser, N. A., Dresden, E., Keeney, G. B., & Warren, N. (2004). Status of women and infants in complex humanitarian emergencies. *Journal of Midwifery and Women's Health*, *49*(4 SUPPL.), 7–13. https://doi.org/10.1016/j.jmwh.2004.05.001

Banatvala, N., & Zwi, A. B. (2000). Public health and humanitarian interventions: Developing the evidence base. In *British Medical Journal* (Vol. 321, Issue 7253, pp. 101–105). https://doi.org/10.1136/bmj.321.7253.101

Blanchet, K., Ramesh, A., Frison, S., Warren, E., Hossain, M., Smith, J., Knight, A., Post, N., Lewis, C., Woodward, A., Dahab, M., Ruby, A., Sistenich, V., Pantuliano, S., & Roberts, B. (2017). Evidence on public health interventions in humanitarian crises. In *The Lancet* (Vol. 390, Issue 10109, pp. 2287–2296). Lancet Publishing Group. https://doi.org/10.1016/S0140-6736(16)30768-1

Blitz, B., d'Angelo, A., Kofman, E., & Montagna, N. (2017). Health Challenges in Refugee Reception: Dateline Europe 2016. *International Journal of Environmental Research and Public Health*, *14*(12), 1484. https://doi.org/10.3390/ijerph14121484

Bowles, R. (2005). Social Work with refugee survivors of torture and trauma. *Social Work Fields of Practice*, *Herman*, 249–267. http://www.startts.org.au/media/Bowles-Robin-Social-Work-with-Refugee-Survivors-of-Torture-and-Trauma-2005.pdf

Checchi, F., Warsame, A., Treacy-Wong, V., Polonsky, J., van Ommeren, M., & Prudhon, C. (2017). Public health information in crisis-affected populations: a review of methods and their use for advocacy and action. In *The Lancet* (Vol. 390, Issue 10109, pp. 2297–2313). Lancet Publishing Group. https://doi.org/10.1016/S0140-6736(17)30702-X

Ersel, M. (2015). Water and sanitation standards in humanitarian action. In *Turkish Journal of Emergency Medicine* (Vol. 15, pp. 27–33). https://doi.org/10.5505/1304.7361.2015.48753

Hodes, M., Vasquez, M. M., Anagnostopoulos, D., Triantafyllou, K., Abdelhady, D., Weiss, K., Koposov, R., Cuhadaroglu, F., Hebebrand, J., & Skokauskas, N. (2018). Refugees in Europe: national overviews from key countries with a special focus on child and adolescent mental health. In *European Child and Adolescent Psychiatry* (Vol. 27, Issue 4, pp. 389–399). Dr. Dietrich Steinkopff Verlag GmbH and Co. KG. https://doi.org/10.1007/s00787-017-1094-8

Pavli, A., & Maltezou, H. (2017). Health problems of newly arrived migrants and refugees in Europe. *Journal of Travel Medicine*, *24*(4). https://doi.org/10.1093/jtm/tax016

Project, T. S. (2018). The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. In *Response* (Vol. 1). https://doi.org/ISBN 978-1-908176-00-4

Roberts, L., & Hofmann, C. A. (2004). Assessing the impact of humanitarian assistance in the health sector. In *Emerging Themes in Epidemiology* (Vol. 1, Issue 1, p. 3). https://doi.org/10.1186/1742-7622-1-3

Rose, J., & O'Keefe, P. (2016). Relief Operations. In *International Encyclopedia of Public Health* (pp. 278–285). Elsevier Inc. https://doi.org/10.1016/B978-0-12-803678-5.00375-1

Spiegel, P. B. (2017). The humanitarian system is not just broke, but broken: Recommendations for future humanitarian action. *The Lancet*. https://doi.org/10.1016/S0140-6736(17)31278-3

