

Report

69<sup>th</sup> World Health Assembly

**Technical Briefing**

**‘Migration and Health’**



27 May 2016

## Executive Summary

There are approximately 244 million international migrants and 740 million internal migrants in the world - one in seven of the global population. In addition, more people have been forced to migrate than any other time since the Second World War. There are 60 million people forcibly displaced (20 million refugees, and 40 million internally displaced persons).

Globalization, conflict, poverty, climate change, urbanization, inequality and poor job prospects are among the reasons that compel people to leave their homes in search of a better future for themselves and their family. Despite many benefits of migration, migrants themselves remain among the most vulnerable members of society. Governments face the challenge of integrating the health needs of migrants and refugees into national plans, policies and strategies as recommended by resolution WHA61.17 on the Health of Migrants adopted in 2008.

A technical briefing on Migration and Health was organized on 27 May 2016, attended by over 200 participants from Member States, UN agencies, civil societies, NGOs, partners and the Press. The objectives of the briefing were to review the current situation and priorities related to migration and health, to review best practices and to look at lessons learnt and implications for the future of WHO's work in relation to migration and health, which has up to now been guided by the action points of WHA Resolution 61.17 on migrant health. The human face of all that surrounds access to health care for migrants and refugees was emphasized. The recommendations from the briefing along with outcomes of the WHA 14.7's discussions on the health of migrants will be used as a basis for the development of a WHO roadmap towards an organization-wide strategy on migration and health.

The session was opened by the WHO Director-General, followed by the IOM Director General. A WHO analysis was provided by the EURO Regional Director outlining actions by all WHO Regions, followed by UNHCR on refugee health needs. Country perspectives within the panel were organized into 2 themes.

### **Theme1: Sustainable Development and Migration**

Costa Rica, Liberia, Sri Lanka and Thailand

### **Theme 2: Large scale displacement - for refugees and internally displaced persons**

Greece, Italy, Lebanon, and Turkey

## Key challenges discussed during the briefing

- **Unprecedented human mobility** since World War II with continued upward trends. Governments face immediate challenges to meet the health needs of migrants and refugees.
- Many displaced people - undocumented migrants in particular - are given **no or inadequate access to quality health services** and suffer from inhumane **migration policies** aggravating preventable medical emergencies and continued deterioration of migrants' health.
- Service providers in many countries are obliged to report or denounce **undocumented migrants** to migration authorities. This **severely hinders access to health care** for migrants with irregular migration status.
- **Universal Health Coverage (UHC)** is high on the global health agenda. UHC only exists if health systems **account for all** community members, including migrants and refugees.
- **Integrating** refugees and migrants into **national healthcare and health insurance schemes** - whether public, private or public-private partnerships - will only work where these systems exist and are sufficiently robust to assume the added responsibilities.
- There is a lack of **flexible multi-year funding** for countries coping with the influx of refugees and migrants.

## Main recommendations emerging from the briefing

### Health policies and legal framework

- 1) Mainstreaming migrants and refugees within national healthcare systems is essential to achieve the 2030 Sustainable Development Goals (SDGs) to ensure healthy lives for all and to leave no one behind. Countries hosting migrants and refugees should integrate them into national and local development planning where it is possible.
- 2) It is important to bridge short humanitarian response with long term approaches. Rapid, agile and effective emergency response – sometimes delivered in parallel to national systems – will continue to be essential to save lives. But longer-term planning for more development-oriented approaches can and must begin early.
- 3) Countries should promote coherence among policies of various sectors that can affect migrants' and refugees' abilities to access health services in a country as well as among countries.
- 4) Countries must shift from the current toxic narrative on migration, to one that takes full account of the contribution migrants make to the social and economic development of both their countries of origin and destination. Migrants need to be considered as human capital.

### Migrants' and refugees' sensitive health services and UHC

- 5) Countries must work towards UHC for all, including migrants and refugees, irrespective of their legal status and without discrimination or stigmatization.
- 6) Migrants' and refugees' sensitive health systems must be strengthened to be able to provide UHC and equitable access to quality health services irrespective of their legal status. We should change the way we work with more investment in local solutions and local structures. We need to increase the resilience and the ability of a system to respond to crises and to face emergency. We need to build local capacity to prevent local catastrophes.

### Health monitoring and health information system

- 7) Countries must have an adequate health information system with robust epidemiological data on migration. Good quality public health information is of paramount importance to develop evidence-informed policy options.

### Health Financing

- 8) To meet SDG 2030 – leave no one behind – donor countries and the World Bank should provide flexible multi -year financing needed to support countries affected by the migration process.

### Multisectoral collaboration and partnership

- 9) The unprecedented rise of influxes has called for a well- coordinated multisectoral and multi-country response. Collaborative networks and international dialogue are essential to manage the health needs of migrants and refugees.

### Requests to WHO

- 1) To develop a **Comprehensive Global Strategic Framework** on migration and health.
- 2) To **advocate** and **support** Member States in developing **inclusive health policies and legal frameworks** to ensure **the right to health for all, irrespective of migrant legal status**.
- 3) To advocate and support Member States in **making the changes to law and policy** needed to bring migrants and refugees within national and local development planning.
- 4) To support Member States in **health system strengthening** towards achieving **UHC** for all.
- 5) To develop **technical guidelines, tools** and conduct research to help **build the evidence base** to inform migrant health policy formulation and changes.
- 6) To **draw good experiences** and **document good practice** from countries having migrant-sensitive health policies, and **share such evidence** to donors, and policy makers in developed and developing countries.

## **Annexes**

### **Annex 1: Briefing Agenda**

### **Annex 2: Remarks by WHO and international organizations**

- Opening remarks by Director-General, WHO
- Introduction by Director-General, IOM
- Presentation by Regional Director EURO 'WHO analysis
- Statement by UNHCR on access to health for refugees

### **Annex 3: Speeches and Presentations by countries**

#### **Theme 1: Sustainable development and migration**

- Costa Rica
- Liberia
- Sri Lanka
- Thailand

#### **Theme 2: Large scale displacement**

- Greece
- Italy
- Lebanon
- Turkey

### **Annex 4: Summary and conclusions**

### **Annex 5: Postcards distributed during the session**

## Annex 1: Migration and Health - Technical Briefing

Friday 27 May 2016, 12:30pm

### AGENDA

Time	Session description
12.30 – 12.40	<b>Opening remarks</b> <ul style="list-style-type: none"> <li>• Dr Margaret Chan, Director-General, World Health Organization</li> </ul>
12.40 – 12.45	<b>Introduction to the session</b> <ul style="list-style-type: none"> <li>• Ambassador William Lacy Swing, Director-General, International Organization for Migration</li> </ul>
12:45 – 12:50	<b>Video</b> : Personal stories from the frontline of migration and health
12.50 – 13.00	<b>Migration and Health in the WHO European and other WHO regions</b> <ul style="list-style-type: none"> <li>• Dr Zsuzsanna Jakab, WHO Regional Director for Europe</li> </ul>
13.00 – 13.05	<b>Access to health for refugees</b> <ul style="list-style-type: none"> <li>• Steven Corliss, Director, Division of Programme Support and Management, UNHCR</li> </ul>
<b>Theme 1: Sustainable development and migration</b>	
13.05 – 13.35	<p><b>Costa Rica: <i>Costa Rica, country of destination for Central American migrants and transit region for migrants from the Caribbean, Africa and Asia</i></b></p> <ul style="list-style-type: none"> <li>• Dr Fernando Llorca Castro, Minister of Health, Costa Rica</li> </ul> <p><b>Liberia: <i>Migration and Health - Bridging humanitarian action with development</i></b></p> <ul style="list-style-type: none"> <li>• Dr Bernice Dahn, Minister of Health, Liberia</li> </ul> <p><b>Sri Lanka: <i>Experience in multi- sector engagement in the policy process: national and international</i></b></p> <ul style="list-style-type: none"> <li>• Dr Palitha Gunarathna Mahipala, Director-General of Health Services, Ministry of Health, Nutrition and Indigenous Medicines, Sri Lanka</li> </ul> <p><b>Thailand: <i>Achievements and key challenges in migrants' health policies</i></b></p> <ul style="list-style-type: none"> <li>• Dr Phusit Prakongsai, Director, Bureau of International Health, Ministry of Public Health, Thailand</li> </ul> <p><b>Discussion (10 min)</b></p>
<b>Theme 2: Large scale displacement – leave no one behind</b>	
13.35 – 14.05	<p><b>Greece : <i>The fundamental right to health of migrants and refugees - The experience from Greece and the National Action Plan</i></b></p> <ul style="list-style-type: none"> <li>• Dr Ioannis Baskozos, General Secretary of Public Health, Greece</li> </ul> <p><b>Italy: <i>Health of migrants : a priority for Italy</i></b></p> <ul style="list-style-type: none"> <li>• Dr Ranieri Guerra, Director General of Preventive Health and Chief Medical Officer, Ministry of Health, Italy</li> </ul> <p><b>Lebanon: <i>Displaced Syrians in Lebanon: Health system resilience and aid effectiveness</i></b></p> <ul style="list-style-type: none"> <li>• Dr Walid Ammar, Director-General, Ministry of Public Health, Lebanon</li> </ul> <p><b>Turkey: <i>A holistic approach to protect the right to health of migrants</i></b></p> <ul style="list-style-type: none"> <li>• Professor Hikmet Selçuk Gedik, Director-General for Emergency Health Care, Ministry of Health of the Republic of Turkey</li> </ul> <p><b>Discussion (10 min)</b></p>
14.05 – 14.15	<b>Summary and close</b> <ul style="list-style-type: none"> <li>• Ambassador William Lacy Swing, Director-General, IOM</li> </ul>

**Moderator: Dr Edward Kelley, Director, Department of Service Delivery and Safety (SDS), WHO**

## **Annex 2**

### **Remarks by WHO and international organizations**

- Opening remarks by Director-General, WHO
- Introduction by Director-General, IOM
- Migration and Health in the WHO European and other WHO regions, presentation by Regional Director EURO, WHO
- Access to health for refugees, statement by Director, Division of Programme Support and Management, UNHCR



## **Opening remarks**

*Dr Margaret Chan,  
Director General, WHO*

In a world increasingly defined by vast inequalities in income levels and opportunities, migration is a fact of life. People will always migrate to places that promise a better life for themselves and their children.

