

Side Event Report

UN General Assembly High-level Meeting to Address
Large Movements of Refugees and Migrants

Health In the Context of Migration and Forced Displacement



**Organized by the Governments of Italy and Sri Lanka,
with WHO, IOM, and UNHCR**

22 September 2016

Executive Summary

Background

On 19 September 2016, the UN General Assembly hosted a high-level summit to address large movements of refugees and migrants. It was the first time the General Assembly had called for a summit of Heads of State and Government on this topic. It was a historic event, which produced the blueprint for a better international response to this growing phenomenon, with a more humane and well-coordinated approach. World leaders adopted the New York Declaration for Refugees and Migrants which articulates a political commitment to protecting the rights of refugees and migrants, to save lives and share responsibility for large movements on a global scale.

The links between human mobility, health and migration management are unequivocally important when considering universal health coverage (UHC), global health security, public health, human rights, gender, equity, and human and sustainable development. Unprecedented migration flows and globalization have brought new challenges to addressing the health needs of migrants and refugees, particularly when part of large population movements, which require innovative solutions and new partnerships. Both migrants and refugees have human rights which should be respected, protected and fulfilled, and the right to health has been well stipulated within the WHO Constitution since 1948.

Despite health being a prerequisite for sustainable development and inclusive growth, the health of migrants and refugees has not been extensively included in debates *outside* the health sector and within the 2030 Sustainable Development Agenda. Indeed, the New York Declaration for Refugees and Migrants only marginally mentions health, despite efforts made by WHO, IOM and a number of key ministries of health, lobbying for much stronger health commitments.

This side event therefore aimed to raise awareness and bring attention to the urgent question of the health of migrants and refugees, which had, up to then, been insufficiently addressed in multi-sector platforms, including the New York Declaration. It facilitated the sharing of current perspectives and good practices and emphasized the need for shared responsibility in promoting the health of migrants and refugees. This is a prerequisite for achieving UHC for all, regardless of status, and the management of safe, orderly and regular migration and the provision of asylum. These achievements would contribute towards the 2030 Sustainable Development Goals, in particular goals 3.8 and 10.7, ensuring healthy lives for all and no-one being left behind.

Key challenges discussed during the briefing

Access to health. Despite existing and ratified international human rights standards, conventions and resolutions including World Health Assembly 61.17 resolution on the health of migrants, many migrants, asylum seekers and refugees still lack equitable access to health services and financial protection. Many are exposed to poor living and working conditions and occupational health hazards. The discriminatory and stigmatizing practices that migrants and refugees suffer from further limit their access to health services.

Legal status. This is still the most important factor governing migrants' and refugees' access to health care in many countries, despite a global call on achieving UHC and access to quality essential health services (Sustainable Development Goal 3.8). Lack of UHC often leads to excessive out-of-pocket expenditures for migrants and refugees. This prevents many from accessing the necessary health services, which exacerbates health conditions that could otherwise have been prevented, often at reduced costs, if services had been available to them sooner.

Vulnerability. Tangible differences have been noted between migrants coming overland from the Middle East and moving to central European countries and those who come by sea. The former are families and organized population groups, the latter are mainly individuals coming from a variety of countries, sometimes infiltrated by criminal organizations. The male proportion has decreased, while an increase in females and unaccompanied children and teens has been observed, whose health needs are even more challenging.

Health systems. Until now, there has been low investment in local solutions and local structures in many countries. This has caused an inadequate local health system capacity, resilience and the ability to respond to

crises and face emergencies. Poor continuity of care between and within services for national citizens, refugees and migrants are of concern, with little attention being given to mental health issues and lack of understanding around the dynamics of cross-border mobility.

Service delivery. There is a strong history of providing standard packages of services and prioritizing programmes according to the phase of an emergency for refugees and asylum seekers, with clear indicators and benchmarks. This type of parallel emergency health system has saved many thousands of lives over the years. However, as crises become more protracted and countries such as Lebanon and Jordan face situations where up to a quarter of their population are refugees (with the majority being outside camps), there will only be one way to meet their needs and that is to open up the health system to all and to strengthen its capacity to serve both the host and the refugee and migrant populations.

Health monitoring. Many countries have poor health information systems which lack robust epidemiological data on migration and forced displacement. This reduces their capacity to develop evidence-informed policy options. Furthermore, the lack of understanding on cross-border mobility dynamics, which is essential for disease surveillance and providing adequate supplies of treatment, as envisioned through the Global Health Security Agenda, makes detecting and responding to health threats even more complicated.

Health care financing. In the past, health financing systems have been short-term and unpredictable, often lasting just one year, and being restricted to a few countries. There is a lack of evaluation of health financing systems within different contexts, including assessments of the ability and space of countries, permitting them to borrow and access this financing, and how much countries are able to absorb.

Migration of the health workforce and attacks on health care workers. There has recently been a substantial increase in attacks on health care workers and grave violations of international humanitarian law. According to Physicians for Human Rights, there have been more than 400 attacks on health facilities in Syria alone, and more than 750 health workers killed since the beginning of the conflict there. With the unprecedented systematic targeting of health workers and facilities in Syria and other Middle-Eastern countries, an increasing exodus of health workers will probably happen. This migration or flight of health workers which can further exacerbate the real shortages of health personnel, has not yet been fully recognized, nor addressed.

Employment. Low access to and/or rights to employment for migrants and refugees including health workers in the host countries are a significant challenge and waste of human resources. For instance, Physicians for Human Rights currently estimate that there are about 15 000 Syrian health care workers outside Syria who are unable to practice medicine. Without money, migrants and refugees cannot pay for health services and treatment. Health financing mechanisms, such as insurance programmes, also become inefficient and ineffective. Furthermore, discriminatory and stigmatizing practices which limit entry and stay on medical grounds still persist for regular migrant workers (e.g. restrictions being imposed in the case of having tuberculosis, HIV and even being pregnant in some countries).

Xenophobic attitudes. This is especially a challenge in host communities and countries receiving refugees and migrants. Political dialogue has been focused around the “burden” of migrants and refugees, without looking at the opportunities. There is continued reluctance of a consistent number of states, even of the European Union, and of their political leaders, to accept the simple fact that migration is one of the leading forces shaping our century; it will not disappear and cannot be ignored.

Travel restrictions and human trafficking. Many migrants and refugees are arriving through human trafficking organizations. There is evidence that these criminal organizations have stewards who can bring and manage migrants overseas as very cheap labour. The challenge remains that upon arriving in the host community, migrants and refugees may end up in prison, where they are exposed to many health risks.

Main recommendations

Global commitment to the health of migrants, refugees and asylum seekers

- 1) For policy-makers, to give higher consideration to health as we move towards the development of the Global Compact for Safe, Orderly and Regular Migration, and the Global Compact for Refugees, and to improve the health of migrants and refugees during all phases of the migration process.
- 2) A comprehensive health package such as the Strategy and action plan for refugee and migrant health in the WHO European Region is needed. This package should aim to provide quality and universal health coverage to refugees and migrants and eliminate barriers to health care such as language, culture, administrative hurdles and lack of information about health entitlements.

