World Health Organization

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HEALTH DIPLOMACY:
spotlight on refugees and migrants

The Migration and Health programme

The Migration and Health programme, the first fully fledged programme on migration and health within WHO, was established at the WHO Regional Office for Europe in 2011 to support Member States to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges for refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020 and provides support to Member States under four pillars: technical assistance; health information, research and training; policy development; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating policy dialogue and encouraging coherent health interventions along migration routes to promote the health of refugees and migrants and protect public health in host communities. In preparation for implementing the priorities outlined in the Thirteenth General Programme of Work, 2019–2023, the Migration and Health programme was co-located with the Office of the Regional Director in August 2019.

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Health diplomacy: spotlight on refugees and migrants

Abstract

Nowadays, refugees and migrants are the focus of intense political debate worldwide. From the public health perspective, population movement, including forced migration, is a complex phenomenon and is a high priority on the political and policy agenda of most WHO Member States. Health diplomacy and the health of refugees and migrants are intrinsically linked. Human mobility is relevant to all countries and creates important challenges in terms of both sustainable development and human rights, to ensure equality and achieve results through the Sustainable Development Goals. This book is part of the WHO Regional Office for Europe's commitment to work for the health of refugees and migrants. It showcases good practices by which governments, non-state actors and international and nongovernmental organizations attempt to address the complexity of migration, by strengthening health system responsiveness to refugee and migrant health matters, and by coordinating and developing foreign policy solutions to improve health at the global, regional, country and local levels.

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(Technical Officer, Migration and Health, Office of the Regional Director, WHO Regional Office for Europe) Simona Melki (Programme Assistant, WHO Regional Office for Europe), Sharon Miller (Administrative Assistant, WHO Regional Office for Europe) and Dubravka Trivic (Administrative Assistant, WHO Country Office in Bosnia and Herzegovina).

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Contributors

Editors

Santino Severoni, Special Advisor, Migration and Health, Office of the Regional Director and Acting Director, Division of Health Systems and Public Health, WHO Regional Office for Europe.

Monika Kosinska, Programme Manager, Governance for Health and Regional Focal Point for Healthy Cities, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe

Palmira Immordino, Technical Officer, Migration and Health, Office of the Regional Director, WHO Regional Office for Europe

Michaela Told, Executive Director, Global Health Centre, the Graduate Institute; Visiting Lecturer, Global Studies Institute, University of Geneva

Mihály Kökény, Faculty of Public Health, University of Debrecen, Hungary and Senior Fellow, Global Health Centre, Graduate Institute, Geneva, Switzerland

Authors

Professor Ibrahim Abubakar, Director, Institute for Global Health, University College London, London, United Kingdom

Professor Emine Alp Meşe, Deputy Minister, Ministry of Health, Republic of Turkey

Professor Malek Bajbouj, Head of the Centre for Affective Neuroscience, Charité – Universitätsmedizin Berlin, Germany

Eliana Barragan, Migration Health Programme Officer, Migration Health Division, International Organization for Migration, Geneva, Switzerland

Ioannis Baskozos, Secretary General for Public Health, Greece

Professor Kayvan Bozorgmehr, School of Public Health, Bielefeld University, Bielefeld and Head of the Social Determinants, Equity and Migration Research Group, Heidelberg University Hospital, Heidelberg, Germany

Alfred Bridi, Content and Outreach Advisor, Analysis Department, Médecins Sans Frontières Operational Centre of Brussels, Belgium

Katarina Carlzén, Director, Partnership Skåne and Project Leader, MILSA, County Administrative Board of Skåne, Sweden

Poonam Dhavan, Senior Migration Health Policy Advisor, Migration Health Division, International Organization for Migration, Geneva, Switzerland

Cetin Dikmen, National Professional Officer, WHO Country Office in Turkey

Professor Julio Frenk, President of the University of Miami, United States of America and former Minister of Health of Mexico

Professor Charmaine Gauci, Superintendant of Public Health, Department for Health Regulation, Ministry for Health, Malta

Octavio Gómez-Dantés, Senior Researcher, Center for Health Systems Research, National Institute of Public Health, Mexico

Kia Goolesorkhi, Senior Lecturer, Department of Operational Medicine, University of Pécs Medical School, Pécs, Hungary

Zsuzsanna Jakab, Deputy Director-General and Regional Director, WHO Regional Office for Europe

Zoltan Katz, Department of Operational Medicine, University of Pécs Medical School, Pécs, Hungary

Afshan Khan, Regional Director, Europe and Central Asia and Special Coordinator, Refugee and Migrant Response in Europe, United Nations Children's Fund, Geneva, Switzerland

Fatima Khan, External Relations Officer, WHO headquarters

Michele LeVoy, Director, Platform for International Cooperation on Undocumented Migrants, Brussels, Belgium

Allen G. K. Maina, Senior Public Health Officer, Office of the United Nations High Commissioner for Refugees, Geneva, Switzerland

Erika Marek, Senior Lecturer, University of Pécs Medical School, Pécs, Hungary

Julio Cesar Mercado, Minister, Director for North America, Ministry of Foreign Affairs and Worship, Argentina

Ioannis Micropoulos, National Professional Officer, WHO Country Office in Greece

Ministry of Health of Jordan with the support of the WHO Country Office in Jordan

Dorit Nitzan, Coordinator, Health Emergencies and Programme and Area Manager, Emergency Operations, WHO Regional Office for Europe

Pia Oberoi, Advisor on Migration and Human Rights, Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland

Victor Stefan Olsavszky, WHO Representative to Bosnia and Herzegovina

Miriam Orcutt, Coordinator, UCL–Lancet Commission for Migration and Health, Institute for Global Health, University College London, London, United Kingdom

Aurélie Ponthieu, Coordinator of the Forced Migration Team, Médecins Sans Frontières Operational Centre of Brussels, Belgium

Natalia Popova, Labour Economist, Labour Migration Branch, International Labour Organization, Geneva, Switzerland

Professor Oliver Razum, Department of Epidemiology and International Public Health School of Public Health, Bielefeld University, Bielefeld, Germany

Elena Sánchez-Montijano, Senior Research Fellow, Barcelona Centre for International Affairs, Barcelona, Spain

Professor Joachim Seybold, Deputy Medical Director of Charité – Universitätsmedizin Berlin and Coordinator of the Programme for the Medical Care of Refugees in the City of Berlin, Germany

Alyna C Smith, Advocacy Officer, Platform for International Cooperation on Undocumented Migrants, Brussels, Belgium

Professor Tit. Istvan Szilard, Chief Scientific Adviser, Co-head of WHO Collaborating Centre for Migration Health Training and Research, University of Pécs Medical School, Pécs, Hungary

Adam Tiliouine, Technical Officer, Governance for Health, Division of Policy and Governance for Health and Well-being, WHO Regional Office for Europe

Pavel Ursu, WHO Representative to Turkey

Elisabeth Waagensen, Migration and Health, Office of the Regional Director, WHO Regional Office for Europe.

Jacqueline Weekers, Director, Migration Health Division, International Organization for Migration, Geneva, Switzerland

Kolitha Wickramage, Global Migration Health Research and Epidemiology Coordinator, International Organization for Migration, Geneva, Switzerland

Hope Witmer, Department of Urban Studies, Malmö University, Sweden

Slobodan Zdravkovic, Department of Care Science, Faculty of Health and Society, Malmö University, Sweden

Dominik Zenner, Senior Regional Migration Health Adviser, Migration Health Division, Regional Office for the European Economic Area, the European Union and NATO, International Organization for Migration, Brussels, Belgium

Foreword

Health diplomacy has had a key role in facilitating international actions for health for over 150 years, since countries began to cooperate on health-related matters and started to engage in a coordinated and cooperative manner, not only to deal with common threats to human health but also to address the many factors that determine health.

In the light of the resolution, Health in foreign policy and development cooperation: public health is global health, approved by the 60th session of the WHO Regional Committee for Europe in 2010, WHO has partnered with academic institutions such as the Global Health Centre at the Graduate Institute in Geneva to contribute to strengthening the capacity of diplomats and health officials in global health diplomacy with a wide range of supporting courses and books. As a result of this strong collaboration, the WHO Regional Office for Europe published Health Diplomacy: European Perspectives in 2017, which included case studies tailored to the European situation to strengthen the consistency of education.

Because the increasing global attention on migration-related issues has created yet more demand for skilled health diplomats, two years later the WHO Regional Office for Europe's Migration and Health programme is publishing the first book of its kind to reflect the increasing attention to the links between migration, health diplomacy and cross-cutting fields of international relations.

Health issues related to population movement have been on the WHO agenda for many years, particularly in the WHO European Region. The health sector is central in responding to the short- and long-term public health challenges of migration and the need to develop adequate preparedness, response and capacity within a framework of cooperation, humanity and solidarity. However, the health sector alone cannot ensure high-quality care for refugees and migrants, which requires addressing cross-cutting social determinants of health governed by other sectors, such as education, employment, social security and housing.

All of these sectors have a considerable impact on the health of refugees and migrants: on the one hand, the health sector can help to build relationships between all relevant sectors and can act as an entry point for reaching agreements; on the other hand, diplomacy helps to create the alliances needed to achieve health outcomes. The current approach to health diplomacy strongly takes into account this intersectoral approach. Governments have a better understanding of the role of multiple determinants of health and the need for a multisectoral involvement to achieve better health and well-being for all, leaving no one behind. As this book shows, such broad approaches are essential in tackling public health issues related to migration and for addressing the health of refugees and migrants.

WHO is the leading health-specialized agency within the United Nations system to coordinate the health sector's response, set health agendas, adopt strategies and coordinate international health support. It can provide support to Member States and partners in promoting the health of refugees and migrants, as outlined in World Health Assembly resolution WHA70.15, Promoting the health of refugees and migrants.

In order to ensure that health systems of countries are adequately prepared to meet the health needs and rights of refugees and migrants, strong cooperation between different sectors and different countries is needed. We took a step towards this in September 2016 with the adoption of the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region, founded on a spirit of international and interagency cooperation and developed in close consultation with United Nations agencies and other international organizations.

WHO's commitment to the health of refugees and migrants was recognized by WHO Member States in the Thirteen General Programme of Work, which provides the WHO's high-level strategic vision for the period 2019–2023.

During recent years, countries have worked together to agree on instruments and mechanisms to take the health of refugees and migrants forward as a common goal through resolutions, regional action plans and international frameworks. In 2018–2019, two crucial global negotiations relating to international migration took place, both involving WHO: the Global Compact for Safe, Orderly and Regular Migration and Promoting the Health of Refugees and Migrants: Draft Global Action Plan 2019–2023. No progress could have

been achieved in either case without skilled health diplomats, who negotiated for health in the face of the interests of other sectors and of other global stakeholders and in an arena where technical and political issues intersect. Often the security of nations and protection of sovereignty clash with the need for collective action to protect the right to health for all.

I believe this book may be used as a tool by public health professionals and diplomats to learn diplomatic strategies and successful practices through which governments, non-state actors and international and nongovernmental organizations attempt to address the complexity of migration and to ensure that the health of refugees and migrants will be placed high on the political agenda for the years to come.

Dr Zsuzsanna Jakab
WHO Deputy Director-General
and WHO Regional Director
for Europe

There is no #HealthForAll as long as people are left behind. Today we joined forces with @UNmigration by signing an MoU[1] to promote and improve #MigrantsHealth. Thank you my brother António Vitorino, @IOMchief, for working with us for a healthier, fairer and safer world.

Dr Tedros Adhanom Ghebreyesus
Director-General of the
World Health Organization

[1] MoU: memorandum of understanding.

Abbreviations

ASEAN	Association of Southeast Asian Nations
BiH	Bosnia and Herzegovina
BLMA	bilateral labour migration agreement
DOTS	directly observed treatment, short-course (for tuberculosis)
EU	European Union
EUPHA	European Public Health Association
FBiH	Federation of Bosnia and Herzegovina
GCM	Global Compact for Safe, Orderly and Regular Migration (also referred to as the Global Compact for Migration)
GCR	Global Compact on Refugees
ILO	International Labour Organization
IOM	International Organization for Migration
MMR	measles, mumps, and rubella (vaccine)
MSF	Médecins Sans Frontières
NCD	noncommunicable disease
NGO	nongovernmental organization
OHCHR	Office of the United Nations High Commissioner for Human Rights
PHILOS	Emergency Health Response to Refugee Crisis programme (Greece)
PICUM	Platform for International Cooperation on Undocumented Migrants
SDG	Sustainable Development Goal
TB	tuberculosis
UHC	universal health coverage
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund

Reading guidance

Although their treatment is governed by separate legal frameworks, refugees and migrants are entitled to the same universal human rights and fundamental freedoms as other people. Refugees and migrants also face many common challenges and share similar vulnerabilities *(1)*.

The WHO Regional Office for Europe has had an important role in promoting joint actions by Member States. The adoption of the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region *(2)* has contributed to the development of the global WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants *(3)*, and to the Global Action Plan on Promoting the Health of Refugees and Migrants, which was noted by the World Health Assembly in May 2019 *(4)*.

The work of WHO focuses on achieving universal health coverage (UHC) and the highest attainable standard of health, as mandated in its Constitution, for refugees, migrants and host populations within the context of WHO's Thirteenth General Programme of Work, 2019–2023 *(5)*.

This book uses the definition of **refugee** contained in the 1951 Convention relating to the Status of Refugees and its 1967 Protocol (Article 1 stating that "For the purposes of present Convention, the term 'refugee' shall apply to any person who… owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it") *(6)*.

There is no universally accepted definition of the term **migrant**. "Migrants may be granted a different legal status in the country of their stay, which may have different interpretations regarding entitlement and access to essential health care services within a given national legislation, yet under international law such access remains universal for all in line with the 2030 Agenda for

Sustainable Development, in particular with Sustainable Development Goal 3 (ensure healthy lives and promote well-being for all at all ages)" *(4,7)*.

Public health circumstances and obstacles that affect refugees and migrants are specific to both those populations and each phase of the migration and displacement cycle (before and during departure, travel, arrival at destination and possible return) *(8)*.

Nationality should never be a basis for determining access to health care; legal status (often) determines the level of access, as appropriate within national insurance schemes and health systems, without revoking the principle of UHC as set in international agreements *(4)*.

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Executive summary

Refugees and migrants are today the focus of intense political debate across the WHO European Region and worldwide. These debates increasingly generate polarization and politicization but shed precious little light on the evidence or do not focus on the substantive questions that demand answers. A better understanding of the economics of migration, its social impact and the associated political dynamics is urgently needed. The movement of people and health diplomacy are intrinsically linked. From the public health perspective, movement of refugees and migrants is a complex phenomenon of people with varying health profiles and backgrounds moving (often en masse) across the borders of countries, and usually in vulnerable and precarious circumstances. The relationship between population movement, health, foreign policy and diplomacy has long been acknowledged. Recently, the field of global health diplomacy has recognized refugee movements and migration as an issue deserving particular attention because of the necessity to protect the health of these mobile populations and of the hosting societies.

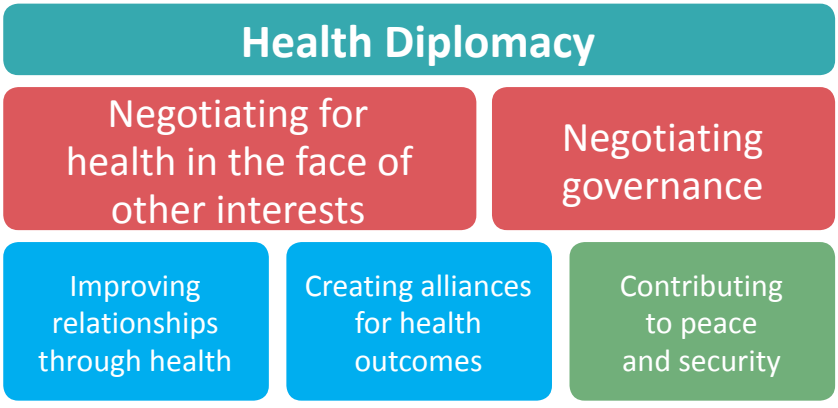
This book, Health Diplomacy: Spotlight on Refugees and Migrants, is, therefore, both crucial and timely. It builds upon the rich foundation of recent work undertaken by the WHO Regional Office for Europe intended to better equip Member States in addressing possible public health challenges presented by refugee movements and migration, and the role of health diplomacy in doing so. The book follows on from the 2017 Regional Office's publication Health Diplomacy: European Perspectives, which was the first of its kind in gathering experiences of health diplomacy from across the WHO European Region. This new book presents 25 chapters structured into five sections covering first general features and then global, regional, country and subnational perspectives. Eight chapters, highlighted with a coloured title (5, 6, 8, 11, 12, 14, 16 and 17), illustrate how migration-related health issues have been tackled by international organizations, nongovernmental organizations (NGOs), civil society organizations and academic institutions.

This book gathers perspectives from the previous decade of management of public health aspects of refugee movement and migration and of experiences and good practices by which governments and non-state actors, international

organizations and NGOs attempt to address the complexity of migration. It illustrates through selected examples how global health can be improved by approaches such as investing in collecting evidence, developing knowledge and country capacity, building partnerships, responding to the needs of mobile populations, and developing foreign policy solutions. These efforts can be coordinated and developed within the framework of the five dimensions of health diplomacy (Fig. ES.1): negotiating for health and well-being in the face of other interests; improving relations through health and well-being; creating alliances for health and well-being outcomes; negotiating governance for improved health and well-being; and contributing to peace and security.

The WHO Regional Office for Europe has been working to address refugee and migrant health needs since 2011 based on health as a fundamental human right. It has responded to the phenomenon of refugee movement and migration through its Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region, while using health diplomacy for developing concerted action among Member States. This unique experience is documented for the first time and presented from the perspective of the WHO Regional Director for Europe and the Regional Office's Migration and Health programme in Chapter 1. The chapter examines the process leading up to the

Fig. ES.1. The five dimensions of health diplomacy



Source: courtesy of Ilona Kickbusch, Global Health Centre, the Graduate Institute, Geneva, 2016.

adoption of the Strategy and Action Plan, including the role of Health 2020, the regional policy and strategy framework for health and well-being.

Responding to refugee movements and migration from the public health perspective requires sophisticated and comprehensive responses involving actors from across the whole of government and the whole of society. This needs to be supported by solid evidence, strong and credible technical assistance and a process of knowledge sharing and capacity-building. Health diplomacy is one governance tool that is crucial in this response. This is the premise in Chapter 2, where the authors explore the relationship between governance for health, multi- and intersectoral approaches to refugee and migrant health needs, and health diplomacy. They argue that health diplomacy is critical to facilitate the multi- and intersectoral responses necessary to address the public health challenges of refugee movements and migration. They also emphasize that issues of refugee movements and migration demonstrate that health diplomacy is increasingly needed as a skill set and mode of action in modern systems of governance where multi- and intersectoral actions are negotiated, designed and implemented.

The challenge of successful public health responses to refugee movements and migration is further complicated by the transnational nature of population movements, meaning that multilateral and multisectoral arrangements are crucial to ensure the health and well-being of refugees and migrants. Recent developments in the global governance landscape reflect the growing recognition of the need for a multilateral and concerted effort among countries, international organizations and partners in civil society and beyond. Chapter 3 examines the role of selected United Nations actors in the governance of the global migration system and its delivery for the health and well-being of refugees and migrants. The author provides a short overview of the interconnectedness of the different levels of governance. She argues that governance manages not only interdependence and complexity but also relationships and conflicting interests, and that health can be a connecting political force to drive a common agenda forward. This requires health diplomacy in order to improve health and well-being and also to improve relations, shared responsibilities and better governance structures.

Global governance for refugee and migrant health has been strengthened by the Global Compact for Safe, Orderly and Regular Migration (GCM, also

referred to as the Global Compact for Migration), the first intergovernmentally negotiated agreement prepared under the auspices of the United Nations. The negotiations around the GCM and the inclusion of health are explored in Chapter 4, where the authors demonstrate how experience in the WHO European Region enabled a successful outcome in the inclusion of health and well-being in the draft. Key roles were played by different United Nations agencies in the negotiation and adoption of the GCM and the Global Compact on Refugees (GCR). Chapter 5 outlines the experience of the International Organization for Migration (IOM) in the GCM process, while Chapter 6 describes the role of the Office of the United Nations High Commissioner for Refugees (UNHCR) in the negotiations for the GCR. Both these negotiations demonstrate the need and the opportunity to reaffirm the central role of multilateralism with strong interagency cooperation throughout the United Nations system in the implementation of global frameworks and the 2030 Agenda for Sustainable Development (2030 Agenda).

In addition to commitments at United Nations level, there are increasing numbers of commitments to action by countries in the framework of WHO, both regionally and globally. At the 66th session of the WHO Regional Committee for Europe in 2016, the 53 European Member States adopted the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region, as detailed in Chapter 1. On a global level, countries at the Seventieth World Health Assembly adopted a resolution to promote the health of refugees and migrants globally, which is explored in Chapter 9. The author argues that diplomatic skills with a strong technical background can make a significant difference when operating in a multilateral context, and that there is still a need for stronger links between the health and diplomatic arenas. Diplomatic services should make a greater allocation of resources to training in technical matters related to health and to the health and economic implications of decisions made in the international arena.

When considering the health of refugees and migrants, often it is the acute needs and challenges faced during unexpected large influxes of people during times of emergency or crisis that dominate perspectives and headlines. Chapter 13 demonstrates how adopting a public health approach with a sensitive political lens is critical to organize and implement effective responses. The importance of using the strengths of different actors, including the flexibility and speed offered by non-state actors, to support policy-makers

in meeting the immediate and acute needs of vulnerable people is shown in Chapter 14, which outlines the role of Médecins Sans Frontières (MSF) in interventions to protect people undertaking dangerous sea passages.

However, the health needs of refugees and migrants need to be seen much more broadly than in just emergency settings. In order to achieve the Sustainable Development Goals (SDGs) of the 2030 Agenda and meet global commitments on UHC, refugees and migrants cannot be left behind. Ensuring access to health systems throughout the different stages of migration and in accordance with needs across the life course is fundamental to delivering the right to health for refugees and migrants. Chapter 10 presents best practice examples on how to protect the health of people on the move.

It is these principles of upholding human rights, promoting the health of refugees and migrants, ensuring access to essential services under different and demanding contexts, and formulating tailored policies for specific health needs that are critical to meeting our commitments to the SDGs and UHC. Moreover, they are at the heart of equity, development, globalization, diplomacy and public health. Chapter 11 from the Office of the United Nations High Commissioner for Human Rights (OHCHR) presents the importance of promoting and protecting the human rights of refugees and migrants in vulnerable situations and Chapter 12 from the United Nations Children's Fund (UNICEF) addresses meeting the needs of refugee and migrant children.

Health diplomacy is a critical tool to uphold the values of solidarity, humanity and human rights and to facilitate equity-oriented dialogue and solutions for refugee and migrant health and well-being. Complex discussions between multiple actors at all administrative levels can be navigated through health diplomacy. Chapter 19 outlines the Greek experience of operationalizing these values and translating them into policy, demonstrating the crucial role of Greek foreign policy in its respect for human lives, dignity and equality in helping the country to organize and respond to the challenge of large numbers of refugees and migrants. In Chapter 18, the author illustrates how the commitment to ethical and humanitarian concerns led a country (Turkey) to overcome an unexpected and unprecedented challenge.

The use of health diplomacy as a tool to optimize resources allocated to the provision of accessible, culturally sensitive and quality health services to refugees and migrants is outlined in Chapter 20, where the authors reveal

how cooperation between the Ministry of Health and the WHO Country Office in Jordan facilitated access to essential health services for Syrian refugees. Innovation in service delivery and the need to move away from so-called business as usual is exemplified in Chapter 25, which explores the role of health diplomacy in delivering acute care, mental health care, medical screening and vaccination for refugees in Berlin.

Policy windows are important: Chapter 23 addresses how these windows of opportunity have a critical role to bring actors together to introduce reforms to benefit asylum seekers and refugees. Health diplomacy is crucial to facilitate common understanding among different actors and the public at large as well as for combating myths and fears, particularly in relation to communicable diseases. Chapter 21 explores how Malta used health diplomacy to secure a multisectoral approach for the control of communicable diseases.

However, securing the health and well-being of refugees and migrants cannot be achieved by countries and international organizations alone. The growing role of nontraditional actors in health diplomacy, such as civil society, is well documented, and this advocacy in the process of creating the Global Compacts was crucial. One such perspective from a civil society organization is presented in Chapter 7, where the authors describe the role of the Platform for International Cooperation on Undocumented Migrants (PICUM) in acting as a conduit for over 160 other organizations. The authors argue that given the highly politicized and complex nature of migration, the engagement of nongovernmental actors is indispensable. In addition to civil society, the work of academics must also be translated into messages for policy-makers and citizens alike, bringing nuance, evidence and humanity to the debate. This is explored further in Chapter 8 with the experience offered by the UCL–Lancet Commission on Migration and Health.

The role of non-state actors in promoting health equity and social inclusion is critical; however, they can be supported by regional knowledge and support structures. Chapter 24 illustrates how a partnership in Skåne, Sweden, used communication and collaboration between public sector, civil society and academia to strengthen understanding and cooperation and create better outcomes.

The rich experience in the WHO European Region is facilitating learning, and governments are starting to acknowledge that implementing public health

policies for refugees and migrants from a human rights perspective can be a unique entry point to generate political consensus to sensitive policies around refugees and migrants. The clear role of WHO in its convening function can support the navigation of complex political environments, and this is illustrated in Chapter 22, using the example of Bosnia and Herzegovina (BiH).

Finally, the complexity of population movements and the specificity of the health and well-being of refugees and migrants bring challenges to already existing pressures and demands on the health workforce. This is a two-sided challenge: training and professional skill building need to be provided to enable the workforce to respond to refugee and migrant needs and they are also needed to leverage the skills and experience of migrant workers, thus reducing pressures on the health workforce. These are crucial challenges for health diplomacy: Chapter 15 illustrates a successful outcome for skills recognition and accreditation for migrant workers in the health sector; Chapter 16 explores the provision of training in migrant-sensitive health-care systems in Hungary; and Chapter 17 demonstrates how health workforce policies should be part of a holistic policy approach to integrate refugees and migrants.

In conclusion, refugee and migrant health has become a specific and politicized area of health diplomacy, where political forces representing the benefits of globalization and human movement are seen on one hand and the sovereign nature of nation states and refugee- and migration-related challenges are seen on the other. In this political infighting, public health and humanitarian considerations may be undermined, as well as the evidence that underpins value-based health policies. This book is intended to increase awareness that health diplomacy skills are critical at all levels of the system for building and fostering an understanding of the potential health and public health impact at domestic level and of transnational events and actions. This will strengthen the health literacy of national institutions and policy-makers and reinforce global health diplomacy for better refugee and migrant health.

1. Introduction

1. The WHO European Region's response to refugee and migrant health needs in the 21st century

Zsuzsanna Jakab, Santino Severoni and Mihály Kökény

Challenges need a solid public health approach

People are moving within and between countries and within and between continents at a rate that demands appropriate attention, with a modern governance approach involving all government sectors and able to address the human right to health and deliver the principles of UHC and equity. This requires development of adequate capacity, preparation and response from all levels of government and society, supported by robust evidence. Health diplomacy has been crucial in the many achievements observed for these issues and has been characterized by great political sensitivity and often a polarizing political debate. Health diplomacy has allowed multisectoral challenges to be confronted during discussions on refugee and migrant health within the international community. Some of the challenges that need to be addressed when considering the health of refugees and migrants are outlined below.

Multi- and intersectoral approaches. Ministries of health are not necessarily directly involved in decision-making around migration

policies and measures. The public health implications of migration are still widely considered a so-called side-effect of population mobility, requiring ad hoc health interventions when needed. Therefore, the public health perspective may be lost or subordinated to law enforcement considerations. Governments have the responsibility to involve the health sector in elaborating and implementing their migration strategies. Intercountry collaboration is equally important to ensure disease prevention and to provide the capacity for responses to public health threats that might be associated with population movements, as clearly indicated by WHO's International Health Regulations in 2005 *(1)*. This is all the more significant because vested sectoral interests, the predominance of vertical structures and the lack of susceptibility or commitment towards horizontal governance mechanisms often prevent efficient intersectoral cooperation in most Member States.

Understanding the health impact of migration. Mass and sudden movements of people may affect (i) the health of the people who move, (ii) the health of those they come into contact with in transit and destination countries, and (iii) the health systems of the receiving nations. Evidence of poor health among refugees and migrants is generally confined to certain infectious diseases and conditions associated with maternity, with some data indicating increased rates of infant mortality *(2)*. The prevalence and proportion of infectious diseases such as tuberculosis (TB) and HIV/AIDS vary among Member States in the WHO European Region, depending on the migratory pattern and the domestic prevalence rates. In addition, the conditions in the country of origin of the refugees and migrants, the way they travelled and their circumstances after arrival can vary widely and influence their health status. For example, TB has frequently been associated with people moving from poor socioeconomic backgrounds; however, there is growing evidence that a proportion of the new cases reported well after arrival in host countries result from poor housing conditions and poor overall quality of life after resettlement for many low-income migrants *(2)*. Although research data differ considerably, the risk of noncommunicable disease (NCD) increases in proportion to the duration spent in the host country, although the risk of mental disorders is significant at all stages of the migration process *(2)*. More data are needed

not only to inform policy and set realistic priorities but also to address public anxieties and concerns.

Access to care. Some groups of refugees and migrants can only access emergency health-care services in transit and receiving countries, although there is a huge variation among the Member States of the WHO European Region. Lack of access to care can have an unacceptably high impact on the burden of ill health for the individual and the health system, for example, if immunizations, caesarean sections and treatment for pneumonia are denied. Providing preventive care for those who do not have full legal status – as opposed to waiting until a condition must be treated as an emergency – not only improves people's health but could also save money. The European Union Agency for Fundamental Rights studied this in the settings of Germany, Greece and Sweden *(3)*. The study concluded that providing regular care for hypertension could save about 9% in a year and 13% over five years and helped to prevent more than 300 strokes and more than 200 heart attacks per 1000 migrants in each country over their lifetime *(3)*. In addition, WHO cannot achieve SDG 3.8 on UHC *(4)* or the target of 1 billion more people benefiting from UHC, as outlined in WHO's Thirteenth General Programme of Work 2019–2023 *(5)*, unless the health needs of all vulnerable groups including refugees and migrants are met. The access of refugees and migrants to quality health services is of paramount importance to rights-based health systems, global health security and public efforts aimed at reducing health inequities *(6)*. Evidence has confirmed that appropriate access of refugees and migrants to health services, including public health such as vaccination, would also serve the health of the resident population *(2)*.

Sensitive care for refugees and migrants. Provision of sensitive care means that health systems must be susceptible to the needs of refugees and migrants: services should be available in the right language and pay attention to priority health problems, including reproductive and child health, mental illnesses and injuries.

Responsible communication. There are several dimensions to effective communication. In terms of host communities, the lack of accurate information leads to possible tensions among people living with large

groups of refugees and migrants. For example, there is a common anxiety that migration brings infectious diseases. While vigilance should always be maintained, evidence indicates that there is no systematic association *(7)*. Carefully planned public communication is crucial to minimize hostile reactions. Equally, it is important to ensure effective communication with refugees and migrants within communities because they may not find mainstream communication methods easy to access.

Working more closely with the local level. Competencies for service provision, and for receiving refugees and migrants, are often split between the national and the subnational levels. Consequently, it is important that governance for health and well-being within countries ensures coherence between different levels of government and integrates the local level – which feels the impact of increased migration most vividly in its services and communities – into decision-making processes and strategies regarding responses to large influxes of refugees and migrants. Engagement of migrant communities may be an advantage in this process.

Alignment of WHO European Member States for joint work. Since refugee and migrant populations are primarily rights holders under international human rights laws, one of the action areas of health diplomacy remains to protect and improve their health within a framework of humanity and solidarity and without prejudice to the effectiveness of health care provided to the host population. In addition, health diplomacy contributes to overcoming single-country solutions and achieving a coherent and consolidated national and international response to protect lives.

Role of the Regional Office in promoting joint action. The WHO Regional Office for Europe has had an important role in promoting joint actions by Member States. In 2016, the WHO Regional Committee for Europe adopted the Strategy and Action Plan for Refugee and Migrant Health *(8)*. This contributed to the development of the global WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants *(9)*, which was endorsed by the World Health Assembly in resolution WHA70.15 in 2017, and to the Global Action Plan on Promoting the Health of Refugees and Migrants, which was noted by the World Health Assembly in May 2019 *(10)*.

Antecedents: WHO commitment to work towards the health of refugees and migrants

Looking back at the then landmark resolution of the World Health Assembly in 2008 entitled Health of migrants (WHA61.17) *(11)*, it appears that the proposed actions in the Global Action Plan on Promoting the Health of Refugees and Migrants in 2019 *(10)* are almost the same as they were then. Health policies that are sensitive to the issues faced by refugees and migrants, the role of health in promoting social inclusion and the appropriate training of health professionals are equally on the agenda today as they were in 2008. However, in 2008, the WHO European Region had yet to face so many migration-related challenges.

In the intervening period, worsening of conflicts and the subsequent effect on economic and living conditions in affected countries, and the effects of climate change, have triggered tides of migration towards Europe's high-income countries. International organizations, including WHO, met a new phenomenon: multilateral diplomacy and transformative approaches are being challenged by nationalist/populist rhetoric about refugees and migrants. WHO has been challenged to keep its standpoint on refugee and migrant health based on public health evidence, solidarity and respect for human rights in this demanding political climate.

This was made easier by the fact that, in 2010, the WHO Regional Office for Europe received a clear mandate from Member States to work closely with foreign ministries to assist health ministries in establishing policy links and to consider the health diplomacy implications of refugee and migrant health, which was by then one of the top health agendas for the Region. The resolution entitled Health in foreign policy and development cooperation: public health is global health *(12)* was approved by the 60th session of the WHO Regional Committee for Europe in 2010. It opened up channels to improve the integration of global health in foreign policy and development cooperation throughout the WHO European Region, which proved to be an important prerequisite for interpreting migration and health in a broader context.

With regard to the principles of WHO's migration and health policy, it is worth highlighting three visionary documents: Health 2020, the European health policy framework for the WHO European Region in 2012 *(13)*, and, globally, the 2030 Agenda for Sustainable Development in 2015 *(4)* and WHO's Thirteenth General Programme of Work in 2018 *(5)*.