But what we are seeing now is forced migration, caused by armed conflict and violent extremism. War-torn countries are emptying. Their generous neighbour countries are saturated.

The 2030 agenda for sustainable development recognizes migrants, refugees, and displaced persons as vulnerable groups and calls for full respect for their human rights.

Let me outline four urgent needs.

First, we need better data on the health needs of migrants as a foundation for setting priorities.

Migrants travel with their health profiles, which mirror health conditions and diseases in their countries of origin. Health problems can also arise from the stress of travel, over-crowded conditions, with no guarantee of safe food and water.

Second, we need policies and legal frameworks in recipient countries that guarantee access to health care in an integrated way. Policies that keep migrants in camps and deal with their health needs through separate services contribute to marginalization.

Third, we need migrant-sensitive health services that are culturally and linguistically appropriate and recognize mental health needs.

Finally, collaborative networks and international dialogue, as we are seeing today, are essential to manage a health crisis of this magnitude.

Thank you.

## Introduction to the session

*Ambassador William Lacy Swing,  
Director-General, International Organization for Migration*

I would like to welcome the distinguished panelists and participants to this event, and to **congratulate Director General Margaret Chan** and the World Health Organization for organizing this session. It shows the importance both our Organizations place upon the link between migration and health in our globalized world.

IOM has enjoyed a close collaboration and a longstanding partnership with WHO. It is a great pleasure and honor to open this technical briefing. I thank Dr. Chan for this unique opportunity.

I am also pleased to be alongside colleagues from **UNHCR**, our longstanding partner; the distinguished representatives of countries who champion the migration and health agenda: **Costa Rica, Liberia, Sri Lanka, Thailand, Greece, Italy, Lebanon, and Turkey**; and all the other countries represented here today who support an equitable migrant health agenda.

This briefing is a further step in **building up the momentum that migration and health is regaining**. IOM recognizes the continuing challenges countries face in trying to meet the health needs of migrants. I hope that our exchanging views and experiences will lead us towards meaningful results for the health and well-being of migrants and all our communities.

I would like to emphasize three realities that we must come to terms with:

### **1) We live in an era of unprecedented human mobility, a period in which more people are on the move than ever before, and the trend is on the rise.**

- We live in an era of unprecedented human mobility, a period in which more people are on the move than ever before, and the trend is on the rise. Today, there are approximately 244 million international migrants and 740 million internal migrants in the world - one in seven of the global population.
- Additionally, more people have been forced to migrate than any other time since the Second World War - some 60 million - 20 million refugees, and 40 million internally displaced persons (IDPs). Forced migrants constitute a population the size of France.
- All of these migrants have physical and psychosocial needs that need to be addressed both for their own sake, and for the sake of their host societies. Health is, the most important component of the integration process. It has an immediate impact on the migrants' sense of well-being, on their families, on their workplaces and on their social interlocutors. It would hardly be an exaggeration to say that healthy migrants are well-integrated migrants. The reverse is unfortunately just as true.
- It is the international community's responsibility to ensure that appropriate policy frameworks and programmes are in place to provide the services that will be equally sensitive to the needs of migrants and the communities in which they live.

**2) We must shift from the current toxic narrative on migration, to one that takes full account of the contribution migrants make to the social and economic development of both their countries of origin and destination.**

- The most important challenge we face today, however, lies not in the numbers, but in the fact that policies have not kept pace with the realities and drivers of human mobility, such as disparities, the unprecedented number of crises, demographic trends, skill shortages, and consequent increased diversity in our societies. This increasingly visible crisis of the current humanitarian and solidarity system as well as integration strategies and management of diversity in societies and their unintended consequences, calls for a new way of thinking about protection and development, including within the health sector.
- The contribution migrants make to the social and economic development of both their countries of origin and destination is only made possible if migrants are physically and mentally healthy, regardless of their migration status.
- Once our communities recognize the inherent dignity and human rights of all, including migrants, it will not be difficult to advocate for a comprehensive health care that caters to the needs of everyone.

**3. We need action that ensures the migrants' right to health is respected, and that universal health coverage and equitable access to quality health services is realized, regardless of the migratory patterns and migration legal status.**

- To this effect, there are two major global health goals that have direct relevance for the health of migrants. **First**, the reduction of disparities that create and sustain adverse health outcomes. **Second**, programs designed to manage or mitigate the global spread of diseases or the global burden of disease should include components focused on migrants and mobile populations.
- We need innovation, sharing of experience, and collaborative efforts to this end, and therefore we are eager to hear the views of the distinguished panelists on the podium today.
- Because of these three realities I have highlighted, I am eager to hear the views of the **distinguished panelists** on the podium today.

## **Presentation on Migration and Health in the WHO European and other WHO regions**

*Dr Zsuzsanna Jakab,*

*Regional Director for Europe, WHO*

The 2030 Agenda for sustainable development with its promise to leave no one behind seems to be a cliché when time comes to talk about human rights of migrants.

Migration is a growing phenomenon that has health implications for the migrant populations. Overall, there are an estimated 244 million international migrants living worldwide, of whom 20 million are refugees. Only in the European Region there are about 77 million international migrants, which represent 8% of its population.

The world has seen a significant rise in a number of migrants and refugees. The European Region has seen increasing arrivals since 2011, with over 1 million refugees and migrants arriving to EURO throughout 2015. Similar trends in other regions, EMR hosted 4.2 million refugees, countries in AFR, AMR, WPR, SEAR have also seen a rise in a number of economic and other types of migrants.

Countries including the European countries are going through an unprecedented situation which does not represent a humanitarian crisis in our Regions, but a crisis of humanity. Many countries are well prepared. However, the significant rise of influxes has called for an urgent coordinated response, as the health of mobile populations is key for population health overall.

In 2012, the WHO Regional Office for Europe had established, with the financial support of the Ministry of Health of Italy, the Public Health Aspects of Migration in Europe (PHAME) project to assist Member States in adequately responding to the public health challenges emerging from migration, and to protect the health of refugees and migrants and of the host population. The activities of the PHAME project cut across four main areas of activity: technical assistance to countries; collection of health information and evidence; policy development; advocacy and communication activities.

Responding to the growing requests from European countries in 2015, the Regional Office established an inter-divisional Task Force on migration and health to scale up technical assistance, provide policy advice, deliver medical supplies, as well as host migration health training workshops. Our aim was to provide our Region with the necessary capacity to guarantee adequate standards of health and well-being to both migrant populations and host societies.

Member States committed to responding in a spirit of solidarity and mutual assistance to a common framework for collaborative action, and in this context, the WHO Regional Office for Europe and the Ministry of Health of Italy organized a High-level meeting on refugee and migrant health, held in Rome on 23-24 November 2015.

Participants included 50 countries from the European, Eastern Mediterranean and African Regions; the Regional Offices of EURO, EMRO, AFRO and HQ; and other UN agencies and International Organizations. The results of the meeting were gathered in the outcome document *Stepping up action on refugee and migrant health*.

European countries agreed in the Rome outcome document that the public health implications of migration warrant a concerted and coordinated response. This is essential for population health, as well as for the human right to health for all. Public health interventions are needed in the short and long-term, with special focus on the most vulnerable.

The Rome outcome document acknowledges the need to strengthen national, international and intersectoral collaboration, and in particular to build bridges of collaboration among the countries of origin, transit and destination. European countries also agreed on the need to strengthen coordination among UN agencies and other international organizations in the area of migration health.

The Rome meeting was a milestone for the Region, and an excellent example of inter-regional collaboration to address a global health issue that transcends countries and regions. It proved that countries within and beyond the European Region are willing and committed to collaborate on migration and health. After this meeting, the SCRC requested us to develop a European strategy and action plan on refugee and migrant health, accompanied by a resolution.

In the African and the Eastern Mediterranean Regions, emergency response and humanitarian assistance has been provided to support countries in new and protracted emergencies for both refugees and internally displaced persons such as in Syria, Lebanon, Jordan and Sudan. In the South East Asia and the Western Pacific countries, universal health coverage (UHC) is used as an umbrella to meet health needs of migrants. Regional collaboration includes the initiative such as Healthy Border Programme with a focus in countries in Greater Mekong Sub Region which includes Cambodia, China, Laos, Myanmar and Thailand with particular emphasis on TB, HIV and malaria. For economic migrants, Sri Lanka has led the Colombo Process with 11 countries in EMR, SEA and WPR for fair labor contractual arrangements as the countries of origin sending workers abroad. A review of access to services by migrants in the Greater Mekong Subregion is forthcoming.

In AMR countries, emergency response and humanitarian assistance has been provided to Colombia to support emergencies for internally displaced persons together with the incorporation of the human security approach in health plans of communities of destination. AMRO has partnered with IOM to improve the health of children and youth migrating alone from Northern Central American countries to the US. Overall, AMRO activities are based on the resolutions for the plan of action for humanitarian assistance, human health security and universal health coverage strategies.