Integration of migrants and refugees into national health systems

- 3) To move away from standalone services that work in parallel with national programmes, towards more integrated approaches which reinforce the Right to Health and build on national service delivery systems. Refugees and migrants should be included and integrated into national health systems, where this is possible, in line with the New York Declaration.
- 4) To encourage Member States hosting refugees to consider the possible “win-win” opportunities by implementing rights-based policies and approaches that provide the basis for equitable refugee- and migrant-sensitive health and social systems, with particular attention being given to those with specific needs such as women, children, the elderly and those with chronic health conditions.
- 5) To bridge the short-term humanitarian response with more sustainable long-term approaches. Rapid and effective emergency responses – sometimes delivered in parallel to national systems – will continue to be essential to save lives. But longer-term planning for more development-oriented approaches towards health system strengthening and capacity-building can and must begin early.

Migrant-sensitive health systems and service delivery

- 6) To strengthen health systems so they are better able to provide universal health coverage and access to quality health services regardless of their legal status. More investment in local solutions and local structures are needed to strengthen local health capacity and build the resilience and the ability of health systems to respond to crises for both short- and long-term situations.
- 7) Health care systems must be tailored to respond to the needs of refugees and migrants, particularly of those groups in the most vulnerable situations such as children, pregnant women, the elderly, people with disabilities and victims of torture and of gender violence.
- 8) Continuity of care of care must be provided for those with specific health needs such as patients with HIV, tuberculosis, mental health and other chronic health conditions. The development of a migrant and refugee health passport could be considered.

Health workforce and attacks on health care workers

- 9) Innovative long-term approaches to training the health workforce are needed as many health workers are optionally migrated or forcibly displaced, or even killed during conflicts. Attention and action needs to be stepped up and given to impunity and increased international protection for health care workers.

Health monitoring

- 10) Countries must have an adequate health information system with robust epidemiological data on migration and forced displacement, to provide evidence-informed policy options and to prevent communicable diseases based on strengthened and coordinated epidemiological surveillance for refugee and migrant populations.
- 11) Cross-border mobility dynamics need to be monitored in order to develop effective preparedness and response plans. Health systems need to become more aware and prepared to respond to the needs of transnational communities, diverse population profiles and needs, and an expanding scope and size of human mobility.

Health care financing

- 12) Donor countries and development banks need to respond early in humanitarian situations with flexible and multi-year financing mechanisms to support both the humanitarian response and the needs of migrant and refugee-hosting countries.
- 13) There is the need to evaluate the impact of financing mechanisms in different contexts.

Combating xenophobia

- 14) To educate local communities about good practices and experiences, and the positive contribution of migrants to society and development. This must include working with the media and the private sector.
- 15) To ensure that governments and the public know that the resources are going to citizens, and the resources that are going to the refugee populations are not a cost to the state and will be a benefit for both host, refugee and migrant populations. It is the most important argument for politicians to sell to their constituencies – that migration benefits all; it is not depriving the citizens in host countries. Concrete examples of how local health systems can benefit from refugees and migrants should be collected and disseminated.
- 16) To change the tonality of international dialogue on the health of migrants and refugees from focusing on disease and refugees and migrants as a burden to the health system, to an acknowledgement on how migrants and refugees can contribute to a society and its development.

Multi-sectoral partnerships and collaboration

- 17) A well-coordinated, multi-sectoral and multi-country response to managing the needs of migrants and refugees is required. Collaborative networks and international dialogue are essential to manage their health needs.

Employment

- 18) Refugees and migrants need to be allowed to work. Innovative payment mechanisms such as health insurance mechanisms and/or refugee health bonds will only work if migrants and refugees can pay.

Requests to WHO

- 1) To review and **update WHA 61.17** on the health of migrants by the next (70th) World Health Assembly.
- 2) To develop **a Comprehensive Global Strategic Framework** and **Plan of Action** on migration and health.
- 3) To **advocate** and **support** Member States to develop more **inclusive health policies** and **legal frameworks** to ensure a **right to health for all, regardless of legal status**.
- 4) 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.
- 5) To support Member States in **health system strengthening** towards achieving quality **UHC** for all, regardless of legal status.

Annexes

Annex 1: Agenda

Annex 2: Opening Remarks, Speeches and Presentations by countries

- Dr Ranieri Guerra, Director General of Preventive Health and Chief Medical Officer, Ministry of Health, Italy
- Dr. H.S.R.P de Silva, Director of Organization and Development and the National Focal Point for Migration Health and Development, Ministry of Health , Sri Lanka
- Dr Peter Salama, Executive Director, WHO's Health Emergencies Programme, WHO
- Ambassador Laura Thompson, Deputy Director General, IOM
- Mr Volker Turk, Assistant High Commissioner for Protection, UNHCR
- Mr Ernest Massiah, Practice Manager, Health Nutrition and Population, MENA Region, World Bank
- Dr Paul Spiegel, Director, Center for Refugee and Disaster Response, John Hopkins University
- Msgr. Robert Vitillo, Executive Director, ICMC

Annex 3: Discussion

Annex 4: Summary and conclusions

To watch this side event online, please visit: <http://webtv.un.org/search?term=migration+and+health>

Annex 1: AGENDA

Time	Session description
08.00 – 08.15	Opening remarks <ul style="list-style-type: none"> Permanent Mission of Italy - Dr Ranieri Guerra <i>Director General of Preventive Health and Chief Medical Officer, Ministry of Health, Italy</i> Permanent Mission of Sri Lanka - Dr. H.S.R.P de Silva <i>Director of Organization and Development and the National Focal Point for Migration Health and Development, Ministry of Health, Sri Lanka</i>
08.15 – 08.20	Video: Personal stories from the frontline of migration and health https://drive.google.com/file/d/0B1SJ48PyzW4aWfo5dUh3Nm5JZFk/view
Panel: The health of migrants and refugees involved in large population movements: leaving no one behind	
08.20 – 09.00	<p>WHO</p> <ul style="list-style-type: none"> Dr Peter Salama, Executive Director, WHO's Health Emergencies Programme <p>IOM</p> <ul style="list-style-type: none"> Ambassador Laura Thompson , Deputy Director General <p>UNHCR</p> <ul style="list-style-type: none"> Mr Volker Turk, Assistant High Commissioner for Protection <p>World Bank</p> <ul style="list-style-type: none"> Mr Ernest Massiah, Practice Manager, Health Nutrition and Population, MENA Region <p>Johns Hopkins University</p> <ul style="list-style-type: none"> Dr Paul Spiegel, Director, Center for Refugee and Disaster Response <p>ICMC</p> <ul style="list-style-type: none"> Msgr. Robert Vitillo, Executive Director <p>The distinguished panel will assist in responding to questions such as:</p> <ul style="list-style-type: none"> What recommendations could be included in the Global Compact for Safe, Orderly and Regular Migration as well as the Global Compact for Refugees, in order to improve the health of migrants and refugees at all phases of the migration and forced displacement cycle? How can we achieve universal health coverage for all, regardless of legal status? What needs to be in place? How can Member States with limited health system resources and consequent challenges in addressing their nationals' health needs, meet the health needs of refugees and migrants?
09.00 – 09.25	Discussion and Q&A
09.25 – 09.30	Closing remarks

Moderator for panel discussion: *Richard Horton, Chief Editor The Lancet*

Annex 2

Opening remarks, speeches and Presentations

Dr Ranieri Guerra

Director General, Preventive Health and Chief Medical Officer, Ministry of Health, Italy

The massive arrival of undocumented migrants and refugee asylum seekers from North Africa and from the Middle East is under our eyes and cannot be denied. Nor it can be denied that we are facing a global crisis exacerbated by the social and political unrest of many Countries of the Mediterranean area as well as of other regions. The crisis net result is a growing population of economic and climate migrants as well as of refugees and asylum seekers.