Health 2020 was adopted by all 53 WHO European Member States at the 62nd session of the WHO Regional Committee in 2012. It introduced the whole-of-government approach in addressing the comprehensive health problems of our age and provided a focus on promoting equity in order to improve health and well-being for all people. Health 2020, therefore, provided the foundation for WHO's response to the changing health concerns of refugees and migrants. Global developments since then have emphasized WHO's organizational commitment to UHC, improving health and well-being for all and reducing inequalities within and between countries. These goals are entrenched now not only with Health 2020 at the level of the WHO European Region but also at global level in the 2030 Agenda *(4)* and in WHO's Thirteenth General Programme of Work 2019–2023 *(5)*. Striving for and delivering improved health and well-being outcomes for refugees and migrants are fundamental elements of achieving the goals outlined in these important documents. These guidelines convey the firm conviction that there can be no public health without refugee and migrant health.

Developing a model-value project on migration and health in the WHO European Region

Since 2012, the WHO Regional Office for Europe has taken a leading role in assisting Member States in promoting and protecting the health of refugees and migrants, successfully identifying opportunities, initiating research, collecting evidence and achieving strong political influence. There have been a number of achievements.

In 2012, the Regional Office established the Public Health Aspects of Migration in Europe (PHAME) project (now the Migration and Health programme), the

first fully fledged WHO programme on migration. Since then, the programme has provided continuous support for ministries of health. Health system assessment missions have been conducted in several countries. The Regional Office has provided support and policy advice on contingency planning, technical assistance and guidance, public information and communication tools, medical supplies, and training modules on refugee and migrant health for health and nonhealth professionals. A collaborating centre on migration and health has been set up at Pécs University, Hungary.

A Knowledge Hub on Health and Migration was established in 2016 as a joint effort between the WHO Regional Office, the Ministry of Health of Italy, the Regional Health Council of Sicily and the European Commission *(14)*. Three successful summer schools on refugee and migrant health were conducted in 2017, 2018 and 2019. The first two were in collaboration with the European Commission, the European Public Health Association (EUPHA), IOM and the Italian National Institute for Health, Migration and Poverty and supported by the Italian Ministry of Health and the Sicily Regional Health Authority. The 2019 school was in collaboration with EUPHA and IOM and supported by the Ministry of Health of Turkey.

In December 2018, the Regional Office published a report on the health of refugees and migrants in the Region *(2)*. This report was the first of its kind, aiming to support evidence-informed policy-making to meet the health needs of both refugee and migrant populations and host populations. As a result, the Regional Office has been at the forefront of thinking and practice concerning refugee and migrant health. Based on this rich and timely experience, the Regional Office was able to respond quickly and effectively to the inflow of record numbers of refugees and migrants in 2015. It seized the window of opportunity to take action in promoting public health considerations.

This emphasis on public health considerations was even more necessary because security concerns had started to dominate the diplomatic discourse over societal viewpoints regarding the needs and priorities facing public administrations in managing and responding to the influxes of refugees and migrants. It also explained why a call was made in early September 2015 for Member States to avoid being misled by false rhetoric: “While we should remain vigilant, this should not be our main focus. We should focus on ensuring that each and every person on the move has full access to a hospitable environment and, when needed, to high-quality health care,

without discrimination on the basis of gender, age, religion, nationality or race" *(7)*.

During the 65th session of the WHO Regional Committee for Europe in 2015, an informal ministerial discussion was convened that requested Member States to implement public health policies giving refugees and migrants access to a broad range of health services, including those for prevention and care, which would also benefit the wider population. In addition, it was agreed that a high-level meeting on refugee and migrant health was needed as soon as possible. In an unprecedented diplomatic achievement by all involved, the meeting took place in Rome, Italy, in November 2015 just two months after the proposal had been made.

In Rome, Member States from the European, Eastern Mediterranean and African Regions considered the legal, definitional and public health challenges involved in migration, and jointly encouraged WHO to prepare a common framework for coordinated collaboration and action on refugee and migrant health. Participants gathered from over 35 countries understood that debates on refugee and migrant health should not be left to those who would exploit public anxiety for political advantage. Public health arguments allowed Member States to move from political discussions to actions focused on delivering an inclusive public health approach. Dedicated approaches within health diplomacy led to the politically strong outcome document that emerged from the meeting *(15)*.

Commitments made in Rome served as an overture for a lengthy consultative process in elaborating documents for the 66th session of the WHO Regional Committee for Europe (2016). There delegates adopted the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region *(8)*, which has since been a guide to migration and health at the national, regional and global levels. The nine strategic priority areas in this Strategy and Action Plan cover activities that are required for a fair and human approach:

- establishing a framework for collaborative action
- advocating for the right to health of refugees, asylum seekers and migrants
- addressing the social determinants of health
- achieving public health preparedness and ensuring an effective response
- strengthening health systems and their resilience
- preventing communicable diseases

- preventing and reducing the risks posed by NCDs
- ensuring ethical and effective health screening and assessment
- improving health information and communication.

Each priority area is supported by WHO and Member State commitments. Accountability is promoted by a series of indicators and a process of regular review.

The WHO Regional Office for Europe created the Knowledge Hub on Health and Migration to facilitate the implementation of the European commitments. The Knowledge Hub is committed to supporting the building of expertise and competency on the public health aspects of migration and to ensuring that knowledge and information in this area are widely available. The Knowledge Hub offers a platform for governments, programme implementers, academicians and researchers, international organizations, NGOs and civil society to build upon the available evidence. It creates a platform for dialogue and critical thinking on this complex and interdisciplinary field. The platform works across five priority activities: strengthening the evidence available on migration and health, provision of a webinar series, a yearly summer school for sharing science-based and evidence-informed interventions, policy dialogues, and high-level summits. In terms of technical assistance, the Regional Office sends consultants to Member States to assist in the development of contingency plans and it develops technical guidance on key urgent issues *(14)*.

Endeavours at a global level

The pioneering work of the WHO Regional Office for Europe, driven by the strong voice of some European Member States, served as an example for WHO globally, but it was difficult to find the appropriate wording for a new global document. The whole debate – spoken and unspoken – around the so-called migrant crisis is a mismatch between perceptions and current evidence: the migrant crisis is not a crisis of numbers but rather it is a crisis of governance and of policies not keeping pace with current challenges *(16)*. After exhaustive drafting work led by Argentina, the World Health Assembly adopted resolution WHA70.15, Promoting the health of refugees and migrants in May 2017 *(9)*.

It urged WHO's 194 Member States to strengthen international cooperation on the health of refugees and migrants in line with paragraphs 11 and 68, and other relevant paragraphs, of the New York Declaration for Refugees and Migrants *(17)*. The resolution also requested countries to consider providing the necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants. In addition, it inspired Member States to use the annexed framework of priorities and guiding principles to promote the health of refugees and migrants at all levels.

This latter recommendation was appropriately referred to in both the GCM *(18)* and the GCR *(19)*, both of which were recently adopted by the United Nations General Assembly. These Compacts are important attempts to strengthen the governance system for refugees and migrants. However, they rely on states adopting and implementing them and creating coherent strategies to do so effectively, which requires bringing refugee and migrant health into the mainstream of national health *(20)*.

Promoting the Health of Refugees and Migrants: the Global Action Plan 2019–2023 *(10)*, noted by the World Health Assembly in May 2019, has six priorities, which include promoting refugee and migrant health through short- and long-term public health interventions and countering misperceptions about their health. After lengthy debate, which reflected the changed political landscape and the often emotionally charged anti-migrant issues that surround the current migration situation, Member States only "noted" the plan, the preparation of which was called for in a resolution at the 2017 World Health Assembly. They agreed to report progress on a voluntary base. This outcome was the only acceptable way for some countries that did not feel ready to accept any obligations from the Action Plan at that moment.

Forecast and conclusions

Cautious forecasting suggests it may be likely that, in spite of the currently declining trends, migration will remain a major social, political and public

health challenge for the WHO European Region. Eventually, policy-makers will be compelled to develop sustainable, specific and coherent policies addressing the health needs of refugees and migrants, in full accordance with the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region *(8)*. So far, over half of European Member States have developed an explicit component on migration and health in their national and subnational health policies and strategies *(2)*.

The lessons in migrant health since the landmark resolution of the World Health Assembly in 2008 suggest that the challenge is to negotiate for health in the face of other strong interests at the national and international levels. There is increasing need for intersections of health with many different sectors, and for tools and methods to facilitate this. The response required includes the orchestration of regional and national policy solutions in the WHO European Region that place the health and well-being of all at their centre and ensure the equal treatment of refugees and migrants from a health perspective. A sound base in public health evidence is essential for health diplomacy within such a highly politically charged issue. The recently published reports from the WHO Regional Office for Europe and the UCL–Lancet Commission on Migration and Health *(21)* provide a thorough analysis of how scientific evidence can contribute to synergistic and equitable health, social and economic policies, and for feasible strategies to inform and inspire action by refugees and migrants, policy-makers and civil society.

In conclusion, human migration is a phenomenon that has occurred for centuries and, realistically, is unlikely to end or to be impeded by state borders. That said, it can and is used as a handle for nationalists, nativists and politicians to advance their political interests and power. Wiser shapers of public opinion would and do consider the beneficial effects of migration and acknowledge that this feature of globalization can be a key driver of economic and social prosperity, bringing with it new ideas and an energetic, innovative and highly motivated workforce. This is as true for the WHO European Region as it is globally. In this context, investing in migrant health is an investment for the future, and health diplomacy will be crucial in ensuring that this investment is both effective and sustainable.

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2. Multi- and intersectoral action for the health and well-being of refugees and migrants: health diplomacy as a tool of governance

Monika Kosinska and Adam Tiliouine

Introduction

Population movement, including forced migration, is a complex public health challenge that might require multistakeholder and multisectoral responses. Successfully addressing migration and health engages a variety of non-state and government actors, including home and foreign affairs, justice, labour, social affairs, education and health; the policies and interventions of these have implications across sectors *(1)*. Moreover, because of the different categories and subsequent legal statuses of individuals arriving in a country (labour migrants and their families, international students, internally displaced people, asylum seekers, refugees, unaccompanied minors, victims of human trafficking and other irregular migrants), there is often a disconnect between sectors (e.g. education, housing, justice and others) *(1)*. Crucially, it is the health sector that often has to deal with the most acute consequences

of a lack of multi- and intersectoral action, as the physical and mental health and well-being of individuals are negatively impacted by a failure to access and engage with the appropriate services, in particular in the health, social and educational sectors *(2)*. Adopting and implementing successful multi- and intersectoral responses and actions to ensuring health and well-being is, therefore, critical but equally complex; these actions are enabled by governance and facilitated by health diplomacy. This chapter looks at how health diplomacy can play a key role in strengthening governance for the health of refugees and migrants, including in governing multi- and intersectoral action.

The WHO European Region has many years of experience in documenting successful multi- and intersectoral approaches across different public health challenges, and this evidence and learning can provide rich lessons for policy-makers developing multisectoral approaches to ensure the health and well-being of migrating populations *(3)*. A number of key issues (Box 2.1) have been identified by countries in the Region as enabling factors influencing the success of multi- and intersectoral policies and approaches. Critical among these is political will or the political dimension – which is fundamental in the area of refugee and migrant health.

Recently, there has been greater emphasis on and a greater understanding of the critical role of governance in developing, implementing and sustaining multi- and intersectoral action. While at global level this has been brought to international attention through the adoption of the United Nations 2030 Agenda *(4)*, the WHO Regional Office for Europe has invested in developing systematic approaches to support countries in strengthening governance for health and well-being, and tools to assess and implement relevant approaches *(3,5–7)*.

WHO defines governance for health and well-being as the attempts of governments and other actors to "steer communities, whole countries or even groups of countries in the pursuit of health as integral to well-being through both whole-of-government and whole-of-society approaches" *(8)*. Governance for health and well-being is a central building block of good governance; it is guided by a values framework that includes health as a human right, a global public good, a component of well-being and a matter of social justice *(8)*.

Box 2.1. Enabling and facilitating factors for implementing multi- and intersectoral action for health and well-being

- High-level political support and commitment for multi- and intersectoral action
- Focus on the long-term outcomes and policy changes
- Existence of a clear mandate
- High-quality evidence and information for policy planning and monitoring
- Adequate financial and human resources for implementation
- Competence of the health sector to reach out to other sectors
- Cross-sectoral relationships based on trust and a shared understanding of the problem
- Clear objectives and identified co-benefits among partners
- Engagement of the civil society
- Public pressure
- Media support and involvement.

Source: WHO Regional Office for Europe, 2018 *(3)*.

The expanded understanding of health includes considering health as an emerging property of many societal systems; it, therefore, requires action in many systems, sometimes with and sometimes without the involvement of the health sector. Whole-of-government and whole-of-society approaches reflect this reality and are grounded in strategies that enhance joined-up government, improved coordination and integration, and diffusion of responsibility for health throughout government and society.

Governance for health builds on experiences gained in the health arena with intersectoral action, healthy public policy and Health in All Policies.

Whole-of-society, whole-of-government and Health in All Policies approaches require systematic multi- and intersectoral governance structures and processes that can facilitate and support the requisite action. This moves beyond the policy cycle and includes mechanisms for coherence and accountability, enabling regulatory and legal frameworks, and instruments for financing and joint action, as well as improved capacity both within and beyond government actors.

The instruments and mechanisms for governance are broken down and elaborated in Box 2.2. It is these instruments and mechanisms that are the tools at the disposal of countries for governing, and they can be used separately or in conjunction with each other. Many of these instruments and mechanisms are dependent on others in order to function or to operate (e.g. public sector financing mechanisms require legal mandates).

Crucially, there is a key role for health diplomacy as an important set of skills to support the instruments of governance, navigate political complexity and act as a bridge between different sectors. This will strengthen governance and facilitate multi- and intersectoral action to improve health and well-being *(9)*. While this is relevant to all the complex public health challenges of the 21st century, the specific complexity of migration, and the enhanced political dimension of the issue, renders both health diplomacy and governance for health of particular importance because the traditional instruments of governance may be absent or not usable for political reasons. Consequently, in the area of refugee and migrant health, health diplomacy may be considered a key instrument – or mode – of governance in its own right, as it can steer "communities, whole countries or even groups of countries in the pursuit of health as integral to well-being [of refugees and migrant] through both whole-of-government and whole-of-society approaches" *(8)*.

Box 2.2. Instruments and mechanisms to govern for health and well-being

Policy. Strengthen the existing public health institutions and the essential public health operations and processes that contribute to sustainable development. Integrate health and well-being, and their determinants, with SDGs in national development strategies and roadmaps.

Structural. Create permanent intersectoral structures such as mega-ministries or interministerial committees.

Legal. Implement and strengthen legal and regulatory frameworks, public policies and strategies in sectors outside health that tackle shared risk factors (e.g. exposure to air pollution) or unhealthy commodities (e.g. alcohol, drugs and tobacco).

Financial. Use financial mechanisms (e.g. voluntary budget pooling, delegated financing, longer-term investments) and other incentives to stimulate intersectoral activity. Support financial strategies through enabling legislation and regulation by allowing the sharing of budgets between agencies and ensuring accountability for funds received.

Technical. Promote the use of health impact assessments and fortified guidelines, norms and standards for public health across sectors.

Political. Create clear leadership and accountability for public health with the engagement of the head of government and with parliamentary legitimacy. Aim to develop strong, well-resourced and fit-for-purpose public health frameworks, supported by clear institutional bases and adequate human resources and capacities.

Source: WHO Regional Office for Europe, 2018 *(5)*.

Challenges for using health diplomacy to govern for refugee and migrant health

There are two main challenges when conducting health diplomacy in the context of strengthening multi- and intersectoral approaches and improving governance for refugee and migrant health and well-being. The first challenge is in facilitating the understanding of the "what", in the context of what needs to be done and by whom. The second challenge is in negotiating for the "how" in the context of how to create processes, establish mechanisms and develop instruments that contribute to improved refugee and migrant health and well-being. Health diplomacy is critical in both facilitating an understanding of what needs to be done among the different stakeholders and actors and in negotiating how to do it.

Three discrete but mutually reinforcing and interlinked concepts can be identified: multi- and intersectoral action, health diplomacy, and governance for health and well-being (Fig. 2.1). The relationship between these – specifically how governance enables and health diplomacy facilitates the multi- and intersectoral responses necessary to the public health challenge of population movement – presents an opportunity to support the development of systematic approaches to strengthening action across the migration cycle, at different levels of governance, and in the context of the complex and diverse partnerships within and beyond the public sector.

Although existing academic literature explores in detail each of these concepts separately, the relationship between all three has not been examined. These concepts and their respective relationships are visualized in Fig. 2.1 as overlapping areas that can be categorized as discrete but related sets of actions:

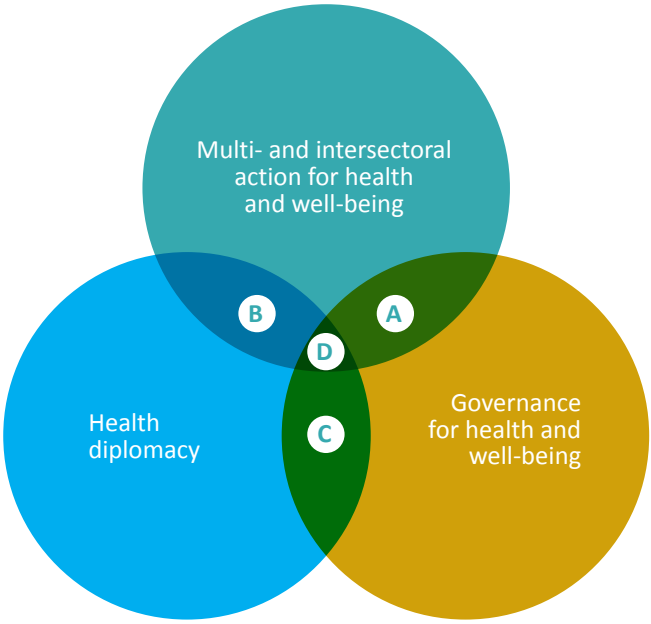
Action A. Governing multi- and intersectoral action for health and well-being

Action B. Negotiating multi- and intersectoral action for health and well-being

Action C. Negotiating governance for health and well-being

Action D. Using diplomacy to govern multi- and intersectoral action for health and well-being.

Fig. 2.1. Interconnection between health diplomacy, governance and multi- and intersectoral action for health and well-being



Considering these areas as discrete sets of actions allows a better understanding of how to manage and respond to issues such as refugee and migrant health. Such an approach can support countries in identifying where there are gaps and opportunities for greater health diplomacy in their responses and provides for concrete entry points. This chapter considers these four set of actions and aims to explore and demonstrate that effectively responding to the challenge of migration from a public health perspective means understanding, strengthening and combining the actions, skills and relationships needed *(1,9)*. The chapter also explores the relationship between these concepts when applied to refugee and migrant health: it examines the refugee movement and migration process, and it provides example actions by different sectors at each stage and the health diplomacy elements. The aim is to demonstrate that health diplomacy in all its dimensions is critical to facilitate the multi- and intersectoral responses necessary to address

the public health challenge of population movements. It is also essential to provide an increasingly needed skill set and mode of action in modern governance systems in which multi- and intersectoral actions are negotiated, designed and implemented.

The changing role of health diplomacy

Although traditional diplomatic relations are still predominant in the global governance arena, new actors with real-time information – whether global civil society activists, highly organized and influential global economic actors, or social-media-driven public responses – mean that these diplomatic endeavours are undertaken in a complex and interconnected arena and on a global scale. Therefore, the field of diplomacy is populated no longer simply by representatives of foreign services of national governments but also by representatives of other national ministries, local governments, multinational corporations, civil society organizations and even influential individuals who do not represent a particular state, organization or corporation *(10,11)*.

Literature has largely explored global health diplomacy in the context of global health governance *(8,12,13)*, and although this encompasses its multiactor and multilevel nature, more recently there has been a growing understanding of the role of health diplomacy in negotiating health and well-being at the domestic level *(14)*.

Strengthening the use of health diplomacy in domestic policy supports the creation of synergies between public health and diplomatic fora and increases the understanding that public health challenges have no borders and are, therefore, intrinsically linked to global health *(15,16)*. In an interconnected and globalized world, traditional understandings of diplomacy as "the conduct of relations between sovereign states with standing in world politics by official agents and by peaceful means" *(17)* is less useful in the public health context. The increasing global movement of goods, people, services and capital is arguably shaping and influencing the greatest public health challenges of our time, including movements of people.

Health diplomacy is understood as a key set of skills that facilitate multilevel, multisectoral and multiactor responses to health challenges; the five key dimensions are presented in Box 2.3. This is predominantly carried out by improving relationships and creating alliances between actors that will enable them to effectively deliver multi- and intersectoral action, negotiate for governance for health and well-being, and defend health and well-being in negotiations involving stakeholders with competing objectives. Ultimately the goal is to create and ensure peace and security within a situation where societies experience extensive and dynamic shifts in social, cultural and economic contexts (e.g. when receiving large influxes of refugees and migrants).

Box 2.3. Five key dimensions of health diplomacy

- Negotiating for health and well-being in the face of other interests
- Improving relations through health and well-being
- Creating alliances for health and well-being outcomes
- Negotiating governance for improved health and well-being
- Contributing to peace and security.

Source: presented at the Executive Course in Global Health Diplomacy at the Global Health Centre, Graduate Institute, Geneva.

This set of skills is clearly critical when negotiating multi- and intersectoral action for health and well-being (Box 2.4), where the necessary actions to improve health and well-being lie outside the scope of the health sector. Health diplomacy can support understanding among the different actors of what needs to be done, and by whom, and present the case for considering and including health and well-being in the design and implementation of actions outside the health sector. There is considerable literature on the use of these soft skills in multi- and intersectoral approaches, particularly in the context of implementing Health in All Policies.

Box 2.4. Multi- and intersectoral action for health and well-being

Multisectoral action refers to multiple sectors working independently for a common goal *(3,9)*.

Intersectoral action refers to two or more sectors working together for a common goal *(3,18)*, including "actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health equity outcomes or on the determinants of health or health equity" *(7)*.

Intersectoral actions are implicit in Health 2020, the European policy and framework for health and well-being, which highlights the importance of multi- and intersectoral action, through whole-of-government and whole-of-society approaches, to tackling the WHO European Region's most pressing health challenges *(19)*. A whole-of-government approach refers to "the diffusion of governance vertically across levels of government and arenas of governance and horizontally throughout sectors" *(19)*. A whole-of-society approach extends the sphere beyond the traditional governmental decision-making by calling for increased engagement of the private sector, civil society, communities and individuals in health-related actions.

The complex challenge of migration transcends sectoral boundaries, mandates and competencies. An effective response, therefore, requires sectors to work together through existing and new models of operation to implement joint solutions through multi- and intersectoral actions. The issues linked to migration also demonstrate the clear role and need for actors beyond national government in preparing for and responding to the movements of people, whether these actors are civil society, local government or others.

In order to support the effective implementation of multi- and intersectoral action, health actors need to consider and successful navigate the system in which these actions are developed and implemented – the system of

governance as a whole with the tools available within it to govern multi- and intersectoral action (Box 2.2). Health actors also need to be aware of the relationships and differences in power between different actors and interests operating within the system *(20)*. The soft skills provided by health diplomacy are, therefore, clearly essential for health actors when negotiating governance for health and well-being (Box 2.5), particularly in negotiation of the instruments and mechanisms of governance, such as tobacco legislation in its progress through parliaments or high-level committees on health considering issues of health impact in the context of economic objectives.

Box 2.5. Governance for health and well-being

Governance for health and well-being entails ensuring that a system of governance within a country works best for the people within it, and for their health and well-being. The biggest challenges in public health, including those related to refugee and migrant health, cannot be solved without improving and strengthening governance. Improving systems of governance is at the heart of the global, regional, national and local responses to public health challenges and is the main challenge for a new public health agenda *(5)*. Adopting systematic approaches to governance and working towards models of governance that are fit for purpose in order to address the public health challenges of the 21st century can only be expected to become more important. This will include the causes of, and responses to, migration and movements of people across and within countries.

Moving towards models of governance that are designed to deliver health, equity and well-being, while leaving no one behind, is an example of the transformative response called for by 2030 Agenda *(4)*. In order to achieve global, regional and national goals and targets, including in the area of refugee and migrant health, it is necessary to involve, manage and coordinate diverse actors across all levels of government and beyond and to develop accountability and coherence and support the implementation of action between them.

(Continued)

Box 2.5. Governance for health and well-being (Continued)

By building a system of governance that works for improving health and well-being for all, or strengthening an existing system, it is possible to systematically and comprehensively address the wider determinants of health and well-being (cultural, social, political, commercial and economic). These may have a negative impact on health and well-being, perpetuate inequalities, lead societies towards conflict and instability and isolate those most at risk of vulnerabilities across our communities and societies. Strengthening a system of governance for health and well-being means addressing its key elements: building accountability for health outcomes, ensuring the participation of key stakeholders, fostering trust and integrity, supporting appropriate transparency, and ensuring policy and governance capacity.

However, governance does not occur in a vacuum or out of context. Rather, governance for health and well-being is embedded in the overall governance capacity of a country or system *(5)*. Therefore, when applied to populations movement, it provides for an underlying critical assumption that the governance of refugee and migrant health and well-being is not separate from the overall governance challenges and opportunities of a country or system.

There has been a growth in understanding that modern public health approaches and specialized health skills within complex modern governance models require new soft skills and approaches such as health diplomacy. Persuasion itself is increasingly understood as a soft mode of governance in addition to the more traditionally understood legal or political mechanisms. Persuasion is emerging as a new and critical mode of governance as we move towards a more complex policy environment based on consensus and cooperation, and involving increasing numbers of sectors and stakeholders both within and beyond government *(21)*. This new role of persuasion as a means to govern is particularly evident within governing for multi- and intersectoral actions for health or Health in All Policies approaches *(22)*.

Towards multi- and intersectoral action for better refugee and migrant health

Seeing these concepts as discrete yet mutually reinforcing allows for a better understanding by the health sector of the knowledge, relationships and specific health diplomacy skills needed in different stages and at different levels of the policy process. This is particularly important in the area of refugee and migrant health, which has a high political profile and multistakeholder and multisectoral complexity at the national level of governance. It also has a multilevel dimension, with key roles played by the local level and with domestic policy responding to and influencing the international and multinational levels of governance.

The relationships between health diplomacy, multi- and intersectoral action and governance for health and well-being (as outlined as actions A–D above) can be broken down specifically for the issues of migration (Fig. 2.2 and Box 2.6).

Fig. 2.2. Discrete areas of action related to health diplomacy, governance and multi- and intersectoral action for health and well-being of refugees and migrants

Box 2.6. Areas of action related to health diplomacy, governance and multi- and intersectoral action for the health and well-being of refugees and migrants

Each of the four action areas is considered with specific reference to actions for refugee and migrant health.

Action A. Governing multi- and intersectoral action for health and well-being. This refers to steering decision-making through processes, mechanisms and instruments that would facilitate multi- and intersectoral action to maximize the positive impact on refugee and migrant health and well-being while minimizing the negative impacts. For example, actions can be undertaken through intersectoral governmental committees, in parliamentary committees or through dedicated joint-funding mechanisms.

Action B. Negotiating multi- and intersectoral action for health and well-being. This refers to health diplomacy employed by the health sector in the design, development and implementation of multi- and intersectoral action in order either to improve access for refugees and migrants to relevant services within other sectors or to improve the working relationships, synergies and cooperation between relevant services in other sectors for the protection and promotion of refugee and migrant health and well-being.

Action C. Negotiating governance for health and well-being. This refers to high-level political health diplomacy where the objective is to support the creation of a multilevel governance system that facilitates refugee and migrant health. An example is ensuring that health interests and considerations are present and represented in high-level discussions on refugee and migrant health or that transnational legal frameworks and political mechanisms are considerate of and able to respond to the needs and health impacts of movements of refugees and migrants.

Action D. Using diplomacy to govern multi- and intersectoral action for health and well-being. This refers to the use of diplomacy – negotiation or persuasion – to govern the necessary actions to improve refugee and migrant health and well-being based on consensus and cooperation in a complex policy environment involving increasing numbers of sectors and stakeholders both within and beyond government. This is a separate area of action but it overlaps with the three spheres of action (Fig. 2.2).

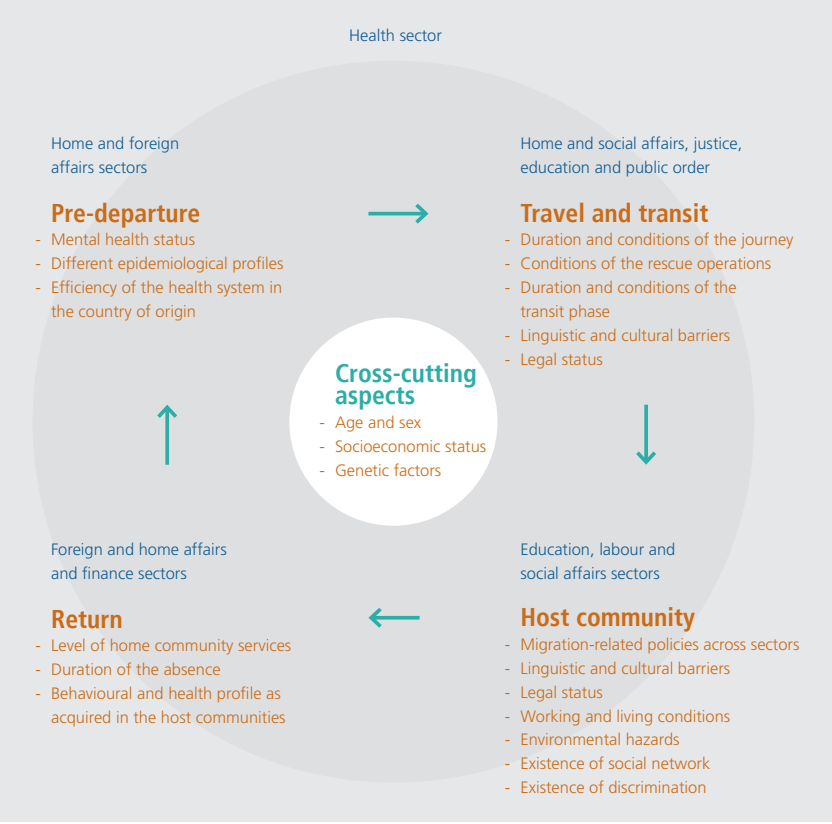
Achieving these actions requires the inclusion of health diplomacy skills in the education and skills development curricula of the diplomatic community, as well as for health stakeholders both within and beyond the health sector. It means understanding and developing soft and institutionalized mechanisms to promote dialogue between health and other sectors in order to shape, develop and implement action through the identification of co-benefits and management of conflicts of interest.

What must be done and by whom?

The value of using a systematic approach to understanding the different areas for action is evident when they are applied to the different stages of the migration process (Fig. 2.3). The migration process covers the conditions that refugees and migrants experience within the countries of origin and transit, during the journey, in the countries of destination and during the return process; it entails potential exposure to health risks that can affect physical, mental and social well-being. Although most of the risk factors lie outside the health sector, they strongly impact the health and well-being outcomes of this population group and the host community. For example, refugees and migrants might have limited access to preventive care and health-care services in transit and destination countries, which increases their susceptibility to infectious diseases and NCDs. Because of the great variability in the profiles of refugees and migrants, the multistage migration process will have very different impacts on individual refugees and migrants. Understanding the potential health and well-being hazards arising throughout this process, and the actors involved at each stage, is essential to embark on a multi- and intersectoral response to address the public health aspects of refugee and migrant movements *(1)*.

Given the multitude and diversity of actors and stakeholders involved in refugee movement and the migration process, interventions are needed both within and beyond the health sector in order to address effectively the underlying determinants of health and well-being that impact refugees and migrants. The sectors involved, and the nature of their involvement, will differ from country to country. For example, although local level services,

Fig. 2.3. The migration process and sectors involved at each stage



Source: WHO Regional Office for Europe, 2016 *(1)*.

communities and amenities are often on the front line across the refugee movement and migration process, local government may be more powerful and have a greater role in the governance of refugee and migrant health and well-being in some countries than in others.

Health diplomacy, as a tool of governance, plays a crucial role in creating an enabling environment for, and subsequently facilitating, the multi- and intersectoral actions undertaken across the migration process to improve the health and well-being of refugees and migrants.

Applying the first three action areas (A-C) that are presented in Fig. 2.2 and Box 2.6 to the different stages of the migration process in Fig. 2.3 demonstrates that each stage is best approached by applying specific governance actions. Action area D is applicable across all four areas of the migration process. The application of each action area to the migration process is explained below:

Action A (governing multi- and intersectoral action for refugee and migrant health and well-being) is most relevant to the time when refugees and migrants are within the host community. Crucially, during this stage individuals are at their most stable, and, therefore, this is when interventions to protect and promote their health and well-being can be delivered most effectively. At all other stages of the migration process, the complexity and instability of the individuals' situations makes this much more difficult. Challenges include reducing the negative effects of poor living and working conditions on health; reducing inequities in obesity and in tobacco-related and alcohol-related harm, particularly in those of low socioeconomic status; and improving the social inclusion of the refugee and migrant population, thus reducing discrimination and stigma. To achieve this, actions must engage multiple sectors, including labour, social affairs, education and local government. The process of engagement must be steered carefully by the health sector using the available instruments and mechanisms presented in Box 2.2.

Action B (negotiating multi- and intersectoral action for refugee and migrant health and well-being) relates most acutely to the travel and transit stage of the migration process. It is at this most complex stage of the process that the broadest range of challenges is faced in relation to the health and well-being of refugees and migrants. These include reducing mortality and morbidity during rescue operations; identifying the public health needs of refugees and migrants; reducing the negative effects of criminal or administrative detention on their physical, mental and social well-being; reducing systemic barriers in access to services; and reducing the negative impact of an uncertain legal status for individuals on their health and well-being. Responding to this vast array of challenges requires the engagement of various sectors beyond the health sector, including education, home affairs, justice, labour, local government and social affairs, again using the available governance instruments and mechanisms presented in Box 2.2. Effective engagement of other sectors through these instruments and mechanisms requires careful and considered negotiation by the health sector to ensure that the appropriate multi- and intersectoral actions are effectively implemented.