Migration is a global reality, linked on the one hand to long-term globalization and unequal developmental patterns, and on the other to forced-migration as a result of conflict and war. The health of migrants is fundamental to protect and promote the health of all. In this regard, there is no public health without refugee or migrant health. The health dimensions cannot be addressed with single-country solutions, and within WHO globally we must work with Member States to achieve a number of policy aims, to:

- Reduce excess mortality and morbidity;
- Minimize negative impact of the migration process in communities of origin, transit, destination, and return;
- Avoid disparities in health status and access;
- Ensure refugees and migrants' health rights.

Migration is a global reality. Countries must develop inclusive migrant health policies in national development plans and put these into practice.

Health systems must be strengthened to provide UHC and equitable access to quality health services. Bridging short humanitarian response with long term health system strengthening is required. Furthermore countries must have adequate health information systems with robust epidemiological data on migration; careful planning, training and, above all, adherence to the principles of equity and solidarity and to human rights and dignity. Also, good quality public health information is of paramount importance to develop evidence-informed policy options.

Equally important, countries should promote coherence among policies of various sectors that may affect migrants' and refugees' abilities to access health services, as well as among countries.

## **Statement by UNHCR**

*Mr. Steven Corliss,  
Director, Division of Programme Support & Management, UNHCR*

Distinguished Delegates,  
Ladies and Gentlemen,

I would like to thank WHO for inviting UNHCR to join this technical briefing on migration and health.

Let me start by being very frank. We are talking about migrants and refugees this year at the World Health Assembly because more than a million of them came to Europe in 2015 and 2016. The Syria crisis has been on Europe's doorstep for five years and, last year, it crossed the threshold.

Refugees and migrants are a crisis for Europe, but this is a broader challenge. Globally, 86 percent of the world's 60 million refugees and internally-displaced people live in developing countries. With the recent, overwhelming focus on Europe, I was pleased to see the diversity of countries represented in the panels that will follow my presentation.

Forced displacement has captured the world's attention, but this is not a new story. Sudanese refugees – now South Sudanese – first reached neighbouring countries in the mid-1950s. Afghanistan refugees began entering Pakistan and Iran in 1979. The movements of Somali refugees also started in the 1970s and then accelerated from 1988 onwards.

Millions of people around the world are born, grow up, go to school, get married, have children, become ill, grow old and die as refugees. New conflicts break out before old conflicts are resolved. Peace, security and the possibilities for solutions to displacement that they bring remain elusive.

The sheer scale of displacement and the duration – often lasting for decades – mean that purely humanitarian responses to meeting the needs of refugees and the internally displaced are not adequate, effective or efficient.

For many years, UNHCR's approach was to maintain refugees in camps and meet their basic needs for protection, shelter, food, water and health care, working with governments and NGO partners. This does not describe reality today, where more than half of all refugees live in cities.

Let me tell you how UNHCR is changing its approach through our Policy on Alternatives to Camps and our Global Strategy for Public Health. We are moving decisively away from parallel systems – funded by UNHCR and implemented by our partners – that work in parallel to Ministry of Health programmes.

Today – together with Ministries of Health – we are moving decisively towards more integrated and development-oriented approaches that reinforce and build upon national service delivery systems and health care financing mechanisms.

Let me tell you about a few places where we are making this new approach work:

- In Ghana, UNHCR and the Ministry of Health are implementing a three-year plan to integrate refugees into national health services and the national health insurance scheme;
- Similarly, in Egypt, more than 130,000 Syrian refugees have access to the same primary health services available to Egyptians at a nominal fee, as well as to free vaccinations and medications;
- The Islamic Republic of Iran and UNHCR have signed an agreement that will ultimately give over a million Afghan refugees access to government-sponsored universal health insurance;
- We are also exploring how healthcare delivery for refugees in Cameroon, Niger and other countries can be integrated into national health systems.

Working through national health systems has the potential to be more sustainable and cost-effective, while also ensuring more comprehensive coverage of all people living in the same area and equity in the services they receive. Working in parallel to national health systems is costly and is ultimately unsustainable. It can also undermine or distort national development planning.

While working in Tanzania, I saw a very fine district hospital building in Ngara town that UNHCR had built with scarce humanitarian funds. It stood empty – with no staff and no budget – because it was “off the radar” of the Ministry of Health. I also saw huge gaps in health care emerge when refugees went home, camps closed and the clinics that served refugees and local people disappeared.

We see the mainstreaming of refugees in national systems as the best way to achieve universal access and improved health outcomes for both nationals and refugees. The logic of integration is clear. Preventative health care – such as immunisations – as well as prevention and response to disease outbreaks are most effective when pursued through a single, unified system. Put simply, refugees do have different healthcare needs, but we can meet them through differentiated responses delivered within one system.

We do need your help to make this vision a reality.

- First, we encourage Member States hosting refugees to consider the possible “win-win” opportunities created by integrating refugees into national health systems, wherever possible;
- Second, we ask WHO to work with Member States and support them in making the changes to law and policy needed to bring refugees within national and local development planning;
- Third, we call upon the Member States that support UNHCR and provide development assistance to make the multiyear funding commitments needed to support change;
- Fourth, we look to the World Bank and other development partners to help us build the data and evidence base in support of mainstreaming and to provide the flexible financing it requires.

We do need to be realistic. Integrating refugees into national health care and health insurance schemes – whether public, private or public-private partnerships – will only work where these systems exist and are sufficiently robust to assume the added responsibilities.

We are also clear that rapid, agile and effective emergency response – sometimes delivered in parallel to national health systems – will continue to be essential to save lives. But longer-term planning for more development-oriented approaches can and must begin early. Let me add that we welcome WHO’s review, rethinking and possible reinforcement of its role in emergencies.

Finally, we are convinced that mainstreaming refugees within national health care systems is essential to delivering on the promise of the 2030 Agenda for Sustainable Development to ensure healthy lives for all and to leave no one behind.

Thank you.

## Annex 3

### Speeches and Presentations by countries

#### Theme 1: Sustainable development and migration

- Costa Rica
- Liberia
- Sri Lanka
- Thailand



#### Theme 2: Large scale displacement

- Greece
- Italy
- Lebanon
- Turkey



## **Costa Rica**

### **Costa Rica- country of destination for Central American migrants and transit region for migrants from the Caribbean, Africa and Asia**

*Dr Fernando Llorca Castro,  
Minister of Health, Costa Rica*

Migration to Costa Rica is not a new phenomenon. Costa Rica is a country of destination for migrants from Latin America and a country of transit for migrants from Africa, Asia and the Caribbean who want to reach the United States of America.

As a destination country, Costa Rica has registered 385.899 migrants since 2011. 75% of regional migrants are from Nicaragua and they are mostly economic migrants. Migrants from Panama are mainly involved in the coffee agriculture (about 12.000/year). Costa Rica has started working with the government of Panama to facilitate the movement of migrants from Panama. Further, Costa Rica provides a health card to migrants which permits access to critical health services such as vaccination.

Costa Rica is considered to be a "migratory bridge". It acts as a migration route inside the region for a labour component, as well as inter-regional and inter-continental that target the United States as a final destination.

Costa Rica has established the National Council of Migration which is an Inter-sectoral Committee comprised of the Ministry of Health, the Ministry of Foreign Affairs etc. The aim of the Council is to discuss integration issues. Costa Rica coordinated with other countries of the region that were involved in the migration route to find concrete solutions.

Costa Rica has drafted a policy for migration integration for the period 2013-2023 and a Plan for National Integration. The National Plan for Health 2015-2018 includes a paragraph on the right of migrants to receive health assistance.

Costa Rica faced a serious migration crisis due to a massive flux of migrants from Cuba. In November 2015 the criminal organization dedicated to human trafficking that transported Cuban citizens outside the continent from the southern border with Panama to the northern border with Nicaragua was dismantled. The connection was cut in the whole region; the migratory route and irregular income was stopped. This generated overcrowding at borders. Nicaragua closed borders generating a large "bottle neck" effect. Humanitarian aid and contingency mechanisms were provided. Central American countries opened an "exceptional step, safe and orderly" to the 8000 Cuban migrants that were found in Costa Rica.

Between November 2015 and March 2016, with 8000 extraordinary transit visas, half were able to continue their journey to the US in a safe and regularized manner. The other half left the country through their own means in an irregular way. Costa Rica coordinated with other countries of the region that were involved in the migration route to find concrete solutions.

An extraordinary case is the flux of migrants from outside the region and specifically from Africa. 1459 people arrived, in general originating from Africa (Congo, Niger, Togo, Mozambique, Nigeria, Senegal, Cote d'Ivoire, Ghana and Somalia). Other countries of origin include Haiti, Iran, Bangladesh and Nepal. Cultural and language barriers, physical conditions, long journeys, as well as poverty have resulted in greater vulnerability, particularly in minors and pregnant

women. Three temporary shelters have been created to provide basic humanitarian aid and pre-hospital care. Logistics and financial capacity of the country are exceeded.

Migration issues require a coordinated action of all actors from the healthcare sector but also social sector to guarantee health security as well as social security.

Migration is not always a health risk, but it is a determinant in the health-disease process.

Costa Rica is a country that seeks to respect human rights and will continue to operate with national and international migration standards. Migration requires the health sector to articulate with social actors for access to basic sanitation, food security and social security. Ensuring the right to the health of migrants is a challenge, especially for minors and pregnant women.