Italy joined forces with WHO, UNHCR, IOM and other partners, such as Greece, Malta, Cyprus in generating technical and political deliberations that keep an ethical and human perspective when dealing with migrants. Yet we see countries in denial who are trying to adopt unilateral containment measures. I make reference to my Prime Minister's recent comments and proposals, as he rightly urged the UN system and Member States and NGOs to act united.

We appreciate the New York declaration adopted at the Monday summit, but we need to stay vigilant to ensure that the global compact on migrants and on refugees is adopted by 2018, as promised and reiterated during yesterday special event organized by Italy, Ethiopia and other partners.

Italy has faced alone the initial challenge of migrants crossing that sea, which has become a burial place, as the Pope recently commented. Peer countries joined eventually, especially after migrants started walking and running, crossing land borders. It is impossible to stop what has become a true population in the move, in need of hospitality, assistance, support as we are rescuing human beings who are the prime victims of man-made and natural acute or chronic disasters impacting fragile environments and economies.

Conflicts and social unrest are inevitably making existing poverty and misery more severe, resulting in the tragedy of migration. Today the victims of this situation try to land in our ports, seeking asylum and a better life and Italy has refused to add further unacceptable discrimination, denial, neglect.

We count on the UN family, and WHO and IOM in particular, to continue addressing the public health implications of migrants' move and their impact on hosting systems, providing the required evidence and an impartial view based on technical and scientific knowledge and objectivity that may allow to overcome the reluctance of a consistent number of States, even of the European Union, and of their political leaders to accept the simple fact that migration is one of the leading forces shaping our century, will not disappear and cannot be ignored.

On the contrary, Italy and WHO have been joining forces on the migrants' health agenda for the past four years, and the high level meeting held in Rome in November 2015 paved the way for this week's series of events here in New York.

In 2015, more than 750,000 refugees and migrants have reached European countries, adding to the almost 2 million who have taken shelter in Turkey and the additional 2 million in Lebanon and Jordan. 250,000 crossed the sea, more than doubling 2014 numbers. Since 2014, Italy has rescued more than 400,000 migrants. In the first semester of 2016, close to 150,000 undocumented migrants, asylum seekers and refugees have already reached the Italian coasts, rescued at sea by the Italian Navy and Coast Guard and by the other forces engaged in the EU Frontex operations and NGOs.

Tangible differences have been noted between migrants coming from the Middle East and moving to central European countries and those who come by the sea. The former are families and organized population groups, the latter are mainly individuals coming from a variety of countries, sometimes infiltrated by criminal organizations. The male proportion has decreased in favor of females and unaccompanied children and teens, whose needs are even more challenging.

A week ago, the 53 WHO/EURO Member States have adopted a regional strategy, an action plan and a resolution on public health and migration. This comprehensive package, the first of its kind worldwide, aims at providing quality and universal assistance to the refugees and migrants who have often suffered a traumatic journey, do not speak the local language and are fearful. The plan aims at eliminating barriers to health care such as language, administrative hurdles and lack of

information about health entitlements, and takes account of cultural and religious differences, addressing also the physical and mental health of refugees and migrants, as well as the host community, with a migrant and gender and age sensitive approach.

We need to prevent communicable diseases based on strengthened and coordinated epidemiological surveillance that may allow for targeted comprehensive immunization programmes for the refugee and migrant populations. The groups in most vulnerable situations within the migrant and refugee population, such as children, pregnant women, the elderly, people with disabilities and victims of torture and of gender violence need tailored assistance, including sexual and reproductive services. Migration and health is a complex area. We must acknowledge that we are dealing with an issue of great political sensitiveness and where the scenario is constantly changing. For this reason, coming up with an agreed document that is relevant today and will remain relevant in the years to come has not been an easy task.

We all need to act together and implement the plan. We must use all opportunities to bring vertical (Agencies, international entities, the UN family) and horizontal (interregional and intercountry) coherence into a picture that needs visibility and support, working side by side with the countries of origin, transit and destination, but also with all other key actors in the field, such as NGOs and local Governments.

In this regard, I am grateful for the organization of this side event that responds to this scope, despite the little space dedicated to it by the General Assembly.

We believe much remains to do to make sure that equity and fairness are adopted when addressing migrants' health and that no single country will be able to act alone or in isolation. The need for global collaboration cannot be underestimated and innovative perspectives discussed and supported. Italy detailed these global issues at the Technical briefing offered at the end of the 69th WHA on May 27th with WHO, IOM and committed Member States. Based on that and on the WHO/EURO resolution, we think that time has come for the 70th WHA to review and update resolution WHA 61.17 on the Health of Migrants adopted in 2008.

Today meeting will surely facilitate the relevant roadmap implementation. We do not want to launch any other complex naval operations bringing a sunken boat out of water in an attempt to give a name to a thousand bodies. We do not want to see more children bodies on the Mediterranean beaches.

Dr. H.S.R.P de Silva
Director, Organization and Development and the National Focal Point for Migration Health and Development, Ministry of Health , Sri Lanka

Sri Lanka is pleased to co-host this side event together with Italy, WHO, IOM and UNHCR. As we understand it is in the first time the UN general assembly has considered to bring on to the agenda through a side event, the subject of health of Migrants.

The challenge for providing Health for migrants is complex. It certainly questions our understanding for Universal health coverage beyond borders, which in turn would affect sustainable development to which we are all now committed. It questions our responsibility towards global public health and country level capacities to respond in specific situations of large movements of migrants.

Migration unfolds different situations in different countries, the challenges vary. A national diagnosis, mapping all possible types of migrants that affect the country and the health challenges that can arise is vital.

Ladies and Gentlemen, Sri Lanka acknowledges and appreciates the direction given to Member States in the World Health Assembly resolution of 2008 on "Promoting Health of Migrants". In Sri Lanka, the subject has received continued political commitment. The Ministry of health responded by establishing a focal unit to define our agenda for Migration and health. We received timely support from the International Organization for Migration where a rapid analysis of the countries migration profile was examined together with analysis of national stakeholders and the countries policy, legal and institutional frameworks pertaining to migration and health. To address the gaps identified we explored options further, through several commissioned studies, supported by the IOM.

This extensive research, was the basis for the National Migration Health Policy that was launched in 2013 under the leadership of His Excellency the President Maithripala Sirisena who was at the time the Minister for Health.

Ladies and Gentlemen, the migrant profile in Sri Lanka has many facets, being that of outbound migrants and the returnees, other inbound migrants, internal migrants. We also consider the families left behind of outbound labor migrants as there are several issues that have health, social and economic implication.