The Rise of the Taliban in Afghanistan: Mass Mobilization, Civil War, and ... - N. Nojumi - Βιβλία Google. (n.d.). Retrieved January 12, 2020, from https://books.google.gr/books?hl=el&lr=&id=h18YDAAAQBAJ&oi=fnd&pg=PP1&dq=taliban+torture+refugees&ots=OyraBLnG_I&sig=XjZ4HsbBBrjA7j5CVWyN7T1GLAQ&redir_esc=y#v=onepage&q=torture&f=false

Tree, T. P. (1993). *The Problem Tree*. 943–944. https://foodgrainsbank.ca/uploads/tips/tips103.pdf

UNHCR. (2007). *Guidelines for Implementing Interagency Health and Nutrition Evaluations in Humanitarian Crises*. *August*, 71. https://www.unhcr.org/47692e3b4.pdf

UNHCR Data Portal- Greece. (2015). *Greece data snapshot- 28 Dec 2015*. https://data2.unhcr.org/en/documents/download/46636

United Nations, Department of Economic and Social Affairs, P. D. (2016). *International Migration Report 2015: Highlights*. http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2015_Highlights.pdf

VanRooyen, M., Venugopal, R., & Greenough, P. G. (2005). International humanitarian assistance: Where do emergency physicians belong? In *Emergency Medicine Clinics of North America* (Vol. 23, Issue 1, pp. 115–131). W.B. Saunders. https://doi.org/10.1016/j.emc.2004.09.006

Why Pork is Forbidden in Islam (All parts) - The Religion of Islam. (n.d.). Retrieved January 21, 2020, from https://www.islamreligion.com/articles/2513/viewall/why-pork-is-forbidden-in-islam/

Wikipedia. (n.d.). *Arab Spring*. Retrieved January 4, 2020, from https://en.wikipedia.org/w/index.php?title=Arab_Spring&oldid=724060662

Εργασία, Π., Φοιτήτριας, Τ., & Ναστούλη, Ό. (n.d.). *ΤΟ ΜΕΤΑΝΑΣΤΕΥΤΙΚΟ ΠΡΟΒΛΗΜΑ ΣΤΗΝ ΕΛΛΑΔΑ ΣΗΜΕΡΑ*. Retrieved February 10, 2019, from http://repository.teiwest.gr/xmlui/bitstream/handle/123456789/5946/DE ΝΑΣΤΟΥΛΗ ΟΛΓΑ.pdf?sequence=1&isAllowed=y

Κρατικό Θεραπευτήριο Λέρου – Νοσοκομείο Λέρου. (n.d.). Retrieved January 22, 2020, from http://www.leros-hospital.gr/

Κρατικό Νοσοκομείο Λέρου. (n.d.). Retrieved January 22, 2020, from https://www.λεροσ.com/nosokomeio.html

Νέο διπλό ναυάγιο με 43 νεκρούς και πολλούς αγνοούμενους πρόσφυγες σε Καλόλιμνο και Φαρμακονήσι - Ειδήσεις - νέα - Το Βήμα Online. (n.d.). Retrieved January 28, 2020, from https://www.tovima.gr/2016/01/22/society/neo-diplo-nayagio-me-43-nekroys-kai-polloys-agnooymenoys-prosfyges-se-kalolimno-kai-farmakonisi/

Πρόσβαση των Ανασφάλιστων στο Δημόσιο Σύστημα Υγείας - Ανάπτυξη Μονάδων Υγείας - Υπουργείο Υγείας. (n.d.). Retrieved January 12, 2020, from https://www.moh.gov.gr/articles/health/anaptyksh-monadwn-ygeias/3999-prosbash-twn-anasfalistwn-sto-dhmosio-systhma-ygeias

ΥΓΕΙΑ | ΡΙΖΟΣΠΑΣΤΗΣ. (n.d.). Retrieved January 22, 2020, from https://www.rizospastis.gr/page.do?publDate=29/6/2014&id=15310&pageNo=16

Φαρμακονήσι - Βικιπαίδεια. (n.d.). Retrieved October 24, 2019, from https://el.wikipedia.org/wiki/Φαρμακονήσι