Local populations are showing high levels of solidarity towards migrant people. Constant interventions of local health personnel and other community and institutional actors include General Directorate of Migration and Foreign Residents, Ministry of Health, Costa Rican Red Cross, National Child Welfare Agency, among others.

Migration issues require coordinated action of all actors from the healthcare and social sectors to guarantee health security as well as social security.

Thank you

# **Liberia**

## **Outbreak Response amongst migrants and mobile populations**

### **Lessons from the Ebola Response in Liberia**

*Bernice N T Dahn, MD MPH,  
Minister of Health, Republic of Liberia*

Sub-optimal capacity of the national health system including weakness in International Health Regulations (2005) national core capacities required for surveillance, detection and response to outbreaks and other health threats contributed to the scale of the 2014-2015 Ebola Virus Disease (EVD) Outbreak in Liberia. This spread of EVD within the most affected countries was further aggravated by highly mobile populations.

Prior to the 2014-2015 EVD crisis, Liberia had over 22,000 registered refugees from neighbouring countries in refugee camps in five counties in the country.

The first EVD case that was confirmed in Liberia in March 2014 was a result of cross border movement of an infected individual from the first outbreak epicentre in Guinea. Significant cross border population movements between Guinea, Liberia and Sierra Leone, occur as a result of socio-cultural, family and economic reasons. A rapid response by the Government of Liberia, with the support of WHO and US CDC, resulted in the first wave of EVD cases confirmed in March 2014, being rapidly confined in geography and number. There were only six confirmed cases between March and April 2014 and these were confined to one county- Lofa – that shares international borders with Guinea and Sierra Leone.

A second wave of EVD cases was detected in late May 2014. This wave spread from Lofa county, as a result of mobility of the affected population from rural to urban area. In June 2014, the first EVD case was confirmed in a very densely populated township in Liberia's capital city, Monrovia. Insufficient capacity for isolation of infected individuals, poorly equipped and trained health workers that were unable to effectively implement infection prevention & control measures at health facilities and the initial lack of community awareness of actions to take to protect themselves resulted in dramatic and exponential rise in EVD incidence. By early August 2014, Liberia was reporting between 60-70 suspected EVD cases per day.

Several individuals from urban Monrovia fled the city and went back to their rural homes once they started showing signs and symptoms of EVD infection. These resulted in the spread of infection to un-infected counties. By October-November 2014, all 15 counties in the country had reported confirmed EVD cases.

The Government led EVD response effort that was very generously supported by technical, financial and logistical support from the international community integrated specific strategies to address spread of EVD transmission by mobile populations:

1. Intensified social mobilization and community engagement to ensure that communities and their leaders were aware of the risks and dangers of transporting sick patients and dead bodies from infected areas to non-infected areas;
2. Extensive capacity building of thousands of health workers and front line volunteers in surveillance and contact tracing, infection prevention & control, case management as well as community engagement and social mobilization;
3. At the height of the outbreak (August 2014-February 2015), the Head of State imposed a national state of emergency that was associated with curfew, banning of movement of dead bodies across county borders and closing of international borders;
4. When the national state of emergency was lifted and international borders were opened in February 2015, a multi-sectoral Border Coordination Group led by the Ministry of

Health with participation the Bureau of Immigration, Liberia National Police as well as partners including IOM, US CDC, WHO, UNICEF and NGOs was constituted. The main role of the border coordination group was to strengthen cross border surveillance, screening, infection prevention & control as well as community engagement;

5. UNHCR continued to partner with Ministry of Health to provide health services to registered refugees in the established camps. The key preparedness and response components of the national EVD response effort were integrated into the services provided to the refugees in the registered camps.

The intensified EVD response efforts in Liberia had the desired results. By end 2014, the incidence and geographical spread of EVD transmission had reduced most significantly. On 9<sup>th</sup> May 2015, WHO declared the first end of human-to-human transmission of EVD in the country. Since then, Liberia has had 3 flare ups in July 2015, November 2015 and January 2016. The flare ups have been kept very small (3-6 cases each in 1-2 counties) as a result of the significantly increased capacity in surveillance, detection and response at both national and sub-national level.

The important lessons learned by Liberia during the response, with particular regard to limiting outbreak spread in mobile and migrant populations include the very critical importance of:

- **Government leadership and ownership** of the overall response effort that enhanced coordination of all response actors including international responders, national responders, civil society and community leaders;
- **Strong and effective partnership and multi-sectoral collaboration:** The strong technical, financial and logistical support of the international community ensured local strategies and tactics could very rapidly be operationalized. Collaboration with other sectors such as Bureau of Immigration, Liberia National Police ensured that all needed resources were effectively mobilized in an integrated manner;
- **Effective community engagement and leadership:** Community leaders and members implemented effective and innovative strategies to ensure effective community based contact tracing activities as well as infection prevention and control measures including limiting movement of symptomatic patients; ensuring safe and dignified burials of deceased patients.

It is important that WHO supports the EVD affected counties as well as other resource limited countries, to mobilize required technical, financial and logistical resources to consolidate and implement lessons learned from the EVD outbreak as part of the national efforts to build more resilient health systems that include compliance with all IHR core capacities.

Thank you

## Sri Lanka

### **Experience in multi- sector engagement in the policy process: national and international**

*Dr Palitha Gunarathna Mahipala,  
Director-General of Health Services, Ministry of Health, Nutrition and  
Indigenous Medicines, Sri Lanka*

Madam Chair, distinguished presenters from member countries, ladies and gentlemen, Sri Lanka wishes to share her experiences in Multi Sector Engagement, both at the national level in the policy process and international level for implementation of the National Migration Health Policy.

The Sri Lanka national migration health policy was developed and launched in 2013 to address multi-faceted challenges in health due to migration. They are due to outbound migration, inbound migration, internal migration and health and social issues of families left behind of labor migrants. Our policy addresses all these issues pertaining to us in the migration cycle.

#### **Evidence based approach in policy development**

For policy development, we followed an evidence based approach, which was supported by the International Organization for Migration. At the beginning a rapid situation analysis was conducted using this framework and we identified gaps where further research studies were commissioned.

#### **The National Research Studies (January to July 2011)**

- **Inbound study:** Key informant interviews of employers in multinational companies, administrators and the foreign employees and returning Sri Lankan refugee families, IDPs and host population as well as families left behind study;
- **Outbound study:** Quantitative study of labour migrant workers and returning labour migrant workers;
- **Internal migration study (health issues pertaining to Internal migration):** Comparative study of internal migrant workers and non-migrant workers.

The findings from these studies, together with stakeholder and other expert opinions were the basis for policy formulation.

**Inter-Ministerial & Inter-Agency Coordination Framework for Migration Health Development :** The policy process was an inter-ministerial and inter agency one. We included all relevant stakeholders. The Ministry of Health leads the process through a National Steering Committee on migration health where high level decisions were taken. The National Migration Health Task Force comprised of technical focal points representing all relevant ministries, UN agencies and the academia. A migration health secretariat was set up in the Ministry of Health planning unit which coordinated the national migration health agenda.

**Reporting progress on WHA Resolution 61.17:** We understand the importance of sharing our intentions as well as progress made. We tabled our progress made on the 2008 Resolution on Health of Migrants at the WHA in 2011 and 2013 in the form of report cards, although it was not required at that time. We were the only country that reported progress and we think that showcasing accountability is important. Our President, who was the Minister of Health at the time was applauded for presenting these report cards at that time.

We faced certain health challenges from Sri Lankans who were returning to the country after a long period of living in South India. We took a non-discriminatory approach and they were made aware of comprehensive health services that were available to them upon return. They were linked to the community health services as soon as possible after reaching their destinations.

**Indigenous vs imported malaria cases in Sri Lanka :** Sri Lanka has reached elimination status in Malaria control, with zero indigenous cases since 2012. Awareness is made at points of entry to motivate voluntary screening for those visiting Sri Lanka from endemic countries and we have also adopted a follow up system.

**Coordinated care plan- for families left behind:** The National Migration Health Policy does not pose any discrimination to those wanting to migrate based on gender or their age of children. The Ministry of Foreign employment together with other relevant Ministries are developing a tool for a coordinated care plan which will look into health and social issues of families including the carers of those left behind. This will ensure that an informed judgment is made before migration and that access to health and other services can be met for family members.

**Improving health assessment guidelines for those leaving the country:** Sri Lanka is part of a multi country study being conducted in collaboration with IOM to assess the quality of outbound health assessments provided by different health assessment providers. Our policy recognizes the need for national guidelines to streamline health assessments. A key aim is to link those with identified health problems with the health services to make them fit for any future employment.

**The Colombo Process:** The Colombo Process is a forum that originated in 2003 where 10 Asian countries discussed issues of temporary contractual workers. Mainly issues of labor, welfare, wages have been discussed with a view to enhancing dialogue with destination countries. The process has rotating chairmanship and the country level focal points are usually Ministries of Labor, foreign employment and foreign affairs.

Sri Lanka is the current Chair to the Colombo Process. Last year at the 3rd senior officials meeting of the Colombo Process, technical presentations on Health of Migrants was made by the Ministry of Health. The issue that SDGs does not currently identify the context in which UHC applies to migrants was highlighted. Further it was felt that there is a need to identify a focal point at each country level to take forward an agenda to address migrants' health.

**International Dialogues:** Permanent representatives to the UN in several countries too have been active in issue pertaining to labor migrants through the Colombo Process dialogues. They all have the potential for taking the agenda of Health of Migration.