In Sri Lanka we have significant public health challenges posed due to migration, such as maintaining a malaria free country, the low prevalence for HIV and controlling TB. However, our concern for the health of migrants is not merely seen from a protection point of view of the public health of a country. Our experience tells us that differences in providing for health lead to wide disparities in health outcomes between the Sri Lankan host population and the Estate/plantation communities. Today, after decades of interventions, although the disparities have narrowed we recollect that we have had to put a concerted effort into health service delivery to do this.

Ladies and Gentlemen, we faced the challenge from internal migration during the aftermath of the internal conflict where large numbers of our own people were freed from previously terrorist held areas. We had to adopt temporary arrangement to secure their safety during a transition period and health received priority attention. With the extension of our existing public health services and setting up of special hospitals through a rapid response plan we were able to achieve good health outcomes. We were able to do this as we already had an organized public health system, and replicated the same model within a short time to serve this transition period of internal migration.

We also saw a steady return of our Tamil speaking citizens who had been residing in south India for decades during the time of the conflict. Here too we followed an approach of getting them to access local health services soon after their return, rather than creating barriers to their return due to health concerns.

A growing number of asylum seekers also use Sri Lanka as a transit point. We recognize the need to have a better preparedness plan. Currently we adopt public health measures to prevent possible disease outbreaks as well as look into their primary health care needs and any emergency health care.

Ladies and Gentlemen, Sri Lanka is considered a labor sending country, but in recent times we are also now a labor receiving country. We recognize that whilst we expect primary health care access to our labor migrants in other host countries, it is time we consider reciprocal for the labor migrants who are supporting our economy. We are to introduce a health assessment for inbound migrants applying for resident visa, which will apply to the labor migrants as well. The health assessment will not be a barrier for employment. As currently there is no health screen, it will pave the way to identify

diseases of public health importance to us and we will ensure that treatment is provided. We consider that offering treatment will minimize fraudulent practices of migrants.

Ladies and Gentlemen, Sri Lanka recognizes the importance of international dialogue on migration, Health and development. In the context of the SDGs this becomes important. Migrants would be the group, left behind, in country estimates of UHC.

The WHA resolution in 2008 called upon member states to take action to promote migrant sensitive health systems, and having developed our own national policy on migration health and development, we recognized that addressing several aspects of migrants health is beyond our scope and borders. Sri Lanka had noted that global dialogues were infrequent and the WHA resolution too needs to be reviewed and its monitoring strengthened. We have been engaged to bring migration and health into international attention through our regional platforms such as the Colombo Process and at the recently concluded South-East Asia regional committee of the WHO. Sri Lanka also made a request for its inclusion into the agenda of the next Executive Board meeting of the WHO so that recommended revisions can be considered to the existing WHA Resolution on promoting health of migrants.

In February 2017, Sri Lanka will also be hosting the 2nd Global Consultation on Migrant Health, focusing on Resetting the Agenda. The event is jointly organized by the IOM, WHO and the Government of Sri Lanka.

Ladies and gentlemen, although Health of Migrants has come to the limelight due to needs of addressing the health of migrants and refugees moving in large numbers, this side event of the UNGA is certainly an opportunity to revisit the WHA resolution on Promoting health of Migrants, where a significant global populations' health coverage is focused upon, in keeping with our commitments to SDGs.

Thank you.

Dr Peter Salama
Executive Director, WHO's Health Emergencies Programme

Thank you to the Permanent Missions of Sri Lanka and Italy for co-hosting this session. Given the events in the Middle East this week, and the theme on the movement of migrants and refugees being right at the top of the political agenda, many commitments are being made. But although health is mentioned in the New York Declaration of Refugees and Migrants, that is being endorsed this week, health has not been featured predominantly in the discussions except through a disease-risk lens. It is clear that declarations, protocols and standards are necessary, but not sufficient to guarantee UHC and financial protection - especially for the most vulnerable people.

As we address the issue today more systematically, I would like to bring a focus to three particularly complex dimensions:

First is the balance of ensuring that people in any legal category, refugees, migrants, whether regular or irregular, all have their right to health care met, on one hand. On the other hand, ensuring the specific and at times very different needs of different demographic groups, are recognized and met. In many situations, the majority of refugees are women and children. And their health needs and indeed opportunities for access, will vary greatly between migrants, for instance young men, presiding in detention centers across North Africa. So specific tailored approaches are needed. This will require a detailed understanding of context, in source, transit or destination countries. The issue of data will be a crucial step that needs to be addressed.

Second, in the refugee health sector, there is a strong history of developing standard packages of services, and prioritizing programmes according to the phase of an emergency, with clear indicators and bench marks. This type of parallel emergency health system has saved many thousands of lives over the years. However, as crisis become more and more protracted, and countries such as Lebanon and Jordan, face situations where up to 1 in 4 or 5 of their population are refugees themselves, the majority being outside camp situations, there will only be one way to meet their needs; to open up the health system to all, while at the same time strengthening its capacity for serving both host and refugee populations.

Third, there is one dimension of the migration or flight of health workers, that poses a particular risk currently, and I do not think it is fully recognized. With the unprecedented systematic targeting of health workers and facilities in Syria and other Middle Eastern countries, I believe we may well see an increasing Exodus of medical workers, due to these grave violations of international humanitarian law - fearing for their professional lives and their lives in general.

So far for example, according to the physicians for human rights, there have been more than 400 attacks on health facilities in the Syrian war, and more than 750 medical workers killed - including two nights ago in Southern Aleppo. So to address these issues, WHO has outlined some key steps.

- We must bridge short-term humanitarian response with sustainable long term approaches. Rapid 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 towards health system strengthening and capacity building can and must begin early.
- Health systems must be strengthened to provide universal health care and access to quality health services regardless of their legal status. We need to change the way we work: we need more investment in local solutions and local structures; we need to build local health capacity; we need to increase the resilience and the ability of health systems to respond to crises and to face emergencies.
- Countries must have an adequate health information system with robust epidemiological data on migration in order to have evidence-informed policy options.
- We need well-coordinated multi-sectoral and multi-country response. Collaborative networks and international dialogue are essential to manage the health needs of migrants and refugees.

Moving forward, WHO is committed to working with countries and global partners in the development of the global compacts for refugees and safe migration, and in meeting the health needs of refugees and migrants. Health must be considered as one of the most important elements in the development of these global compacts.

And we really thank our colleagues at IOM and UNHCR for their collaborative work, and count on their cooperation and collaboration as we move forward together.

Thank you.

Ambassador Laura Thompson
Deputy Director General, IOM

Thanks first of all to Italy and Sri Lanka for organizing this. My first point is that the increased human mobility around the world today entails a lot of challenges and a lot of opportunities as well. One of the challenges is to health, and public health emergencies. This cannot be ignored. When we talk about increased human mobility, this has to be there. Particularly in the context where migration is taken place in forced migration, due to emergencies. So that brings an additional element of difficulty in managing these things.