Action C (negotiating governance for refugee and migrant health and well-being) is most relevant to the predeparture and return stages of the migration process. These stages are the most highly politicized of all and require interventions of health diplomacy at the highest level, both within a country and on the international stage. The challenges in these stages are both political and technical. In the predeparture stage, challenges stem from the necessity of foreseeing large movements of refugees and migrants with different epidemiological profiles, mental health issues, and linguistic and cultural barriers. In the return stage, challenges include the prevention of unhealthy behaviour and health risks and ensuring the continuation of treatment and follow-up of diseases among those returning to their country of origin. The political sensitivity of these stages and challenges requires encouraging the traditionally most powerful sectors within a country – foreign affairs, finance and home affairs – to coordinate and collaborate with the health sector. This is something only possible at the highest offices of state.

Action D (using diplomacy to govern multi- and intersectoral action for refugee and migrant health and well-being) is an outlier as it is relevant across all the stages of the migration process. In a complex policy environment, fraught with political, cultural, social and economic sensitivities, so-called hard governance instruments and mechanisms such as those presented in Box 2.2 will not suffice because of the plethora of different sectoral objectives and conflicts of interests. Rather, understanding and developing soft and institutionalized mechanisms to promote dialogue between health and other sectors, with the purpose of shaping, developing and implementing action through the identification of co-benefits, are necessary to manage the conflicts of interest and deliver the actions that are necessary for refugee and migrant health and well-being across the migration process.

Conclusions

The new diplomatic context of refugee and migrant movements means that health diplomacy skills are critical at all levels of the system for building and

fostering an understanding of the potential health and public health impact at domestic level and of transnational events and actions. The health literacy of national institutions and policy-makers needs to be strengthened so that they can contribute effectively to a new diplomatic system at national level to support and reinforce global health diplomacy.

Interventions within and outside the health sector are needed to address the underlying determinants of health for refugees and migrants. The context of the process of migration will be specific for a country and, therefore, the sectors involved and the nature of their involvement will differ from country to country, with different sectors having a greater or lesser role in the governance of refugee and migrant health and well-being.

Although the relationship between governance systems and multi- and intersectoral action is increasingly understood, use of the underlying concepts is facilitated by their consideration in practical applications, such as responding to the public health challenge related to refugees and migrants. It is through this lens that the critical role of health diplomacy in all its dimensions is demonstrated, not only in facilitating multi- and intersectoral responses or building systems of governance but also as a mode of governance in its own right. It is, therefore, evident that health diplomacy is urgently needed as an essential skill set and mode of action in the modern, diffused systems of governance in which multi- and intersectoral actions are negotiated, designed and implemented.

Adopting a systematic approach to understanding the relationship between health diplomacy, governance for health, and multi- and intersectoral action is essential to build capacities and capabilities to meet the current complexities affecting global health. Climate change, conflict and other global trends mean that people will continue to move in increasing numbers. Stronger multilevel and multipartner governance for health will become only more important as multi- and intersectoral action becomes more urgent. Specifically, health diplomacy plays and will continue to play a crucial role in managing and responding to the complexity of ensuring the health of refugees and migrants. Health diplomacy is needed not only in negotiation of the processes and actions of different stakeholders and partners but also as a tool in governing for improved health and well-being in an increasingly complex world.

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3. Global governance of the migration system and its interface with health

Michaela Told

Introduction

The year 2015 "moved" the world in many different ways: more than 1 million refugees and migrants arrived in Europe *(1)*, with most fleeing conflict and persecution in Afghanistan, Iraq and the Syrian Arab Republic *(2)*. This large-scale population movement triggered fierce political debates in Europe, enabling a shift from framing refugee movement and migration as a human security issue to making it a national security issue *(3)* and, consequently, facilitating the rise of populism and nationalism. It triggered political action not only at the level of individual governments but also at the European Union (EU) and global levels. For example, the EU started to rethink its approach towards refugees and migrants and the European Parliament proposed a reform of the EU asylum system *(4)*. For the first time in history, the United Nations General Assembly called for a summit at the level of heads of state and government on large movements of refugees and migrants, which was held in September 2018. Alongside this event, the then President of the United States of America,

Barack Obama, hosted a Leaders' Summit on Refugees, together with Canada, Ethiopia, Germany, Jordan, Mexico and Sweden. The New York Declaration for Refugees and Migrants was signed by 193 countries *(5)* and paved the way for the GCR and the GCM.

The Global Compacts in migration

The two Global Compacts were adopted in 2018 *(6,7)* and are rooted in the 2030 Agenda *(8)* and the Addis Ababa Action Agenda *(9)*, both agreed in 2015. However, the two Global Compacts differ considerably from a (health) diplomacy and governance perspective (Table 3.1).

The GCR is a "framework for a more predictable and equitable responsibility-sharing" *(6)* that was affirmed by the United Nations General Assembly in New York on 17 December 2018 after a two-year consultation process led by UNHCR in Geneva with Member States and other stakeholders.[1] The GCR builds on the 1951 Refugee Convention and other international legal instruments on refugees, human rights and humanitarian law and focuses on international cooperation at large. It has four parts:

- an introduction setting the background, guiding principles and objectives;
- the Comprehensive refugee response framework, as agreed in Annex I of the New York Declaration;
- a Programme of Action outlining concrete measures to help to meet the objectives of the compact; and
- a reference to arrangements for follow-up and review.

The GCM "offers a 360-degree vision of international migration and recognizes that a comprehensive approach is needed to optimize the overall benefits of migration, while addressing risks and challenges for individuals and communities in countries of origin, transit and destination" *(7)*. It sets

[1] It was adopted without the support of Hungary and the United States.

Table 3.1. Comparison of some key diplomacy features of the GCR vs GCM

Features	GCR	GCM
What?	Responsibility-sharing framework for a comprehensive refugee response	Cooperative framework on international migration in all its dimensions
How?	Member State consultations in Geneva led by UNHCR	Intergovernmental negotiation led by Mexico and Switzerland in New York
Where?	Affirmed by the United Nations General Assembly in New York and negotiated in Geneva	Negotiated at the United Nations headquarters in New York, adopted by the Intergovernmental Conference in Marrakesh, Morocco, and endorsed by the United Nations General Assembly in New York
Secretariat?	UNHCR	IOM
Innovation?	A follow-up and review mechanisms through the Global Refugee Forum to be held every four years, an annual high-level officials meeting held every two years between forums and the High Commissioner's annual report to the General Assembly	Comprehensive framework with a 360-degree vision on migration, with the International Migration Review Forum (previously the High-level Dialogue on International Migration and Development) and the United Nations Network on Migration as follow-up and review mechanisms
References to health?	Mentioned in the Programme of Action: • reception and admission: under Safety and Security §57	Mentioned in: Objective 1: collect and utilize accurate and disaggregated data as a basis for evidence-based policies (§17j)

(Continued)

Table 3.1. Comparison of some key diplomacy features of the GCR vs GCM (Continued)

Features	GCR	GCM
	• meetings needs and supporting communities under specifically dedicated subsections on health (§72 and §73) and integrated under women and girls (§75) and under children, adolescents and youth (§76)	Objective 2: minimize the adverse drivers and structural factors that compel people to leave their country of origin (§18b) Objective 6: facilitate fair and ethical recruitment and safeguard conditions that ensure decent work (§22i) Objective 7: address and reduce vulnerabilities in migration (§23c) Objective 13: use immigration detention only as a measure of last resort and work towards alternatives (§29f,h) Objective 15: provide access to basic services for migrants (§31e) Objective 16: empower migrants and societies to realize full inclusion and social cohesion (§32c) Objective 22: establish mechanisms for the portability of social security entitlements and earned benefits (§38b)
Relevance for health?	Dedicated subsection on health	Reference to the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants

23 objectives to better manage migration at the local, national, regional and global levels and is the first intergovernmentally negotiated instrument on migration. Although it is not legally binding, the GCM represents a cooperative framework that 164 Member States (31 fewer than those endorsing the New York Declaration) adopted and signed at the Intergovernmental Conference in Marrakesh, Morocco on 10 December 2018 *(10)*.[2] It was endorsed by the United Nations General Assembly on 19 December 2018 *(7)*.

For the first time in the history of the United Nations, a global instrument of migration governance had been negotiated and adopted in an otherwise fragmented space. In her closing remarks at the Marrakesh Conference, Louise Arbour, Special Representative of the United Nations Secretary-General for International Migration, thanked the Member States and acknowledged the "cooperative spirit, in the best traditions of United Nations multilateralism" and "the contributions from civil society, the private sector, mayors and many other stakeholders" *(11)*. She further stated: "We have attained an unsurpassed level of knowledge, competence and ingenuity, allowing us to both imagine a better world and actually begin to construct it" *(11)*.

The GCM, therefore, represents an achievement – despite its nonbinding character and other shortcomings *(12)* – because it recognizes migration as a complex, collective issue that should be addressed in a holistic and comprehensive way through cooperation. Its relevance for health is found in several places but particularly in paragraph §31(e), which refers to the WHO Framework of Priorities and Guiding Principles, although there were challenges to the inclusion of this section in the negotiation phases. Only once monitoring has assessed its implementation will its relevance be proven as the first negotiated global migration governance instrument (Box 3.1) in an otherwise fragmented migration governance landscape *(3,13–15)*.

[2] The following countries did not adopt the GCM in Marrakesh: Austria, Czechia, Hungary, Poland and the United States.

Box 3.1. Migration governance as defined by IOM

The combined frameworks of legal norms, laws and regulations, policies and traditions as well as organizational structures (subnational, national, regional and international) and the relevant processes that shape and regulate states' approaches with regard to migration in all its forms, addressing rights and responsibilities and promoting international cooperation.

Source: IOM, 2019 *(16)*.

The governance interfaces

The complexity of migration and its interconnectedness with health need to be well managed and require health diplomacy not only to negotiate governance for health and well-being but also to govern and negotiate multi- and intersectoral actions for health (a point made frequently over the course of this book). Box 3.2 outlines three levels of governance *(17)*. The challenges to facilitate the understanding of the "what" (as in what needs to be done by whom) and the "how" (as in how to create processes, establish mechanisms and develop instruments) require, nevertheless, also a sound understanding of the "who" and the "where" in order to be able to contribute effectively and efficiently to improving the health and well-being of refugees and migrants at the national, regional and global levels. "Who" and "where" will encompass different venues, fora and institutions that all have specific mandates; follow their respective set of rules, norms, policies and practices; engage different actors; and use a specific set of instruments and mechanisms in their respective decision-making processes *(3)*.

It is also worthwhile to map and highlight the interface of the three different governance domains that link and impact on health in migration (Fig. 3.1) and influence the system and method of health diplomacy. Whereas health diplomacy is primarily focused towards better health outcomes, migration diplomacy concerns the "use of diplomatic tools, processes, and procedures to manage cross-border population mobility" *(18)*. Even though both operate within a political system, their outcomes may differ considerably: health

Box 3.2. The governance interface for health

Global health governance refers mainly to those institutions and processes of governance that are related to an explicit health mandate, such as WHO.

Global governance for health refers mainly to those institutions and processes of global governance that have direct or indirect health impacts, such as the United Nations, World Trade Organization or the Human Rights Council.

Governance for global health refers to the institutions and mechanisms established at the national and regional levels to contribute to global health governance and/or to governance for global health, such as national or global health strategies or regional strategies for global health. It can also refer to club strategies, such as agreements by a group of countries such as the BRICS (Brazil, Russian Federation, India, China and South Africa).

Source: Kickbusch and Cassar Szabo, 2014 *(17)*.

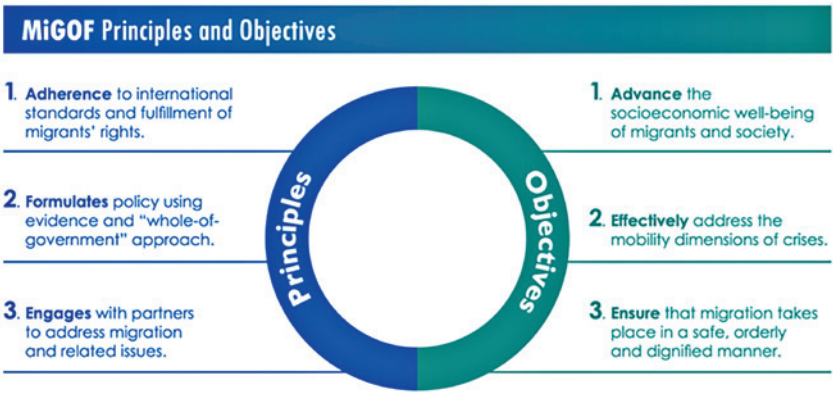
diplomacy is usually directed to create better health but migration diplomacy can be used (particularly by states) to manage migration processes in either a restrictive or a more open way. Migration diplomacy is, therefore, a contested arena, giving room for much political debate, as was seen in the GCM process. The more important it is to define the different political spaces in which migration diplomacy occurs, and to recognize these political spaces as venues that are instrumental to affect change for refugee and migrant health, the more important it is to involve health diplomacy. Consequently, it is essential to bring health diplomacy actors and migration diplomacy actors and their venues together more frequently and to build on the synergies between them. Migration diplomacy for health helps to negotiate these governance interfaces to achieve better health outcomes within the migration context, both for refugees and migrants themselves and for the host population. This chapter cannot provide a fully fledged analysis of the three governance interfaces but will instead focus on outlining the "where" and highlight some of the venues that are particularly relevant in the context of this book.

Fig. 3.1. The governance interfaces on migration impacting on health

Global migration governance

Global migration governance refers to those venues and actors that specifically have a mandate in migration in its broader meaning. Martin and Weerasinghe in 2017 *(15)* analysed and described the global migration governance system, highlighting, among others, the role of IOM, the Office of the Special Representative of the Secretary-General for International Migration and UNHCR in the preparation of the World Migration Report 2018 *(19)*. The mandates, decision-making and organizational structures differ considerably and directly impact on health diplomacy. IOM, as the United Nations migration agency, has set up a Migration Governance Framework (Fig. 3.2) that not only describes principles and objectives of engagement but also has the core principle that migration can only be addressed effectively in partnerships *(20,21)*. This in itself also strengthens the call for increased health diplomacy in migration.

Fig. 3.2. The IOM Migration Governance Framework: principles and objectives



Source: IOM, 2015 *(21)*.

IOM. A dedicated health division within the Department of Migration Management systematically integrates health dimensions in IOM's operational and policy work and collaborates closely with WHO. IOM's Migration Crisis Operational Framework *(22)* enshrines health as a key pillar. In addition, a number of other approaches have been developed in the context of health emergencies to address migrant health, for example within the Health Border & Mobility Management Framework *(23)*. At global level, the International Dialogue on Migration incorporated health in its deliberations, for example in its session on migration and cities in 2015. More recently, a panel discussion on migration health was held at the IOM Council for the first time *(24)*, which opened another window of opportunity to integrate health more systematically in the governing body discussions of IOM. New impetus will be also gained through the adoption of the GCM and the creation of the United Nations Network on Migration as successor to the Global Migration Group in order to "ensure effective, coordinated system-wide support to the implementation, follow-up and review of the Global Compact for Safe, Orderly and Regular Migration" *(25)*. IOM serves as Coordinator and Secretariat of this Network of 38 members, one of which is WHO. The organization will, therefore, play

a further enlarged role in health diplomacy, especially within its dimension of relationship building, in order to coordinate the follow-up and review mechanisms of the GCM, which will involve different stakeholders and ensure that health is well considered in all further measures.

UNHCR. The mandate of UNHCR is more specifically directed towards refugees, returnees, stateless people, internally displaced people and asylum seekers. Set up in 1950 after the Second World War, its work is closely linked to the implementation of the 1951 Geneva Convention on the Protection of Refugees and is governed by the United Nations General Assembly and the Economic and Social Council. UNHCR's Executive Committee, consisting of 102 members as of 2018, approves the organization's programme and budget on a yearly basis. Health is frequently integrated into the programme activities, which would also imply a strong focus on health diplomacy concerning the governance of migration.

In the global health domain, blocs, clubs, alliances and informal networks gain in importance and by default are geared towards positive outcomes in improving health and well-being. The migration landscape is equally manifold, complex and political but it also reacts with great sensitivities to a political context unfavourable to migration flows (e.g. the Visegrad Group and Austria Summit, 2018 *(26)*). In recent years, many of the migration dialogues and consultations have been linked towards the mutually reinforcing relationship between migration and development. The Global Forum for Migration and Development is an important voluntary, informal and nonbinding, but government-led, process open to all Member States and Observers of the United Nations. Since its inception in 2006 at the United Nations High-level Dialogue on International Migration, it has evolved into a multistakeholder platform with a distinct mechanism to engage with civil society, business and mayors, thus keeping its relevance as a global consultative forum.

The only health-specific forum that has so far had a fully dedicated political dialogue on migrant health is the Global Consultation on Migrant Health. The Second Global Consultation was held in 2017 in Colombo, Sri Lanka, and gave rise to the Colombo Statement *(27)*. This has been particularly relevant in expressing the support of governments for the multisectoral promotion of migrant health, thus linking back into the need for multi- and intersectoral action at national level.

Global governance for migration

Global governance for migration refers to those institutions and venues whose mandate is outside of migration but who directly or indirectly impact on migration. This includes the International Labour Organization (ILO), OHCHR, UNICEF, the United Nations General Assembly, the United Nations Security Council and WHO. Even though none of these has migration specifically in their remit, and none apart from WHO is dedicated to health, all show a strong nexus of health and migration within their respective mandates.

ILO. ILO relies strongly on its normative function and has, therefore, a number of conventions that relate to labour migration and to health. Whereas the health instruments do not necessarily include a migration component, the migration-related conventions usually refer to the health dimensions. In addition, ILO adopted a global framework on labour migration in 2006 *(28)* that reflects a strong rights-based approach and refers to occupational health and safety and access to health care. Its tripartite constituents allow for a unique entry point for health diplomacy despite its focused mandate on labour migration and decent work.

OHCHR. With its mandate on human rights, OHCHR has a solid system of charter- and treaty-based instruments that relate to both migration and health. The Human Rights Council and the Special Procedures of the Human Rights Council are charter-based bodies with frequent resolutions and thematic reports related to health and migration. As an example, in 2018, the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health submitted his annual thematic report on the right to mental health of people on the move *(29)*. The Special Rapporteur on the Human Rights of Migrants also frequently integrates the health dimension in his reports. In addition, health is also mentioned into treaty bodies but it is also worth highlighting in particular the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families *(30)*. This convention makes reference to the right to health or access to health services in Articles 25, 28, 43, 45 and 70. The Human Rights Council or other bodies related to OHCHR allow for constructive engagement and many entry points for health diplomacy in different ways (e.g. through the engagement with the special rapporteurs or experts or through the drafting process).

UNICEF. The organization's work on child protection and inclusion allows for a systematic inclusion of the health dimension. The Agenda for Action for Refugee and Migrant Children specifically addresses the interface of health and migration and, therefore, represents an important tool to use in health diplomacy efforts *(31)*.

United Nations General Assembly. The notion of a shared vision and collective responsibility is at the heart of the SDGs, which were passed in the General Assembly as the main deliberative, policy-making and representative organ of the United Nations. On the basis of this broader framework, the General Assembly has hosted high-level dialogues on international migration and development. More importantly, in 2016 the General Assembly convened a high-level plenary meeting to address the need for greater international solidarity and support in response to large movements of refugees and migrants. This Summit for Refugees and Migrants led to the New York Declaration and ultimately the adoption of the GCM and GCR. The implementation of these instruments will not only fuel further political debates but also need increased dialogue and diplomacy at all levels of governance.

United Nations Security Council. The primary responsibility of the Security Council is the maintenance or restoration of international peace and security; consequently, any topic discussed in this forum of permanent members and 10 nonpermanent members must be presented within a security framing. Only few health-related resolutions have been passed so far (HIV epidemic S/Res/1308 (2000); Ebola S/Res/2177 (2014) and S/Res/2439 (2018); and attacks against medical facilities and personnel in conflict situation S/Res/2286 (2016)). Resolution 2437 (2018) in the context of Libya has given renewed authorization to inspect vessels suspected of smuggling migrants off Libya's coast. United Nations Secretary-General António Guterres also addressed the Security Council in 2017 in relation to the Mediterranean crisis, relating it back to human smuggling but also going beyond this *(32)*:

> There is a clear need to address the drivers of displacement. We must also address the worrisome increase in xenophobia and discrimination against refugees, migrants and minorities. This is a shared, global responsibility. It is essential to re-establish the integrity of the refugee protection regime on both sides of the Mediterranean and increase resettlement and relocation programs.

WHO. It was only in 2008 that WHO adopted its first resolution on the health of migrants (WHA61.17 *(33)*). Nine years later, it negotiated resolution WHA70.15 on promoting the health of refugees and migrants *(34)*, which makes reference to a WHO framework of guiding principles and priorities to promote the health of refugees and migrants. Finally, the Global Action Plan on Promoting the Health of Refugees and Migrants *(35)* was discussed at the Seventy-second session of the World Health Assembly in 2019 but deliberations were not concluded, reflecting the different interests and priorities of the Member States involved.

Governance for migration

Governance for migration refers to institutions, rules, norms, actors and processes at the national and regional levels.

In the EU, the European Commission, the European Parliament and the Council of the European Union have been the main drivers for action, setting a number of policies, directives and strategies concerning migration (e.g. the Global Approach to Migration and Mobility, European Agenda on Migration, Common European Asylum System, Dublin Regulation, Asylum Procedures Directive, Reception Conditions Directive, and Qualification Directive). A number of decentralized agencies, such as the European Border and Coast Guard Agency (also known as Frontex) or the European Union Agency for Law Enforcement Cooperation (better known as Europol), act as implementing bodies.

Information and data to support migration diplomacy for health are available from the Eurasian Economic Union, with its decisions and dispositions concerning labour migration; the United Nations Economic Commission for Europe; and the Organisation for Economic Co-operation and Development. The Council of Europe has also a Special Representative of the Secretary General on Migration and Refugees, who has identified several thematic areas in respect of which the Council can provide advice and support to all its 48 Member States. The first general topic he has focused on as a priority is the protection of refugee and migrant children *(36)*. The regional complexity, however, is complemented by the different national legal frameworks that regulate stay in and entry to a country. Ultimately the political system at national level and in the institutional context determines potential action.

Conclusions

In global health diplomacy, the issues of "what to do" and "how to do" it have to be complemented by the issues of "who" and "where". The mapping of the different governance interfaces – linked to different venues and actors – outlined here should create a further awareness of the complexity of the interface of health and migration. The ability to act and take decisions in the different venues requires an understanding of the different rules, norms, policies and practices in these institutions. However, people are always involved, both as decision-makers and as those affected by the decisions. Consequently, governance is not only about managing interdependence and complexity but also about managing relationships and conflicting interests. It also relates to power imbalances and domestic politics, which drive decision-making processes. Health can be a connecting political force that helps to drive a common agenda forward and allows for a different framing of contested migration issues. This requires a two-fold approach that breaks down the silos between migration and health diplomacy: it means actively engaging in migration diplomacy for health at the different levels, with the potential to create social innovation through new relations and social practices in the migration setting. This can lead not only to improved health and well-being but also to improved relations, shared responsibilities and better governance structures. At the same time, health diplomacy for refugees and migrants should carve out a space in all health-related discussions for the specific inclusion of their issues. If sustainable solutions are to be found in this field, these interdependences have to be addressed much more systematically.

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2. Global perspectives

4. *Negotiating the inclusion of health in the Global Compact for Safe, Orderly and Regular Migration: from the New York Declaration to the adoption of the Compact*

Fatima Khan, Santino Severoni, Palmira Immordino and Elisabeth Waagensen

Introduction

Dealing with a complex and multifaceted dynamic phenomenon such as migration requires a multisectoral approach where United Nation agencies act from their respective areas of expertise. Within the United Nations system, WHO's Constitution defines it as the "directing and coordinating body on international health work", which provides its mandate to contribute on migration-related issues *(1,2)*. On 19 September 2016, the United Nations General Assembly convened a high-level plenary meeting to address large movements of refugees and migrants in consideration of the need for greater international solidarity and support in response to such movements. The New York Declaration for Refugees and Migrants was adopted *(3)*, and

WHO provided the health inputs. The Declaration set out principles and recommendations applying to refugees and migrants as well as separate commitments for refugees and migrants, and its two annexes paved the way for the GCM and the GCR in 2018. WHO's contribution to the negotiating process is a meaningful example of health diplomacy in action, and the experience can be used for similar processes moving forward.

The WHO Regional Office for Europe has been working on migration and health along with other issues related to vulnerabilities since 2011. Since then, many developments have taken place in other regions and in WHO headquarters. The Regional Office has been taking a leading role, scaling up its activities on migration and health across the WHO European Region and beyond and has made the capacity developed over years of experience in dealing with this paramount topic of concern fully available to other regions.

As capacity was increasing within the WHO Regional Office for Europe, interregional migration and health plans started to be developed and are ongoing in the various other WHO regional offices. The work of the WHO Regional Office for Europe filled a gap globally and this approach model positioned WHO in the international arena on public health aspects of refugee and migrant health. The Regional Office has provided constant support to WHO headquarters to inform discussions among Member States and partners engaged in the development of the GCM, thus contributing to the intergovernmental negotiation process followed by the WHO Office at the United Nations on behalf of WHO.

Over the six months of negotiations, regular contact was maintained between the WHO Regional Office for Europe, the WHO Office at the United Nations and the United Nations headquarters to form strategies and receive guidance.

The Co-facilitators Juan José Gómez Camacho, Ambassador and Permanent Representative of Mexico to the United Nations, and Jürg Lauber, Ambassador and Permanent Representative of Switzerland to the United Nations, went to great lengths to ensure that all stakeholders could contribute to the proceedings, holding informal dialogues with stakeholders in the margins of the negotiation rounds. They were also open to technical advice from United Nations agencies to support drafting of the GCM. The Secretary-General's Special Representative for International Migration, Louise Arbour, also made herself available to advise and support agencies throughout the process.

The negotiation arena

It is important to stress and acknowledge the massive amount of work that WHO had put into the GCM process prior to the intergovernmental negotiations at the United Nations headquarters. This consisted of two phases commencing in April 2017. The consultation phase included a series of informal thematic sessions, regional consultations and stakeholder consultations. WHO contributed to relevant issue briefs for the thematic sessions, as well as the co-organization of side-events. The inputs received during the consultation phase were then assessed and fed into the GCM preparatory meeting in Puerto Vallarta, Mexico, in December 2017. WHO participated in that meeting and contributed to the discussions. The report from Puerto Vallarta was the basis for the zero draft of the GCM.

As in other intergovernmental negotiations, United Nations agencies, NGOs and other non-state actors were not permitted to actively negotiate, although WHO was invited to observe and provide technical advice as requested and appropriate throughout the proceedings. WHO and other United Nations entities and interested partners were in constant communication with Member States and the Co-facilitators throughout the process. In this regard, WHO's expertise in health diplomacy was critical for contributing to the process and making a positive impact. The negotiations took place in six rounds, through a carefully constructed format to focus on major themes and areas that required more in-depth consideration as the draft GCM was further developed. Given also that migration issues are traditionally discussed in Geneva, the Co-facilitators made sure to travel to Geneva on a regular basis to brief Member States on the process, as well as to meet with Geneva-based partners. The process itself was intense, given that the lead-up time between a draft being issued and the negotiation itself was usually no longer than around two weeks. During this time, the draft was reviewed, WHO finalized its position and lobbied Member States as needed. Bearing in mind that all stakeholders were going through the same process, there was limited time to raise any concerns or issues, or to have an impact on positions that had been crafted well in advance with the involvement of various ministries. This rigorous schedule made for a solid six months focused solely on the GCM.

The substance

From a WHO perspective, there were two important things to keep in mind throughout the negotiations, and these should be taken into account in the future when engaging in any negotiation process taking place at the United Nations headquarters, including on migration. The first is that diplomats, rather than policy experts, have the major role at the United Nations headquarters. The second is that the representatives there are from ministries of foreign affairs rather than from ministries of health. This makes negotiations at the United Nations headquarters more challenging than those at the WHO headquarters in Geneva. Member States in New York are represented by heads of state who are diplomats, not necessarily policy experts, while in Geneva at the World Health Assembly, negotiations take place with permanent missions and the WHO counterparts are representatives from ministries of health. Consequently, in New York, every issue tends to be politicized, if not explicitly then implicitly; this is particularly true for issues such as migration. Today, migration issues have become very political and this was enhanced during the negotiations in New York. Many social issues discussed in the context of migration were affected, as regulatory, security, sovereignty and economic considerations took precedence. The second issue when comparing negotiations at the United Nations headquarters with those at the WHO headquarters in Geneva is that, although the same Member States are involved, the representatives in New York will come from ministries of foreign affairs, which have a very different mandate to ministries of health and, certainly, a different understanding of health-related issues. This can have a significant effect on the outcomes of negotiations and, in fact, the position of each country can vary depending on whether the negotiation is in New York or Geneva. This has been seen throughout the GCM process, which added another layer of complexity and sometimes frustration as WHO tried to advocate for health in the GCM. Understanding of the political nuances was vital for WHO's successful contribution.

WHO staff put a lot of effort into paving the way for health references in the GCM during the consultation and stocktaking phases, and the results fed directly into the zero draft of the GCM. This included consultations and events in New York to ensure that Member States were aware of the linkage between health and migration, and also to identify potential champions for health. By

the time the intergovernmental negotiations commenced, there was a good basis for health. WHO's Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants *(4)* was published in 2017 and has guided and contributed throughout the course of the negotiations. Despite these efforts, it was still a challenge to ensure that the health content was maintained and/or enhanced.

The negotiation process

There were six rounds of negotiations and, therefore, six iterations of the GCM. The zero draft was shared by the Co-facilitators on 5 February 2018 *(5)*, followed by the first round of negotiations starting on 20 February and lasting three days. The first round invited delegates to share their general views on the draft, which was helpful to understand the key concerns of Member States. Subsequent negotiations focused on different issues depending on the Co-facilitators' assessment of the themes and issues that required further examination.

Health references were scattered throughout the text, with the more substantive input in Objective 15 (provide access to basic social services for migrants) *(5)*. In the section, with regards to health, the focus was on providing migrants with access to health care and promoting the operationalization of the WHO Framework of Priorities and Guiding Principles.

The Framework of Priorities and Guiding Principles was the basis for the development of a draft global action plan to promote the health of refugees and migrants *(6)*. This would support Member States in the development of their health strategies in this area and be the key driver for WHO's work on migration and refugees and the implementation of the GCM. It would fulfil WHO's commitment to support the United Nations Secretary-General's call to work as One United Nations to improve the efficiency and effectiveness of operational activities at country level towards achievement of the SDGs *(7)*. WHO's commitment to the health of refugees and migrants is also further espoused in the Thirteenth General Programme of Work 2019–2023, which lays out three interconnected strategic priorities to ensure healthy lives and

well-being for all *(8)*. The concept of UHC is at the heart of SDG 3 (ensure healthy lives and promote well-being for all at all ages), which means that "everyone – irrespective of their living standards – receives the health services they need, and that using health services does not cause financial hardship" *(9)*. In this regard, it was vital for the GCM to adequately reflect health issues, as well as to reference the Framework of Priorities and Guiding Principles.

At the first round of negotiations, it was clear that the traditional positions and/or negotiating groups were not present; in addition, the United States did not take part in the process *(10)*. Given also the national priorities surrounding migration, it seemed that some social issues, including health, would not be prominently placed.

Furthermore, views on sexual and reproductive health differed widely among Member States and delegations, resulting in this issue becoming a difficult area on which to reach consensus. This is a common occurrence in many negotiation processes, including the negotiation on the GCM. The Framework on Priorities and Guiding Principles refers to the provision of essential health services, which would include the "minimum initial service package for reproductive health, sexual and reproductive health information and services" *(4)*. Because of this reference, there was a push to have the Framework removed and, as the negotiation rounds continued, it seemed that it would be challenging to maintain the reference to the Framework, as well as deepening the health references in Objective 15.

During some informal discussions with delegations, there was some concern about the range of health services referred to in the zero draft, and specifically the types of service accessible for regular and irregular migrants. This point was linked to the concern that the GCM could in some ways encourage irregular migration rather than improve avenues towards regular and orderly migration. This again illustrates the political, multifaceted and complex context of the negotiations.

The health references in the zero draft also did not look at the issue of health systems strengthening, which is not only an important aspect of achieving the SDGs and UHC but also necessary for a country's sustainable development and health strategies and would benefit the entire population. As mentioned above, SDG 3 (more explicitly target 3.8 on UHC) emphasizes the importance of all people and communities having access to quality health services without

risking financial hardship *(11)*. Strengthening the health system of countries leads to progress towards UHC, which embodies the objectives of quality, equity, efficiency, accountability, resilience and sustainability. It also enables countries to address the health needs of a population diversifying through people movement.

The issue of the range of services available for migrants was also linked to a concern for some delegations that the focus on social services for migrants, and especially irregular migrants, would also have an effect on access to these services by the rest of the population. It was important to avoid any creation of a parallel health system and to ensure that national and local health services were enhanced in order to provide services to all.

WHO's focus during the negotiations was to build understanding and support to retain reference to the WHO Framework, to alleviate concerns surrounding access to health services by migrants and to ensure some reference to health systems strengthening. The challenge and opportunity was for WHO to translate technical health issues into diplomatic language in a way that would fit into a politically negotiated document such as the GCM. To achieve this, WHO focused on identifying and working with Member States that seemed open to stronger references and inclusion of health issues in the GCM. It also worked closely with like-minded United Nations entities and NGO partners in order to present a coordinated approach and a critical mass of champions. This included advocacy efforts by colleagues in WHO headquarters and in regional and country offices, not just those at the United Nations headquarters in New York. The Co-facilitators' strong leadership and genuine commitment to the GCM was also critically important. Throughout the process, they maintained an open and transparent dialogue with all stakeholders, including WHO, and welcomed technical advice and suggestions that would help them to draft the GCM.