## **2<sup>nd</sup> Global Consultation on Migrant Health**

Sri Lanka recognizes the importance of regional and global dialogues on Migration and Health. His Excellency the President of Sri Lanka Maithripaa Sirisena made an invitation for the 2<sup>nd</sup> Global Consultation on Migrant Health to be conducted in Sri Lanka this year. The first was held in Madrid, Spain in 2010. We think it is timely for such a Global Consultation to reach consensus on issues of health access to migrants and improving health systems to respond to challenges of health due to migration. Many other regional and global platforms exist to enhance the dialogue on migrant health. We believe that these platforms should be explored to discuss how we can take forward the agenda for migrant health. With this announcement of the 2<sup>nd</sup> Global Consultation on Migrant Health I would like to end my brief presentation. Thank you.

## Thailand

### Achievements and key challenges in migrants' health policies in Thailand

*Dr Phusit Prakongsai*

*Director, Bureau of International Health, MOPH, Thailand*

Thailand is an upper-middle income country with sustained economic growth and relative social stability compared to neighbouring countries in SEA region. With higher minimum daily wage, better job opportunities, and better quality of public services and infrastructure, Thailand attracts millions of permanent and temporary migrant workers, both documented and undocumented migrants, from neighbouring countries namely: Myanmar, Cambodia, Vietnam and the Lao PDR.

In 2015, there were approximately 4.2 million non-Thai citizens living in Thailand. This is equal to six per cent of the total Thai population. The IOM estimation indicates that there are almost two million undocumented migrants and their dependants residing in the country.

From economic perspectives, the ILO estimated the contributions from migrants to Thai economy to be approximately two billion USD per annum which was around 6.2% of the country's GDP in 2007. The demographic changes of the country to become an ageing society and high demand for a labour intensive industry are the key drivers of the demand for migrant labour in Thailand.

There are two health insurance schemes for migrants in Thailand.

First, the Social Security Scheme for migrant workers in the formal sector, imported migrants under the MOU between Thailand and neighbouring countries, and also migrants who have completed national verification process. This social security scheme is under the responsibility of Social Security Office, Ministry of Labour.

Second, Compulsory Migrant Health Insurance Scheme or CMHI for undocumented migrants and their dependants who are working in the informal sector. This scheme is responsible by Ministry of Public Health of Thailand.

In 2012, the social security scheme could cover only 40% of documented migrants registered with the Royal Thai Government. One of the limitations of this scheme is the inappropriate design for health financing, unawareness of migrants about their rights and contracting hospitals that led to the low utilization rate of outpatient services and hospitalization, inefficient management and shallow benefit packages which do not respond to migrants' health needs.

The CMHI managed by the MOPH started registering undocumented migrants in many big cities and provinces. Currently the premium for CMHI is only 1,600 THB or 44 USD per capita per annum. The CMHI also provides health insurance coverage for migrants' dependants and children aged under seven years with a modest insurance premium at 365 THB or around ten USD per capita per year.

The benefit package of the CMHI is similar to that of the UHC scheme for Thai people. It covers curative care, outpatient services and hospitalization, health promotion and disease prevention, ARV for PLHIV, and a wide range of essential health services.

Despite significant achievements in migrants' health policies, we still have a number of key challenges to be resolved.

First: there is a lack of policy coherence among different Ministries, e.g. the Ministry of Defence, the Ministry of Interior, the Ministry of Labour and the Ministry of Public Health. The government should have a clear policy on migrants and non-Thai citizens who are residing in Thailand.

Second: Many Thais and public health workers still have negative perspectives on migrants. Migrants and their dependents are still seen as additional burdens and workloads for the health care system, as well as carriers of serious communicable diseases.

Third: Unavailability of data. Since data on migrants' health is very important for monitoring progress of the migrants' policies and assessing the current situation, data on migrants in Thailand are still fragmented, not timely, and inaccurate. Many nationally representative household surveys in Thailand deny collecting household data from undocumented migrants.

Our recommended priority is to advocate for having a paradigm shift on attitudes towards migrants. Migrants should be seen as a part of social development of both recipient and original countries. They should also understand as positive human resources and social assets of the country.

We would like to request WHO and other development partners to draw good experiences and document good practice from countries having migrants' health policies, and then share such evidence to donors and policy makers in developed and developing countries.

## Greece

### **The fundamental right to health of migrants and refugees - The experience from Greece and the National Action Plan**

*Dr Ioannis Baskozos,  
General Secretary of Public Health, Greece*

Around 900,000 people arrived in Greece by sea during 2015 and a further 150,000 during the first months of 2016. Demographics imply that, with amongst them being 38% children, migration flows are even more vulnerable in terms of health. According to robust UNHCR data, food, health access and WASH are covered in an acceptable manner, but are still subject to certain improvements.

The main healthcare needs are mostly due to five conditions: Trauma; respiratory tract infections; chronic diseases; and gastrointestinal and skin maladies. Constant healthcare provision and emergency treatment are needed in conjunction with efforts to deter the spread of infectious diseases, adhere to the principles of public health, and improve living conditions in the migrant and refugee sites to address healthcare issues and to respect, protect and fulfill human rights. The aforementioned illustrate the core values and elements of the Greek National Plan for the health of moving populations.

Moreover, a framework was created with view to allow the involvement of national and international organizations in an effective manner.

The understaffing and underfunding of the National Health System due to the austerity policies imposed by the memorandum made our task of treating refugees and immigrants even more difficult. In a stifling environment and with the National Health System in tatters, the proud endeavours of the health work force along with the touching assistance of the Greek citizens, volunteers, solidarity organizations and NGOs contributed to smooth progress on the matter.

The magnitude of needs implies that ensuring financial support and expertise are pressing matters, which could constitute a priority area for WHO. The projections for a permanent residency of at least a part of refugee and migrant population in Greece and the change of seasons bring forth a necessity to focus on chronic disease management, children vaccinations, maternal care, food inspections and mosquito control methods, among others.

In an ever changing environment, versatility and alertness combined with strong political will and commitment can unilaterally shift the point of view for migration flows, from “trouble” to a tremendous opportunity to strengthen public health policies in each country, which encompasses the basic lesson learned from the Greek experience.

Furthermore, our experience could be epitomized by the following:

1. Priority to public health policies against “security” measures for example campaigns of universal immunization;
2. Assessing need in accordance with seasonal variations;
3. Coordination and optimal utilization of NGO capacities;
4. Consideration to “delicate” issues that affect public opinion;
5. The refugee and migrant protection in terms of health is the fundamental measure to protect public health;
6. Management of vaccine supply;
7. Handling of the workload of healthcare professionals;
8. Cultural health mediators;
9. Providing psychosocial support;
10. Maternal, children and mother-child care.

Solidarity, communication and respect of human rights are key.

## Italy

### Health of migrants : a priority for Italy

*Dr Ranieri Guerra,*

*Director General of Preventive Health and Chief Medical Officer,*

*Ministry of Health, Italy*

Director General, Regional Director, Authorities, Colleagues, friends, thank you for being here today.

Unfortunately, Minister Lorenzin had to respond to a last minute political call and was prevented to address her concern and commitment.

In the last two days our Navy rescued more than 9,000 migrants who were otherwise going to die in front of the Libyan coasts in 33 different operations. As for today only, we have 11 ships at sea carrying 4,000 people.

We are proud of what our people are doing.

Let me remind you that while the world mobilized to face the Ebola crisis, and WHO is now reforming its governance to re-establish its capacity and leadership in emergency management, currently thousands of lives are lost in the sea, more than the estimated deaths from Ebola. While migrants coming from the Middle East and moving to central European countries are predominantly families and small communities, people crossing the sea are mainly individuals coming from a variety of countries, sometimes infiltrated by criminal organizations. The male proportion is decreasing in favor of females and unaccompanied children and teens, whose needs are even more challenging.

We are also proud to participate in this session, which brings together so many countries and so many interests, listening to our voices, as we cannot act alone and will not be able to continue our mission without global support.

We spent two years alone trying to stimulate the world's attention. Today no one denies the challenge and all countries and agencies may finally decide to join forces. We are particularly grateful to WHO/EURO, and Dr. Jakab personally, for her constant and unqualified support and for the successful advocacy that led to the Rome conference of November 2015, whose outputs are a policy and strategy draft and a plan of action endorsed by the SCRC/EURO last week.

To improve first aid and rescue at sea, we are working closely also with the IOM on project PASSIM, aiming at identifying situations of vulnerability and need of care very rapidly, before arrival.

The documents generated by the constant collaboration between Italy and WHO aim at providing the required evidence and an impartial view based on technical and scientific knowledge, objectivity, the possibility to advocate for migrants' needs and expectations, overcoming the reluctance of a consistent number of States to accept the simple fact that migration is one of the leading forces shaping our century, and that it will not disappear and cannot be ignored.

The excellent collaboration with WHO will materialize in a resolution for the next September Regional Committee, and possibly in the updating of the resolution WHA 61.17 from 2008, as we have pointed out during the general discussion this week.

As you know, our position is based on an explicit human rights approach, no matter whether we deal with refugees, asylum seekers, migrants, documented or not.

We want to go beyond the constraints of an outdated and unnecessary classification, and consider them all victims and not perpetrators, deserving to be treated with compassion and humanity. Italy is a land of migrants, with 15 million Italian passport holders around the world and with 65 million second and third generation ethnic Italians, pairing the number of current residents: They all look at us and support our approach reflecting their past struggle for survival.