Most migrants make the choice to move, though poverty and necessity remain for many the major reason behind that choice. However, we are also facing record levels of forced migration, brought about by an unparalleled number of simultaneous, complex, protracted crises involving armed conflicts, political upheavals, natural disasters, and human rights deprivation. To compound this, we are witnessing an additional crisis, that is a crisis of political courage, and an erosion of international moral authority on migration issues with anti-migrant sentiments reaching daunting levels in some parts of the world. An important challenge we face today is that migration policies have not kept pace with human realities and do not sufficiently acknowledge migrants' valuable contributions to the social and economic development of both their countries of origin and destination. For instance, the global volume of migrants' remittances exceeded 450 billion USD in 2015. Money sent back by migrants is spent on health, education, and contributes to poverty alleviation and stabilization of communities at origin; this makes migrants 'part of the solution and not part of the problem'.

Although the large focus of UNGA is on displacement in disasters, it will be misleading to consider migration only within the scope of emergencies. It is a lot more broad than that. The vast majority of international migrants are moving for other reasons, not only emergencies. It may be a choice that they make to live in search for better opportunities. Even when it is as a necessity, it is driven by other factors, disparities, inequalities, even the distribution of resources and working opportunity. We must keep in mind we cannot limit this to emergencies. And the impacts on health are the same.

We need to reconcile the health needs determined by large scale acute crisis driven movements of people, as well as those of the smaller scale migration movements, and bring them together. We have to develop health systems that are migration and human mobility competent.

Another point I would like to say, the little prominence that the migration health has played in the global health and development agendas of governments and international organizations, there is a lot to do. Health must be given due consideration as we move towards the Global Compact for Safe, Orderly and Regular Migration, and the Global Compact for Refugees, to improve the health of migrants and refugees during all phases of the migration cycle, as well as to respond to global public health needs of hosting societies.

This is a cross-cutting element across all organizations. We live in an era of unprecedented human mobility, a fundamental component of both the current and future human condition. We have therefore in front of us the great responsibility of helping systems in the development of strategies and responses to migration and population mobility, that are in sync with societal changes, and emerging and re-emerging health challenges.

Despite important milestones such as a 2008 World Health Assembly Resolution on the *Health of Migrants* (WHA 61.17) that asked eight years ago governments, organizations and other stakeholders to jointly promote the health of migrants, many migrants, asylum seekers and refugees alike, still lack equitable access to health services, and many are exposed to poor living and working conditions and occupational health hazards. Moreover, despite a global call and emphasis on achieving Universal Health Coverage with the Sustainable Agenda 2030 (*i.e. the goal of ensuring that all people obtain the health services they need without suffering financial hardship when paying for them*) in many countries the most important factor governing migrants' and refugees' access to health care is their legal status and the interest in controlling immigration.

Additionally, discriminatory and stigmatizing practices that limit entry and stay on medical grounds still persist (e.g. restriction to entry and stay based on TB, HIV, but even pregnancy). The discriminatory and stigmatizing practices that migrants in regular conditions suffer limit their access to health services. Obstacles to migrants' access to health care, whether societal, cultural, or economic need to be identified and removed. As well as those conditions and practices that enhance their vulnerability to ill health – the so called social determinants – across sectors, by multiple actors and partners, and within the broader scope of the many Sustainable Development Goals we have all subscribed to adhere to last year.

So this take me to my third point, it is not only understanding health, we need to understand the cross-border mobility dynamics. It is crucial because we cannot develop effective plans if we do not understand the health component but also the cross border components. Cross border mobility, brings about disease surveillance and treatment challenges that makes

understanding cross-border mobility dynamics a critical component of effective public health interventions, if we are to prevent, detect and respond to health threats, as envisioned through the Global Health Security Agenda. Health systems need to become more aware and prepared to respond to the needs of transnational communities, diverse population profiles and needs, and an expanding scope and size of human mobility. We have seen this in Ebola, yellow fever, and a lot of pandemics that happen.

There are promising developments to underline though, including at the international level. Last week, we saw the endorsement of a *Strategy and action plan for refugee and migrant health for the European Region*, during the 66th Session of the WHO Regional Committee in Copenhagen that should be reflected by the Global Compacts to be developed. In addition, the Declaration of the Fifth Ministerial Consultation on Overseas Employment and Contractual Labour for Countries of Origin in Asia (the “Colombo Process”) recommended migrant health as a new thematic priority for the region. Similarly, later this month we will see migrant health included in the Regional Conference on Migration for the Americas, or ‘Puebla Process’, in Costa Rica. Lastly, IOM, WHO, and the government of Sri Lanka, are co organizing the *2nd Global consultation on migrant health*, in Colombo next year.

Let me conclude by saying that the Development agenda 2030 Sustainable Development Goals rightly identify migration as a driver and enhancer of sustainable development. In particular, SDG 3.8 call for Universal Health Coverage, which, by default, is only achieved when the health and equitable access to health services of all people, including migrants and refugees, are addressed. As long as migrant populations have restricted abilities and rights to access affordable health services, concepts as ‘Universal Health Coverage’ and ‘Leaving no one behind’, are pointless.

This UNGA *High-level Meeting to Address Large Movements of Refugees and Migrants* is our chance to ensure the development of a meaningful Global Compact for Safe, Orderly and Regular Migration. This is our unique opportunity to promote the health of migrants and refugees within this framework.

Thank you for your attention.

Mr Volker Turk
Assistant High Commissioner for Protection, UNHCR

Thank you very much and it is great there is a focus on health both on migrants and refugees in this UNGA, because it does not often get enough attention.

A couple of observations from UNHCR's perspective - it is interesting that refugee issues for much too long have been a *niche* area. Meaning they are not nationals, they do not necessarily have a political institution that is a driving force behind them, I think it is also the same for migrants at times, but particularly refugees. It often polarizes discussions, not just in Europe, but also across the world including the Global South. What has changed over the past year or so, and particularly this week at the UNGA, is that it is no longer a *niche* issue. That has propelled everyone to actually think about what displacement means for an individual, what the consequences are for an individual, and how the individual and not just the 'individual', girls, women, boys, men, are affected by displacement and being someone who has fled violence, conflict, and human rights violations. And of course it asks all of us in our respective areas to look at what this concretely then entails, and in the health area, the traditional approach was especially in emergencies, was, because of the urgency of a situation, because of the health systems being overwhelmed, to find ways and means to establish a quick response, done through our partners, NGOs and so forth.

In the type of situations we see now, this is obviously not sustainable, it also creates almost a parallel structure outside, and it is not anchored in the local ownership that is so much needed to create the space needed for refugees.

I remember when I was in Malaysia, self-critically as well, traditionally UNHCR would not necessarily talk to the line ministries, our main counterparts is ministry of foreign affairs, or ministry of home affairs. It is over the last couple of years, we have learnt that we do actually need to talk to all the line ministries. Health is a crucial one, and I remember a conversation with the Malaysia Minister of Health at the time who had never heard about migrants and refugees and never considered that there needs to be special conditions for it, because of their lack of documentation, because of their lack of legal status, they would not be having access to health services, and as a result, would actually become and affect national health systems in a negative way, and then UHC comes in as a very important element of that.