WHO was successful in promoting health in the GCM, as well as in reaching our goals to retain the reference to the Framework, not to lose language and content on access to health services by migrants, and to gain language on incorporating the health needs of migrants into national and local health-care policies. Given the volatile political climate during the negotiations, it is to WHO's credit that such a strong result was achieved in the intergovernmental negotiated and agreed outcome of the GCM *(12)*. Objective 15 (provide access to basic services for migrants) section (e) states:

> Incorporate the health needs of migrants in national and local health care policies and plans, such as by strengthening capacities for service provision, facilitating affordable and non-discriminatory access, reducing communication barriers, and training health care providers on culturally-sensitive service delivery, in order to promote physical and mental health of migrants and communities overall, including by taking into consideration relevant recommendations from the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants.

WHO's success was largely a result of the support from Member States that championed health throughout the process, good internal collaboration within WHO and senior leadership's commitment to the GCM. It was also helped by the expertise that WHO had in intergovernmental negotiations, both in the context of negotiations at the United Nations headquarters in New York and in health diplomacy more generally. At the time of the GCM negotiations, WHO's in-house capacity for migration issues was limited to that within the WHO Regional Office for Europe, and WHO was unable to undertake a wider advocacy approach. Indeed in such negotiations, WHO would have benefited from having a worldwide knowledge on the topic internally, which would include mobilizing country offices and WHO country representatives. WHO as an organization would also benefit from a more in-depth understanding and training in health diplomacy, which at present is a skill held by a small number of staff members and is not institutionalized. Throughout the process, regional and country offices were kept informed of developments. In future negotiations of a similar nature, WHO will benefit from the lessons learned to make a WHO-wide advocacy strategy possible, on migration-related and other issues.

The movement of the negotiation on the GCM into a political and security-related discussion was illustrated by the attendance at the GCM High-level Meeting in Marrakesh in December 2018. Participation from the health sector was only through representatives from the WHO Regional Office for Europe, the UCL–Lancet Commission on Migration and Health, UNICEF and some NGOs and civil society organizations. Against this, 164 Member States were present and about 10 were represented by the head of state or head of government. The other Member States were represented by delegates from ministries,

mostly ministries of interior and home affairs, ministries of foreign affairs and ministries of labour, with some Member States having a representative from a ministry of migration or refugees (e.g. Lebanon and Rwanda). Across most of the country statements, there was a strong endorsement of the IOM role in coordinating the implementation of the GCM and in taking the secretariat role to lead the newly established United Nations Migration Network *(13)*. Even though most statements were in support of the GCM, highlighting in particular the need to work in cooperation among countries to stop trafficking and smuggling of migrants and to have special attention to woman and children, countries clearly spelt out conditionalities, such as no binding status; no creation of new legal obligations for countries; respect of the sovereignty of countries; clear differentiation of refugees as the only group entitled to support or protection by a legal framework; regular migrants to be received and assisted according to national laws; and irregular migrants to be treated with respect but to be promptly repatriated. Despite the call on the governments who did not join the Compact to reconsider their position and to banish the myths surrounding migration *(14)*, and despite the international accord, it was clearly said that the Compact does not create any new right to migrate and it does not impose obligations on Member States or infringe their sovereignty. States with a restrictive migration agenda considered the symbolic act of approving the GCM as a sign that they are promoting migration. The regulation of migration is not only seen as a matter of laws, policies and border walls but also as a matter of communication. Some officials believe that a country perceived to be open towards migration is providing incentives for migration, whereas harsh rhetoric is seen as a deterrent *(15)*. While state officials are well aware that the GCM is nonbinding, those that have rejected it fear it will turn into common practice, or even common law. Some countries that have rejected the GCM are especially worried about human rights references within the document. In their view, an emphasis on human rights contradicts what matters for them: securing borders. Hostility to the GCM mirrors the growing influence of new far-right movements, especially in countries where radical right parties are in power or are prominent *(15)*.

Against these concerns and being mindful of the complexities of positions in Member States regarding migration, WHO did manage to include health in the objectives of the final GCM and not as a mere side-effect of migration.

Conclusions

Health is a prerequisite for individuals to actively take part in and contribute to the societies they live in. There was a strong need to acknowledge health as a priority in the GCM as well as to recognize that migration can impact the well-being of individuals as well as public health aspects of host societies: there is no public health without refugee and migrant health. Including health as a priority in the GCM ensured a people-centred and human rights-oriented approach in addition to issues of national sovereignty.

The complexity of migration and health issues is illustrated by the large number of different ministries involved in the negotiation process, which was made particularly clear when comparing the levels of support seen from Member States for the health aspects of the GCM during negotiations in New York and in Geneva. WHO needs to be aware of these issues and move forward in its understanding and application of health diplomacy. Following the adoption of the GCM and GCR, as well as with the newly noted Global Action Plan on Promoting the Health of Refugees and Migrants, which followed a number of regional WHO policies and strategies, WHO now has the tools to support countries to develop and strengthen national priorities with regards to health and migration. This is critical if countries are going to achieve the SDGs and UHC. The international stage is currently at a very pivotal time for health and WHO is well placed to shape and lead the conversation, given its role as the lead authority on health in the United Nations system.

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5. The Global Compact for Safe, Orderly and Regular Migration: adoption and implementation

Dominik Zenner, Poonam Dhavan, Kolitha Wickramage, Eliana Barragan and Jacqueline Weekers

Introduction

Commitments to develop the GCM *(1)* were first formalized in the New York Declaration for Refugees and Migrants, which was adopted by the United Nations General Assembly on 19 September 2016 *(2)*. Although health was not identified as a specific topic for thematic sessions, WHO and IOM worked together with Member States to ensure that health would be properly included in the GCM. A key event in the GCM process was the Second Global Consultation on Migrant Health, held in Sri Lanka in February 2017 *(3)*. The resultant Colombo Statement *(4)* was accepted as a formal input into the GCM. Point 3.3 of the Colombo Statement affirms commitments to

> lead in mainstreaming the migration health agenda within key national, regional and international fora, in domains such as migration and development, disease control, global health, health security, occupational safety, disaster risk-reduction, climate and environmental change, and foreign policy as guided by the 2030 Agenda for Sustainable Development.

Throughout 2017, the health of refugees and migrants was kept on the agenda through a number of different side-events at high-profile meetings, such as during the United Nations General Assembly High-level Week *(5)* and in three of the six thematic sessions *(6–8)*. Underpinned by principles based on World Health Assembly resolution WHA70.15 *(9)* and the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants *(10)*, multiple stakeholders (including civil society and United Nations organizations such as ILO, IOM, the Joint United Nations Programme on HIV/AIDS, OHCHR and WHO) developed a joint proposal to recommend elements to be included in the GCM *(11)*. The proposal contained eight suggested commitments, a number of which can be found in the final objectives of the GCM. They included the recommendation to adopt "migrant-sensitive, non-discriminatory and inclusive health policies" (commitment 2, now included under GCM Objective 15), to "enhance… health information and health monitoring systems on migrant health" (commitment 4, now included under GCM Objective 1), the "protection of vulnerable populations" (commitment 7, now included under GCM Objective 7) and "health insurance social protection for migrant workers and their families" (commitment 8, now included under GCM Objective 22). The inclusion of these commitments can be seen as a significant step forward to promote migrant health, with health-related commitments and actions featuring throughout the GCM.

Health-related commitments and actions

The text and objectives covering health and health-care access in the GCM *(1)* are firmly rooted in the principles enshrined in a large number of international treaties and covenants, some of which are binding. These include the Universal Declaration of Human Rights *(12)*, the International Covenant on Civil and Political Rights *(13)* and the International Covenant on Economic, Social and Cultural Rights *(14)*, among many others. The GCM objectives are also closely linked to a number of SDGs, and link SDG 10 target 10.7 (well-managed migration policies) with SDG 3 target 3.8 (UHC). The GCM comprises a total of 23 objectives, and while health is not listed under a separate heading, it permeates many of the objectives and is unequivocally connected

and essential to a number of GCM objectives, for example Objectives 3, 8, 12 and 23. Many of the wider determinants of health are also covered in the GCM, including labour conditions, detention policies and better access to humanitarian aspects for refugees and migrants. The objectives are also aligned with the WHO Framework of Priorities and Guiding Principles *(10)*.

Objective 15 of the GCM (to provide access to basic services for migrants) is linked to efforts to achieve UHC (SDG target 3.8). However, the remit of Objective 15 is broader than just basic services: it encourages migrant-inclusive health delivery systems and actions to promote equity and improve information on services (action c) and culturally sensitive service delivery and other migrant health needs to be incorporated into national plans (action e). Objective 1 is to "collect and utilize accurate and disaggregated data as a basis for evidence-informed policies", which includes migrant health (action j). Timely and reliable data are key to understanding epidemiology and health-care needs, and to dispel myths. They also inform health service planning and policy development and can help to monitor health indicators and SDGs.

Actions to mitigate the vulnerabilities of migrants are emphasized in Objective 7; this includes providing psychosocial services where appropriate, and health care for specific, more vulnerable, populations such as children (action f). Psychosocial provision for vulnerable people (victims of trafficking) is also addressed in Objective 10 (action h). Objective 16 aims to foster inclusion and integration into the host society, including health, education and labour market integration (action c). This is linked to both safeguarding labour conditions in the receiving country (Objective 6) and establishing mechanisms for the portability of social security entitlements and earned benefits (Objective 22), which is particularly important for health insurance.

Experts have commented on the absence of a designated health objective within the GCM *(15)*, and that the basic health services envisioned in Objective 15 may be fewer than those enshrined in already existing covenants *(14)* and nonbinding commitments for comprehensive primary health care for all *(16)*. Others have pointed out that, despite the clearly evident child-sensitive approach to health care with equitable and specialist services for minors, some gaps remain in related areas, such as reproductive health and maternity care *(17)*. Nevertheless, the GCM can be seen as a major milestone offering a 360-degree perspective on the different aspects of migration, reaffirming

previously agreed international principles and encouraging Member States to cooperate in implementing the GCM. It gives the international community a comprehensive policy framework that will guide action on migration at the national, regional and global levels, and it establishes the United Nations Network on Migration *(18)*, which will monitor its implementation.

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6. Negotiating the Global Compact on Refugees: health implications of coping with the displaced millions

Allen G. K. Maina

Introduction

In September 2016, the United Nations General Assembly held the first-ever summit to address the issue of large movements of refugees and migrants. The summit called on governments, international organizations, development actors, civil society, the private sector and others to work together to save lives, protect rights and share responsibility on a global level.

United Nations Member States unanimously adopted the New York Declaration for Refugees and Migrants *(1)*, which gave the General Assembly two years in which to develop a comprehensive response framework and to present two Global Compacts – one on refugees (the GCR *(2)*) and one on migrants (the GCM *(3)*). This presented a unique opportunity to create a more responsible and predictable system for responding to, and creating safe and legal pathways for, large movements of refugees and migrants.

The General Assembly mandated UNHCR to provide international protection to refugees and to find sustainable solutions to the challenges that they face.

The 1951 Convention relating to the Status of Refugees *(4)* recognized that a satisfactory solution to refugee situations cannot be achieved without international cooperation, as the grant of asylum may place unduly heavy burdens on certain countries (also referred to in Article 2 (2) of the Declaration on Territorial Asylum *(5)*). According to the Joint Letter from IOM and UNHCR on the collaboration between the two organizations *(6)*, "Refugees and migrants are entitled to the same universal human rights and fundamental freedoms, which must be respected, protected and fulfilled at all times. However, refugees and migrants are distinct groups governed by separate legal frameworks."

The two Global Compacts seek to strengthen national systems with the aim of benefiting refugees, migrants and host communities. Improving the coordination of efforts, including by engaging a broader set of actors in responses, is an important objective in this regard.

The GCR, which was adopted by the United Nations General Assembly in December 2018 *(2)*, was developed following two years of intensive consultations with Member States and other stakeholders, including refugees, civil society, international organizations, the private sector and experts. While UNHCR led the development of the GCR and its implementation, efforts were made to ensure complementarity with the implementation of the GCM, particularly in areas of common concern.

Health-related commitments and actions

The GCR sets out a range of measures to promote international cooperation, solidarity and responsibility sharing to improve the lives of refugees and their host populations, including enhancing access to important services such as health. Health is mentioned in the GCR, where several elements are included, for example on the contribution of resources and expertise to expand and enhance the quality of national health systems to facilitate access by refugees and host communities. Provisions for gender and age have also been included.

The GCR was built on decades of experience in protecting refugees, supporting host countries and communities and finding solutions, as well as on more recent

data gathered in the context of efforts to roll out the Comprehensive refugee response framework in 15 countries *(7)*. The Framework envisions concrete measures to facilitate a comprehensive response to support refugees and the countries particularly affected by large refugee movements or a protracted refugee situation. Measures include those areas needing support, from initial reception and admission of refugees through to meeting the needs of communities and supporting them, and finding solutions to specific problems.

UNHCR consulted with Member States and a wide range of other stakeholders through an extensive multilateral process. The first phase included collecting good practices and lessons learned from a wide range of refugee situations through the practical application of the Comprehensive refugee response framework in more than a dozen countries and at regional level. It also included a series of five thematic discussions on key topics involving Member States, international and regional organizations, NGOs, academics, experts, private sector partners, refugees and host community representatives. This phase was followed by six formal consultations with Member States to discuss successive drafts of the GCR, from February to July 2018, during which time the text was revised based on the feedback received.

In 2017, the World Health Assembly endorsed resolution WHA70.15, Promoting the health of refugees and migrants *(8)*, and plans to strengthen international cooperation on the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants *(1)*. This resolution was accompanied by the Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants *(9)*.

Member States also tasked WHO with developing a global action plan on the health of refugees and migrants. This was agreed at the Seventy-second World Health Assembly in 2019 *(10)*. The development processes for the Framework and the Global Action Plan were, in some ways, complementary to the GCR process and offered a clear home for some of the more specific health-related issues under the broader umbrella of improving access to health for refugees and migrants. In some respects, the GCR provides an overarching framework in the refugee context, whereas tools such as the Framework of Priorities and Guiding Principles and the Global Action Plan offer useful ways forward in thinking through what better access to health can and should mean at the national and regional levels.

Internal and external efforts by certain Member States and other stakeholders (such as the GAVI Alliance and others) made a real difference in ensuring that the issue of health was consistently raised as a priority throughout the formal consultation process. However, views differed as to which health priorities should be reflected in the GCR. In addition, there were divergent views on the extent to which multilaterally agreed documents, such as the WHO Framework as well as others, could be factored into the GCR. For example, some Member States preferred to include all elements of the WHO Framework, while others preferred to keep only some elements.

In the end, and thanks to the support of Member States, WHO and other stakeholders, a reference to the Framework was included in the GCR. This was a significant breakthrough. Consequently, this framework document is a more thorough outline of relevant public health considerations and associated technical content for promoting the health of refugees and migrants. This was a key success of health diplomacy and getting this detail included in the GCR represents an excellent example of support and solidarity by Member States.

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7. Advocating for health inclusion in the Global Compact for Safe, Orderly and Regular Migration

Alyna C. Smith and Michele LeVoy

Introduction

A United Nations resolution, unanimously agreed by 193 Member States in September 2016, to develop and agree on a shared framework of principles and action in the area of migration was truly ambitious and historic *(1)*. The processes to develop the GCM *(2)* and the GCR *(3)* were launched following this and were greeted by civil society with a mixture of hope and concern. The GCM was launched when migration had become a deeply politicized and divisive issue; in the United Kingdom a referendum decision had been made to leave the EU and elections were upcoming in several European countries where immigration featured prominently (Austria, France and the Netherlands). Efforts to reform Europe's common asylum system had reached an impasse, and EU Member States had yet to agree on an adequate response to refugees and migrants arriving at its southern shores. The opportunity presented by the GCM to strengthen the rights of refugees and migrants was, therefore, clear, as was the prospect of these being weakened.

The GCM was adopted by the United Nations General Assembly in New York on 19 December 2018 by an overwhelming majority despite some Member

States being hesitant ahead of the final GCM conference in Marrakesh in early December 2018 *(4)*. Overall, the GCM represents a positive development. While the final text falls short of initial expectations in several areas, including on the rights of refugees and migrants to health care, it is better than many advocates had expected given the political context. Moreover, the process for developing the Compact in itself was groundbreaking in its transparency. This marks the first time that open international dialogue among states addressed issues such as access to justice and services, including health care, for irregular migrants and so-called firewalls to remove any linkage between the delivery of services and immigration enforcement.

An inclusive process

While, ultimately, the GCM is a political document, negotiated and finally adopted by United Nations Member States,[3] civil society was active in all phases of the process, participating in thematic and regional consultations and stocktaking meetings throughout 2017, as well as attending the negotiations in New York during the first half of 2018. This engagement was possible because United Nations agencies deliberately made space for the participation of a range of nongovernmental actors. Negotiations were entirely state led, but transparent; civil society could attend all the official negotiation sessions and provide input at the short multistakeholder hearings held during each round (albeit with minimal government participation).

PICUM is a network of over 160 organizations "working to ensure social justice and human rights for undocumented migrants". It approached the GCM process by:

- being present and actively participating throughout all phases of the process;
- working directly and constructively with state delegations on critical issues; and
- working closely with United Nations agencies and civil society partners, including regional and thematic networks.

[3] Participants in the negotiation phase were primarily representatives from ministries of foreign affairs of Member States.

Being present and actively participating throughout all phases of the process

During the consultation phase in 2017, PICUM participated in several of the United Nations multistakeholder thematic consultations, co-organized the European regional civil society consultation and supported its members in giving input to their national consultations.

PICUM also participated in all six rounds of the intergovernmental negotiations, which took place from February to July 2018 in New York. For PICUM's small secretariat, this represented a significant investment of time and resources and reflected the organization's belief in the historic nature and potential of the GCM as a framework for intergovernmental dialogue and action on issues affecting irregular migrants.

PICUM made the most of its opportunities to participate in various fora open to civil society, making a statement during the informal stakeholder hearings held during each negotiation round and participating by providing a speaker or panellist in 10 side-events held during the negotiation phase in New York. PICUM also provided a panellist in related United Nations-led side-events in New York and Geneva, as well as during the Global Forum on Migration and Development meeting and the Intergovernmental Conference to adopt the GCM held in Marrakesh in December 2018.

Working directly and constructively with state delegations on critical issues

NGOs did not have a formal role in the state-led negotiation phase of the GCM. They could, however, attend hearings where delegations presented their views on the text and meet with state representatives in the margins of these discussions.

Throughout the six rounds of negotiations, PICUM held more than 50 bilateral or multilateral meetings with government representatives. In addition to one-on-one meetings with delegates, PICUM engaged with various groupings of states, including an informal so-called Like-Minded Group, which gathered delegations from Asia, Canada, Latin and South America, Lichtenstein and

Switzerland, and the Africa Group. These shared concerns and perspectives about irregular migrants and were proactive in raising them in their interventions during the formal negotiations.

PICUM focused its efforts on providing timely analysis and recommendations that sought to address the concerns of some governments – particularly within the EU – while ensuring key human rights commitments and policy responses were retained in the text. To this end, in advance of each round of negotiations, PICUM produced analysis and arguments on the latest draft and suggested revisions to the text based on government statements during the negotiations and discussions with different government representatives. These briefings were shared with the two Co-facilitators and multiple delegations (often upon request) and served as the basis for global civil society advocacy.

As one of the few civil society networks with membership mainly in Europe attending the negotiations, PICUM used the global platform to highlight existing practice within the EU supporting the rights of irregular migrants, including through access to services. For example, PICUM emphasized how a number of EU Member States have ensured the social rights of refugees and migrants regardless of status for decades, including Belgium and France, where legislation grants a right of access to preventive and curative care to irregular residents; Spain, which announced in 2018 that it would once again extend the right to UHC to all regardless of residence status; and municipalities, including Utrecht and Ghent, which have taken steps to facilitate access to services for their residents regardless of migration status *(5)*.

PICUM's briefings focused on several areas, including gender responsiveness, access to services, so-called firewalls around health provision, migration detention of children, noncriminalization of assistance, and protection for migrant workers. PICUM led the impetus for language on the firewall concept (clear separation between the provision of health-care services, on the one hand, and immigration enforcement mechanisms, on the other, to ensure protection of and respect for fundamental rights) by disseminating its brochure on the firewall and access to health care, which was actively promoted by some Member States. During the last session, PICUM also co-organized a side-event with the International Federation of the Red Cross and OHCHR on firewalls, which was hosted by the Philippines.

Working closely with United Nations agencies and civil society partners, including regional and thematic networks

PICUM collaborated closely with civil society partners in the development of the two Global Compacts, including as members of the Global Coalition on Migration, the Women in Migration Network and the Initiative for Children's Rights. It also collaborated with other stakeholders, such as ILO and the International Trade Union Confederation. Within the global civil society formations meeting in New York, PICUM was a key driver behind a more active and strategic advocacy approach.

As one of the first global civil society partners to set up an intensive schedule of bilateral meetings with United Nations delegations in New York, PICUM actively reported back to other NGOs and encouraged them to increase their own advocacy and to proactively meet with delegations and advance civil society's recommendations and messages. PICUM's briefings were widely supported and shared by global civil society organizations, and specific language suggestions were taken up by several states and groups of states.

In February and March 2018, at the start of negotiations, PICUM held two meetings in Brussels to exchange thoughts with broader civil society on the developments of the GCM and how they could develop their advocacy strategies at both the EU and national levels.

PICUM members were also supported to engage in the compact process, with many using the negotiations as an opportunity for dialogue with national governments.

PICUM's membership in numerous alliances with civil society organizations on migration at a global level helped to steer their efforts in this pivotal year on global migration policy. PICUM is a board member of the Global Coalition on Migration, a steering committee member of the Women in Migration Network, a member of the Action Committee on the Global Compacts and a member of the International Steering Committee of the Global Forum on Migration and Development's Civil Society Days. PICUM's presence at these fora have enabled it to contribute to joint statements and analyses produced by civil society throughout 2018 on global migration, as well as to contribute insights on civil society's potential contribution to the new United Nations Migration Network.

Health in the GCM

The zero draft presented to states during the first round of negotiations in February 2018 contained several explicit mentions of the firewall and services for all migrants, regardless of status. During the subsequent rounds of negotiations, states proposed revisions each time these specific objectives were discussed.

The final text of the GCM is much better than might have been expected, given the context. This was no doubt due, in some measure, to a strong first draft produced by the Co-facilitators, who were committed to grounding the GCM in existing human rights standards and ensuring that it served the interests of refugees and migrants in their countries of origin, as well as their countries of destination. The final language in several paragraphs of the GCM also reflects the significant engagement of civil society with states, as described above, to press for a rights-based and holistic approach.

The GCM still falls short in several important areas and, in some respects, is a step backwards from international standards and regional practice. The final language of the text relating to the noncriminalization of refugees and migrants and those who assist them, and to access to services, was toned down.

Nevertheless, health care is far from absent. The final text of the GCM *(2)* contains 15 references to health: five of these appear under Objective 15, which addresses access to basic services for migrants, including an important reference to the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants *(6)*. This recalls Member States' commitment, just months earlier, to addressing migrant health in a comprehensive, nondiscriminatory way. Also significant are references to health in the context of fair and ethical recruitment and safeguarded conditions that ensure decent work (e.g. covering migrant workers' rights; Objective 6), and access to services for migrants as part of a component of inclusion and social cohesion (Objective 16). Health is also an important, unspoken concept in other parts of the Compact.

> **Objective 4** addresses adequate documentation and the reform of rules that require proof of nationality at service delivery centres, to ensure that refugees and migrants "are not precluded from accessing basic services nor denied their human rights".

Objective 7, on reducing vulnerabilities, includes this extraordinary language: "Review relevant policies and practices to ensure they do not create, exacerbate or unintentionally increase vulnerabilities of migrants, including by applying a human rights-based, gender- and disability-responsive, as well as an age- and child-sensitive approach". Mitigating vulnerabilities caused or exacerbated by existing policies is critical to improving health and would require a genuinely whole-of-government, whole-of-society approach.

Objective 8 commits to "saving lives".

Objective 13 refers both to ensuring access to health care in detention and to reducing "the negative and potentially lasting effects of detention on migrants", effectively recognizing the damaging health-related impact of this practice.

Objective 17, on eliminating discrimination, refers to access to redress mechanisms for abuses, which is also addressed in several other places; this is significant because health-care workers are often the first point of contact for survivors of violence.

It is true that, unlike the GCR, no section of the GCM is devoted specifically to health. However, the inclusion of health at various places offers important additional dimensions to the Compact. Given the resistance of several prominent states and a difficult political climate, it represents a victory for the NGOs, health professionals (e.g. a submission by the International Child Health Group *(7)*), intergovernmental bodies *(8)* and cities (e.g. cities in the United States *(9)* and more than 50 cities worldwide whose representatives signed the Mechelen Declaration in 2017 *(10)*) that worked in the background.

This success regarding health mirrors a related victory in the intergovernmental negotiations. During one round, the Co-facilitators dedicated an entire discussion to the topics of access to services and to firewalls. States were asked to present their policies and practices in these areas. All states explicitly acknowledged that irregular migrants have rights. This affirmation was significant in a political context where people in an irregular situation are frequently portrayed as threats to borders and to societies, and not as bearers of rights. States also acknowledged their own practices when providing services to irregular migrants. Although, in some cases, this was

done grudgingly, several states were insistent in underscoring the rights of all migrants, regardless of status, and the need to realize these rights by creating firewalls and removing barriers to care.

A framework for action and accountability: an opportunity for health diplomacy

Since 2006, when the first of two United Nations High-level Dialogues on Migration and Development (2006 and 2013) were convened, and in the annual Global Forum on Migration and Development's meetings, which have taken place since 2007, issues such as legal entitlements and policies and practices concerning access to health care, education, social services and justice for irregular migrants have been regularly discussed by civil society and United Nations bodies, but not thoroughly addressed by states.

The GCM process was the first time the rights of irregular migrants to access health care and other services was a specific item for discussion on states' agenda. This, in itself, marks an important step forward.

As already mentioned, the GCM process, including the governmental negotiations, was significant for its transparency and openness. The Compact is not a binding legal treaty: it is a cooperative framework whose "authority rests on its consensual nature, credibility, collective ownership, joint implementation, follow-up and review" *(3)*. To maintain its authority and credibility, implementation of the GCM must reflect the same collective effort and inclusiveness of the process that created it.

The experience of Europe is instructive. A decade ago, under the auspices of the Portuguese and Spanish EU presidencies, migrant health was a high priority on the European agenda, with resulting detailed recommendations and pledges by governments and other stakeholders *(11,12)*. Member States have also promoted positive action on refugee and migrant health through their engagement in intergovernmental bodies such as WHO and IOM. The European Union Agency for Fundamental Rights has conducted several analyses of the situation of migrants in an irregular situation, including a 2011 study on their access to health care in 10 EU Member States *(13)*.

Its 2015 report showed the damaging financial impact on health systems of excluding people from accessing care other than emergency care based on their residence status *(14)*.

In 2010, WHO and IOM organized the first high-level Global Consultation on Migrant Health, following the 2008 World Health Assembly resolution WHA61.17 on the health of migrants *(15)*. The consultation generated a detailed report that reflected the shared priorities of governments, academics and civil society to improve health for refugees and migrants. This included promoting cooperation across sectors to achieve more migrant-sensitive health systems and equal access to health services, as well as protection in health and social security for all refugees and migrants. In 2016, the 53 Member States of the WHO European Region, which includes all 28 EU Member States, agreed a comprehensive strategy and action plan on refugee and migrant health *(16)*. In 2017, the World Health Assembly adopted the New York Declaration for Refugees and Migrants *(1)*, which gave WHO a mandate to develop a global action plan on migrant health by 2019.

These developments took place while the EU was consolidating its strategy to further secure its external borders and deter irregular migration, which led to publishing its agenda on migration in 2015, which prioritized securing the external borders and deterring irregular migration *(17)*. In late 2015, hotspots were established in Greece, and the western Balkan route was closed; in March 2016, a deal was struck between EU leaders and Turkey to expedite the return of irregular migrants. The impact of this agenda on the health and safety of refugees and migrants has been well documented (e.g. by MSF *(18)*). In 2017, PICUM co-organized a thematic network on migration and health to increase awareness of the situation of refugees and migrants with a precarious status in Europe among a broad group of health actors. Its aim was to show how policies within and outside the health sector affect their health outcomes, and to start a dialogue about the role of the health sector in achieving sustainable change. The thematic network launched a call to action, inviting other partners to join in calling for a coherent approach to migration and health *(19)*).

Healthy migration and health diplomacy

Within the frame of the United Nations Migration Network, established by the GCM and coordinated by IOM, the health of refugees and migrants must

be pursued not as a side-issue to the main work of migration management but, instead, as a test of the appropriateness, adequacy, humanity and sustainability of existing and proposed approaches. Health diplomacy offers an opportunity to address inequities in access to services faced by refugees and migrants, as well as to move the discussion of refugee and migrant health outside of the health sector and to build a broad approach to migration that is grounded in evidence, ethics and pragmatism. IOM's stewardship provides an occasion to work with ministries of the interior, while WHO is critical to engaging ministries of health.

Civil society must also continue to be given the space and opportunity to take part in a transparent, inclusive process of implementation and review. This should take place both within the framework of the United Nations Migration Network's working groups and through working with national governments to develop national implementation plans. Cities and local government, which are specifically mentioned as key actors in the GCM, should also be involved in the process.

Given the highly politicized and complex nature of migration, the engagement of nongovernmental actors is indispensable. Organizations and health professionals working in refugee and migrant rights, for example, have been critical actors for the past 30 years, not only in delivering care to people excluded from the health system because of their insecure status but also in bringing about policy change *(20)*. They should be included in the implementation phase of the GCM as credible partners in developing pragmatic, humane strategies at the national and local levels, in communicating the messages of health diplomacy – of healthy migration – to a broader audience, as well as in pressing for change from their own political contexts. The important work of academics must also be translated into messages that can reach the ear of policy-makers, and the hearts of citizens, bringing nuance, evidence and humanity to an often one-sided debate on migration.

Indeed, the first recommendation of the UCL–Lancet Commission on Migration and Health, whose comprehensive report on migration and health was published in December 2018, evokes the concept of healthy migration and calls on states to invest the political capital and resources needed to achieve this *(21)*. The concept of healthy migration underscores the need for a holistic approach that engages governments across different ministries and levels. In other words, healthy migration is not just a matter for states'

health agendas but also essential for the credibility and sustainability of their migration agendas. This is the insight that health diplomacy provides.

The WHO Global Action Plan on Promoting the Health of Refugees and Migrants was presented to the World Health Assembly in May 2019 *(22)*. It provides an opportunity for the world's leading health body to adopt a model (perhaps inspired by the truly multistakeholder strategy embodied in the Stop TB Partnership *(23)*) designed around partnership with civil society organizations to achieve important changes, recognizing these organizations as instrumental in tackling the complex and multisectoral dimensions of this issue. WHO has a critical role as partner and convener through elevating and supporting existing expertise and insights and ensuring that migration remains on the health agenda.

Conclusions

The WHO European Region provides a stark example of how migration policy has been profoundly disconnected from priorities in other policy areas. It also exemplifies how the health sector has managed to resist the trend towards the politicization of migration. Indeed, in many instances, the sector has taken an approach that is pragmatic, evidence informed and rights based. Looking at migration through the health lens means that the existing political and technical consensus on good practice can be used, and it highlights the deep and fundamental human dimensions of migration, which are easily obscured when policies are discussed without reference to their impact on human health and well-being.

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8. The UCL–Lancet Commission: how academia can engage with policy-makers and contribute to health diplomacy for migration

Ibrahim Abubakar and Miriam Orcutt

Introduction

Effective collaboration between academics and policy-makers in the field of migration and health is essential in order to move the global migration health agenda forward and to consolidate migration and health as a priority research and policy area. It is also imperative in order to address the predominant negative narratives, racism and xenophobia surrounding migration, and to demonstrate the benefit of refugees and migrants to national and global economies. With positive joint action, policy-makers and academics can work together to uphold the rights of all refugees and migrants through evidence-informed policies.

The project

The UCL–Lancet Commission on Migration and Health *(1)* was a two-year project addressing migration and health as a global public health priority *(2)* and one of the defining issues of our time. The Commission presented evidence-informed approaches to inform public discourse and policy to address migration as a global health priority, including proposing recommendations for maximizing the health of all people on the move.

The Commission provided a template for how policy engagement in migration and health could be effectively achieved at multiple levels of migration health governance. In addition, the Commission's policy activities over the two years highlighted:

- the importance of engaging academia with policy-makers and the global migration and health policy agendas over the longer term;
- how relationships between academia and policy in migration can be fostered with the aim of reaching a common goal; and
- how critical it is to translate effectively the academic output regarding migration and health into policy actions.

The project was led by 24 leading academic experts from 13 countries and resulted in the publication of a 50-page report in December 2018 that included new data analyses and represented a comprehensive synthesis of evidence *(2)*. The Commission liaised continually with key actors in governmental and intergovernmental sectors to influence international health and migration policy.

During all phases of the Commission, the academic process was oriented towards policy-makers at the global, regional and national levels through active interaction with policy-makers and with global policy processes. The Commission's activities were divided into the following phases: planning, research, writing, dissemination, advocacy and engagement.

During the planning phase, initial links with actors at international level were made, for example, IOM, WHO and the World Bank. During the planning,

research and writing phases, the Commission engaged with some of these actors through named individuals, who were involved in a personal capacity as co-authors of the Commission's work or had input through attending the Commission's annual working meetings.

The Commission was primarily involved in two main policy areas and agendas. The first area was migration and sustainable development, which involved engaging with the wider commitment by multilateral agencies to the SDGs. Interactions with key United Nations agency staff in a personal capacity ensured that the evidence synthesis and recommendations were informed by ongoing developments in these organizations and, consequently, that emerging evidence from the Commission fed into key documents and policies being developed at global level using a soft influence strategy. Second, the right to health for all refugees and migrants was identified as a central theme through iterative discussions between health system experts. This provided a logical avenue to support the view of other global health actors on UHC and in line with WHO's Thirteenth General Programme of Work 2019–2023 *(3)*.

To initiate the dissemination phase, the report and its recommendations to improve the public health response to migration was launched at an official side-event to the United Nations Intergovernmental Conference to adopt the GCM, held in Marrakesh in December 2018 *(4)*. Launching the report at a venue where global policy actors were discussing migration was not only symbolic but also an excellent opportunity to highlight the evidence base to an international audience.