We acknowledge the different causes and triggers of migration, from criminal human trafficking (90%, worth 5.5 billion USD cashed yearly), to climate changes, from violence and war to droughts, poverty and a legitimate aspiration to improve life conditions. And we have no doubt that migrants must be provided with quality health services, as Italy does, from on-board screening and first aid to sophisticated hospital care on arrival to mainland. We have adopted the DG's mantra that no one, ever, must be left behind, and are practicing accordingly.

We are going now further on, with the migrants' compact that the Government of Italy has presented to the EU and to the African leaders who met in Rome ten days ago.

It is by means of coherence, solidarity and a common approach that we will succeed, as we do not want to see more dead children on a beach or floating in the sea.

We hope that our colleagues from WHO and from IOM, whose Rome office has been an extraordinary partner on several aspects of migration, will continue working together, with Greece, Malta, Cyprus, Turkey, Jordan, Lebanon and other EU Member States, as well as with EMRO and AFRO.

We need all goodwill parties to advocate strongly and continue implementing concrete actions, as Italy is doing. In fact, our universalistic health system provides care not only to all ethnic Italians, but also to the hundreds of thousands who have landed and continue to land, in a spirit of equality and equity, following the WHO Venice office's guidelines. They believe in us and trust we can meet their hopes for a better and healthy future. On our side, we will continue advocating for their right to access unrestricted care and cure.

The quoted joint WHO/EURO-Italy programme PHAME and other collaborative work with IOM and HCR aims at assessing countries' capacities to do so, and facilitating the adoption of contingency plans allowing for the delivery of a full package of services.

I want to extend Minister Lorenzin's deep appreciation to Dr. Jakab's vision and more than friendly collaboration and to the DG's global perspective that have led us here today. May I conclude now with an appeal in favour of the symbol islands of Lampedusa and Lesbo, competing for the Nobel prize for peace. Five million Sicilians are constantly sharing their homes and their resources (and they are not the richest area in Italy or in Europe) in silence and respect, being an example to us and to the world.

May I finally acknowledge the bravery and dedication of the Ministry of Health border health offices' staff, supporting the regional health authority of Sicily, the Navy and the Coast Guard in their exceptional capacity to rescue lives.

Thank you for your kind attention and for what you will do with us next.

# **Lebanon**

## **Displaced Syrians in Lebanon: Health System Resilience and Aid Effectiveness**

*Walid Ammar MD, Ph.D*  
*Director General, Ministry of Public Health*

Refugees registered in Lebanon currently represent around 25% of the population residing in the country. This is the highest refugee concentration per inhabitant in the world. The sudden and dramatic increase in population has exerted a lot of pressure on the country's infrastructure and institutions. The impact of the influx is exacerbated by the uneven distribution of the refugees and their concentration in the poorest areas of Lebanon. 85% of registered refugees live in 182 localities in which 67% of the host population lives below the poverty line.

### **Health needs and health services**

According to a vulnerability assessment conducted in 2013, 41% of the households among the displaced have at least one pregnant or lactating woman, while 33% counted at least one member with a specific need (chronic disease, permanent disability, temporary disability or another issue). In 10% of the households there were members who needed support with their daily basic activities.

Chronic diseases are evident across the displaced population particularly type 2 diabetes, renal failure, cardiovascular disease, hypertension, chronic obstructive pulmonary disease, cancer, and mental disorders. However, there are currently few resources available to ensure continuity of treatment of chronic conditions particularly when hospitalization is needed.

The disruption of immunization activities in Syria coupled with poor living conditions of the displaced in Lebanon has heightened risks of disease outbreaks, including measles, mumps and polio, and the introduction of new diseases such as cutaneous leishmaniasis to the host community.

Rising incidence of tuberculosis, including multi-resistant TB and waterborne diseases such as Hepatitis A have been noted since the advent of the crisis. The outbreak of Poliomyelitis in Syria and Iraq in 2013 was particularly alarming. It was faced by a massive mobilization of all health partners and civil society in Lebanon to undertake a nationwide door to door vaccination campaign. This successful mobilization under the leadership of the MOPH, led to a high level of immunization coverage among Lebanese and Syrian children alike and maintained Lebanon Polio free.

While the MOPH with the support of UN agencies is meeting, to a certain extent, the refugees' needs for primary health care, access to hospital care remains limited. Secondary and tertiary care for displaced Syrians are financed by UNHCR at up to 75% of the total cost and are restricted to lifesaving emergencies, delivery and care for newborn babies. The 25% co-payment remains most often unpaid and causes increasing budget deficits, especially for public hospitals that are struggling to remain operational. Patients that do not fit the UNHCR coverage criteria – mostly those with chronic illnesses – are suffering from the disease and its complications and find their conditions worsening.

UNHCR has repeatedly stated in its reports that “even for prioritized life-saving interventions, financial resources are severely stretched”.

### **Health system resilience**

Despite the Syrian crisis, however, the Lebanese health system is still showing considerable resilience. Financing and delivery at the primary, secondary and tertiary levels have been maintained for Lebanese, while primary and secondary care services were expanded to cover Syrians as well.

Lebanon has been able to take the necessary measures to face communicable diseases and pandemic threats, preventing major outbreaks.

In terms of health outcomes, and despite the ongoing insecurity climate and sociopolitical instability for decades, the Lebanese healthcare system has been able to sustain achievements like the decrease in out of pocket expenditures while improving the health status of its population. Despite the strain caused by high fertility rates among the Syrian population, both maternal and child mortality rates, which include mortality among Syrians, remain low. Lebanon is among the few developing countries that achieved both MDGs 4 and 5.

### **Health response strategy and aid effectiveness**

The health sector is now threatened with under-funding, resulting in a reduced capacity to meet the increased population demand and ensure the continuity of health service provision. Responding to the needs of displaced Syrians in Lebanon is the responsibility of the international community. With the shift from a state of emergency into a state of protracted crisis in Syria, scarce resources ought to be directed strategically, after careful deliberations with national authorities. Priorities ought to be set at the government level instead of being driven by calls for funding emanating solely from UN agencies and NGOs. Therefore a financing dialogue is urgently needed between donors and the Ministry of Health and partners operating in the health sector.

The Ministry of Public Health (MoPH) encourages partners to reduce intermediaries as much as possible – donors are encouraged to finance the health institutions providing health services as directly as possible, with as few partners in between as possible. This is to maximize the use of resources for service delivery and avoid administrative wastage. This would also enhance visibility, transparency and accountability of health services.

The budget deficits borne by national health facilities, as a result of the insufficient funding of the Syrian patients, are too great for any institution to compensate for. Donors are therefore encouraged to address the inadequate financing while supporting the sustainability of health institutions in Lebanon.

The MoPH is the primary national authority in the health sector in Lebanon and has, as such, assumed its leadership role in coordinating health response efforts and guiding them in the direction that best fits the national strategy. A Health Response Strategy (HRS) was developed by MoPH in line with the recommendations of a “Health Steering Committee” which includes UN agencies, the WB, the EU and NGOs representatives. It serves two interdependent strategic objectives:

1. To respond to the essential health needs (primary, secondary and tertiary care) of the displaced Syrians and host community; and
2. To strengthen national institutions and capacities to enhance the resilience of the health system.

In addition of course, preventing and controlling outbreaks and preserving health security.

We plead the international community to reorganize its aid and efforts to serve this strategy.

## Turkey

### A holistic approach to protect the right to health of migrants

*Professor Hikmet Selçuk Gedik, Director-General for Emergency Health Care, Ministry of Health of the Republic of Turkey*

The Syrian refugee crisis is the biggest humanitarian emergency of our era. Turkey is the country hosting the largest amount of refugees in the world – 2,750,000 Syrians. The conflict in Syria has turned out to be the biggest humanitarian emergency since World War II. More than 200,000 Syrians have been killed, with more than half of the population either having been displaced or having immigrated.

Every human being has the right to access health care. Since the crisis, political, economic and military interests are now beyond just "human" disease. It is necessary to help those affected by conflict and natural disasters.

To reach all people and attain a solution that is oriented towards the needs of the country, a people-centered approach should be adopted.

Taking all of these health factors into consideration, it must not be forgotten that uniting people to contribute to global peace is one of the most important sectors and we should begin to pursue activities for this purpose. The solutions brought to you by our country to counter these shortcomings can be listed under four headings: equity and inclusiveness; people - centered approach; effective and productive cooperation; and supporting humanitarian values.

As mentioned in the previous section, a peaceful approach is a vital factor, as well as continuing financial contribution. Periodic blood donations and financial assistance will be useful in healing wounds. A financial fund established by the international community cannot remain indifferent to the problems solely due to their geographical and cultural ties. Conscientious and well-intentioned countries can alleviate the burden on their shoulders, and they must by efficiently channelled into said financial fund.

Despite all adversities and systematic failure experienced by some during the migration, a receptive and willing host community is very substantial.

#### **Financial burden**

- Turkey's total humanitarian aid for Syrians: 10 billion US Dollars;
- International Support to Turkey for Syrians: 455 million US Dollars.

#### **Challenges**

- Linguistic and cultural differences;
- Overwhelmed health workforce;
- Increasing logistical, infrastructural requirements;
- Heavy financial burden;
- Cooperation and coordination between actors.

Host them like a guest, Serve them like your own. Thank you

## Statements from the floor

### **Médecins Sans Frontières (MSF)**

We are facing the greatest displacement of humanity in decades, with more than 60 million people forced from their homes by war, misery or oppression.

For Médecins Sans Frontières, we witness daily the humanitarian consequences of mass displacement, from Southeast Asia, to camps in South Sudan and Lebanon, along transit routes in central America, to the shores of Europe. Displaced people are given no or inadequate access to health care and continue to suffer from inhumane migration policies that provoke preventable medical emergencies themselves and continue deterioration of migrants' health.