What I think has changed with the New York declaration, it has built on the practice over the last couple of years, and it has given a certain paradigm shift in the education area, the employment area, health area, but ensuring that national health care providers and not just the government, also the NGOs, non-private, that the health actors open up to migrants and refugees, that they are aware of their plight. And then of course they need the support, which is why the development side comes in, not only in protracted situations, but much earlier. And the engagement of the financial organizations and particularly of the World Bank has been absolutely crucial. For instance in LMICs, in the past, despite the fact that, for example, Lebanon had over 1 million refugees, with a population of 4.5 million, that this means the health services are obviously challenged, how does one deal with this? And I think that is where the real paradigm shift is starting to emerge. And we know we need to put more flesh to the bones of the New York Declaration, including in the health area, but a lot of work has started, and obviously we look forward very much to working very closely with different organizations, civil society, the education organizations, to really create some of the evidence base that we also need when we present in 2018 a global compact on refugees.

And one last point on health professionals and the risks that health professionals have, these are war crimes, fundamental violations of international humanitarian law, there is unfortunately not enough attention paid to impunity. We increasingly have to put health professionals into categories of people who are in need of international protection, which shows that conflicts have become so atrocious that they want to even deny some of the fundamental human rights, but it is very unfortunate this is happening.

As a last point, health care professionals have traditionally been strong advocates for refugee protection, for the protection of migrants, they are aware of their background, and that is very important.

**Mr Ernest Massiah,
Practice Manager, Health Nutrition and Population, MENA Region, World Bank**

Let me say thank you for the event, and also for the video, because as I was looking, what it does capture is all the issues we need to discuss, but it also reminds me of my humanity. Who we are actually dealing with, we are dealing with people and people's lives, and the situations in which they find themselves in.

A couple of points, number one, and it came out in the video. The dialogue on refugees and the discussion, is often very much on disease, it is a problem, it is on refugees as a burden to the system, and I think number one, one of the things we need to do is change the tonality of that dialogue, because what refugees can do, is that they can contribute to a society and its development. And it is ironic that we are in New York, in a city that welcomed migrants, after the contribution of migrants this country actually grew. And I think it is important to remember, that if we do not change the lexicon of what migrants can do, it then pushes us into a series of policy options, that are looking at migrants, as to how does one prevent that burden on a society, and how does one look to see how they can be excluded from development in the society.

So we must change the lexicon about migrants and the opportunities from them. And in the video there was a little girl, and when I heard her speak, about "let me see what I can do to help", that is actually the contribution that a migrant makes to society, and that is right there in the video. That is absolutely key to going forward.

There are a couple of things that have happened in the past couple of weeks that have changed that lexicon. First for us in the bank, it is the link between the humanitarian response, the development response and the rights based approach. And putting those together, so the binary that was before, between what was humanitarian, and what was considered developmental, seeing them as different bits, is broken. In the bank, we are now doing this, looking at it as a continuum.

But, what does that actually mean? To look at this from a developmental perspective, three critical things that come up we can look at:

1) If we take a developmental approach, we can start looking at what are the long standing challenges that we need to address. Let me be very clear, the challenge of ill-health did not start with migrants in our countries, we have had many excluded populations who have been not able to have access to health services without the impact of migrants in their societies. Health systems have struggled for years, to see how do you get the poor into the services, how do you have health care that is provided to citizens, that does not exert a catastrophic financial impact on their livelihoods.

The migrant crisis, if we look at it as an opportunity, is a chance to ask, what are some of the long-standing problems that need to be addressed, and how does one address them, within all of the national borders.

2) How do we look at the host communities? We have some very interesting operations at this point in time at the bank - one of them in Lebanon, which started off looking at providing health care to poor Lebanese; bearing in mind that influx of migrants and refugees into Lebanon, of 1.2 million, in a population of 4 exerted pressures not only on the health system, but also very real political challenges for the State of Lebanon. Then, the role of the bank was to see, how does one keep the bottom from falling through, how does one protect the health needs of poor Lebanese. But now we are in a phase of seeing how we can expand that so that the system that is created, will cover both the poor Lebanese, as well as the refugees -one delivery mechanism.

In a way, what has happened. The opportunity that the migrant crisis has created, is to allow the country to improve the health system for host communities - in particular the poorest in society.

4) The other opportunity that has cropped up is in thinking of innovative approaches to health service delivery. What we have had is a health system that has focused in certain ways. And I think it came up again in the video. I always say that the forgotten child of our health service delivery system is often mental health, but we are faced now with serious issues of trauma, serious issues of mental health, and the approaches that we have had before do not necessarily suffice in dealing with community mental health issues that is unprecedented in many of the countries.

We have to think of innovative approaches to service delivery, to address the problems in which we are facing. And mental health comes up as one of those we need to look at.

5) It is also forcing us to think of innovative approaches to training our health workers. We have been looking very much at what we could do in Syria, Lebanon and Jordan. And this is where technology is starting to come in, when thinking of how to train doctors, and looking at the situation in Syria, it takes roughly 5 years to train a doctor, but in the next 6 months more

doctors are killed or migrate, thinking long term, what will the health sector need in Syria to rebuild itself, we have to then start coming up with innovative approaches to how we train medical professionals.

It is - how can we look from a broader developmental perspective, as to what we can do in countries that are in conflict, but also to have large migration now, but also to displaced populations. And I was very glad to see that the video started off with that mention of displaced populations. Because there are migrants, but we have also had long standing issues of displaced populations, and the need to address their health issues also remains, and perhaps has sometimes been ignored.

One of the things we look at in the Bank is financing. I want to juxtapose a conversation that took place in the UN last night, on the concessional financing facilitating, which has now expanded to include LMICs, and at that meeting the Lebanese Minister for planning was very appreciative of what has happened now that a mechanism that was once restricted to two countries, has now become a global mechanism.

A couple of challenges come up that I think are important:

- 1) How do we evaluate impact moving forward. Yes we can provide financing, but the evaluation impact, how does one do it in these contexts is vital.
- 2) The second thing that comes up, is in countries that have access to financing, there is still the question that remains as to what is the physical space that allows them to be able to borrow and access this financing, and how much will they be able to absorb. So the financing mechanisms are there, it is innovative, it is agile, it is growing, it is looking at grant financing. But the impacts are going to be important to be measured. But it still is not enough, because the size of the problem is so big. We are providing millions and he said he is needing billions.

So I think overall we have three things we have got to look at. We have to change in the way we look at the response. We have to change in how we deal with the financing. And we need to look at the partnerships we need in order to make this work, it is not something the World Bank can do alone.

Thank you

Dr Paul Spiegel
Director, Refugee and Disaster Response, Johns Hopkins University

I want to focus on some practical points for the Global Compact. One is the need to integrate into existing health systems, and to avoid parallel systems. It is clear that that needs to be the case, and if we do it correctly we should be able to improve the national health systems, and not see it as a negative aspect.

In order to do that, we need to allow these people, the refugees, the migrants, we need to allow them to work. And the reason for this, if they have work they have money to be able to pay, increasing the amount of money going into the system.