The side-event was entitled Health: the Key to Migration's Role in Sustainable Development. It included a panel presentation with representatives from the International Rescue Committee, IOM, MSF and WHO. Two interventions were also made by Commissioners at the main intergovernmental conference, both advocating for the human right to health for all migrants regardless of their legal status. These were two of the key interventions on migration and health made during the process of developing the GCM and they represented an important step in working towards the goal of ensuring dignity for all migrants.

Subsequently, in a series of seven regional events, the Commission engaged senior policy-makers and country-level actors. These events included a human rights-focused regional launch in Germany; a legal- and rights-based event in New York; broad-based events with a regional focus in Brazil, South Africa

and the United Kingdom; a refugee- and forced-displacement-centred event in Lebanon; and an Asian regional launch in Nepal. The Commission continues to engage senior policy-makers through an ongoing process of regional policy roundtables.

Policy recommendations

The Commission made the following policy recommendations *(2)*:

- dedicate political capital, financial and human resources to fulfil global commitments to secure healthy migration and improve the security and well-being of mobile groups, especially the most marginalized;
- rebalance policy-making in migration, trade, the environment and foreign affairs to give greater prominence to health;
- foster cross-sectoral, complementary decision-making that integrates health considerations across policies and services that determine the health of migrants;
- confront urgently, vigorously and persistently the divisive myths and discriminatory rhetoric about refugees and migrants;
- advocate for and improve the rights of refugees and migrants for safe and healthy education and working conditions, which includes freedom of movement without fear of arbitrary arrest; and
- urgently ensure adequate monitoring, evaluation and research to support the implementation of both the GCM and the GCR.

Ultimately, global health diplomacy requires politicians in the highest law-making fora in each nation state and in regional mechanisms to be proactively engaged. Consequently, to ensure the dissemination, engagement and uptake of the recommendations in policy circles, a series of parliamentary events and interventions on access to health care for refugees and migrants and UHC were organized in country and regional contexts. A German parliamentary intervention presented the Commission's policy recommendations for ensuring access to health care for migrants in Germany, alongside the NGO Médecins du Monde Germany. Two parliamentary events were arranged in the United Kingdom, one on access to health care for migrants in the United

Kingdom and a policy roundtable entitled Improving global governance in migration and health: moving the agenda forward.

The German policy event identified the critical importance of linking back to the human rights arguments enshrined in the German Constitution. While politicians and citizens often sympathize with this argument, actually implementing human rights policy approaches was not currently viewed favourably by politicians or the general public. Consequently, considering ways of bridging this divide between perspectives was important.

Both events in the United Kingdom sought to discuss the best approaches to transform evidence summarized in the Commission into tangible policy action that would have an effect on migration and health. The politicians who attended these events were largely sympathetic to the issues raised, but all recognized the difficult policy context in which the current global health diplomacy agenda is unfolding. The fact that refugees and migrants contribute to health systems as well as to the wider economy, while an important message, is not one that is reaching the public. Nevertheless, attitudes towards migration in the United Kingdom have moved in a more positive direction since the Commission report was launched. The events explored ways to better package and present the Commission's messages in order to improve policy reach.

The Commission has engaged at international and regional levels on the topic of UHC and migration in a coordinated policy focus in the run-up to the United Nations High-level Meeting on Universal Health Coverage in September 2019, through the following activities:

- a policy roundtable on UHC and migration in collaboration with Chatham House, London, attended by 40 representatives from policy, academia and practice;
- a series of regional policy roundtables on UHC and migration, one to be held in South Africa and one in South America (Peru);
- engaging with the World Bank preparatory process for the United Nations High-level Meeting;
- co-organizing a side-event with WHO focused on migration and UHC at the World Health Assembly 2019, with seven health ministers from different regions discussing the challenges and opportunities in migration and UHC in their region; and

- co-organizing a launch and policy event in April 2019 with IOM and the Pan American Health Organization in South America on policy engagement in the context of the health system response to migration from Venezuela.

The Commission continues to engage with the implementation stage of the GCM *(5)* to advocate for the right to health for all refugees and migrants by engaging with other key actors, such as WHO. The Commission has directly contributed academic expertise to the development of the WHO draft for the Global Action Plan on Promoting the Health of Refugees and Migrants 2019–2023 *(6)*. It has also provided input into the First Expert Meeting on Migration and Health at WHO, highlighting the importance of prioritizing the linkage between academia and migration and health policy, particularly in order to help to consolidate technical and programmatic expertise in migration and health across the policy arena.

Moving forward: how academics can engage effectively with policy-makers

Three areas can be identified where academics can effectively engage with policy-makers regarding migration and health: engaging with a long-term strategy to build combined knowledge and experience between policy-makers and academics; fostering collaboration between policy-makers and academics on common themes through advocacy and training; and ensuring the most effective implementation of policies and evaluating their impact.

Engaging with a long-term strategy on migration and health to build knowledge and experience between policy-makers and academics

Fostering collaboration between academics and policy-makers at all stages. The use of existing and new research to provide evidence to inform migration and health policies is facilitated by effective collaboration across all areas. Such collaboration can be key during all stages of academic work, from the inclusion of policy-informed objectives in research through to the

implementation of migration health research, where policy-makers can be engaged during key phases. Finally, effective dissemination of knowledge from the research process into policy recommendations and briefings is essential.

Creating evidence-informed indicators. The use of indicators allows progress to be monitored. It also helps to ensure transparency and accountability at the national, regional and international levels, for example in the implementation of the GCM. Migration health research can inform the creation of these indicators and encourage their effective use in the implementation of global migration and health policy processes. Indicators are important as impartial and independent evaluators of the success of policy implementation.

Encouraging long-term research and policy collaborations. The exchange of knowledge across regions on scientific and technical work enables the sharing of best practice and lessons learned in migration and health policy and research. Academia may often be well placed to encourage the sharing of knowledge and best practice through independent platforms.

Fostering collaboration between policy-makers and academics on common themes through advocacy and training

Appointing country-level focal points on migration and health. Effective, long-term engagement and knowledge sharing between policy-makers and academics is made easier if there are focal points in each country through which academics can link effectively with ongoing policy processes. Furthermore, developing a communication channel between the focal point and academics may help to identify future areas of policy or academic work or opportunities for expert working groups. This is helpful for concurrently improving the health of migrants and advancing the migration health agenda.

Establishing networks and working groups of policy-makers and academics. Having collaborative mechanisms in place can help in predicting and responding rapidly to major drivers of migration, such as environment and climate change, urbanization, natural disasters

and conflict. Mechanisms of this type would help to address one of the common challenges in the migration and health arena, which is the often-slow response of both policy-makers and academia to emerging migration trends. Examples include the health system response to rapid mass migration, migration associated with environmental and climate changes, and predicting effective longer-term policy for changing migration trends.

Identifying common objectives in policy areas and academia. There may be areas where aspects of policy agendas converge with ongoing academic work and joint advocacy may be effective; examples include assessing the effective integration of migrants into UHC and migrant-centred health-care provision and access.

Ensuring awareness of the health impacts of racism, prejudice and discrimination through regulatory and training bodies. Output from migration and health research clearly demonstrates the negative health impacts of racism and discrimination. Therefore, collaboration between academia and policy-makers on such topics, which have been clearly identified as priorities in migration and health research, is essential. For example, academia could help in identifying the most effective way of presenting information that will change public opinion or public behaviour on these issues.

Ensuring the most effective implementation of policies and evaluating their impact

Including academic perspectives and academic experts in policy implementation and the evaluation of policies. The planning and implementation phase of any migration policy can be supported by academic input. For example, policy-makers and academic experts in migration health can work together to create evaluation tools to assess the health and nonhealth impacts of policies, and to analyse where and how migrant health can be integrated most effectively into all policies to ensure a whole-of-government and whole-of-society approach.

Engaging academics in the implementation of global migration and health mechanisms. The implementation of initiatives such as the GCM *(5)*, the GCR *(7)* and the WHO Global Action Plan *(6)* can be supported

by the use of expert working groups that include migration and health academics to provide technical expertise on specific aspects of policy implementation.

Longer-term engagement of academics with international migration and health policy stakeholders is an ongoing process and will continue after the launch of the next phase of the Commission, which is Lancet Migration *(1)*. This will be a global initiative, between *The Lancet*, academic institutions and multilateral agencies, which aims to tackle the issue of global migration and the associated health challenges.

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9. Health diplomacy in action: negotiating resolution WHA70.15, Promoting the health of refugees and migrants

Julio Cesar Mercado

Introduction

Refugee and migrant health proved to be a highly relevant issue at the World Health Assembly in May 2017. The WHO Secretariat's report Promoting the Health of Refugees and Migrants with its annexed framework of priorities and guiding principles to promote the health of refugees and migrants *(1)* was considered and approved in resolution WHA70.15 *(2)*. The discussions and negotiations highlighted the diverse views held by Member States but also underlined the need and provided an opportunity for an in-depth debate on the subject. While it could have been predicted that such a complex and multifaceted issue would require considerable time and effort to reach an agreement, in the end a solution was found, once again through dialogue and a sincere search for consensus.

This chapter highlights the importance of multilateral diplomacy as applied to the negotiation of a resolution on a very politically sensitive issue. The chapter covers the process initiated by the Italian and Argentine delegations

to WHO with the aim of updating the 2008 resolution WHA61.17 on the health of migrants *(3)*. The chapter will examine not just the steps that resulted in the new resolution being approved but also the political context in which they took place and will also try to highlight the lessons learned for health diplomacy from the entire process.

The work that was carried out at the governing bodies of WHO in Geneva was preceded by discussions and resolutions approved by the WHO Regional Committee for the Americas on migrant health (resolution CD55.R13) *(4)* and by the WHO Regional Committee for Europe in the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region *(5)*. Both resolutions – together with the Global Consultations on Migrant Health that took place in Spain in 2010 *(6)* and in Sri Lanka in 2017 *(7)* – paved the way for the global discussions at WHO headquarters.

The negotiation surrounding acceptance of resolution WHA70.15 was preceded by a long round of consultations, which were led by the WHO Secretariat in Geneva, to help to build and develop the Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants. The process was mandated by decision EB140(9) *(8)*, which was approved by the WHO Executive Board at its session of January 2017.

During the consultations, the Secretariat produced a first draft, which served as the basis for a series of rich and fruitful discussions with Member States. Following the consultations, the Secretariat presented a final draft text of the framework to the Member States (A70/24 *(1)*) to be considered by the Seventieth World Health Assembly in May 2017.

After considering document A70/24, the World Health Assembly adopted resolution WHA70.15 *(2)*. The Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants, which was contained in the resolution as an annex, was recognized as a working guide for WHO to use in its advocacy, leadership and support to the Member States on the issue of refugee and migrant health. It also became an important tool for informing discussions among Member States during the negotiation for the GCM in Marrakesh in December 2018. In fact, the relevance of the framework was recognized in Objective 15 of the Compact: "Incorporate the health needs of migrants into national and local health-care policies and plans… including by taking into consideration relevant recommendations from the WHO

Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants" (action e) *(9)*.

Although the discussions around health and refugees and migrants are diverse and multifaceted, this chapter will focus on the diplomatic negotiation process of resolution WHA70.15, its complexity and the lessons learned. Each negotiation process has its own distinct characteristics and takes place in a political context that varies with time in a dynamic world. However, there are common elements in negotiations from which we can draw conclusions and provide lessons that could prove useful in finding successful solutions in similar future negotiations.

Migration and health

The challenges posed by the growing number of humanitarian crises means we must redouble our efforts to find innovative governance mechanisms and focus diplomatic action on a collaborative search for sustainable solutions to the causes and consequences of these crises. However, it must also be recognized that international migration is an everyday reality that has always existed. In some respects, the history of humanity is the history of human migration, which has shaped the ever-changing world we live in. As acknowledged in the GCM *(9)*, "Migration has been part of the human experience throughout history" and "The majority of migrants around the world today travel, live and work in a safe, orderly and regular manner" (paragraph 8).

The international community also recognized the need for migration governance when it was included in the 2030 Agenda for Sustainable Development, which was adopted in 2015 *(10)*. In SDG 10, to reduce inequality within and among countries, Member States agreed to target 10.7: "Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies". However, since health is a fundamental prerequisite for refugees and migrants to be able to work, be productive and contribute to the socioeconomic development of their countries of origin and destination, the SDGs contain a number of goals and targets that are, in some way, related to the promotion of refugee and migrant health (Box 9.1) *(11)*.

Box 9.1. SDG targets related to the promotion of refugee and migrant health

Target 1.3: implement nationally appropriate social protection systems and measures for all, and by 2030 achieve substantial coverage of the poor and the vulnerable.

Target 1.5: build the resilience of the poor and those in vulnerable situations and reduce their exposure to economic, social and environmental crises and disasters.

Target 3.8: achieve UHC.

Target 3.c: increase health financing and train the health workforce in developing countries.

Target 3.d: strengthen the capacity of all countries for early warning, risk reduction and risk management of national and global health risks.

Target 5.2: eliminate all forms of violence against women and girls, including trafficking and sexual and other types of exploitation.

Target 5.6: ensure universal access to sexual and reproductive health and reproductive rights.

Target 8.7: eradicate forced labour, end modern slavery and human trafficking, eliminate child labour.

Target 8.8: protect labour rights and promote safe and secure working environments for all workers, including migrant workers.

Target 11.1: ensure access to adequate housing and basic services, improve marginal neighbourhoods.

Target 11.5: reduce the number of deaths and of people affected by disasters, and reduce the related economic losses.

Target 16.1: reduce all forms of violence and related deaths.

(Continued)

Box 9.1. SDG targets related to the promotion of refugee and migrant health (Continued)

Target 16.2: end abuse, exploitation, trafficking and all forms of violence against and torture of children.

Target 17.16: utilize global and multistakeholder partnerships to support the achievement of the SDGs in all countries.

Target 17.18: support developing countries to increase the availability of high-quality data disaggregated by migratory status.

The SDGs form the basis of the international community's work on the health of refugees and migrants and they demonstrate the issue's relevance on the global agenda. The challenge that migration presents to global governance has also been highlighted on numerous occasions by United Nations Secretary-General António Guterres, who has repeatedly advocated for the issue to be given high priority and for the benefits of migration and the contribution that refugees and migrants make, in their countries of destination and origin, to be reinforced. Mr Guterres said, "The fundamental challenge is to maximize the benefits of this orderly, productive form of migration while stamping out the abuses and prejudice that make life hell for a minority of migrants" *(12)*.

Health diplomacy and migration diplomacy: political context

The governance of migration has, historically, been an inevitable component of diplomacy. Given that population movement is a multifaceted phenomenon, the development of migration governance schemes for health requires an important aspect of this diplomacy, known as health diplomacy, which is understood as the combination of diplomatic skills and technical knowledge in health matters.

The negotiation of resolution WHA70.15 *(1,2)* took place in a political context that was auspicious but also characterized by some reluctance among certain

Member States. On the one hand, the negotiations benefited from the momentum created by the adoption of the New York Declaration for Refugees and Migrants by the United Nations General Assembly in September 2016 *(13)*. This adoption showed that the international community was ready, at that time, to initiate discussions that would enable migration, like other aspects of international relations, to be guided by a set of common principles and approaches. On the other hand, it was evident that a few Member States had some difficulties in making certain commitments, which reflected internal political concerns within their own countries where public opinion was opposed to the idea of expanding the range of health-care services provided to refugees and migrants. There are a number of possible reasons for this public attitude: overburdened national health systems; the rise of nationalist sentiment; concerns among some countries that receive large numbers of refugees and migrants (and feel that international efforts to share the burden are insufficient); and general misconceptions about international migration.

Against this backdrop, how should diplomats and diplomacy contribute to improving the health of refugees and migrants? The role of diplomats is undoubtedly crucial when it comes to elaborating and interweaving international commitments that promote the health of refugees and migrants. Health diplomacy is fundamental in constructing the global governance of migration because it ensures that the element of health is present in each of the multiple areas where migration is discussed, such as human rights, labour, humanitarian assistance and international humanitarian law, and even in economic and commercial negotiations where issues related to migration arise.

One of the most interesting aspects of the negotiation of resolution WHA70.15 was the fact that diplomats who were experts in health, human rights, international humanitarian law and migration came together and applied their expertise to the issue of refugee and migrant health. The negotiation of the resolution involved a level of difficulty that went even beyond the need for health diplomacy, moving into a type of diplomacy that could best be described as migration diplomacy. In the discussions that took place within the framework of WHO, it was necessary to include diplomats whose expertise was related to other humanitarian aspects of migration, particularly diplomats who were experts in protection issues and who had never previously taken part in discussions related to health within the context of WHO. They had to familiarize themselves with the dynamics of negotiating at WHO, which was an enriching experience for all concerned.

Background to the consideration of refugee and migrant health at WHO

The process of negotiating resolution WHA70.15 began, as in many other cases, with the creation of a core group of countries interested in the issue. The invitation to be part of this group and its leadership was taken up by Italy and Argentina, which began by taking as a precedent resolution WHA61.17 *(3)*. This resolution was adopted in 2008 and was promoted, at the time, by Italy.

The core group of countries was selected based on their demonstrated interest in the migration issue and also to ensure that they were representative not only of different regions but also of different viewpoints. Most of them subsequently cosponsored the draft resolution. The cosponsors were Argentina, Colombia, Ecuador, Greece, Haiti, Italy, Luxembourg, Mexico, Panama, the Philippines, Portugal, Switzerland, Thailand and Zambia.

Italy and Argentina raised the issue of refugee and migrant health in order to place it higher on the WHO agenda, as it had become obvious that the international context had changed since 2008. It was, therefore, necessary to update the terms of the 2008 resolution WHA61.17. Although resolution WHA61.17 had been the basis for the work on refugee and migrant health at WHO, the new context required a renewed commitment from Member States to give visibility to the crucial issue of refugee and migrant health and also to promote further cooperation and assistance in matters of health care for countries receiving and hosting large numbers of refugees and migrants.

Furthermore, the international community was focused on preparing and negotiating the GCR and the GCM, following the mandate contained in the New York Declaration *(13)*. It was clear, at the time, that the issue of refugee and migrant health was not sufficiently represented in the New York Declaration or in discussions. Italy and Argentina, therefore, considered it a priority to update the old WHO resolution in order to develop a guide for Member States, to strengthen cooperation among them and to give the WHO Director-General better tools to ensure that health was present in the two Global Compacts, considering that it is widely acknowledged that health is a precondition for development.

The fact that Italy and Argentina had taken the lead on the issue of the health of refugees and migrants was well received and came as no surprise. In fact, there was recognition of the close relationship between the two countries, which has its roots in migration. During the 19th and 20th centuries, Argentina received a massive number of migrants from Italy, as well as from several other countries and regions, which reshaped the country forever. Furthermore, civil and human rights for migrants are enshrined in the country's constitution *(14)* and its migration law (Law 25871) *(15)*, which transformed Argentina into a country of immigration.

During the same period, the WHO Secretariat had been trying to change the approach to refugee and migrant health from a humanitarian one (emergency response) to a broader and longer-term vision related to strengthening health systems and UHC. In other words, the new strategy sought to promote collaboration with Member States to develop the necessary tools to prepare their health systems for a world in which "migration is not a problem to be solved, but a reality to be managed", as former Director General of the IOM William Swing would often state *(16)*.

Negotiation process

From the first meetings of the core group, to which around 20 Member States were invited, it was clear that the challenges in reaching agreement on the issue of refugee and migrant health would prove difficult to overcome. The WHO Secretariat provided technical assistance throughout the process and its participation was instrumental in achieving the approval of resolution WHA70.15. This is not only because it brought its technical expertise to bear on the issue but also because it accompanied each step of the process, ensuring a collaborative approach with other United Nations agencies. It was WHO's role to " act as the directing and co-ordinating authority on international health work" (Article 2 (a) *(17)*) that enabled a successful process.

As mentioned above, the WHO Secretariat prepared the first draft of the annexed framework of priorities and guiding principles, and it conducted several consultations to discuss the text with Member States following the mandate of

decision EB140(9) *(8)*, which had also been promoted by Italy and Argentina at the WHO Executive Board.

The final text was included in the report presented to the World Health Assembly by the WHO Secretariat in document A70/24 *(1)*. This document provided the basis for the work that Italy and Argentina then carried out in planning, negotiating and presenting a draft resolution to the World Health Assembly, which was ultimately adopted as resolution WHA70.15 *(2)*.

The first meetings of the core group of countries were intended to introduce the subject, to receive technical comments from the WHO Secretariat and to take note of the first reactions to the initiative and the draft resolution, before inviting all Member States to join the work. The series of core group meetings that followed provided the opportunity to examine the different views of Member States and the challenges ahead, taking into account the political implications associated with the issue of refugees and migrants.

Once the first draft of the resolution had been approved by the core group, the text was ready to be submitted to the World Health Assembly by Italy and Argentina, along with their cosponsors. The first draft was ambitious. It was drafted with the intention of securing the adoption of the framework, among other provisions such as the promotion of the framework as a tool to inform the negotiations on the GCR and the GCM, as well as with the intention of collecting information to develop a global action plan to be presented to the Seventy-first World Health Assembly in 2018. A few Member States challenged some of the provisions and, following normal practice, Italy and Argentina convened numerous informal meetings to which all Member States were invited before and during the Health Assembly to finalize the text and to present a consensus text for approval by the plenary session.

The challenges that had to be overcome during the process included technical issues, aspects related to the political nature of the governance of migration and concerns about the negotiation process itself.

With regard to technical issues, a distinction had to be made at all times between refugees and migrants. Although their health needs are similar, refugees are protected by a specific legal body that could not be ignored during the negotiation of the resolution. In this case, the expertise of diplomatic experts working with UNHCR was crucial. During the meetings,

there was also a reliance on UNHCR officials for ongoing help and support to guide any discussions on refugees.

Other technical challenges included a lack of knowledge, and myths and misconceptions, about aspects of migration, which threatened to lead the debates to the wrong conclusion in terms of statistics, the causes of migration and the countries of origin and destination. In order to counteract this, IOM officials offered their knowledge and experience at each step of the process. In addition, the lack of disaggregated data on the health needs of refugees and migrants also made the work difficult at times and demonstrated the need for concrete and reliable data. Finally, the WHO Secretariat coordinated the response to the technical challenges and helped to maintain a focus on health during the discussions.

Issues related to the political nature of the governance of migration were, perhaps, the most difficult to resolve. Nevertheless, at the end of the process, it was shown that consensus can be reached through dialogue and mutual trust. On the one hand, some Member States were reluctant to commit to granting additional rights to refugees and migrants and it was evident that the delegates' instructions gave them limited room for manoeuvre to make any real progress. On the other hand, the discussions revealed how the impact of different migratory flows into a health system varies widely; the impact is significantly greater for some countries, especially those that share a border with countries facing a humanitarian crisis.

For this reason, one of the strands of the discussion centred around the need to find cooperation mechanisms that promote burden sharing among the international community in order to compensate countries that are overburdened by a migration crisis in their region. During the negotiations, some Member States tried to promote a search for cooperation mechanisms to assist those countries suffering disproportionately, while averting a situation where any aspect of the framework could be interpreted as an extra burden for themselves.

Finally, some of the difficulties faced were connected to the negotiation process itself. These included the need for interagency work between IOM, UNHCR and WHO. Joint work with other agencies is always a challenge in the United Nations system because of the special dynamics of each agency and the different work cultures. However, the negotiation process was a clear

example of complete and harmonious collaboration between agencies, which benefited the matter in hand.

Another challenge related to the process was the natural tendency to begin discussing aspects that would be discussed later, particularly during the planning and negotiation of the GCR and the GCM. A great effort was required during the process to focus the work on a framework of priorities and guiding principles that would serve as tools for future discussions about the Global Compacts. This avoided predetermining the outcome of the later discussions.

While it is true that a consensus was reached on the draft resolution presented by Italy and Argentina, it later became clear that some Member States had some challenges to allowing the text of the framework, as intended by the authors, to be adopted. It was felt that adoption of the framework would signify commitments that some Member States were not ready to assume. Following long discussions, an agreement was reached to attenuate the wording of the resolution to simply note the framework with appreciation, and to add a new provision on international cooperation urging Member States "to consider providing necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants" (Article 2 (4) of resolution WHA70.15 *(2)*).

Another change to the original text concerned the draft global action plan that the WHO Secretariat was to present to the Seventy-first World Health Assembly. An agreement was made for the draft to be presented at the last session in 2019, the Seventy-second World Health Assembly. The reason for the delay was to allow the GCR and the GCM to be finalized as these were, at the time, still in progress. This would allow the future global action plan to be adapted to the health-related provisions that were to be included in both Global Compacts.

Even though the original text of the draft resolution WHA70.15 was more ambitious than the text that was ultimately approved, the process was generally regarded as positive for all the actors involved from the early stages. The negotiations brought the health needs of refugees and migrants to the attention of the international community. It allowed the relevant actors to agree to promote the issue and initiate discussions on the urgent need for international cooperation, particularly for those Member States affected by humanitarian crises in their region. Each of these successes came about because of the open

discussions that were held under the leadership of Italy and Argentina, and with the support of specialist agencies within the United Nations system, namely IOM, UNHCR and WHO.

Conclusions and lessons learned

As in any negotiation process, the expectations of all the participants are often not fully met, and this was the case at the end of the discussions on resolution WHA70.15. However, the exercise can still be considered very valuable because it gave the issue of refugee and migrant health a place on the international agenda that was long overdue when compared with the work that other international organizations (e.g. ILO) had been carrying out to highlight the influence of migration issues within their area of competence. At the same time, it enabled an honest and in-depth exchange on the different positions on the subject that, undoubtedly, informed and contributed to the GCR and the GCM.

From a health diplomacy perspective, perhaps the most important lesson was the confirmation that all differences can be reduced through frank and open dialogue until a consensus is reached. As experienced negotiators might say, while it is not always possible to satisfy every requirement, it is always possible to find common ground and an intermediate solution that satisfies everyone – or at least leaves everyone equally dissatisfied. Even though the framework of priorities and guiding principles to promote the health of refugees and migrants was not adopted as such by the World Health Assembly (because it was not a negotiated document, according to those who were not ready to adopt it), it was accepted as valid voluntary guidance for those Member States while negotiating the two Global Compacts.

Another valuable lesson was the importance of international cooperation and interagency work to achieve any global objective. It is clear that, in order to achieve "the attainment by all peoples of the highest possible level of health" (Article 1 of the WHO Constitution *(17)*), the particular health needs of refugees and migrants have to be taken into account, in a spirit of cooperation, when designing the global governance of migration.

The discussions on resolution WHA70.15 highlighted the need to improve the level of technical knowledge that diplomatic services possess about migration when dealing with related issues at WHO. To this end, the health diplomacy and the migration diplomacy sectors have to develop deeper ties, which will benefit all. Consequently, it is essential that diplomatic services devote sufficient resources to training in technical matters related to health, and in the health and economic implications of certain decisions that are made in the international arena. With an increasingly complex and interlinked international agenda, specialist diplomatic skills combined with a strong technical background can make a significant difference in a multilateral context.

Nevertheless, it should be recognized that the diplomatic services of different countries vary in terms of their capacities and resources. Countries whose diplomatic services have limited capacity and resources need to make greater efforts to remain involved in the technical health discussions held at international organizations. Their limited capacity and resources can be mitigated through a fluid relationship with their domestic technical health agencies, such as health ministries, ministries of social development and agencies specializing in issues such as medicines and animal health. With the right attention and effort, it is easy to see how this interagency work can play a highly positive role in health-related negotiations, and is particularly beneficial for countries whose diplomats lack specialist health training and resources.

Finally, the instrumental role that the WHO Secretariat played should be reemphasized. It supported the process of developing the framework of priorities and guiding principles to promote the health of refugees and migrants and provided technical support during the negotiation of resolution WHA70.15. Its collaboration and experience have, undoubtedly, proved very useful in negotiating a global action plan on a health issue, such as that on promoting the health of refugees and migrants *(18)*. This has now been noted by the Seventy-second World Health Assembly, as mandated by decision EB140(9) *(8)* and resolution WHA70.15 *(2)*.

The draft global action plan to promote the health of the refugees and migrants was based on best practice, experience and lessons learned on the health of refugees and migrants as identified by the WHO Secretariat. The draft global action plan was developed by the WHO Secretariat in full consultation and cooperation with Member States and other relevant stakeholders. The global

action plan will benefit from the GCR and the GCM, and will complete the work at WHO initiated by resolution WHA70.15 and the Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants.

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10. Protecting the health of people on the move: best practices for national health systems

Julio Frenk and Octavio Gómez-Dantés

Introduction

The number of people living outside their country of origin (international migrants)[4] grew from 173 million in 2000 (2.8% of the global population) to 257 million in 2017 (3.4% of the global population) *(1)*. This increase reflects issues such as conflict and natural disasters as well as voluntary reasons, such as greater economic opportunities. All migrants require various goods and services, one of the most salient of which is health care.

This chapter discusses the response of national health systems to the health needs and requirements of international migrants. The first part provides a brief overview of the characteristics of international migrants and their health needs. The second part discusses the best national practices in

[4] In this chapter, the term international migrant will be used to refer to any person who moves to a different country, and will include labour migrants, asylum seekers, refugees, irregular migrants and unaccompanied minors.

dealing with the particular health issues that international migrants face, with an emphasis on those who become permanent residents of their destination country.

People on the move: demographic characteristics and health needs

People migrate for various reasons: to enhance their job prospects, improve their quality of life, escape poverty, or flee conflict, persecution or natural disasters.

According to the most recent estimates, there are over 200 million people living outside their country of origin: around 28 million are refugees and asylum seekers and between 2 million and 3 million are international students *(2,3)*.

The median age of international migrants is 39.2 years and almost half of them are women (48.4%). Some 191 million (74%) are of working age, 36 million (14%) are below the age of 20 years and 30 million are aged 65 years or over (11.7%) *(4)*.

Since members of this group tend to be young and able to face the migration journey, they are usually healthier compared with the population in their country of origin as well as with the population of their host country and, therefore, make little use of health services. This healthy migrant effect, however, tends to diminish as individuals assimilate into the host society *(5)*. In addition, some groups of refugees and migrants may have a higher prevalence of specific conditions, while others may be exposed to health problems that develop during transit and arrival. In general, the health status of refugees and migrants depends on the country of origin, the reason for migration, the route taken to their destination, the time spent in transit, the conditions under which this transit occurred and the conditions in which they live in the host community.

Given the demographic and health profiles of most international migrants, WHO advises against the compulsory screening of refugees and migrants at arrival: it is not cost-effective and may trigger anxiety *(6)*. WHO recommends

providing health care to those with specific needs while they are in transit and at the point of arrival. This is also true for infectious diseases, including vaccine-preventable diseases. Despite the common perception that there is a connection between migration and the importation of infectious diseases, encouraged by recent xenophobic political rhetoric, no link has been demonstrated *(7,8)*. WHO and other international organizations also suggest providing regular and comprehensive health care to refugees and migrants who become permanent residents of the recipient country, regardless of their legal status.

Health care for international migrants

While health care for refugees and migrants is a hotly debated issue, most experts, human rights activists and progressive politicians agree that they should have full access to high-quality health care without discrimination based on gender, age, religion, nationality or race, and regardless of their legal status. This means access to health care to deal with specific problems that arise in transit to the country of destination and at the point of arrival *(9)*, and regular access to comprehensive care once they have become permanent residents, regardless of their documentation. This is easier said than done given the number and nature of the barriers that international migrants face in their search for health care.

Barriers to accessing health care

Several declarations and resolutions have tried to protect the health of refugees and migrants and guarantee their access to health care. Salient among them are the 2008 World Health Assembly resolution WHA61.17, Health of migrants *(2)*, the 2016 United Nations New York Declaration for Refugees and Migrants *(10)* and the 2017 World Health Assembly resolution WHA70.15, Promoting the health of refugees and migrants *(11)*. These resolutions are not binding, but they have helped to bring about changes to domestic laws and regulations without the usual bureaucracy associated with treaties, which require legislative approval *(12)*.

Despite these efforts, refugees and migrants still have limited access to health care, and even to emergency care and health services for children and pregnant women. Moreover, the level of access varies significantly, depending on the prevailing attitudes and policies of the recipient country.

Numerous barriers hamper international migrants' ability to access health care, with the most important of these being stigma, language barriers, cultural differences, financial restrictions and legal status *(13)*.

Social stigma limits the willingness of refugees and migrants to seek care when needed. They are frequently ignored, rejected and/or ill-treated in their efforts to secure health care because they are associated with characteristics that represent a danger to recipient societies, such as crime and disease, and because they are seen as a threat to jobs and cultural identity *(14)*. The end result is that the fear of being mistreated and the fear of deportation in the case of irregular migrants often deter health-seeking behaviours.

Language and cultural barriers also represent major obstacles. They limit the efforts that refugees and migrants make to access health care, and they hinder effective communication between refugees and migrants and the health-care providers in the course of using these services. Such barriers can partially be overcome by using interpreters and improving the cultural competence of health workers and organizations, but such services are not as widely available as might be expected. For example, after 35 years of providing financial support for interpreting services in medical facilities, with positive results, the Dutch Government recently decided to stop funding these services. This is despite the fact that 10% of the total population of the Netherlands are migrants (around 2 million people) *(15)*. Government officials argued that "people are responsible for ensuring their proficiency in Dutch" *(15)*. Despite major opposition, this measure remains in place.

Unfamiliar bureaucratic and medical systems present further barriers. Refugees and migrants may have difficulties in gathering the documentation required to access regular health care, understanding and filling in application forms for health-care programmes, and navigating medical facilities *(16)*.

Financial restrictions are also a major obstacle. A large number of migrants are uninsured and have to pay out of pocket for the care they receive *(17)*. In the United States, for example, 20% of migrants are uninsured, compared with around 7% of the host population *(18)*. This lack of financial security can

drive many migrants into debt, financial hardship and poverty. In addition, untreated medical problems may limit migrants' abilities to maintain a job, which complicates their personal situation even further.

Probably the most fundamental barriers for refugees and migrants in accessing health care are poor legal entitlements and, where these do exist, mechanisms to ensure that people know about these entitlements and respect them *(19–21)*. One of the reasons that states tend to limit health rights for refugees and migrants is the belief that increasing entitlements will encourage more people to move to or remain in a country. Irregular migrants, asylum seekers and refugees face the greatest problems as they tend to have less access to the health benefits offered by public institutions and programmes in recipient countries than the host population and migrants with suitable documentation.