As doctors, we have a responsibility to safeguard the health of these vulnerable people. Free and universal health care for displaced people in camps, in transit, and in host countries will not only save their lives and preserve their dignity, but protects the health of all. In essence this is to stop discriminating patients, and so guaranteeing migrants' access to health care.

Today the right to seek asylum is under attack. The responsibility to humanely welcoming people seeking refuge has degenerated in recent years, from being perceived as a burden to now feared as a threat to national security.

Borders are closing, and human beings are held in squalid camps or detention centers in Europe, Africa, Southeast Asia and the Americas. The largest refugee camp in the world, Dadaab, is now in danger of total closure, portrayed as a security risk to Kenya. Refugees have become scapegoats, forced to suffer the consequences of the political failure of States to share their responsibilities.

The medical consequences of this policy-made crisis cannot be underestimated. Our doctors treat people in transit for respiratory tract infections, traumas and psychological distress that are almost always a result of the horrific migration journey itself or of appalling reception on arrival. 93% of our 79,000 patients along the 'Western Balkan' route in Europe experienced these symptoms while on the move.

In countries hosting refugees, access to primary health care is frequently difficult or unavailable for everyone in need. Undocumented people often do not dare going to hospital, for fear of arrest. Doctors in many countries are being asked to betray their patients and report them to the police. This serves only to push people underground who already fled extreme hardship. Invisibility means vulnerability, resulting in severe delays to receive treatment.

But this seems to cause little concern. We now see Europe advancing its most organized attempt yet to push people back instead of taking them in. Refugees in Greece are suspended in an uncertain holding pattern waiting to either be forced into isolated and poorly equipped camps, or sent back to Turkey under the recently signed 'EU Turkey deal'. This agreement incentivizes

border closure and pushes responsibilities back to countries neighboring Syria, already struggling to offer effective protection to millions.

Closing borders and outsourcing migration management to other countries does not stop desperate people from moving. It simply shifts their routes to often more dangerous ones, jeopardizing basic needs and rights while fueling human trafficking and smuggling businesses.

The medical challenges of caring for people in transit are huge – but not insurmountable. Lessons learned by MSF over the past 15 years show that it is possible. Giving patients ownership of their medical records while in route, and providing enough medication to last the journey has improved the health of thousands suffering chronic conditions. Employing trained cultural mediators builds trust with patients, encouraging them to seek care.

If the global displacement crisis were a communicable disease, it would have been declared a public health emergency of international concern.

Caring for the displaced is not simply our medical obligation, but a responsibility of States. Displaced people should have free and unhindered access to healthcare, regardless of legal status, while States must switch their mindset from how to deter people from coming to how to best care for them instead.

This is how we, and you, as health authorities, can ensure no one is left behind.

Thank you.

## **USAID Middle East Regional Bureau Senior Technical Advisor, Amy Kay**

Excellences, honorable ministers, ambassadors, distinguished delegates, colleagues, ladies and gentlemen

I am pleased to provide an intervention and overview of USAID's work to improve the quality of health for refugees in host communities in the Middle East region.

As Director-General Chan, Ambassador Swing and other distinguished colleagues participating in this technical briefing have stated, Syria is the most complex crisis of our time, and gives us the opportunity – or rather the necessity – to change the way we work.

Steven Corliss emphasized the importance of investment in local systems and host communities, where the majority of refugees reside. I will focus my comments on USAID's work in Jordan where I was based prior to coming here.

Without an end to conflict and a sustainable political solution, we are limited in the work we can do inside Syria – and people will continue to flee. Those who have already fled are unlikely to return any time soon. So a major focus of our work in the region is supporting communities hosting refugees.

Before refugees arrived, neighboring countries were already facing development challenges. Some have doubled or tripled in population size as the Director General from Lebanon and Turkey have noted, and in Jordan this has amounted to a rapid population increase of almost 30%.

USAID is working in Jordan to provide quality education, economic growth and jobs, water and importantly health care, a sector where we have decades of investment and where the Syrian crisis has changed the way we work.

We considered Jordan's health sector a success story in 2012. USAID helped build a robust and responsive health system. Our investments over fifty years resulted in remarkable improvements in maternal and child health. Infant mortality was cut in half. Nearly all (99%) Jordanian mothers labored and delivered with a skilled health provider. And more than 80 percent of births – whether to Jordanians or refugees – were in USAID-supported public hospitals.

However, the influx of refugees has overwhelmed and weakened the system. Demand now far out-paces capacity. Progress on maternal and child health is threatened. Previously eradicated diseases such as TB are re-emerging.

Jordan's government notes the total cost of providing free and subsidized health care to Syrians has ballooned to \$2 billion dollars since 2013.

In response, USAID's Jordan Health Office is working with our Jordanian partners to meet increased demand with quality health services, and to increase the resiliency and stability of the system to respond to current and future stressors.

In Irbid in northern Jordan we are expanding the Princess Rahma Pediatric Hospital, to increase occupancy by 30 percent. In Amman, we plan to expand the emergency department of the main referral hospital, Al Bashir, so it can adequately serve 50,000 patients each month.

Twenty-five years of USAID family planning programming continues, including providing access to free family planning services for refugees and vulnerable Jordanian communities.

And we're working across Jordan to improve the quality of and access to primary health care for 75% of the population, with an emphasis on urban areas where the majority of refugees are concentrated.

In the context of the Middle East and the new world in which we live, USAID focus is not only on strengthening the international humanitarian system, but on providing "greater coherence" between humanitarian and development assistance. The goal is to better address the fragility of communities. To not only respond better to frequent and protracted crises, but to also build resilience and local capacities to prevent or mitigate disasters.

Thank you again for the opportunity this critical World Health Assembly briefing on migration and health, WHO and our partners provide to work together. We look forward to working with WHO and EMRO on all levels- globally, regionally and in-country- to strengthen the health response as the crisis in the Middle East region grows in complexity and need.

### ***Statement from Gender, Equity and Human Right (GER/FWC)***

Global Transformations are also gendered transformations! No more than in the context of global migration.

Discrimination, barriers, resilience and intersection between them must be used to understand movement among women.

Perhaps the most powerful observable connection – the 'care chain' – women as providers of care, from moral and emotional to material and, yes, health care will be explored by WHO this year.

This time next year WHO will launch a Director General's report examining women and movement, exploring these intersections described.

The report will identify key public health and human rights issues, challenges and possibilities for intersectoral action to improve health and wellbeing among women and girls. Audiences include policy makers, programmers and social reformers committed to the 2030 agenda.

## UNICEF

Your Excellences, distinguished delegates, ladies and gentlemen. UNICEF applauds the WHO for this technical briefing that is critically looking at this very important issue of migration and health. UNICEF considers this issue on at-least two fronts:

- 1) The need to abolish legal and practical barriers in accessing health care in line with the Convention on the Rights of the Child (CRC) for all children, no matter their migration status or statelessness;
- 2) The need to support access to birth registration for all children.

On the right to access health care, the CRC stipulates non-discrimination and its Committee has asserted that the enjoyment of rights stipulated in the CRC is not limited to children who are nationals of a state. These rights must be available to all children, including asylum seeking, refugees, and migrant children, irrespective of their nationality, immigration status, or statelessness.

Most often, the practical barriers for migrant children occur under the guise of:

- Undocumented migrants - especially in many countries where service providers are obliged to report or denounce irregular migrants to migration authorities. This severely hinders access to health care for boys and girls with irregular migration status. Here in Geneva, as well as in many other cities, 'firewalls' have been placed between service providers and immigration authorities, allowing migrants – including those with irregular status – to access those services without fear of reprisals;
- Internal migrants - their children may also face barriers to accessing healthcare services, where their right to accessing it is bound to their place of habitual residence.

There are of course additional barriers for stateless children. UNHCR estimates that about 10 million people worldwide are stateless, and many of these are children. The consequences for children in terms of access to healthcare can be serious:

- In more than 30 countries, children need nationality documentation to receive medical care;
- In at least 20 countries, stateless children cannot be legally vaccinated.

A key action to preventing statelessness is through efforts to provide birth registration for all children, including those who are born to refugee, asylum seeking and migrant populations. UNICEF and UNHCR have both undertaken successful programmes to ensure birth registration for refugee populations in camp and urban settings and UNICEF works in over 80 countries to improve national capacities to reach full registration, in line with Goal 16.9 of the 2030 Agenda for Sustainable Development. Health care providers are a key entry point for birth registration.

UNICEF, in cooperation with UNHCR and The World Bank, has already produced some excellent work on indicators for measuring migrants and their families' access to health care (as well as education and the right to work) and has piloted these indicators in Mexico and Tunisia, through our engagement with the Global Knowledge Partnership on Migration and Development (KNOMAD) group. UNICEF is ready and willing to intensify efforts through closely working with partners and governments to improve access to health services for all migrant populations, but also on child protection, human rights and education among others.

## Annex 4

### Summary and conclusions by Director-General, IOM

Thank you, distinguished panellists and delegations, for participating in this technical briefing. The presentations have shown the clear linkage between global health and human mobility. Such linkage should be reflected in policies on security, health care, and integration.

It is important to emphasize that migrants do not generally pose a risk to health for hosting communities and they should not be stigmatized and associated with the risk of importing diseases. However, conditions surrounding the migration process today more than ever can increase the vulnerability of migrants to ill health, particularly for those forced to move and those who find themselves in so called 'irregular' situations. In that sense, migration is a social determinant of health.