There is a special issue around being able to work thought. Currently physicians for human rights are estimating that there are about 15,000 Syrian health care workers outside of Syria who cannot work. So we need to be able to also work with countries that accept these people to ensure they can work. There are of course complex issues, they may not have the same qualifications as the country they are in, but we need to be able to work on that.

The second aspect is using the existing national development plans, and the forward looking aspect of these plans, to be able to look at where we are able to put, or at least augment this national system to be able to see where these health systems should be providing for migrants and refugees. Again, avoiding these parallel health systems, and arranging health systems so they can provide for all in the future.

The third point is around protection and health. In many countries there is still mandatory testing in countries specifically for migrants, HIV is common, and there is also travel restrictions that occur. We know this is bad public health practice, however it has not been sufficiently addressed and it is still occurring because they have not yet been addressed. We must address these issues.

Similarly travel restrictions, we need to look at that to say when they should or should not be applied, for the most part they should not be applied.

Another area is health financing. A problem we have had in the past is that humanitarian funding is one year funding, if we can look at multi-year funding, if we can look at upfront investments, that is more expensive, if countries can recognise the protracted situation, build schools, water, infrastructure, with the thinking of providing for migrants and refugees, it is actually cheaper to do it up front. But that will require more investment and multi-year funding.

Looking at innovative health financing, there are interesting things we can do that in theory, will help the national systems. Firstly, health insurance, and UNHCR has been working with around 14 different Governments, and has had quite a lot of success in providing health insurance to refugees, the Islamic Republic of Iran is one of the most important. But for this to work, refugees need to be able to work so that they can pay, and if they can pay, you increase the risk pool, and it could be a win-win situation. But we have the tension around the issues of work. John Hopkins is also working with the World Bank on something called refugee health bonds (similar to social investment bonds, social impact bonds). It is a new concept we can see, but there may be ways to bring in the private sector and others.

My last point, is the cross-border issues. There have been attempts in the past, but if we can look at standardised protocols, which would allow for bulk ordering of testing kits, we can bring down the cost but also allows for continuity of treatment.

Related to this, one of the biggest problems we have in terms of movement, is continuity of care. And so there is an idea that has been out there for a while, and UNAIDS and others have passed this, is a travel health passport, it can be complex, and we clearly recognise data confidentiality issues, but if you could have some kind of way of knowing people who are on treatment, CD4 counts, those on TB, it could improve continuity of care, and improve drug resistance.

**Msgr. Robert Vitillo,
Executive Director, ICMC**

I will focus on what our own organization is doing, which is a Catholic inspired organization. What I will talk about, I believe, is representative of many other faith-based organizations and civil society organizations involved in refugee and migrant services and especially also in the health area. Some of the work of ICMC is in the humanitarian context, for instance last year we provided assistance for Syrians inside Syria, with basic needs, and also on health care, focusing on women and newborn children. Of course you know that many of the health facilities are destroyed, so we are working with those local facilities, to ensure we can get the best health possible for those people.

In 2013, ICMC worked in partnership with the Caritas Lebanon Migrant Center, to do a study of older refugees. Sometimes, here at the UN, we work at the macro level, but sometimes not looking at the micro level is why we do not get into some of the bigger declarations such as the New York declaration and in terms of a better focus on health. If we speak to migrants, many will say health is one of their basic needs.

If we look at the study, 1100 older Syrian refugees, some of whom being served by this Caritas Lebanon center, and others a women's group in Lebanon.

The average age was 68 years old, youngest 60, older 96 years old, and we collaborated with John Hopkins University. I want to share some of those findings:

- 74% of the respondents noted they were reliant upon humanitarian assistance to reach their basic needs. Here they were in another country, but they still needed basic assistance to meet those needs.
- 66% described their overall health status as bad or very bad. Nearly all listed at least one chronic illness, including hypertension 60%, diabetes 47% and cardiovascular disease 30%.
- Respondents reported a number of physical disabilities including difficulty with walking 47%, and loss of vision 24%. Approximately 10% were physically unable to leave their homes and 4% were bed ridden. They reported the need for a variety of care assistance.
- 87% reported that they were unable to afford medications which had been prescribed by their physicians.
- Common issues included skipping meals, low intake of fruits, vegetables and meats, many reported they were eating less to provide more food to younger members of the family.
- Mental health concerns were mentioned by a significant number of respondents. Nearly 61% reported feeling anxious, other spoke of feelings of depression, loneliness and considering themselves as a burden to their families.
- 57% said that negative feelings restricted their ability to perform a task that a health person of the same age would be expected to do.

I will close with a story from the youngest respondent, Hassan, 60 years old:

'He breathes heavily and struggles to pronounce his words. He suffers from hypertension, diabetes, asthma, and relies on a pace-maker to regulate his cardiac rhythm. With their savings depleted and no right to work in Lebanon, the family struggles to pay 160 USD per month in rent, as well as the cost of the medicines for Hassan. So he often has to skip taking his medicines. Giving evidence of depression and despair, Hassan says, "if I die in Syria or I die in Lebanon, what is the difference. I will never see my country of Palestine again".

Discussion

Comment from Minister of Health from the Philippines

The Philippines support access of migrants to UHC, regardless of their status. We support whatever will come out of this meeting, regarding the essential or basic health services, which are available to migrants. We have to identify the mechanism of financing these basic services. We agree that governments cannot do it alone, we need partnerships from national organizations and faith based organizations, local civil society groups. We would like to emphasize the need for psycho-social debriefing, because this is really an important component. And access to maintenance medicines, or medicines of the migrant population. Whether they be paid through social health insurance, or national governments or international agencies, is vital in terms of maintaining the health of Migrants.

Question: We have heard consistently from all the speakers, that we are adding in addition to the acute conditions of migrants, there are also chronic conditions, long term issues to address - and therefore there is the need to access the local health system. It is very easy to say that, but there are severe practical problems to that recommendation, often deep political problems, and concerns from the national government of the recipient country on the political stability of that country. And indeed from the refugees themselves that they may not wish to be fully integrated into the national health system, concerning being integrated may reduce their ability to return. - In this call for UHC, opening up the local health system, what are the concrete steps to take, to make this wise recommendation a reality?

Responses:

Dr Spiegel, John Hopkins University: If we can convince the national governments that their services to the nationals will improve, and they will because where many of the migrants are located, the services are very poor. In many situations 10-15% of nationals use the refugee services. There may be a time period where the international community needs to come in to ensure that is paid for.

Mr Turk, UNHCR: On the point of refugees not wanting to be integrated, because of their fear of not being able to return - I think we need to separate both. The right to return, is a right in and of itself for refugees. We know because of the protractiveness of the current situation, people spending up to 20 years displaced, people have to get on with their lives. And if they don't, they will also lose skills, they will not be as employable. Therefore the emphasis of refugees should be to resume the norm as much as is possible, so they are employable and healthy on return. In terms of concrete steps, it requires political leadership. How to translate the rational argument into politics, and that is one of the big failures.

Dr Salama, WHO: There needs to be a policy, following their political commitment, to open up systems to refugees, and there is good learning from the education sector in the middle east. And there also has to be financing and incentives to back up that political risk the governments are taking. That could be insurance, or large-scale international grants for a period of time, until there are longer term sustainable mechanisms in place.