Expanding access to health care

In order to improve access to health care for refugees and migrants, organizations dealing with refugee and migrant health suggest working around five basic general measures:

- develop explicit health policies for refugees and migrants;
- establish health-care entitlements for refugees and migrants;
- strengthen health systems to provide access to effective, appropriate and culturally acceptable health care for refugees and migrants;
- establish information systems to assess the health status of refugees and migrants and their access to health care; and
- create national diplomatic strategies to deal with the health of refugees and migrants.

Develop explicit health policies for refugees and migrants

One of the measures that can help refugees and migrants to access high-quality health care on a regular basis is the development of policies designed specifically for them. Establishing such policies demonstrates a concern for their well-being, and this concern becomes part of the public

agenda. Steps can then be taken to meet their needs and resources can be allocated accordingly.

The Migrant Integration Policy Index is a multidimensional tool that measures policies to integrate migrants in all EU Member States plus Australia, Canada, Iceland, Japan, New Zealand, Norway, South Korea, Switzerland, Turkey and the United States. The Index groups countries according to the existence of national policies to integrate migrants. These include labour market mobility, education, political participation, access to nationality (naturalization), family reunification, health, permanent residence and antidiscrimination *(22)*. According to the Index, the most advanced countries in terms of the health-care coverage of migrants and their ability to access services are Australia, Austria, Italy, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States *(23)*.

The data gathered to generate the Index indicate that migrant health policies tend to be stronger and services more responsive in countries with higher gross domestic product, more migrants and tax-based health systems as opposed to insurance-based ones. It seems that tax-based health systems, with their focus on UHC, find it easier to adopt health policies for refugees and migrants than health systems based on social health insurance, where entitlements are mainly linked to earmarked contributions *(24)*.

The existence of specific health policies for refugees and migrants, however, should not be overvalued. Some countries fail to enforce them, while others, which used to have progressive migrant health policies, may withdraw them when the political context changes. This was recently the case in the Netherlands and Spain, for example *(25)*.

Establish health-care entitlements for refugees and migrants

The right to health care has been enshrined in various international legal instruments, such as the WHO Constitution (which states that the right to health and health care is universal, fundamental and inalienable and cannot be made dependent on conditions such as nationality or legal status *(26)*), the International Covenant on Economic, Social and Cultural Rights *(27)* and the European Social Charter *(28)*. However, there is still a long way to go

in order to implement this human right in practice, especially for refugees and migrants *(29)*.

Many countries provide acute health care for refugees and migrants at arrival into the recipient country and access to emergency care and health care for children and pregnant women once they become residents. In 2003, for example, the Council of the European Union established minimum standards for asylum seekers, which include emergency care, the essential treatment of illnesses, and necessary medical or other assistance for applicants with special needs *(10)*. However, such minimum standards are not fully met in many countries in the EU, and there are huge differences between EU countries regarding health entitlements. Some countries provide less than the minimum standards of health services free of charge to refugees and irregular migrants, such as Luxembourg; some countries only provide the minimum health services free of charge, such as Belgium and Germany; while others provide comprehensive health care immediately and free of charge, such as Italy and Portugal *(30,31)*.

The global health community should advocate for their national governments to establish minimum health-care entitlements for refugees and migrants and to design mechanisms to guarantee their enforcement. The goal should be to avoid focusing on creating parallel mechanisms to address the specific health needs of refugees and migrants, instead moving towards fully integrating them into local health systems. This is the case, for example, in Thailand, where 5% of the workforce comes from Cambodia, the Lao People's Democratic Republic and Myanmar. In Costa Rica, workers with an irregular migrant status, from Colombia, El Salvador, Honduras, Nicaragua and Panama, can access services provided by the Costa Rican Social Security Fund *(32,33)*.

Strengthen health systems to provide access to effective, appropriate and culturally acceptable health care for refugees and migrants

Strengthening health systems to respond to the demands of refugees and migrants implies expanding the supply of effective and culturally acceptable health services at arrival and at settlement in the host country.

Recipient countries should avoid compulsory screening on arrival, which has proved to be unnecessary. Screening should be rationalized and restricted

to refugees and migrants arriving from settings with a heavy burden of disease and for conditions where there is an effective treatment, rather than attempting to cover all arrivals, particularly where local services are overwhelmed *(34)*.

After arrival, it may be important to assess the immunization status of refugees and migrants to reduce the risk of disease outbreaks, especially if refugees and migrants originate from areas with inadequate vaccination programmes. The German surveillance system, for example, identified low measles immunization in incoming refugees to Lower Saxony, while the refugee resettlement programme in the United States and its electronic disease notification system has improved the timeliness and accuracy of infectious disease notifications *(9,35)*. In both countries, measures to overcome low immunization coverage are regularly implemented.

Once refugees and migrants have established themselves in their new country, the main challenge is to integrate them as soon as possible into both their recipient societies and the local health systems. They should be provided shortly after arrival with information in their own language about the health-care system of their host country and the health benefits they are entitled to. They should also receive detailed instructions on how to navigate the health-care system. Health systems should only transfer the responsibility to provide health care for refugees and migrants to NGOs and other parallel structures when it is strictly necessary in order to achieve maximum and sustainable synergies.

Interpreters play a vital role in the provision of health care, particularly when dealing with people with mental health problems and other conditions with a strong cultural component. In California, health-care providers are required to collect data on the language needs of their patients receiving Medicaid (public health insurance for the poor), to provide interpreting services when needed, and to create advisory committees with representatives of refugee and migrant communities to help to develop policies to address language barriers *(13)*. Equally important is the cultural competence of both health-care organizations and health-care providers. Sweden has recently recruited refugees who are already medically trained into their health-care facilities in order to address the challenges of staff shortages, language barriers and cultural sensitivities *(36)*.

Telemedicine can also help to boost the provision of culturally appropriate services to refugees and migrants. The number of Internet consultations provided by doctors and other health-care providers working in the country of origin is increasing. These consultations usually have the support of agencies and refugee and migrant networks in recipient countries that are responsible for the provision of diagnostic procedures and the supply of medicines and other inputs *(37)*.

Since international migrants may often be provided with health services of a lower quality compared with host populations, it is also important that the quality of care is monitored and measured to guarantee its continuous improvement.

Finally, in the absence of health services offered by government agencies, international migrants should be provided with information on how to contact NGOs and other local networks that can provide health services.

Establish information systems to assess the health status of people on the move and their access to health care

It is also important that local and global information systems are created to monitor the health status and health service utilization of refugees and migrants. Few countries gather this type of information, and most of the available research has been conducted in a small number of western European countries *(3)*. Consequently, data on the health problems of international migrants are limited in terms of extent and geographical scope.

Ideally, this information should be collected through a national census, regular information systems and surveys, and it should be focused on the main health needs, health coverage and health services utilization for refugees and migrants. It would also be advisable to use indicators that can be applied across different countries.

In 2015, a major step was taken in this direction with the publication of a joint declaration by European countries, the European Commission and WHO on the health needs of refugees coming into Europe, and the design

of a health record that will be piloted at borders to assess refugees' health needs and to reconstruct their medical history *(38)*. This record could eventually be used as a reference for collecting information on arriving international migrants globally.

Another important recent initiative, proposed by the UCL–Lancet Commission on Migration and Health, is the creation of the Global Migration and Health Observatory "to develop evidence-based indicators and measurements methods… and to monitor the progressive inclusion of migrants within universal health coverage country plans and achievements" *(39)*.

Create national diplomatic strategies to deal with the health of international migrants

Finally, states need to develop health and migration diplomacy, which may be defined as using diplomatic tools, processes and procedures to manage issues related to the health of all refugees and migrants *(40)*. This implies, for example, incorporating their health issues into bilateral and multilateral diplomatic agendas, especially those that have a direct impact on interstate relations.

A good example of this migration diplomacy is the inclusion of two important health topics related to migrants in the Mexico–United States diplomatic agenda: access to health care for Mexican migrants living in the United States and the Medicare (public health insurance for Americans aged 65 years and older) coverage of health expenses of American retirees living in Mexico. There are around 11 million Mexican migrants living in the United States, and 37% of them are uninsured and have serious problems accessing health care *(41)*. In recent years, discussions about alternative options to provide some sort of insurance cover to this population have been included on the agenda of Mexico–United States diplomatic meetings. Another issue that has sometimes appeared on the same agenda is the possibility of allowing the 1 million Americans living in Mexico, most of them Medicare-eligible beneficiaries, to receive their Medicare benefits there *(42)*.

Conclusions

In order to achieve UHC by 2030, as stated in the SDGs, countries hosting refugees and migrants should integrate them into their national health systems and provide them with comprehensive, effective and culturally acceptable health care. Denying refugees and migrants access to high-quality health care not only creates ethical dilemmas related to excluding specific population groups from receiving essential services but also increases the workload of hospital casualty departments, where barriers to access tend to be lower but where health care is considerably more expensive than in regular outpatient clinics.

Migration is such a widespread phenomenon that several countries on every continent have developed successful methods for dealing with the needs of refugees and migrants. These experiences have included establishing health policies; health-care entitlements; and comprehensive, appropriate and culturally acceptable health services for refugee and migrant populations. These measures have helped refugees and migrants integrate not only into local health systems but also into their recipient countries as a whole, making their communities more prosperous and safer places to live.

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11. Global Migration Group creating principles and guidelines: promoting and protecting the human rights of migrants in vulnerable situations

Pia Oberoi

Introduction

The international human rights system that states have put in place provides protection to all people, including all migrants. The Universal Declaration of Human Rights (1948) clearly sets out the basic premise that all human beings are born free and equal in dignity and rights (Article 1) *(1)*. However, how this framework applies to migrants, who are in situations of vulnerability, is often less clearly understood.[5] States and other stakeholders have, therefore, lacked complete guidance on how to operationalize the framework in such situations.

[5] This chapter specifically focuses on migrants outside the legal category of refugees.

In 2016, OHCHR, along with partners in the United Nations, embarked on a detailed process to provide advice to states (and other stakeholders, as relevant) on how they should implement their obligations to respect, protect and fulfil the human rights of migrants who are in vulnerable situations, including in the course of large or mixed movements. This decision was dictated by the compelling need to address critical protection gaps in the respect, protection and fulfilment of the human rights of excluded migrants, particularly in relation to those who may fall outside existing legal protection categories. The initiative was formally led by the Global Migration Group's Working Group on Migration, Human Rights and Gender, which was co-chaired by OHCHR and UN Women.[6]

Migrants in vulnerable situations

Where migrants fall outside the specific legal category of refugee, it may be particularly important to ensure that their human rights are respected, protected and fulfilled. Some migrants need specific protection because of the situations they have left behind, the circumstances in which they travel or the conditions they face on arrival; others need specific protection because of personal characteristics such as age, gender identity, disability or health status. Migrants in vulnerable situations are people who are, effectively, unable to enjoy their human rights, are at increased risk of violations and abuse and, accordingly, are entitled to call upon a duty bearer's heightened duty of care.

The process of developing principles and guidelines on the human rights protection of migrants in vulnerable situations took over two years, between 2016 and 2018. The guidelines were developed by the Global Migration Group's Working Group through a process of extensive technical engagement

[6] Members of the Working Group include ILO, IOM, UNHCR, UNICEF, United Nations Office on Drugs and Crime, UN Women and WHO. In a meeting on 23 May 2018, the United Nations Executive Committee decided to establish a United Nations Network on Migration, as a successor to the Global Migration Group, to ensure effective, coordinated system-wide support to the implementation of the GCM.

with Member States, civil society organizations and academics. An initial conceptual workshop held in Geneva in 2016, supported by the Swiss Government, brought together representatives of Member States and civil society organizations from all regions to discuss and provide input to the range of diverse issues that should be included in such principles and guidelines.

The Working Group produced five successive drafts that were open for feedback, both online for public comment and through direct engagement with relevant stakeholders. A number of civil society organizations accompanied the process from the beginning, including several that were focused on the issue of health, for example the Association for the Prevention of Torture, the International Federation of Red Cross and Red Crescent Societies and MSF International. In addition, some Member States provided specific comments to the drafts, as well as indicating areas of good and promising practices in their national contexts. Through this process of inclusive and participatory consultation, the Global Migration Group's Working Group engaged with states and over 100 experts from United Nations agencies, United Nations human rights mechanisms, academia, civil society, national human rights institutions and regional organizations.

The development of the principles and guidelines interfaced with other key intergovernmental processes, as the development process coincided with the negotiation and adoption of several other processes. Notably, in 2016, in the New York Declaration for Refugees and Migrants *(2)*, 193 Member States acknowledged and called for the continuation of the process of developing principles and guidelines on the human rights protection of migrants in vulnerable situations. The United Nations Human Rights Council considered the principles and guidelines at its thirty-fourth session, as a progress report, and at its thirty-seventh session, as a final report *(3)*.

The GCM pays particular attention to the issue of migrant vulnerability through Objective 7 (address and reduce vulnerabilities in migration): "Develop national policies and programmes to improve national responses that address the needs of migrants in situations of vulnerability, including by taking into consideration relevant recommendations of the Global Migration Group Principles and Guidelines, Supported by Practical Guidance, on the Human Rights Protection of Migrants in Vulnerable Situations" (action l) *(4)*.

The Principles and Guidelines produced by the Global Migration Group is a comprehensive document intended to provide specific and norm-based

advice to states and other stakeholders, as relevant, on measures to protect and promote the human rights of migrants in vulnerable situations *(5)*. The document looks both at specific rights for all migrants, such as the right to health, and at the rights for specific groups of migrants in vulnerable situations, such as women and girls.

Accordingly, Principle 12 asks states and other stakeholders to ensure that "all migrants enjoy the highest attainable standard of physical and mental health". The accompanying guidelines to Principle 12 recommend states to ensure that health systems and national plans of action on health include migrants, regardless of their status, and recommend further the establishment of legal and administrative mechanisms to ensure that migrants are included. The accompanying guidelines also highlight the importance of recognizing that migrants may experience severe emotional distress and have specific, and often urgent, mental health needs. They call on states to ensure that migrants have access to adequate mental health care, including at reception, and can be referred to appropriate secondary services.

Principle 11 asks states and other stakeholders to protect the human rights of migrant women and girls, and the accompanying guidelines recommend ensuring that trained personnel are available at all sites to identify and support migrant women and girls who have experienced trauma, including sexual and gender-based violence. Migrant women and girls should be able to obtain specialist medical and psychosocial support; sexual and reproductive health services, products and information; and other relevant gender-responsive services, such as trauma counselling and legal advice.

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12. Health risks of unaccompanied refugee and migrant children: the role of the United Nations Children's Fund

Afshan Khan

As Nelson Mandela once said, "There can be no keener revelation of a society's soul than the way in which it treats its children" *(1)*. No matter his or her race, ethnicity or religion, a child is a child.

In line with its mandate and core commitments for children, UNICEF has been advocating protection of the rights of all children, particularly the most disadvantaged, and supports governments in over 130 countries to do so.

The issue

The number of unaccompanied and separated children on the move around the world is rising. This is no less true in Europe, where over 223 000 unaccompanied and separated refugee and migrant children sought international protection between 2014 and 2017 *(2)*. Many of them have fled violence, insecurity and a lack of economic and educational opportunities in

Afghanistan, Eritrea, Iraq and the Syrian Arab Republic, but they also come from Bangladesh, Nigeria and west Africa *(3)*. Often they have spent long months, and sometimes years, in transit.

Testimonies from unaccompanied boys and girls on the move, especially through the so-called central Mediterranean route, speak of arbitrary detention, extortion, exploitation and violence, including gender-based violence *(4)*. Evidence shows that these risks are exacerbated when combined with lower levels of education, longer journeys and limited resources.

Arduous journeys reduce resilience and undermine physical health, while the uncertainty and hardship of prolonged transit takes a psychological toll. As most unaccompanied children are adolescents, the behavioural and emotional transformation that characterizes this age group is also a compounding factor *(5)*.

For many, Europe represents hope and a new chance to build their lives – to go back to school or to find work in order to support their families back home – yet, they often face a very different reality. With an increase in the number of border closures across the WHO European Region, children remain stranded with inadequate access to basic services, such as accommodation, education and health care. Children also face social and cultural barriers and discrimination, as well as the loss of family and friendship networks *(6)*. When combined with substandard conditions on arrival, these factors may result in poor health outcomes *(6)*, psychosocial distress *(5)* and negative coping strategies, such as transactional sex or other forms of gender-based violence *(7)*.

Across Europe in 2016, national health, education and child protection systems were generally unprepared to care for large numbers of unaccompanied and separated children *(8)*. Long delays in asylum and family reunification procedures, combined with ineffective guardianship schemes and a lack of information, have been cited as stress factors and have resulted in late referrals to the relevant service providers. Symptoms vary, from difficulty in sleeping at night and aggressive behaviour towards peers and reception centre staff, to self-harming, depression and anxiety.

Often frustrated at having their lives put on hold, many children abscond from the shelters where they are placed and continue their journey to asylum destination countries *(9)*. They become easy prey for criminal gangs, particularly if they have already endured violence and abuse, or experienced psychosocial and mental health issues.

In such circumstances, it is essential that early identification, referral and specialist service provision are made available, in a culturally appropriate manner, for boys and girls who have experienced gender-based violence or other physical or mental health issues. However, this is rarely on offer.

Children's access to medical care may be restricted because of insufficient or inadequate staffing, a lack of interpreters and competent intercultural mediators, and the absence of standard operating procedures, in both reception centres and health facilities. The availability of mental health and psychosocial support services is also limited by pre-existing systemic weaknesses, language barriers and cultural norms, which may occur in any country but are more likely to be the case in countries implementing austerity measures.

The response

Keeping unaccompanied and separated children safe while on the move requires a holistic, multisectoral response that mobilizes governments, United Nations agencies and national and international civil society.

UNICEF combines humanitarian intervention with systems strengthening, which includes technical assistance to national authorities to ensure that unaccompanied children on the move have access to essential services. These services include immunization, psychosocial support, prevention of and responses to gender-based violence, education, and legal aid through case management and referrals. Moreover, UNICEF advocates with governments to ensure the sustained provision, use, quality and efficiency of services delivered through the health system to all children on their territory, irrespective of their migration status or country of origin.

UNICEF also supports capacity-building for governments and civil society to identify and address major systemic gaps, improve guardianship and alternative care for unaccompanied and separated children on the move, enhance child protection standards for reception centres, build national monitoring mechanisms and facilitate the effective integration of children into formal education systems.

The GCM, the first intergovernmentally negotiated agreement to cover all dimensions of international migration in a holistic and comprehensive manner, and prepared under the auspices of the United Nations, represents a unique opportunity to further develop age- and gender-responsive policies that protect and address the particular needs and vulnerabilities of unaccompanied and separated children. These may include health care and psychological and other counselling services. Such policies should protect and respect the rights and best interests of the child at all times, regardless of their migration status or country of origin. This means that actors involved in health, child protection and education need to work closely together to provide a caring and protective response for children at risk.

All unaccompanied and separated children arriving in the WHO European Region should be duly registered and then referred to national child protection systems. Front-line workers should be trained to detect violence, trauma and other health-related issues. They should also be supported by provision of child-friendly, culturally appropriate and gender-sensitive specialist services.

As many children have limited health literacy, it is important that their awareness is raised in a culturally and age-appropriate manner, and that their resilience regarding mental, sexual and reproductive health is also strengthened. This involves providing access to information in a language they understand, as well as access to medication, such as post-exposure prophylaxis in child-suitable doses.

Enhancing opportunities for structured learning and social inclusion is also key to help children to recover from harmful experiences and feelings of anger, frustration and helplessness, which, if ignored, could develop into full-blown mental health conditions. This entails expanding safe and protective guardianship programmes, ensuring timely and meaningful access to formal education or vocational training, and building trust relationships with adults. All-female programmes have also proved to be particularly effective for reaching out to otherwise “invisible” adolescent girls who are at risk.

By building strong partnerships and advocacy alliances with governments, the EU, the Council of Europe, other United Nations agencies, ombudspersons for children and civil society actors, UNICEF works to ensure that all children in the WHO European Region, including unaccompanied and separated children on the move, receive the care and support they need to stay healthy, are protected from abuse and exploitation, and have the opportunity to reach their full potential in order to contribute to their new communities.

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3. Regional perspectives

13. Health diplomacy in action: the "Whole of Syria" initiative

Dorit Nitzan, Cetin Dikmen and Pavel Ursu

Introduction

In a world where globalization has impacted on traditional ways of operating in every sector, including health and international relations, the main actors and tools are also subjected to changes. The WHO Constitution enshrined health as a fundamental human right without distinction of race, religion, political belief, economic or social condition. The objective of WHO is the attainment by all peoples of the highest possible level of health *(1)*. This includes establishing channels for improvement of mental health, health promotion and the social determinants of health while responding to emergencies. WHO was assigned as the guardian of this strengthened concept of human rights, with Article 2 stating that its function shall be to "act as the directing and co-ordinating authority on international health work". Article 37 emphasizes the independence and impartiality expected of WHO staff at all levels and stipulates that "each member of the Organization on its part undertakes to respect the exclusively international character of the Director-General and the staff and not to seek to influence them" *(1)*. The Constitution provides strong grounds for WHO to address health needs in emergencies from an independent and impartial standpoint. Even with its unique technical and operational expertise and well-defined mandate, WHO has faced numerous challenges in tackling different health issues. As the complexity of public

health has increased with globalization, the international concept of health has become renamed as global health. In accordance with such a transition, WHO priorities have been adjusted to fit the needs of the global health community, and this is reflected in the latest general programme of work, the 13th for 2019–2023, which was adopted at the World Health Assembly in May 2018 *(2)*. The Thirteenth General Programme of Work is based on the overall objective to "Promote health, keep the world safe, [and] serve the vulnerable" *(2)*. Achieving UHC, addressing health emergencies and promoting healthier populations are the strategic priorities of WHO, with each targeted at the lives of 1 billion people. These priorities form the foundation of the overarching framework to provide safe, good-quality, people-centred health services for all, without any distinction, as stated in the Constitution. In this regard, refugees are a population group that deserves particular and immediate attention for amelioration of their health status with due respect paid to their cultural and social backgrounds.

Addressing health needs through the "Whole of Syria" approach

Before the armed conflict started in 2011, the health indicators in the Syrian Arab Republic were improving. The country was going through the epidemiological transition observed in developing countries, to an increasing burden of NCDs compared with communicable diseases. The armed conflict changed the overall health status and had an impact on the lives of millions. Over 6 million Syrians have been displaced, and essential service provision capacities are eroded. Health needs have increased because of the weakening of public, primary and hospital services and the increased burden of trauma-related health needs.

Millions of people have fled from the Syrian Arab Republic to neighbouring countries, most into Turkey and then on to other countries. Through the Aegean and Balkan routes, more than 1 million refugees arrived in central and northern European countries, which needed to adapt to the increased needs, including for health services.

To coordinate humanitarian assistance delivery and bring together humanitarian actors working in the Syrian Arab Republic and neighbouring countries, the "Whole of Syria" initiative was established in 2015 to create a coordination approach.

Through the adoption of resolution 2165 (2014), and its subsequent renewals 2191 (2014), 2258 (2015), 2332 (2016), 2393 (2017) and 2449 (2018), the United Nations Security Council authorized United Nations agencies and their partners to use routes across conflict lines and the border crossings up to 10 January 2020 to deliver humanitarian assistance, including medical and surgical supplies, to people in need in the Syrian Arab Republic. The Government of the Syrian Arab Republic is notified in advance of each shipment and a United Nations monitoring mechanism oversees loading in neighbouring countries and confirms the humanitarian nature of consignments. Under the "Whole of Syria" initiative, the WHO Emergency Programme classified this health emergency as Grade 3 *(3)*. There are two response pillars: cross-border and cross-line operations from neighbouring countries, including from Turkey (e.g. involving the WHO Project Office in Gaziantep), and refugee health programmes. As a country neighbouring the Syrian Arab Republic, Turkey has accepted and hosted refugees and includes them in the Turkish health system. In cooperation with national authorities, WHO has provided support for the provision of accessible and quality health services to the refugee population in emergency settings.

Through the "Whole of Syria" initiative, life-saving operations for people in need have been provided through operational hubs in Iraq, Jordan, Lebanon, the Syrian Arab Republic and Turkey. WHO has been leading the health cluster coordination and operations across lines and borders to protect and improve the health of vulnerable populations affected by the conflict.

Developing the health argument from field realities

Responding to diverse and severe health needs on the ground required concerted efforts from WHO and within the international community,

with WHO playing an important role in the context of health diplomacy. In the midst of an ongoing humanitarian crisis and security concerns, WHO developed the health argument through active engagement in humanitarian response platforms, for example during the London and Brussels conferences *(4,5)*, where the humanitarian and developmental needs of Syrians were comprehensively discussed. At these events where high-level policy-makers were present, WHO helped the global community to better address the need for strong political support for health operations and also for the necessary resources for provision of health services. These efforts encouraged the global community to enter into discussions on how to address the needs of displaced populations and prioritize health in a conflict environment.

Following updating of the Emergency Response Framework, the WHO Health Emergencies Programme instituted an incident management system with the core functions of leadership, operational partnerships, health operations and expertise, and logistics support. WHO has been contributing to relieve suffering among those in affected areas with the provision of essential health services, the establishment of surveillance and referral systems, and by creating opportunities to de-escalate security concerns. Advocacy efforts and the promotion of good practices from specific countries, such as Turkey, complemented the intervention cycle to establish an enabling environment in other Member States for promoting the health of refugees.

In responding to the crisis, WHO took responsibility for bringing the health needs of the Syrian population to the forefront of policy-makers' awareness and opened channels of policy dialogue at the highest level, contributing to negotiations by upholding the right to health and advocating for protection and promotion of health from a wider perspective. Based on the United Nations Security Council resolutions and the "Whole of Syria" initiative, the WHO Regional Office for Europe took immediate steps to further strengthen readiness and response capacities and established communication channels with Member States and the EU to address the health needs of the Region. Interregional collaboration was initiated rapidly between the WHO Regional Offices for the Eastern Mediterranean and Europe to quickly scale up support for service delivery and provide access to critical health services.

The role of the WHO Country Office in cross-border health operations

The response capacity of WHO was strengthened significantly with the establishment of the Gaziantep field presence on 10 October 2013 under the auspices of the WHO Country Office in Turkey. Having such a presence near the Turkish border with the Syrian Arab Republic improved the capability of WHO to lead and coordinate activities in the health sector; implement partnerships in the Syrian Arab Republic; collect, manage and analyse health information; conduct health operations; and establish medical supply lines with logistic advantages. The WHO Country Office relied on the newly established field office to seize the limited but valuable opportunities to improve health status in the region. The establishment and operation of health information collection and analysis capacities, as well as surveillance and early warning systems for disease outbreaks, allowed critical operations to be tailored in this unstable conflict environment. Routine briefings with other partners helped to engage all stakeholders in risk and needs assessments, planning, information management, service delivery, implementation of cross-border measures and advocacy efforts. These approaches facilitated collective responses to ensure maximum coverage and quality.

Addressing the health needs of the refugees and migrants required tailored actions. Initially, the WHO Project Office in Gaziantep supported the coordinated work of the Turkish authorities to provide life-saving support. The Office then moved to Ankara, reflecting efforts to ensure longer-term inclusion of refugees into the Turkish UHC. WHO joined the intragovernmental coordination efforts.

Under the joint responsibility lines described above, critical cross-border operations, such as the evacuation of Aleppo, and flagship activities in Turkey, such as the training of Syrian health workers and their integration into the national health system, were conducted to improve the health of the Syrian population in both the northern regions of the Syrian Arab Republic and in Turkey, as well as the health of the host communities.

The role of health diplomacy under the auspices of United Nations Security Council resolutions

Since health diplomacy can also be described as "the chosen method of interaction between stakeholders engaged in public health and politics for the purpose of representation, cooperation, resolving disputes, improving health systems, and securing the right to health for vulnerable populations" *(6)*, it can be considered that WHO used health diplomacy effectively in the Syrian crisis. Adoption and implementation of the relevant United Nations Security Council resolutions can be considered important achievements in this regard; such resolutions are always the product of a lengthy negotiation process between various stakeholders in order to secure the right to health for a population vulnerable to major health risks, such as the Syrian refugees. These resolutions allowed WHO to provide life-saving operations to populations in need. Close cooperation with the Turkish Government, including the Ministry of Foreign Affairs, the Ministry of Health and the Disaster and Emergency Management Authority, allowed the provision of a comprehensive package of health measures for the refugees in Turkey. Technical cooperation needed to take into account the characteristics and needs of each of the agencies involved in order to fulfil both the short-term operational needs identified by the Disaster and Emergency Management Authority and the medium- and longer-term integrative needs outlined by the Ministry of Health and the Ministry of the Interior.

Establishment of an effective field presence in Gaziantep was a tangible achievement for health diplomacy as it significantly increased the operational capacities of WHO and allowed WHO to lead for the health sector in regional multisectoral plans, such as the Regional Refugee and Resilience Plan. This Plan aimed to bring together humanitarian and development partners to address short- and long-term challenges alongside some key aspects of the "Whole of Syria" initiative. WHO initiated lengthy discussions with several stakeholders in platforms such as the Ministry of Foreign Affairs, the Ministry of Health and the Parliament of Turkey in order to establish a presence in Gaziantep. With this field office, WHO was better able to coordinate humanitarian efforts to support response operations conducted by the Ministry of Health.

Pressing requirements from the field, such as overstretched health system capacity, particularly in the southern parts of Turkey receiving large numbers of refugees, and inadequate health service provision in northern areas of the Syrian Arab Republic, stimulated WHO and the Government of Turkey to amend the legal basis of WHO's country presence. Regional and country staff from WHO negotiated with the Government of Turkey to create an amended Country Office Agreement for the benefit of both actors as well as for Syrian refugees and host communities *(7)*. The Agreement allowed scaling up of WHO's operational capacities. A clause in the Agreement allowed the establishment of field offices where WHO could provide more accurate technical advice and operational support to the Government of Turkey. This was intended to help in reducing the high demand in overstretched health facilities, and possible tensions between refugees and host communities. Local provision of expertise supported more sensitive management of public health communication and increased WHO's capacity to address the health needs of vulnerable populations. The establishment of field offices in cities other than Ankara supported the implementation of WHO programmes in Turkey and international collaboration and partnership in the area of health. The guiding principle and a key factor in the success of the negotiations around the amended Country Office Agreement was the emphasis on interventions to address health priorities for the mutual benefit of both Syrian and host communities. Communications took place in an atmosphere of trust and with consideration of the local contexts.

The successful impact of an operational centre: the WHO Field Office in, Gaziantep

The humanitarian emergency in the Syrian Arab Republic and the surrounding region has continued for eight years, leaving 12.2 million people in need of health care, 6.6 million people displaced and more than half a million dead. To deal with this, WHO has had to navigate a rapidly changing environment and address health needs on the ground. WHO has implemented numerous emergency activities in northern areas of the Syrian Arab Republic, facilitating access to health services tailored to the cultural context in these hard-to-reach

areas. Coordination with implementing partners on the ground, including Syrian NGOs, international NGOs, donors and health directorates, enabled the WHO Project Office in Gaziantep to access large numbers of children for vaccination. Primary health care was made available to those in these northern areas who lacked access to essential health services. Several interventions targeted NCDs, including mental health, as there were huge gaps in NCD prevention and management. Training was given to service providers, health facilities were supplied with drugs and equipment, and referral systems were established. Preparedness and response capacities in the region were strengthened with scenario-based contingency planning and training activities. Cross-border logistic channels were established and medical supplies were delivered twice a month and on an ad hoc basis according to local needs. In 2017, medical supplies totalling US$ 6.5 million were taken in 26 cross-border deliveries to provide for the large number of people in emergency settings. Overall, WHO provided support for setting up holistic interventions in northern areas of the Syrian Arab Republic, supporting the building of responsive health systems.

To quote from the Oslo Ministerial Declaration (2007), "armed conflict often leads to the breakdown of health services, with disastrous consequences for people's health and livelihood… the need to preserve life and health is a useful starting point for peace building" *(8)*. The Declaration attributes value to health diplomacy efforts in conflict environments. However, in such circumstances, health facilities and service providers become very vulnerable to attack and are often targeted, in violation of international law. Such attacks damage the functionality of health systems by hindering both demand and supply sides of the health service. In the first six months of 2018, there were 126 separate attacks on health care in the Syrian Arab Republic, a substantial increase over the number in 2017 *(9)*. Using innovative information management tools and with real-time input from health facilities, WHO can monitor potential violations of health care and help to ensure that health workers are protected in conflicts and are allowed to provide medical care in safe and protected environments when their patients need it most. These efforts can be considered an integral component of health diplomacy efforts, since violation of international law and human rights through attacks on health-care providers should be brought to notice at the highest political levels and among the public. This is health diplomacy in a broader context, advocating for the right to health and the right to provide health care.

Health diplomacy to strengthen culturally sensitive service provision to refugees in Turkey

Negotiating for health diplomacy is a complicated process in which determinants interact and there are possibilities of different outcomes to those expected. In this sense, the activities undertaken by WHO described in this chapter can influence the process for the benefit of health but can also be impacted by changes imposed within areas not controlled by health authorities yet still contributing to health needs. Adjusting the design and implementation of activities to be compliant with political developments is particularly challenging. The EU–Turkey Statement on 18 March 2016 had an immediate effect on provision of refugee and migrant health care and for limiting irregular arrivals to Europe.

WHO has supported the Ministry of Health of Turkey in its responses to the broader health needs of Syrian refugees in Turkey, with a focus on removing cultural and linguistic barriers to access for quality health services. This issue was foreseen in the Strategy and Action Plan for Refugees and Migrants in the WHO European Region *(10)*. Turkey provides accessible and quality health services to refugees free of charge and at the same standard as for Turkish nationals, in line with regional and global frameworks. Health diplomacy was a conducive tool for close engagement with the Government of Turkey in establishing multisectoral partnerships to provide health benefits for vulnerable population groups.