To close the panel, I wish to make three quick points:

1. **Complementarity** - to properly address challenges relating to the health and well-being of migrants:
  - We need to work together to better understand the health aspects of mobility, and develop complementarity in our programmes. Migration and health are two cross-cutting issues that should be addressed by multiple partners. IOM and WHO have proven that working together on these two fields is possible;
  - Migrant health issues cannot be solved by the health sector alone. Migration and health are inextricably linked to other policies on development, foreign policy, security, the environment, and so on.
2. **Compassion** - in public discourse and action:
  - We must change the migration narrative. The public discourse on migration is toxic, while historically migration has always been overwhelming positive;
  - Turning migration challenges into opportunities for all requires good migration governance, a broad, durable consensus among a wide constituency; coherent, coordinated policies among partners, **including in the health sector**;
  - Despite migration being a fact of life, migrants remain at risk of social exclusion, discrimination and exploitation. Many migrants lack access to adequate health services.
3. **Comprehensiveness** - in health care coverage, one that includes migrants:

- **Universal Health Coverage** is high on the global health agenda. We can all agree that UHC only exists if health systems account for all of its community members, including migrants;
- This, however, is not the case in many parts of the world today. Successful integration of migrant and mobile populations into health systems is therefore critical to predict and prevent the spread of diseases, design evidence-based responses along mobility pathways, enhance national capacities to better promote the health of migrants, and enhance the contribution of migrants to sustainable development.

## Conclusions

The technical briefing today reminded us that migration is ultimately about human beings. Migrants like others, have the right to enjoy the highest attainable standards of health and to contribute to the sustainable development of societies. We must together raise the profile of migrant health. Migration and human mobility can no longer be an absent theme in global health and human rights agendas.

We must create more opportunities for migration and health stakeholders to meet and consult about how to advance migrant-friendly health policies.

In this respect, I would like to thank Sri Lanka for its offer to host the **2<sup>nd</sup> Global Consultation on Migrant Health**. This consultation jointly organized by IOM and WHO, will take place in Colombo in October this year.

Health is a basic human right and an essential component of sustainable development. Being and staying healthy is a fundamental precondition for migrants to work, to be productive and to contribute to the social and economic development of their communities of origin and destination.

I trust that health ministries, the WHO membership, stand ready to promote the health of migrants and lead the mainstreaming of migrant health into 'all policies' within their respective governments.

## Annex 5

### Postcards

Volunteers help an infant out of an inflatable boat full of refugees and migrants arriving in Lesbos, having crossed the Aegean sea from Turkey.



Source: UNHCR

#### Migration & Health

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#### The 2030 Agenda for Sustainable Development

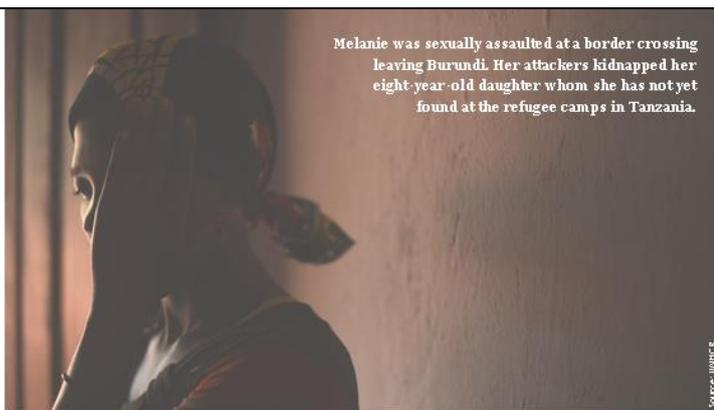
The 2030 Agenda for Sustainable Development specifically refers to migrants and refugees, as well as their host communities:

“Those whose needs are reflected in the Agenda include all children, youth, persons with disabilities, people living with HIV/AIDS, older persons, indigenous peoples, **refugees and internally displaced persons and migrants**. We resolve to take further effective measures and actions, in conformity with international law, to remove obstacles and constraints, strengthen support and meet the special needs of people living in areas affected by complex humanitarian emergencies.

We recognize the positive contribution of migrants for inclusive growth and sustainable development. We also recognize that international migration is a multidimensional reality of major relevance for the development of countries of origin, transit and destination, which requires coherent and comprehensive responses.

We will cooperate internationally to ensure safe, orderly and regular migration involving full respect for human rights and the humane treatment of migrants regardless of migration status, of migrants, of refugees, and of displaced persons. Such cooperation should also strengthen the resilience of communities hosting refugees, particularly in developing countries. We underline the right of migrants to return to their country of citizenship, and recall that States must ensure that their returning nationals are duly received.”

Melanie was sexually assaulted at a border crossing leaving Burundi. Her attackers kidnapped her eight-year-old daughter whom she has not yet found at the refugee camps in Tanzania.



Source: UNHCR

#### Migration & Health

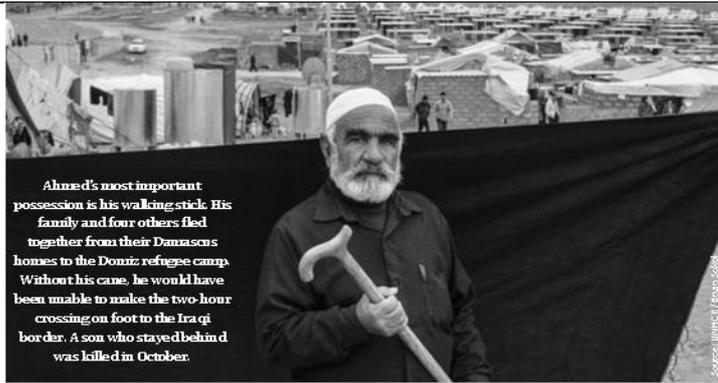
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#### Gender, Equity and Human Rights

Many factors can limit migrants' access to health services, increasing the risk of poor health. These include poverty, stigma, discrimination, social exclusion, language, cultural differences and socio-cultural norms, as well as legal status. Migrant women and children are particularly vulnerable and many are victims of people trafficking, exploitation, isolation, violence and rape. In many circumstances, migrant women have limited access to sexual and reproductive health care and services. In addition, they may be the subject of laws and policies that further compound experiences of marginalization and make it harder to access prevention and care services.

In order to ensure universal and equitable access to quality health services for migrants and refugees, health policies and services need to be sensitive and attend to the needs, diverse contexts, and perspectives of migrants and refugees. Not doing so may marginalize them, and reduce their use of critical health services.

Considerations of gender equality, equity and human rights are central to effective migration policies, for them to be centred on the complex and specific needs of migrant populations. Migration policies should incorporate the perspectives of migrants, refugees and host communities in the formation and implementation of law and practice at every level.



Ahmed's most important possession is his walking stick. His family and four others fled together from their Damascus homes to the Dorniz refugee camp. Without his cane, he would have been unable to make the two-hour crossing on foot to the Iraqi border. A son who stayed behind was killed in October.

Source: WHO/C. Egan/2014

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### Vulnerable migrants and refugees

With increasing numbers of people on the move, vulnerable populations including older migrants can remain invisible. The specific health and social needs of older migrants – complex in any setting – are accentuated in the context of migration. Physical health, mental health and functionality all require attention. Health service delivery for the elderly, commonly involving one or more chronic diseases, requires systems thinking. Older migrants, however, are not simply a vulnerable group. Their knowledge and experience in the migrant community, as well as their position of respect within families and communities, make them valuable resources that should be drawn upon.

Yet the health needs and contributions of older people are generally overlooked in terms of policy and practices.

Awareness of the health needs and contributions of older migrants among those developing policies and guidelines and providing care can contribute to more effective interventions, including equitable access to quality health care and social services to older migrants during all phases of migration.



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### Right to health

Health is a human right. The right to health is tied to the key principle of non-discrimination, for locals and migrants alike. This principle guarantees that human rights apply to everyone, irrespective of nationality, race, colour, sex or other status.

States have an obligation to protect and promote the rights of migrants without discrimination of any kind. Furthermore, states are equally obligated to eliminate any discrimination that takes place in their respective territories. The principles of non-discrimination and equal treatment of all, including migrants, such that states must ensure that health facilities, goods and services are available, accessible, acceptable and of good quality.

These obligations fall upon all states parties to the relevant treaties enshrining the right to health, be they countries of origin, transit or destination.

It is therefore critical for national health systems and policies to address migrants' right to health, regardless of the legal status of the migrant. Doing so requires active collaboration across the different sectors and close cooperation between governments and the many non-state actors involved in the migration process.



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### Community engagement

Refugees, migrants and the host countries and communities that receive them, usually have diverse cultures, societal norms, expectations and values. These differences may be exacerbated at significant times, such as entry or resettlement, when both sides may experience fear and anxiety due to perceived or real threats to physical, economic, and social safety. Conflict, trauma, isolation and physical hardship can also affect familial and societal relations and the ability to relate to others and integrate into new environments.

Responding to the health needs of migrants and refugees will require adaptation from health professionals and local health systems to ensure culturally-competent, quality service provision, that is accessible and which sensitively addresses equity, gender and rights issues. Migrant and refugees communities also need to be supported to understand their rights, identify their needs and actively engage with the health sector.



# Migration & Health

WHO Technical Briefing

We want to hear from YOU!

To have input now, please tweet [#migration](#) – we are following this hashtag.

To have more formal input, please email [kaojaroenk@who.int](mailto:kaojaroenk@who.int)

We look forward to hearing from you!!