Mr Massiah, World Bank: The financing issue needs to ensure that governments know the resources are going to citizens, and the resources that are going to the refugee populations are not a cost to the state. That is the most important argument to the politicians, to sell to the constituencies. It needs to be sold as a benefit for all, it is not depriving the national citizens.

Msgr. Vitello, ICMC: We can have better collaboration and partnership, between the government sponsored services, and other organizations such as the faith based organizations. Too often they are done in parallel or in competition.

Ambassador Thompson, IOM: One of my concerns is that it is very different response, when we talk about refugees and displaced persons, in contrast to migrants. We must keep this in mind. Politically, they do have a big difference, and so it is extremely important with politicians at the end of the day to explain that public health will be affected if these people are not incorporated into the systems.

It is very important that we find a way to keep privacy for health assessments, as they are very important, especially in terms of moving people.

Questions:

IFMCA: Adolescents and children should not be seen as victims but also as first responders. This is my question, what can be the role of young people, any concrete recommendations, in terms of advocacy to improve their access to health, and to strengthen the implementation of policies to strengthen migrant or refugee health.

WHO: Gender Equity and Human rights: There are significant siloes in the way we work within and between UN organizations. What are some good examples of how countries have been able to work across siloes, to a human rights based approach. And secondly to human policy coherence, we have policies that support the demand of economic migrants, but contradictory policies that are underlined by xenophobia in host countries, and these create barriers to health access. How are we dealing with these different forces?

Responses:

How to address xenophobia and racism?

Msgr. Vitello, ICMC: Our organization has been working on that especially in Europe. We were part of a big group of about 2500 civil society organizations working with the city of Sheffield, UK, as well as other cities, to work to change those attitudes. To help the city officials and but also the general population. We were educating about good practices, about the good experiences and positive contribution of migrants in those local communities, and also influencing advocating with young migrants in terms of changing the policies in the communities.

Ambassador Thompson, IOM: If you asked me the most difficult area of work, it is this. We have tried to present to the public and the government, more arguments about real needs for more open channels of migration. On the other hand, we are doing so campaigns on the positive impacts of migrants, going down to the persons. In reality, the majority of the people when you talk to them they have a negative mind-set on migration, but not about the specific migrants they know. So we are trying to bring them to the people. We are doing a campaign called, "I am a migrant, I am a refugee", which is helping to do that. At the end of the day, we must include the media, which is a major challenge, we need to bring in the private sector, as they need migrants, they are more positive but afraid to talk about it, and we need to push politicians to see the positive arguments.

Dr Salama, WHO: Sometimes, these are philosophical debates, and sometimes concrete practical issues. I think the more we can show concrete examples of how health systems can benefit. For instance looking at education, from migration of Syrians into Lebanon, there are now more Lebanese children in schools than there were before the influx of Syrians, because of this opportunity to improve the education system. The more examples we have of this in the health sector, the more examples we have we can see the win-win, rather than loose-loose.

Question: Young people. Not victims but not first responders

Answer:

Mr Messiah, World Bank: In terms of xenophobia and changing attitudes, it sort of takes me back to AIDS, and how the health sector responded to that. There is something that needs to happen at the macro level in response to changing societal attitudes, but there is also something very specific with health workers. The key with that and HIV, was being able to assess where there were problems, and providing that data back to health workers, so it did not remain a problem portal, but where we had tangible evidence on where the types of discrimination are occurring. We need data on the interface between the refugee and the health system, to evaluate it and feed that back. In terms of young people, there is a huge range of things young people can do. In terms of advocacy, young people need to see how they can make the linkages between the various partners, and the advocacy, that is very focused on what are the key issues. That is a key role I see. Also when we look at refugee populations, we have a lot of young people. So how do we get these young people with skills to be involved in the response of these populations.

UNHCR: Released a report yesterday on the youth consultations. Because this is precisely what we have to do, to listen to young people, to what they have to say. What they bring forward, they are often the most effective agents of change in any society or area.

Annex 5

Summary and conclusions

Permanent Mission of Sri Lanka

It took us the issue of refugees to talk about health. And I think most of our governments are not really clear about how health issues should be addressed, and certainly it needs more advocacy. Many of the available platforms for regional international dialogues should be used. It is really a health system response, although governments may not understand it that way. We need to look at how migrants themselves can contribute, as this is not currently understood. We have a good example of how Indian communities that migrated, and how they have helped us.

Even though I mention health assessment, it is not as a barrier, it is to give treatment as well, including HIV. We also need to maintain a low prevalence. It is for prevention and to safeguard the migrants themselves.

The other issue is how countries can actually afford this kind of accommodation. If their health systems alone are not optimum, for their own citizens, then how do we deal with migrants and refugees. We may need to think about mechanisms such as the creation of emergency funds. We need to think in the short and long term lens.

Permanent Mission of Italy

Thank you very much for all of the comments and contributions.

First, the first lexicon that needs to be changed is the one distinguishing between refugees and migrants, because we are talking about refugees mainly. But the real issue is migrants. Refugees can be identified, they have rights that have been established, there is an international community that looks after their rights and defends and protects them. Migrants are a different story, they are usually illegally getting into the country. And a part of that is that we rescue them from the sea and we take them to our country. At that point, the problem starts. We need to identify them, give them a status, we need to recognize their rights, we need to defend their rights, and make sure they are supported continually and systematically. This is a serious issue, because we estimate that less than 10% of arriving migrants can receive a status of refugee. We need to focus on those who are left out of this definition.

Second, the health sector is fundamental to service delivery, but it is also the weakest sector in advocacy and in making sure enough resources, attention, advocacy is provided. Even in the New York Declaration, where health is very tiny. It took us four years to persuade the central government to activate a national commissioner for migration, looking specifically at the way these issues can be overcome. This commissioner will have the duty of working with the nation at large, and ensuring the services are collaborating and working in partnership to their needs.

We must remember that many of these people are coming through human trafficking organizations, that is the reality. We must remember that there may be continuity in the management of these migrants in our home countries. There is evidence that criminal organizations do have these international networks of stewards, that can bring and manage migrants as very cheap labor. The issue is that we rescue them, but then after one year, they come back into our prisons. Within the prisons they are exposed to all the potential risks on their health.

Third, it is very true that health systems must be strengthened for this, but let's be serious... we are a country of 65 million people. We rescued half a million people. That is nothing major. The absorption capacity of the country is high, we can do that, it is not a matter of strengthening to the extent where we need more international funding or resources, so we need additional doctors, health workers, working to provide services.

What is needed is international cooperation, because these people must be recognised, they must be given rights, these people must be absorbed by society or societies. These people do recognise Italy as a country of transit. They do not want to stop there, they want to go to where they have family ties or other connections. But these countries, do not want to receive them. And that is another issue, because we can fight for their rights, but we cannot fight if we are not united. If we are not united, we are lost as migrants and refugees are lost. There is a role for the UN, there is a role to address cross-border problems and solutions, and to make all of these countries aligned, to give the migrants the right to go where they want to go. Basic human rights must be respected and identified. Unless we do this, we are lost. The macro level is very nice, but it must translate into practical action at the micro level.