Cooperative dialogue channels between WHO and the Ministry of Health allowed gaps in service provision to be identified and means explored to further improve access to quality health services in those areas with many Syrian refugees. Cultural and language issues in service provision were the main barriers to overcome. WHO took a key role by addressing the training needs of the health workforce and supporting the Ministry of Health in preparation and delivery of training for a Syrian health workforce. This initiative complemented the Ministry of Health's efforts under the EU-funded SIHHAT project, which aims to train Syrian health professionals on the functions of the Turkish health system and health programmes so that they can work in Turkey *(11)*. Syrian health workers who have successfully completed this training

course are employed in refugee health units/centres in selected provinces for provision of health services to the refugee population. Provision of culturally sensitive health services to Syrian refugees can be regarded as a flagship initiative in Turkey and this initiative was the result of lengthy negotiations. The WHO Country Office took the lead in the design and implementation of the initiative in close collaboration with the WHO Regional Office for Europe and WHO headquarters. In line with discussions held with the Ministry of Health, WHO developed a programme encompassing training through to employment in the national health system. These efforts went hand in hand with plans of the Ministry of Health to increase primary health services in order to provide quality services without barriers, reduce the patient load in emergency clinics and use personnel in primary health-care facilities as gatekeepers for higher levels of care.

WHO supported refugee health training centres in seven provinces (Ankara, Gaziantep, Hatay, İstanbul, İzmir, Mersin and Şanlıurfa). These were strengthened primary health-care centres, providing a family medicine system including some specialty services (internal medicine, paediatrics, obstetrics and gynaecology). Syrian health professionals were trained in the requirements to function in the Turkish health system. Theoretical training (40 hours over five days) on the functions of the Turkish health system and health programmes was followed by six weeks of practical training for hands-on learning under the coaching of Turkish counterparts. Syrian health workers rotated between different polyclinics in refugee health training centres and provided health services to Syrian refugees in Turkey. After successfully completing the practical training, Syrian health workers were entitled to apply for work permits for employment in primary health-care settings providing services for Syrian refugees in Turkey. As of November 2018, 888 Syrian doctors and 999 Syrian nurses/midwives had completed both training modules in the seven refugee health training centres. In addition, 1063 bilingual patient guides/translators received only theoretical training. This health workforce is now employed in primary health-care facilities providing services to Syrian refugees in Turkey. In these centres, on average, 40 000 culturally sensitive consultations are provided to the refugee population every month, including prenatal and postnatal visits, vaccinations and chronic disease management. Each step of this intervention cycle has been monitored and evaluated in coordination with academia and the Ministry of Health. The evaluations indicate significant increases in the knowledge level of the trainees and

increasing trends for accessing health services provided in the seven refugee health training centres. It is planned to continue this flagship initiative with strengthened outreach and home care components.

These successes have only been achieved through facing and overcoming many challenges. Training and certification of the Syrian health workforce was an issue with legal implications. The legal framework in Turkey did not allow refugee health professionals to work in national settings and new legislative regulations had to be adopted. These were driven forward by different stakeholders, such as the Ministry of Health, the Ministry of Family, Labour and Social Policies and the Ministry of Interior. WHO supported the adoption of new laws and advocated using evidence from a public health viewpoint for strengthening health sector capacities and for reducing inequities. WHO also strategically positioned itself to build from the available capacity in the country and to provide support in the areas of greatest need, such as the training of a Syrian health workforce. While encouraging public health awareness to support the initiative, WHO also established necessary dialogue channels with the international community to secure resources for implementation of projects to help in filling gaps in the health system. Cooperation and complementary interventions of this type with the Ministry of Health helped to further mature the argument for good-quality health for refugees in the country, using scientific evidence to inform and support political commitment. Without such an approach, the initiation and scaling up of training efforts would not have been possible.

Conclusions

The world is becoming more complicated in terms of the roles, responsibilities, finance and fragilities of actors in health care and public health. The health diplomacy efforts of WHO described here to support cross-border health care and Turkish health initiatives demonstrate that WHO is capable of fulfilling its responsibilities in the recently adopted WHO Health Emergencies Programme. It was also evident that the development of arguments to support refugee health helped to avoid an even more devastating humanitarian crisis. WHO's support for the Government of Turkey and its field presence in an emergency

context illustrated its strong capabilities to ensure timely life-saving operations in a challenging environment. Health operations and interventions delivered under the framework of United Nations Security Council resolutions are good examples for all stakeholders involved in humanitarian responses. WHO plays a key role in crises by supporting health as a human right and advocating in different arenas using innovative tools and evidence-informed health diplomacy to ensure that health needs are met, for both refugee and host populations.

This chapter describes the responses of WHO when confronted with health needs linked to mass population movements, and the requirements to ensure health service provision in a complex environment. WHO's effective use of innovative tools and approaches during negotiations and operation processes to advocate for public health aspects in the crisis should strengthen WHO's role as the leading authority on global health. By sharing these experiences and lessons with other stakeholders, WHO can inspire further progress in refugee health and health diplomacy and contribute to the capacities of global health actors, thus fulfilling its mandate to work towards "a world in which all people attain the highest possible standard of health and well-being".

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14. Search and rescue as a response to dangerous border crossings: the reasons behind interventions by Médecins Sans Frontières in the Mediterranean Sea

Aurélie Ponthieu and Alfred Bridi

Introduction

The sea between Libya and Italy, the so-called central Mediterranean route, is one of the few migratory routes through the EU's southern border that cannot be sealed by a fence. It is also, unfortunately, known to be the world's most deadly route for people migrating by boat. IOM estimates that more than 17 000 people have died or gone missing on this route since 2014.

Search-and-rescue operations

MSF launched its search-and-rescue operations in the Mediterranean Sea in May 2015. This followed the termination of Italy's Mare Nostrum operation

(a naval and air operation commenced by the Italian Government in October 2013) in November 2014. Despite rescuing 170 000 people at sea since it began in 2013, Mare Nostrum was denied EU financial support, with other EU Member States describing it as a pull factor for people movement. While it is unusual for a medical humanitarian organization such as MSF to intervene at sea, it responded to human tragedy and a vacuum created by EU Member States.

Search-and-rescue operations on the central Mediterranean route are unlike any other: unseaworthy and overcrowded dinghies carry dehydrated and traumatized people, lacking both navigational skills and life-saving equipment. The best way to save lives is to assist people as soon as possible after they depart, and these early interventions also help to reduce the health risks associated with near-drowning, severe dehydration, fuel burns and asphyxia. Search-and-rescue vessels must proactively search for boats in distress as close as possible to where distress is known to occur. They must be ready to respond and be equipped to take care of a significant number of people in need of immediate medical and humanitarian assistance.

Search and rescue is clearly not a long-term solution to unsafe boat migration: only safe alternatives can truly reduce the number of deaths at sea, in the form of resettlement, humanitarian visas, family reunification and legal migration pathways. From the outset, MSF has acknowledged this fact and has regularly lobbied EU Member States for more humane migration policies. Until policies change, search-and-rescue operations remain the only short-term measure that actually saves lives.

Indeed, the obligation to rescue people in distress at sea, regardless of their legal status or nationality, is a long-standing maritime tradition and a legal obligation ratified by 167 United Nations Member States, as well as by the EU. Maritime law states that the master of any vessel has an obligation to render assistance to those in distress at sea regardless of the circumstances in which they are found (Article 98 of the Convention on the Law of the Sea *(1)*). The duty begins with the rescue and ends when a person has disembarked at a place of safety.

However, crucial gaps remain in the legal framework and governance of search and rescue, leading to countless tragedies for refugees and migrants at sea. For example, there is no unanimous definition of what constitutes distress or place of safety, and no mechanism exists to determine where

people should be taken to when the state in charge of their rescue is the one they are attempting to flee. In the Mediterranean – with the exception of a short break between 2015 and 2016, when humanitarian boats were able to operate unhindered – states have long used these grey areas to turn a blind eye, blame each other for lives lost at sea and avoid rescuing would-be asylum seekers.

Between January and April 2015, one month before MSF launched its first search-and-rescue vessels, 1721 people died or disappeared in the central Mediterranean. The EU, acknowledging that stopping Mare Nostrum was a mistake, responded by reinforcing its European Border and Coast Guard Agency operation and launching Sophia, a military-backed anti-people-smuggling operation. EU maritime operations became less politically sensitive for EU Member States once it was made clear that they were not proactively saving lives at sea, and when the focus was on preventing departures, border control and preventing people smuggling.

However, search-and-rescue operations run by NGOs have been facing harsh criticism and obstacles since 2016. They have been characterized – in the media and by politicians and EU officials – as providing a pull factor and increasing deaths at sea. These unfounded criticisms of rescuers are a symptom of the main issue: rescue is only complete with disembarkation, and the disembarkation of refugees and migrants in Europe is not welcomed by EU Member States *(2)*. With EU Member States prioritizing border control and containment, rather than the assistance and protection of refugees and migrants, the space for humanitarian actors to operate at sea has been substantially restricted. Despite interventions by MSF and others, the situation for vulnerable refugees and migrants has deteriorated, with NGO boats being seized and denied access to ports and with staff members facing criminal investigation in Italy *(3)*.

Search and rescue and other MSF assistance projects throughout Europe show that deterrence policies that aim to stem the flow of people are not working. The focus on preventing people smuggling instead of saving lives is not reducing deaths at sea and will have no long-term impact on reducing migratory flows. Instead, additional suffering is being inflicted on the highly vulnerable. As we can see from the results of this strategy, the route is more dangerous than ever, with one third of those attempting the crossing either

going missing or dying in 2018. People smugglers have responded by selling alternative routes.

EU Member States must recognize that migration is a global reality and will continue. Until longer-term solutions are found through policy change, the only short-term solution to saving lives in the Mediterranean Sea is a proactive, dedicated search-and-rescue mechanism, operating as close as possible to Libyan territorial waters. This must be combined with already identified places of safety where protection, assistance and relocation can be provided. What refugees and migrants really need are meaningful safe and regular alternatives, including the full respect of the right to seek asylum at borders.

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15. Recognizing the skills of migrant workers in the health sector

Natalia Popova

Introduction

This chapter refers only to issues affecting migrant workers. Health is a fundamental right for all people, and the governance of labour migration for health-care professionals is directly linked to the achievement of the SDGs, in particular SDG 3 (ensure healthy lives and promote well-being for all at all ages).

Objective 2 of the GCM (minimize the adverse drivers and structural factors that compel people to leave their country of origin) *(1)* states the commitment to

> Invest in programmes that accelerate States' fulfilment of the Sustainable Development Goals with the aim of eliminating the adverse drivers and structural factors that compel people to leave their country of origin, including through… health and sanitation (action b).
>
> Invest in human capital development by promoting… education, vocational training and skills development programmes… in line with labour market needs (action e).

Health diplomacy, therefore, has a key role to play in ensuring adequate and timely skills recognition and certification of health sector migrant workers, as well as the effective protection of their rights.

The recognition of qualifications covers two main areas: academic and professional. Recognition of academic qualifications allows for the continuation of studies at the appropriate level, while recognition of professional qualifications offers an opportunity to practise the acquired professional skills abroad. Professional recognition covers regulated and nonregulated professions. Nonregulated professions do not involve any specific process as the employer assesses qualifications and professional competence.

Regulated professions are governed by legal acts, requiring registration and certification in order to exercise the profession, and imply automatic professional recognition. Occupations may be regulated in a number of ways. The state may require an individual to register with an appropriate national or sector-based agency and may require a fee or a bond, thereby enabling some general oversight of who is practising in a specific area. Certification also requires an individual to pass some form of examination to ensure that they have reached a required level of competence. The most restrictive form of regulation is licensing, which includes all of the former requirements for those practising an occupation and specifically excludes anyone not licensed from performing the occupation *(2)*. Many of the health professions fall within this category.

Skills recognition and certification

Research in Canada shows that migrant workers receive a lower rate of return on their foreign qualifications compared with their national counterparts *(3)*. Furthermore, those migrant workers who have qualifications associated with a regulated occupation are less likely to work in their trained professions *(3–5)*. Licensing examinations have been questioned in terms of their appropriateness, format, timing and costs, among other factors. In addition, a migrant worker's chances of entering a regulated occupation also depend

on other aspects of the accreditation process, such as existing options for addressing gaps in knowledge and language skills *(3)*.

Health diplomacy needs to take into account the existing arrangements for recognizing qualifications and certificates at the national and regional levels. A question that is increasingly being asked is whether regulatory bodies, some dating back to the 19th century, are flexible and efficient enough to address the growing need to recognize foreign qualifications. They have often been focused on domestic conditions and criteria without considering alternative ways of evaluating competencies. As a result, a number of countries have embarked on reforms (e.g. Australia).

In many traditional destination countries for migrant workers (e.g. Australia, Canada, the United Kingdom and the United States), there has been an increase, over time, in the number of occupations to which certain government and nongovernment regulations apply, as well as the number of workers they employ. These developments have resulted in more migrant workers finding jobs outside their area of training because of the administrative barriers and costs associated with foreign qualification recognition *(3)*.

Because of these trends, temporary labour migration arrangements have gained prominence in recent decades. For example, in 2015 up to 74% of skilled migrant workers in Australia had been admitted on a temporary basis *(6)*. Consequently, a significant number of migrant workers have not been interested in investing in full qualification recognition but have, instead, preferred options such as conditional registration or restricted scope of practice *(6,7)*.

Countries can also enter into specific bilateral labour migration agreements (BLMAs) and arrangements (Box 15.1) or in programmes specifically overseeing the migration of health-care professionals (such as the agreements between Germany and several other countries, including the Philippines, for nurses), which often stipulate the recognition and training arrangements to be applied along the specific migration corridor covered by the agreements.

In addition to national regulations, there are regional arrangements for recognizing regulated and unregulated occupations. In order to facilitate labour mobility within regional economic communities, such as the EU, texts can regulate the recognition of qualifications (e.g. EC Directive 2005/36/EC

Box 15.1. BLMAs

An important aspect of health diplomacy is negotiated BLMAs and their actual implementation. BLMAs often suffer from limited implementation, while most of the existing research on BLMAs focuses only on the text of the agreements themselves.

If well rooted in international human rights and labour standards, BLMAs can contribute to better governance of labour migration and improved protection for migrant workers, including in the health sector. The regular monitoring and periodic evaluation of BLMAs have been identified as important challenges *(8)*. BLMAs often do not clearly indicate which party should initiate the monitoring process or who will cover the cost. This means that no party feels responsible for starting the monitoring process. When other stakeholders are also involved, in addition to the signatory parties, responsibility for monitoring is even more diffuse. In order to enhance accountability, all partners should be involved from the very start of the BLMA process.

ILO reviewed 147 agreements from different regions to show the incidence of good practice, based on a set of specific criteria. For example, only 10 agreements out of 147 (7%) included a provision for the recognition of skills and qualifications in the destination countries: six in Asia and four in Europe and the Americas. No such provisions had been included in the BLMAs reviewed in Africa *(8)*.

In 2018, ILO and IOM, with Swedish funding, jointly implemented a project entitled Towards global guidance on developing and implementing bilateral labour migration arrangements. An assessment tool was developed for BLMAs and piloted in the WHO Africa Region. The main purpose of the tool is to contribute to strengthening the implementation of existing bilateral cooperation frameworks and arrangements on labour migration, and to provide practical guidance on how new arrangements could be designed to ensure effective functioning. The tool will also be tested in other regions and will be further fine-tuned before publication.

on the recognition of professional qualifications, which was subsequently amended by Directive 2013/55/EU *(9)*). The aim of the amendment was to modernize the Directive in several ways, including through the creation of the European Professional Card *(10)*, which has been available since 18 January 2016 for five professions (general care nurses, physiotherapists, pharmacists, real estate agents and mountain guides). It may be extended to other professions in the future. The Card is an electronic certificate issued via the first EU-wide fully online procedure for the recognition of qualifications, updating the definition of harmonized training requirements (e.g. for medical doctors, basic medical education should be based on 5500 hours of training over a minimum of five years), the mutual evaluation of regulated professions and common training principles *(11)*. Challenges were also identified with Directive 2005/36/EC in terms of its interface with the Bologna Process (an intergovernmental cooperation of 48 European countries in the field of higher education), which has been progressively consolidated in national qualifications frameworks *(12)*. These national frameworks, in turn, are linked to the European Qualifications Framework for Lifelong Learning *(13)*. The amended directive is expected to address some of these issues.

The Association of Southeast Asian Nations (ASEAN) has concluded mutual recognition agreements in eight occupational fields. The initiative clarifies processes that enable professional qualifications to be recognized and certified in another ASEAN country. Mutual recognition agreements exist for eight professional categories, including nurses *(14)*, medical practitioners *(15)* and dental practitioners *(16)*. The implementation of the mutual recognition agreements has not been without its challenges, mainly because of different education and testing requirements throughout the region *(17)*.

At global level, mode 4 of the General Agreement on Trade in Services *(18)* covers, among other subjects, the temporary movement of service providers, which can also apply to the health sector. This implies gaining access to the labour markets of other countries, thereby requiring recognition of qualifications. The General Agreement encourages bilateral and plurilateral agreements on qualification recognition. Any new recognition agreements should be notified to the World Trade Organization's Council on Trade in Services so that other Member States can negotiate similar arrangements.

Skills and the protection of the rights of migrant health workers

Fair recruitment and the development, matching and recognition of skills are closely linked and form an important part of ILO's effort to contribute to improving the governance of labour migration, including in the health sector. Issues related to poor working conditions in nursing (e.g. low wages) can often result in someone being forced to undertake multiple jobs and work long hours. This, in turn, can have a negative impact on the quality of health care they provide, their work–life balance and retention rates *(19)*. In terms of skills trends, while professionalization has been taking place, a process of deskilling has also been observed. Cost-cutting measures have included transferring certain tasks to lower-paid staff, such as less highly trained nurses and other categories of care worker *(19,20)*.

In this context, ILO developed the General Principles and Operational Guidelines for Fair Recruitment *(21)* at the request of the 2013 ILO Tripartite Technical Meeting on Labour Migration, which asked the organization to "develop guidance to promote recruitment practices that respect the principles enshrined in international labour standards, including the Private Employment Agencies Convention, 1997 (No. 181), and identify, document, and promote the exchange of good practices on reducing the financial and human costs of migration" *(22)*.

The General Principles and Operational Guidelines aim to inform the current and future work of international organizations, national legislatures and social partners on promoting and ensuring fair recruitment in all economic sectors. They may be of particular relevance when designing bilateral, multilateral, regional and international labour migration agreements for the fair recruitment of health personnel in order to ensure mutually beneficial arrangements and address any possible negative outcomes. Such agreements should address skills recognition and training, along with the protection of migrants' rights. They should consider mechanisms for fostering labour migration and development linkages.

ILO's Constitution promotes the principles of social justice and the protection of people in their working environment, including those "employed in

a country other than their own". In formulating national laws and policies concerning the protection of migrant workers, governments should be guided by the underlying principles of the Migration for Employment Convention No. 97 *(23)*, the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) *(24)* and the latter's accompanying Recommendations Nos. 86 and 151. More specifically, in the health sector, the Nursing Personnel Convention, 1977 (No. 149) *(25)*, and its Recommendation No. 157, outline key labour standards, taking into account the special nature of nursing work. In particular, Recommendation No. 157, paragraph 62 refers to

> bilateral or multilateral arrangements to:
> (a) harmonise education and training for the nursing profession without lowering standards;
> (b) lay down the conditions of mutual recognition of qualifications acquired abroad;
> (c) harmonise the requirements for authorisation to practice.

Paragraph 66 states that:

> (1) Foreign nursing personnel should have qualifications recognised by the competent authority as appropriate for the posts to be filled and satisfy all other conditions for the practice of the profession in the country of employment; foreign personnel participating in organised exchange programmes may be exempted from the latter requirement.
> (2) The employer should satisfy himself that foreign nursing personnel have adequate language ability for the posts to be filled.
> (3) Foreign nursing personnel with equivalent qualifications should have conditions of employment which are as favourable as those of national personnel in posts involving the same duties and responsibilities.

In addition, skills development and training organizations and training delivery systems should be strengthened, including in the health sector, by promoting a lifelong learning approach in both origin and destination countries, as highlighted by ILO Recommendation 195 on Human Resources Development 2004 *(26)*. The ILO Multilateral Framework on Labour Migration *(27)* includes the following guideline (Chapter VII: Migration process, Guideline 12.6): "promoting the recognition and accreditation of migrant workers' skills and qualifications and, where that is not possible, providing a means to have their skills and qualifications recognized".

These standards and instruments provide a robust framework for ensuring that migrant workers, including migrant health workers, are treated equally to nationals. Here, it should be noted that international labour standards are legal instruments drawn up by ILO's constituents (governments, employers and workers) with the aim of delineating basic principles and rights at work and regulating other areas of the world of work. These standards mainly include conventions and recommendations. ILO also adopts other legal instruments, such as declarations and resolutions encompassing formal and authoritative statements, confirming the significance of specific principles and values for the tripartite constituents.

In this context, it is also important to mention the WHO Global Code of Practice on the International Recruitment of Health Personnel *(28)*, which sets out and promotes voluntary principles and practices for the ethical international recruitment of health personnel. It is intended to serve as a platform for continuous dialogue and a dynamic framework for global collaboration on the recruitment of health personnel. It makes reference to qualifications and skills in terms of equality in treatment and access to training opportunities. The GCM *(1)* also recognizes the importance of both skills recognition and fair recruitment in Objective 6 (facilitate fair and ethical recruitment and safeguard conditions that ensure decent work) and Objective 18 (invest in skills development and facilitate mutual recognition of skills, qualifications and competences).

Conclusions

Recently, many countries, including low-income countries (e.g. Chad and Togo), have adopted as a policy priority the provision of UHC by developing health protection strategies and legislation, and releasing targeted resources for improving access to quality health and long-term care services *(19)*. Yet, many low- and middle-income countries still face large deficits of workers in the health sector. For this reason, improving the dissemination of information about the labour market and migration could assist in improving labour demand and supply dynamics at national level and anticipating skills needs accordingly.

In countries where the systematic collection of data is still relatively limited, qualitative methods could also be used to forecast skill demands. This will help in the design of up-to-date education and training programmes. Labour market and migration information systems are also important for health diplomacy because they can facilitate the design, implementation and monitoring of adequate bilateral or multilateral labour migration agreements to address shortages in the health sector. In the short term, a monitoring system at national level would enable an analysis of the national health system's needs, gaps and international requirements and support planning to respond to these. This might be part of an overall labour market and migration information system if one were in place.

In the longer term, policy and health diplomacy should also cover issues related to the reintegration of returning migrant health workers into the labour market in order to improve labour migration governance in the health sector and strengthen the migration–development nexus. Policy-makers in origin countries should establish a system to recognize and validate qualifications of prior learning acquired outside of the formal education system. This particularly applies to medium-skilled migrant health workers (e.g. health-care assistants) *(29)*. On-the-job training has been considered the most common type of training abroad for migrant workers in general *(30)* and this is why recognizing prior learning is of particular importance in this case. The public employment service could also play a key role in facilitating the recognition of skills and competencies gained abroad, given its role as a bridge between employers and workers *(31)*.

Health diplomacy requires cooperation at all levels (bilateral, regional and multilateral) between governments, social partners and other stakeholders. It is an essential pillar for ensuring, on the one hand, the protection of migrant health workers' rights, and, on the other, improved development outcomes for countries of origin and destination. To this end, ILO, along with the International Organisation of Employers, the International Trade Union Confederation, IOM and the United Nations Educational, Scientific and Cultural Organization forged a Global Skills Partnership *(32)* in Marrakesh, in December 2018, as a side-event at the Intergovernmental Conference to adopt the GCM. The aim of the Partnership is to mobilize technical expertise to support governments, employers, workers and their organizations, educational institutions and training providers, and other stakeholders to develop and recognize the skills of migrant workers, with a particular focus on women and young people.

The Partnership is in line with Objective 18 of the GCM, which identifies the need to "[b]uild global skills partnerships amongst countries that strengthen training capacities… and foster skills development of workers in countries of origin and migrants in countries of destination with a view to preparing trainees for… the labour markets of all participating countries" (action e) *(1)*.

The Global Skills Partnership will pay particular attention to low- and medium-skilled migrant workers and will be underpinned by skills partnerships at the local, national, subregional and regional levels.

There is also a need to ensure that health sector considerations are central to any labour migration governance arrangements, from both a public health and an economic perspective. In this regard, it is important to identify good practice when implementing BLMAs and to prepare guidance and capacity-building tools that specifically target the health sector as well as policy-makers in health diplomacy. There is also insufficient evidence-informed analysis of protection aspects and skills recognition within temporary labour migration schemes for health professionals, which aim to produce better policy and programming outcomes. Since skills recognition and certification both present major obstacles to the integration of migrant health workers into the labour market, it is important that existing processes are evaluated, also with a view to identifying viable options for funding mechanisms.

In order to facilitate future health diplomacy, feasibility analyses should be carried out for the development of transnational standards for specific health sector occupations. It is also important to consider what lessons can be learned from existing supranational arrangements for professional recognition (e.g. Directive 2013/55/EU on the recognition of professional qualifications and ASEAN health-related mutual recognition agreements) and their potential application in other regions.

The role and potential impact of digitalization for improving access and lowering the cost of skills recognition and certification for migrant health sector workers should also be considered. When digital management platforms store important information, such as work contracts, pay slips and medical certificates, they create a record of documents – a digital trail. This can be useful if disputes arise about contract conditions, payments or other issues between a migrant worker and an employer or recruitment agency *(33)*. The potential application of such platforms could also be assessed for facilitating skills recognition and certification.

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16. Building migrant-sensitive health-care systems: the role of human resources

Istvan Szilard, Zoltan Katz, Kia Goolesorkhi and Erika Marek

Introduction

The EU continues to receive significant numbers of refugees and migrants and their needs remain complex. Assistance tailored to their needs is essential for their smooth and successful integration, which is not only a humanitarian obligation but also of clear economic benefit. The need is clear for specially trained professionals capable of coping with this complex, multidisciplinary task – where health, human rights and intercultural aspects intersect. However, there is a significant shortage in formal higher education programmes to build the human resource capacity of properly trained staff who can address this challenge.

EUPHA published its statement on migration, ethnicity and health in May 2018 *(1)*. The revision in October 2018 *(2)* states on the issue of human resource capacity-building (point 7, covering better provision of education and training in migrant and ethnic minority health).

Although this Statement is primarily concerned with the links between research and policy-making on MEM [migrant and ethnic minority] health,

capacity building in both areas has to be supported by education and training directed at health workers of all kinds, researchers, managers and policy makers. This should not only be provided in optional additional courses, but as part of basic curricula.

Building the capacity of medical students at the University of Pécs Medical School

In response to this recognition and the need for human resource capacity-building as an essential component of migrant-sensitive health-care systems, the University of Pécs Medical School (the site of the WHO Collaborating Centre for Migration Health Training and Research since 2017) began to incorporate migration-related health and public health elements into its training programmes for medical students. Catering for students from more than 50 countries, the training is provided simultaneously in three languages: English, German and Hungarian. The courses are currently offered at three levels: optional courses, compulsory courses and postgraduate studies.

Optional one-semester courses

Optional courses are offered twice in each academic year, with 28 lectures over 14 weeks in English and Hungarian. Each study group comprises approximately 30 students. The course covers the following subjects:

- migration health and travel medicine
- new migration health challenges in the EU health-care system
- health aspects of humanitarian assistance
- special aspects in health assistance of Roma and ethnic minority communities
- primary health care and migration.

In addition to formal lectures, roundtable discussions, analysis of movies and role-play are part of the training.

Compulsory courses integrated into the regular medical curriculum

About 400 students from around 52 countries attend lecturers and seminars (taught in English, German and Hungarian) each academic year in the following subject areas:

- health aspects of migration in primary health care and family medicine
- occupational health aspects of migration.

Postgraduate course: Specialist in Migration Health

The postgraduate Specialist in Migration Health course is a four-semester training programme, generating 120 credits on the European Credit Transfer and Accumulation System (calculated from the required workload of the students). This is sufficient for a master's degree under the System. The pilot phase of the programme was launched in the 2018–2019 academic year and is based on a form of problem-based learning: it mixes face-to face training with distance learning and includes as a basic requirement the development of skills in team working while completing tasks during the distance learning period under the supervisions of tutors. The programme has been developed within the framework of the CHANCE project. The CHANCE consortium of six academic institutions (coordinated by the University of Pécs and co-financed by the EU's Erasmus Lifelong Learning Programme) aims to address gaps in the higher education system across the EU.

The consortium has developed a masters of science curriculum that focuses on the new challenges arising from the increasing ethnic, cultural and language diversity of refugees and migrants. The course covers a number of fields, including direct health assistance, migrant-sensitive health care and health-care system planning, health policy, applied sociology, economics/ health economics and the importance of intercultural competences. Even the entry criteria of the programme reflect its intersectoral approach: not only are health and public health professionals welcome to apply but so are candidates with honours degrees in other fields, such as social and economic sciences, military and law enforcement, teacher training and public administration.

The curriculum provides motivation and orientation, knowledge and skills for postgraduate students and health, public health and social care professionals who are intending to assist, treat, care and refer refugees and migrants; design, plan and implement health and social care programmes for refugees and migrants and their integration; and/or undertake research related to refugee and migrant health. The development of each academic module has been led by a single partner but reflects the joint efforts of all partners. The academic content is built around six core competences:

- epidemiology and research methodology (University of East Anglia, United Kingdom);
- environmental medicine and occupational health (University of Pécs, Hungary);
- economic/health economic impact of migration (University of Pécs, Hungary);
- organization and systems management (Danube University Krems, Austria);
- clinical and public health assessment (Pavol Jozef Šafárik University, Košice, Slovakia); and
- social and behavioural aspects of migration, including multicultural and multireligious aspects and their health/mental health impact (University Medicine Greifswald, Germany).

Training development

Refugees and migrants make up a significant part of the EU population, and both regular and irregular migrants continue to arrive. Refugees and migrants reflect their countries of origin in terms of morbidity profile and public health conditions, as well as in their cultural and religious heritage. Organizations at the highest political and professional level have repeatedly stressed the need to develop institutional (migrant-sensitive health-care systems) and human resource capacity in order to address this challenge.

One of the core elements of any training development is also missing at European level: to ensure that data on refugees and migrant health is standardized and comparable.

While some important – mostly individual – efforts aimed at fulfilling the challenges do exist, until now, there has been an absence of any truly comprehensive programme, even in the most essential area: to ensure an adequate supply of trained staff who are able to transform existing systems into systems that are more sensitive to the needs of refugees and migrants.

Civil organizations engaged in the general and health assistance of refugees and migrants have recognized the contradictions between migration-related policy and practice and it is clear that there is an urgent need for action based on good scientific evidence. The Migrant and Ethnic Minority Health Section of EUPHA took part in preparations for the first Global Conference on Migration, Race, Ethnicity and Health, held in Edinburgh, United Kingdom, in May 2018. That was an excellent opportunity to compose and launch a declaration that was first broadly discussed within the frame of the Section's Board, and then accepted by the EUPHA Presidency. The EUPHA statement highlighted all the important areas requiring more action, including research and databases to support evidence-informed action for refugee and migrant health. The Section's members supported the May 2018 Declaration, which underlined the importance of training for researchers, health workers, managers and policy-makers as their efforts are essential for improving knowledge in this field. Educational programmes are needed that give adequate attention to migrant and ethnic minority health, not just in the form of one-off training and refresher courses but also integrated into the basic curriculum of all the disciplines involved *(1)*. The Declaration emphasized the role and responsibility of higher education institutions in integrating the core elements of migration and refugee and migrant health into their programmes.

Most of the literature relating to human resources capacity-building is in agreement with the Declaration in highlighting its importance and the need to incorporate it into the regular undergraduate programmes of health and public health professionals. It also highlights the need to train a relevant nonhealth workforce as well *(3)* – all of which the University of Pécs Medical School plans to pursue.

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17. Health integration policies matter: obstacles in the integration path for refugees and migrants

Elena Sánchez-Montijano

Introduction

Studies of refugee and migrant health policies began appearing in the 1990s, but it is only very recently that a systematic and broad approach has been taken in migrant health *(1)*. In fact efficient access to health systems for refugees and migrants has become one of the most important factors in determining how refugees and migrants integrate into society in their destination country: their health interplays with socioeconomic dimensions such as improving the access to the labour market and sociopolitical participation *(2)*. In recent years, many national governments, particularly in western European countries, have, to a greater or lesser extent, introduced policies to improve health-care coverage for refugees and migrants. Nonetheless, there are many obstacles in providing quality health care and access to health systems for refugees and migrants.

Integration of refugees and migrants

There are significant differences between destination countries in terms of their success in integrating refugees and migrants. Data analysed by the Migrant Integration Policy Index[7] allows measurement and comparison of the extent that policies on migrant health promote equity in 38 countries *(3)*. The results show that traditional host countries and those with more equal-opportunity policies for refugees and migrants usually have more inclusive health systems generally. Nevertheless, different characteristics that go beyond national policies should be analysed to understand how countries promote the integration of refugees and migrants into health systems. To this end, a multiactor and multilevel approach within the framework of global health diplomacy should be considered.

Not all countries allow refugees and migrants access to their health systems. However, many countries do grant some form of access to regular/documented migrants, particularly if they are long-term residents, but it is not necessarily the same level of access that their citizens enjoy. The main problems are that the information provided by the authorities is not sufficient to ensure access to services, the documentation requirements may be very difficult to fulfil and, in a significant number of countries, there are reports of administrative delays in recognizing access rights for refugees and migrants.

Furthermore, in recent years, many countries have reduced access because of austerity policies, particularly in countries where the financial and economic crisis has had a significant impact, such as Portugal and Spain. Similarly, growing populist discourse has also led to a reduction in access, for example in Austria, Poland and the United Kingdom.

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[7] A multidimensional tool that evaluates and compares what governments are doing to promote the integration of migrants through assessing policies based on 167 indicators. The health strand was co-funded by the EU's Directorate-General for Health and Food Safety, with support from the IOM *(3)*.

Access to health care for asylum seekers also varies by country. While, in some countries, asylum seekers theoretically have the same access rights and coverage as citizens, they also encounter in practice the problems noted above. Many countries differentiate between certain categories of international protection when granting full access. In most cases, migrants without the required documentation (irregular) remain outside the health system (France and Italy are both exceptions), even for emergency care. In addition, health-care staff may be required to report irregular migrants.

Other barriers delay and impede access to the health system for refugees and migrants and the quality of service provided. In a significant number of western European countries, there is a lack of information about which migrant group may access health-care provision, and how it may take place and in which conditions. The documentation required is often in the host language and not always easy to complete. In most cases, services are not adapted to the specific needs of refugees and migrants in terms of language, lifestyle and cultural practices. The training of health-care staff is often inadequate and sometimes absent, and only a few support programmes exist for medical professionals and health-care providers in the 38 countries analysed. A lack of sensitivity among health-care staff to the overall situations for refugees and migrants has also been reported in many countries, as well as some cases of discrimination. Finally, many countries lack effective protocols to monitor the health status of refugees and migrants, particularly at their arrival.

Many studies have demonstrated that refugees and migrants do not represent a risk to health security or an economic burden for social security systems, and that their health is no worse than that of citizens. This is explained by the fact that refugees and migrants tend to be young and their use of the health system is limited to a few services, such as maternity care. However, refugees and migrants do have special health needs, particularly now that migration is characterized by a diversification of migration flows, in terms of motivations, legal status, gender, and geographical origin, and the potential for harsh conditions during migration. As a result, the differences between refugees and migrants and citizens in terms of health habits and lifestyle demands are, to some extent, widening.

In view of the above, some policy instruments should be reinforced.

- Migrants' health status is much more related to social disadvantage and social exclusion (e.g. income, education, type of work or housing) than to their migrant status. From this perspective, mainstream and targeted integration policies (e.g. housing and labour conditions) should be reviewed.
- The specific needs of refugees and migrants require a specific response. Refugees and migrants may differ from the host population in terms of health, culture and lifestyle, which means health access and services provision should be matched to their needs.
- Refugees and migrants should be entitled to a satisfactory standard of health services, free of charge and without administrative barriers. Once this access is granted, it should be recognized and guaranteed by authorities so that it cannot be revoked.
- Entitlement, accessibility and quality should be a priority for asylum seekers and refugees. International protection is recognized as an international human right and the provision of health care should be recognized by authorities.
- Adaptive capacities to new needs are necessary both within and across countries, particularly because health issues transcend borders and require global action. A governance approach should be part of the decision-making process, which means strengthening health diplomacy. This entails cooperation between countries of origin and transit (before arrival), cross-border assistance, coordination between different levels of government and the involvement of social and civil actors.
- Configuring indicators and collecting systematic data to monitor the health status of refugees and migrants will allow major health issues to be anticipated. This information should be reflected in multilevel policies in order to provide equitable access to quality health care. Moreover, efficiency in health provision requires data sharing between international organizations, countries and stakeholders.
- In host countries, a different approach to communication and education is required to counter irrational fears promoted by xenophobic political parties, which are often disseminated through social media.

The connection between the health status of refugees and migrants and their integration into society – such as the labour market and their political engagement – is well established. Successful integration of refugees and

migrants leads to a more cohesive and economically competitive society, and this can be promoted by increasing integration efforts at all levels, driven through operational health policies *(4)*. Previous experience demonstrates that exclusion and segregation can only be reduced by the active interaction of key actors at different levels. It is in this context that a global health diplomacy, based on a multilevel and multiactor negotiation process, should be implemented.

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4. Country perspectives

18. Turkey's experience in migrant health: a success story in achieving universal health coverage for refugees and migrants

Emine Alp Meşe

Introduction

Population movement has always been a part of human history but has become more deeply felt in the world in recent years. International organizations report that, in terms of scope and effects, the most important migration movements in world history are being experienced today. This has drawn attention to the process and consequences of migration.

Because of its geographical and political location, Turkey has a long history of migration, both inwards and outwards, with periods of larger inward movements, including around 100 000 Sephardic Jews from Spain in the 15th century; approximately 1 185 000 people from the Balkans, Germany and Greece, particularly during Republic period of 1922–1945; and approximately 900 000 people from Bosnia, Bulgaria, Iraq and Kosovo (in accordance with Security Council resolution 1244 (1999)) between 1988 and 2000. In recent years, those leaving neighbouring countries undergoing conflict and civil wars

and those migrating for economic reasons from countries such as Afghanistan and Pakistan have given rise to the greatest migrant mobility in Turkey in recent years *(1)*. As of July 2019, there are nearly 3.6 million Syrians under temporary protection, approximately 360 000 citizens of various countries under international temporary protection and 850 000 residence permit holders as migrants in Turkey *(2)*. The geographical location of Turkey, its economic and political stability and its strong humanitarian stance of never turning away from those in need have made Turkey a major country of transit and destination for refugees and migrants from the Middle East.

These movements of refugees and migrants bring social, cultural and bio-psychosocial changes for both the sending and the receiving communities, and migration may create positive and/or negative consequences for both the refugees and migrants and the receiving communities. In Turkey, inclusive immigration policies aim to strengthen the short-, medium- and long-term consequences and improve integration within a framework of respect for different cultures. Migration health policies are effective tools to ensure access to quality health services, protect essential human rights and realize the economic and social benefits of refugees and migrants.[8]

Health policies and services can vary among countries and between different migrant groups. Some refugees and migrants may have difficulties in accessing health services worldwide, and they may lack the necessary information on their health rights. They may also face communication problems because of cultural and language differences. In addition, health professionals may lack awareness and experience in providing health care for refugees and migrants. Turkey quickly responded to these challenges to a unique and outstanding extent, as recognized by the international community in many platforms. Providing health services for refugees and migrants in the same quality and coverage as for its own citizens has been the motto of Turkey's successful migration policies.

Turkey's health interventions for refugees and migrants have occurred in many areas, such as establishing migrant health centres designed to be sensitive

[8] The Ministry of Health of the Republic of Turkey uses the term migrant in this text to cover those with all types of legal status, such as asylum seekers, those with temporary protected status, and regular and irregular migrants.

to the needs of refugees and migrants, awareness-promoting activities for health services and the employment of bilingual health professionals for easier navigation in the system.

Experience of Turkey in migrant health

In Turkey, access to primary, secondary and tertiary health facilities for all refugees and migrants is ensured by the Ministry of Health. Primary health services provided to Syrians under temporary protection in Turkey are organized in community health centres and their affiliates (e.g. healthy living centres or migrant health centres) and in family health centres, while efforts to increase the number of migrant health centres continues in areas where many Syrians are living under temporary protection. Furthermore, protective health services are provided in polyclinics affiliated to community health centres that have been established to overcome language barriers through foreigner polyclinics and family health centres.

Since the beginning of the Syrian civil war in 2011, 13 million Syrians have been forced to migrate and 5.6 million have taken shelter in neighbouring countries *(3)*: Egypt, Iraq, Jordan, Lebanon and north Africa, but primarily Turkey. At the onset of the Syrian crisis, Turkey opened its borders and welcomed Syrians fleeing from the conflict. This approach was called the Open Doors policy, through which Turkey displayed an extraordinary and timely commitment to the human rights of Syrians under dire conditions. Turkey, in this sense, is the country hosting the highest number of refugees.

Although their numbers gradually increased until they exceeded 3.5 million, Syrians have been welcomed as guests in the country based on a cultural heritage of thousands of years in which refugee problems have been approached with great sensitivity, thus demonstrating model practices to other countries worldwide. Using the term guests for Syrians migrating to Turkey has two basic rationales. First, visiting has a special meaning in Turkish tradition, implying enjoyment of sincere welcome and being hosted with all available means. The second is according to Ansar and Muhajir doctrine in Islam, referring to people of Medina sharing all their belongings with Muslim

groups who migrated from city of Makkah, thus embedding the value as an essential element in Islam.

Efforts to provide a full scale of education, health and social services to refugees and migrants as for Turkish citizens were matched with legal measures of protection. The legal status of temporary protection, regulated under the Law on Foreigners and International Protection adopted in 2013, was granted to those in entering Turkey from the Syrian Arab Republic starting in May 2011.

Temporary protection is provided to foreigners under following conditions: those forced to leave their countries; those who cannot return to their country of origin; those arriving at Turkey's borders in crowds to seek urgent and temporary protection; and those arriving or passing the border individually during this massive mobilization period and who need individual international protection *(4)*.

Temporary protection ensures community-based protection for individuals where it is not possible to prove their personal status or when they are not entitled to refugee status under the 1951 Geneva Convention *(5)*. In line with the non-refoulement principle, temporary protection status granted to Syrians arriving in Turkey as an escape from the war and violence ensured their safety and their access to human rights-based public services.

The first temporary accommodation centre was established in Yayladağı on 1 May 2011 by the Disaster and Emergency Management Centre, the sole authorized institution for disasters and emergency management. It acted in coordination with the Turkish Armed Forces, the Ministry of Foreign Affairs, the Ministry of Transportation and other relevant stakeholders, including the Ministry of Health. The Ministry of Health led the health sector and was responsible for service provision to Syrians who had to leave their country.

On 24 January 2019, there were 3 636 617 Syrians with temporary protection status; approximately 3% were staying in temporary accommodation centres while the others were living around the country, including in cities such as Ankara, Istanbul and Izmir and in border provinces (Table 18.1).

Syrians under temporary protection constitute the largest group of migrants with legal status in Turkey. Those given temporary protection, those with so-called humane residence permits and those under international protection can directly apply to health institutions operated by the Ministry of Health

Table 18.1. Syrians living in temporary protection, 2011 to January 2019

Year	No. Syrians living in temporary protection
2011	0
2012	142 237
2013	224 655
2014	1 519 286
2015	2 503 549
2016	1 834 441
2017	3 426 786
2018	3 623 192
2019	3 636 617

Source: Directorate General of Migration Management, 2019 *(6)*.

and can benefit from the health services free of charge as defined in the Health Practice Communique, which determines the scope of health services provided to Turkish citizens. Patients requiring emergency or intensive care or those with burns or cancer who cannot be treated for various reasons (e.g. capacity or access) in the relevant health institutes are transferred to university hospitals or private hospitals and their health services are also given free of charge.

Primary health-care organization was reformed as part of the Health Transformation Programme and services were strengthened within the family medicine system, allowing timely access to health services and improved ownership of health outcomes. Turkey has developed a distinctive service model for providing primary health services with the unique characteristic of employing a Syrian health workforce in specific centres, known as migrant health centres. These centres have been developed under the national Family Physician System. The centres have a minimum of two units, each with a physician and a nurse, and serve 4000 people, on average. They are sited in places where many Syrians are living. The centres have the same physical

conditions and service standards as family health centres. Bilingual patient guides have been trained to help patients to navigate the health system without being inhibited by a language barrier. As of January 2019, services are provided in 180 migrant health centres in 29 provinces, and the number of centres can be increased as service needs require.

The Ministry of Health provides services for Syrians exposed to various risks through the challenging conditions they have faced, including for communicable diseases; health screening and treatment efforts are intense for the epidemic-prone diseases such as leishmaniasis, marsh fever and TB.

Immunizations are offered in line with the National Vaccination Calendar of the Extended Immunization Programme (Table 18.2). Supplementary vaccination campaigns (known as Mop-up) have been organized to support and complement the main vaccination services in order to overcome any issues of access.

Since 2011, the Ministry of Health has organized targeted immunization campaigns in public residential areas and schools for those who have migrated from the Syrian Arab Republic and other foreigners. This includes provision of all childhood vaccines for those under temporary protection living in temporary refuge centres, all refugees and migrants residing in the country and all foreigners arriving at the borders. Vaccines are applied in line with the National Immunization Programme in Turkey.

Between 2013 and 2016, a total of 350 000 Syrian children aged from 6 months to 15 years received measles, mumps, and rubella (MMR) vaccine, whether in or out of the camps. In addition, a total of 2.5 million doses of MMR vaccine were given during supplementary immunization campaigns in streets, schools and workplaces in high-risk areas. In 2017, the Ministry of Health organized a mass vaccination campaign by going from door to door for the first time. A team of more than 5000 health professionals in 2017 gave more than 358 000 doses of MMR to children aged under 5 years and in temporary protection. More than 120 000 children received oral polio vaccine, and the pentavalent vaccine (diphtheria, tetanus, pertussis, hepatitis B and *Haemophilus influenzae* type b) and hepatitis B vaccine were given based on age. These vaccination activities were recorded in the national online immunization database and the children were followed up for routine immunization. All the administered vaccines were

Table 18.2. Childhood inoculation calendar: Turkey

Vaccine	At birth	End of 1st month	End of 2nd month	End of 4th month	End of 6th month	At 1 year	At 18 months	At 2 years	At 6 years (primary school entry)	At 14 years (primary school 8th grade)
Hepatitis B	I	II			III					
TB (BCG)			I							
Pentavalent			I	II	III		R			
Pneumococcal conjugate			I	II	III	R				
MMR						I			R	
DTaP-IPA									R	
Oral polio					I		I			
Tetanus, diphtheria (adult)										R
Hepatitis A[a]							I	II		
Varicella[b]						I				

Notes: BCG: Bacillus Calmette–Guérin; pentavalent: diphtheria, tetanus, pertussis, poliomyelitis and Haemophilus influenzae type B (combination vaccine); MMR: measles, mumps, and rubella vaccine; DTaP-IPV: diphtheria, tetanus, pertussis, poliomyelitis (combination vaccine); I, II, III: first, second and third doses, respectively; R: reinforcement dose.

[a] From October 2012

[b] From December 2012.

Source: Ministry of Health of Turkey.

identical to those used for Turkish citizens and were provided free of charge under the National Vaccination Programme.

Between 2013 and 2015, there were nine Mop-up tours for polio vaccination during which 5 288 639 doses were given to children. The measles control campaign conducted between 2013 and 2015 gave 2 381 626 doses to refugee and migrant children without vaccination. In three tours in February, May and November 2017, approximately 370 000 Syrian children under 5 years of age were visited where they lived; those not registered were recorded and those without vaccinations or with missing vaccination were given MMR vaccine, pentavalent vaccine and hepatitis B vaccine.

Research has often indicated that refugee and migrant women have limited access to reproductive health services and face higher health-related risks in comparison with host communities. In Turkey, the Ministry of Health provides identical services to these women as for the host population in terms of reproductive health services, antenatal and postnatal care services and screening for women of fertile age (15–49 years). To overcome language and cultural barriers, women's health consultancy centres specializing in the health issues of mothers and children were established as part of a collaborative project between the Ministry of Health and the United Nations Population Fund. The centres also provided psychosocial support and increased the scope and quality of health services provided to this group of migrants, plus developing access to rights and services for women and young and disadvantaged groups. Currently, 34 centres have been established in migrant health centres to tackle the challenges of ensuring secure maternal, antenatal and postnatal care, training, and cover for sexually transmitted infections and nutrition. Nearly 400 000 people have been reached in the project.

Migration can be traumatic and lead to psychological problems such as post-traumatic stress disorder, depression, anxiety disorders and sleep problems. The Ministry of Health has developed various interventions to provide support in these issues. Ten community mental health centres are planned for the cities where the most Syrians live and six are currently in service. Mental health services can also be provided to refugees and migrants through psychosocial support units. In order to better address mental health needs in primary care and to improve diagnosis and treatment, Turkish and

Syrian physicians and nurses have been provided with training in the WHO Mental Health Gap Action Programme organized by the Ministry of Health and WHO. More than 1000 Syrian health personnel have taken part in these training sessions.

Furthermore, extended migrant health centres have been established where the refugee and migrant population is greatest to provide more comprehensive health-care services. In addition to the basic capacities of the migrant health centres, these extended centres offer services in internal medicine, paediatrics, gynaecology, oral health and psychosocial support using Syrian health workers in the provision of all services apart from dental care. Services are supported by imaging units and basic laboratory services. The aim is to facilitate much-needed maternal and child health care, psychosocial services and preventive services for chronic diseases in these centres to reduce the burden on secondary care. There are currently 35 extended migrant health centres, seven of which are in service as training centres. In these seven centres, Syrian physicians and auxiliary health personnel receive practical training.

As in many countries of world, health professionals graduating from universities in other countries can take accreditation examinations to work in Turkey. Under normal circumstances, this would be the situation for the approximately 1500 Syrian physicians who have sought refuge in Turkey. A model has been developed to allow Syrian health professionals who can meet the required standards to work within their own professions. This would help to overcome language and cultural barriers for service provision. In the second half of 2014, negotiations took place with the Higher Education Council and the Ministry of Family, Labour and Social Policies to create various legislative amendments so that Syrian physicians and nurses could be employed in the Turkish health system. Under these arrangements, the issue of accreditation was temporarily halted and work permit certificates were provided. The Ministry of Health prepared and implemented a training programme with experts from universities to integrate Syrian health professionals into the Turkish health system. This training programme is not for retraining in medicine; rather it is designed to enable health professional to understand the Turkish health system and how it works.

In collaboration with WHO, Syrian health professionals meeting the criteria requested by the Ministry are given adaptation training consisting of five days

of theoretical training on the functions of the Turkish health system and health programmes and six weeks of practical training for hands-on learning under the coaching of Turkish counterparts. Syrian health workers who successfully completed this training course are employed by the Ministry of Health under the EU-funded SIHHAT project *(7)*. Health professionals are employed and paid their salaries throughout the project under a contract between the EU Facility for Refugees in Turkey and the Turkish Ministry of Health. Currently, 117 expert physicians, 441 practitioner physicians and 725 allied health personnel are employed under the project in migrant health centres and are receiving ongoing training.

An electronic registration system (the Examination Information Management System) was developed under the guidance of the Directorate General of Health Information Systems to keep the records of services provided in migrant health centres. The registration system was designed initially as a system for Turkish patients in community health centres, but it was later adopted for use in the migrant health centres. An Arabic language interface is also available to ensure accurate data submission and compliance. Syrian health professionals receive training on the system from the Ministry of Health and WHO.

All refugees and migrants in Turkey can apply to all health institutions and organizations if they need emergency health services and can benefit from primary health-care services free of charge. Syrians brought as injured or emergency patients to the border are transferred by 112 emergency health teams to hospitals for treatment. Between July 2011 and July 2018, 37 849 Syrians were transferred to hospital from the border.

Health service usage for those with temporary protection in service providers affiliated to the Ministry of Health, universities and private hospitals between 2011 and 2018 is summarized in Table 18.3. Over the seven-year period, services were provided for more than 400 000 births, approximately 48 million outpatient visits, over 1.5 million operations and more than 1.8 million inpatients.

Table 18.3. Health services provided to those with temporary protection, 2011 to November 2018

Service usage	2018	2011–2018
Outpatient visits to polyclinics		
HSGM-affiliated units	3 757 288	12 505 103
KHGM-affiliated units	8 972 377	34 261 904
University/private hospitals	252 884	714 349
Total	12 982 549	47 481 356
Number of inpatients		
KHGM-affiliated hospitals	383 264	1 759 369
University/private hospitals	16 929	64 668
Total	400 193	1 824 037
Number of operations		
KHGM-affiliated hospitals	348 927	1 514 409
University/private hospitals	6 275	33 759
Total	355 202	1 548 168
Number of births		
KHGM-affiliated hospitals	100 430	396 522
University/private hospitals	2 623	8 999
Total	103 053	405 521

Notes: HSGM: Directorate General for Public Health; KHGM: Directorate General for Public Hospitals.

Source: Ministry of Health of Turkey, 2018. (8).

Ministry of Health's migration health vision

Migration and migration health issues are discussed in the Turkish Government's main policy documents, such as the Government Programme and the Strategic Plan of the Ministry of Health, which are expected to be published for the period 2019–2023. Under the strategic objective of ensuring social harmony of foreigners with international and temporary protection status, the Ministry of Health's target is to extend primary health services (2019–2023 Government Programme). The Ministry of Health's 2019–2023 Strategic Plan contains the objective of increasing effectiveness and capacity for migration health services. These documents are being developed with stakeholder negotiations with all public institutions and under the Government's political commitment to the rights of migrants as well as to safe and orderly migration. Experiences gained through extensive service provision to Syrian refugees have been taken on board in development of the strategy documents, with the objectives of improving the inclusiveness of health system to the needs of refugees and migrants and of developing a strategic roadmap for future efforts.

The migration health vision, supported by policy documents, is a new service model to meet migrants' needs for health services and is designed and implemented through negotiations with both in-house and external stakeholders. Extensive consultations and negotiations were held with stakeholders concerning legal, human resources and service delivery planning to ensure that the intervention was firmly based within both public health and the health system. As the target beneficiaries included Syrian health workers, the legal background was explored in detail to identify issues regarding scope of work, entitlements and employment. A collaborative dialogue took place with relevant departments in the Ministry of Labour, the Directorate General of Migration Management and the Directorate General for Health Services to develop a sustainable solution to address these health needs. Initially, the consensus in the Ministry of Health was that migrants' health requirements are a right and this right is of top priority and in no way can be deferred. Yet the process of building an inclusive system for migrants was not so easy. Many bureaucratic negotiation steps were required to ensure that the workforce was placed where it was needed most and to ensure quality service provision and sustainable use of financial resources. Although, country

resources were utilized initially to meet emergency requirements, political trends and evidence from the field indicated that most of the refugees and migrants are likely to stay in Turkey. Consequently, the refugee and migrant health intervention was scaled up to strengthen primary health to overcome language and culture barriers in health service provision and to deal with specific public health issues related to migration. Health centres were set up to minimize disadvantages arising from migration. A sensitivity to the migrant population, quality standards and patient satisfaction were considered as primary requirements to provide migrant-sensitive health services that were of similar standards to those for Turkish citizens and to ensure sustainable integration into the national health system.

Health diplomacy as an instrument for refugee and migrant health

One of the defining characteristics of Turkish foreign policy is humanitarian diplomacy, with a focus on humanitarian assistance responsibilities and a people-centred approach. In this context, Turkey embraced Syrians by applying the Open Doors policy with the philosophy that Turkey would never turn away from people and humanity. This philosophy found its practical application in the efforts of the Government of Turkey to provide quality health services to all refugees and migrants in Turkey. This chapter has described negotiations among internal and external stakeholders for coordinated response operations, all of which fall under the topic of health diplomacy.

Although sustainability is the basic instrument for testing the resilience of health systems, humanitarian crises and emergencies are the most striking experiences and ultimate challenges. The influx of Syrian refugees tested the resilience of the health system in Turkey. However, the country has managed the situation successfully and provided the same scope and quality of care to the refugees and migrants as to its own citizens. Despite protracted delays in assistance from the global community, Turkey mobilized all resources to prevent the further victimization of these refugees and migrants by ensuring that they received timely services.

With a strong health system and political commitment and by moving ahead with the principle of leaving no one behind, health services are delivered free of charge to Syrians in the same quality as for the host community. This achievement has been lauded many times by the world community and by WHO and is recognized as a success story of good management of the tragic results of a crisis, such as that in the Syrian Arab Republic. This situation has meant that Turkey has become a "laboratory" experience for the rest of the world, providing information to support any future response efforts in the area of refugee and migrant health. This is why documentation of such experiences is important, not just to promote good practices in Turkey but also to influence interventions to address the health needs of refugees and migrants worldwide.

Because of all its efforts, Turkey was declared the third leading humanitarian aid provider in the 2013, 2014 and 2015 Global Humanitarian Assistance Reports and the second leading humanitarian aid provider in the 2016 Report. In 2018, Turkey received praise from the international community as it provided the highest rate of humanitarian aid per gross domestic product *(9)*.

From the onset of the crisis in the Syrian Arab Republic, Turkey has spent US$ 37 billion to provide services for Syrian refugees. Health-related components of the total assistance amounted to approximately US$ 7 billion from the start of delivery of health services in 2011; hence, Turkey's expenditure has clearly outweighed the amount of international assistance.

In addition to providing comprehensive services using its own resources, Turkey has also established tailored and effective cooperation with other entities. In this context, with a focus on combating illegal migration, Turkey and the EU came to an agreement for migration management and for facilitating Syrians residing in Turkey to be accepted as refugees in Europe. Under this agreement, €6 billion would be provided as financial support to be spent on Syrians' needs, including health *(10,11)*. The first phase of the funding is for €3 billion with €300 million reserved for the SIHHAT project, which, as discussed above, is for the provision of a health workforce for migrant health. However, because of its project-based nature, approximately US$ 200 million (approximately €180 million) has already been utilized, which is still less than 3% of the amount spent by Turkey for migrant health.

Turkey is actively involved in global policy-making processes in the field of migration and health and has supported the adoption of global documents such as the GCM. Turkey has shared its experiences in various platforms and demonstrated a global model for responding to a humanitarian crisis. The collection of evidence on these strategic processes is important as recently gathered reliable data from the field, analysis of public health interventions and experiences derived from the wide range of policy solutions implemented can all support measures to ensure the health of refugees and migrants worldwide. Collaboration with WHO has helped in collecting this evidence base for policy-making and in establishing discussions on public health aspects away from security and political concerns. However, collaboration with WHO has also been valuable because of the support it has provided over the years and for its role as a facilitating partner for training and certification of Syrian health professionals and in supporting areas such as research. WHO has also been effective in presenting Turkey's substantial response as an example to other Member States and in promoting the good practices used in Turkey to improve refugee and migrant health all over the world.

The Ministry of Health has worked hard to ensure that it continues to improve health services for refugees and migrants without causing disruption to the health services provided to its citizens. Strengthening of health provision for refugees and migrants is occurring in critical areas such as maternal and newborn health, vaccination, chronic disease prevention and management, and the promotion of mental health. The Ministry of Health has also been determined to realize a service delivery to refugees and migrants that avoids any categorizing definitions and is respectful of all human beings and their rights within an effective, comprehensive and sustainable delivery framework.

Conclusions

The services provided by Turkey and described here have a global impact beyond their immediate reach. Interventions in Turkey for refugees and migrants, particularly in public health, also contribute to the prevention and control of diseases over the wider region, particularly diseases that pose

a threat to global security, such as poliomyelitis (polio), which is close to being eliminated.

Turkey is an example of a country successfully overcoming an unprecedented burden, which it was not obliged to take on but did so for ethical and humanitarian reasons. Global mechanisms and interventions in the management of public health aspects of migration have significant areas for improvement. Considering that migration has always occurred and is likely only to get more frequent, establishment of global norms and mechanisms plus closer and stronger collaborations are necessary to respond to ongoing and suddenly arising situations. Health diplomacy is the strongest instrument available to achieve this. Through building on existing knowledge and experiences, health diplomacy should be used more effectively in the future.

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19. Promoting universal health care, public health protection and the health of refugees and migrants in a country facing an economic crisis and fiscal restrictions

Ioannis Baskozos, Michaela Told and Ioannis Micropoulos

Introduction

This chapter focuses on the period 2015–2017 and examines the political dimensions of health diplomacy in Greece, the role of the different actors, their influence on Greece's overall migration policy and the importance of health service delivery during this period.[9]

[9] This chapter was written before the elections in May 2019 and, therefore, do not reflect the new political fabric in the country after the elections.

Migration into Greece

Greece has a long history of migration, both inwards and outwards. At the end of the Greco-Turkish War of 1919–1922 (known in Greece as the Asia Minor Campaign), a mutually agreed exchange took place of Turkish nationals of the Greek Orthodox religion established in Turkish territory and of Greek nationals who were Muslim established in Greek territory. Following this agreement, more than 1 million ethnic Greeks were displaced from the newly established Republic of Turkey and settled as refugees in Greece in 1923.

Later, emigration flows were prominent from the late 1940s until the mid-1970s: in the 1950s and 1970s mainly for economic reasons, and during the rule of the military junta (1967–1974) predominantly for political reasons. In the 1980s, Greece then turned into a transition country for refugees and migrants[10] arriving from Africa, eastern Europe and the Middle East. A decade later, Greece became a destination country with a large influx of refugees and migrants from central and eastern Europe, particularly following the collapse of neighbouring regimes. The massive increase in the flow of refugees and migrants, however, started only from 2007 when they began to arrive through the Aegean Sea from countries such as Afghanistan, Bangladesh, Iraq and Pakistan. Later the route shifted from the sea to the land, and irregular crossings occurred mainly at the land border with Turkey *(1)*. Consequently, Greece has been an important gateway to the EU for some years, with approximate 50 000 border crossings per year *(1)*.

The situation changed dramatically in 2015 when conflict in the Syrian Arab Republic caused millions to flee. Within a period of 12 months, more than 1 million people (between 8000 and 10 000 a day) arrived on Greek territory by boat *(2)*. This influx was concentrated on five islands (Chios, Kos, Leros, Lesbos and Samos), which gave quite a distinct character to the migration flow. First, the geographical boundaries of each island constitute natural borders, facilitating border control and management. Secondly, the interaction of local actors with national actors became of vital importance and determined the complex diplomatic processes and how the situation was managed.

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[10] This chapter frequently uses the term migrants as an umbrella term to include refugees, asylum seekers, economic migrants and other categories used for migrants.

The context

Since the economic crisis in 2008, Greece has been going through a severe debt crisis. Restrictive policies initiated in 2009 and the 2010 memorandum of understanding (Economic Adjustment Programme; often referred to as a bailout) signed between the European Commission (on behalf of the so-called Troika: the European Commission, the European Central Bank and the International Monetary Fund) and the Greek Government *(3)* resulted in a dramatic fall in living standards and prompted more than 400 000 educated Greeks to leave the country *(4)*. In 2010, fierce austerity measures agreed under the Economic Adjustment Programme resulted in spending cuts and increased taxes in return for a €240 billion emergency fund *(5)*. This was followed by two further Economic Adjustment Programmes.

Against this economic background, in January 2015, the leftist Syriza party[11] won a snap election with just short of a clear majority and formed a coalition government with the right-wing Independent Greeks. Prime Minister Alexis Tsipras announced a referendum in which an overwhelming majority voted against the third Economic Adjustment Programme and the associated austerity and restrictive measures that had destroyed the country. This led to protracted negotiations with the Troika and, ultimately, the Prime Minister was forced to accept further (though less heavy) austerity measures and called for new parliamentary elections in September 2015, in which Syriza won the most seats. Syriza then again formed a coalition government with the right-wing Independent Greeks.

The influx of refugees and migrants coincided with this prolonged economic crisis and, therefore, influenced the country's migration policies and related diplomatic endeavours. The Prime Minister at the time, Alexis Tsipras, explained:

> Greece was suddenly confronted with a large influx of refugees entering through its highly vulnerable borders, amid economic turmoil and existing social disparities in its interior. Yet, we responded with solidarity and empathy

[11] Syriza is an acronym signifying Coalition of the Radical Left (*Synaspismos Rizospastikis Aristeras* in Greek).

> towards the displaced people who risked their lives for a better future. Greece's foreign policy was guided by the principles of respect to human lives, dignity, fairness and equality in times when countries in Europe raise walls and far-right rhetoric nurtures xenophobia and prejudice.

Despite the economic challenges, the European values of humanity, solidarity and human rights have taken precedence in Greece's approach to refugees and migrants and have also characterized its diplomatic approach. This value system is not just a vision; it has also been reflected in the legal framework, where refugees and migrants as a population group have the same rights as the rest of the Greek population.

The challenges

This positive, rights-based approach to refugees and migrants faced a number of challenges, which required particular diplomatic efforts. Some were common to responding to a sudden movement of people anywhere but others were more specific to the situation in Greece: structural deficiencies in administration and in the health system were revealed under the pressures; agencies were working in an EU Member State with an established rule of law and organized health system rather than in a country lacking such structures; the main entry points occurred at islands, necessitating multilevel and multiactor engagement; and political and health responses were influenced by Greece's position as an entry point into the wider EU.

First, the massive influx of refugees and migrants highlighted the limitations of Greece's national response capacities and revealed structural deficiencies in the administration in general, and in the health system more specifically. These limitations led Greece to accept the presence of United Nations agencies and international NGOs in the country but, at the same time, the Greek Government wished to be clear about its expectations of them. Health was considered a necessary human right and, therefore, all agencies and actors needed to integrate health services into their response. Diplomacy, as part of a relationship-building process, was needed to find an appropriate way of engaging with these foreign actors – be it United Nations agencies

or international NGOs – and encouraging them not only to integrate health services but also to inspire health professionals in their work with refugees and migrants. This was particularly relevant in 2015 because the Greek health system was severely affected by austerity measures at that time. As a result, health professionals, albeit highly motivated ones, were poorly equipped and preferred to work in urban settings. The situation did improve, however, through the PHILOS programme (Emergency Health Response to Refugee Crisis), which was initiated under the Greek Ministry of Health and implemented by the Hellenic Centre for Disease Control and Prevention (known as the National Organization for Public Health since April 2019). PHILOS is funded by the Asylum, Migration and Integration Fund of the EU's Directorate General for Migration and Home Affairs *(6)*, but it was difficult to find enough trained medical staff: salaries remained low and there was no motivation to work in the refugee camps because of the challenging work environment and the fear of being stigmatized. Recruiting qualified health staff remains an ongoing challenge.

Second, the operational activities in Greece were a new experience for many United Nations agencies and international NGOs. Many had traditionally been engaged in developing countries with failing governance structures and weak health systems whereas Greece was an EU Member State with an established rule of law and an organized health system, although with long-standing problems and severely affected by the terms of the Economic Adjustment Programmes *(7)*. This in itself, necessitated a particular diplomatic effort in interacting with these actors, and for the actors themselves to adapt to a new setting. Creating trust and establishing cooperation among the large number of United Nations agencies, international NGOs and Greek NGOs was one of the major diplomatic achievements of the situation. Here, the Secretariat General for Public Health of the Ministry of Health ensured the successful cooperation between different stakeholders by assuming a leading role in the field of health service provision and by coordinating the common effort.

Third, there were structural challenges and it was essential to have multilevel and multiactor engagement in the response because islands were the main migration entry points. Despite the establishment of an intersectoral task force at national level (consisting of various ministries led by the Ministry of Migration Policy) and a multistakeholder task force at operational level (involving entities such as the Ministry of Citizen Protection, Ministry of

Defence and UNHCR), the Ministry of Health played a specific role in acting as a broker: working downwards towards the local level, working across the different sectors and ministries at national level, and working upwards towards the EU and international agencies level. The main actors at local level were the mayors, the church, the police, the coastguard and civil society, but also the population at large. At national level, the main ministries involved have been the Ministry of Health, the Ministry of Migration Policy, the Ministry of Interior, the Ministry of Defence, the Ministry of Economic Affairs and the Secretariat General of Civil Protection. It has been essential to have a clear understanding of the political dynamics and the mandates and roles of all these sectors to ensure efficient coordination to ensuring an adequate, effective and well-organized response. For example, the Ministry of Health, based on its mandate of public health protection, prevailed against the commonly agreed logic that services (including health services) should not be provided at the makeshift site of Idomeni and instead conducted mass vaccinations there in collaboration with MSF.

At the beginning of the influx, the Government pursued a camp policy at the points of entry at the five islands (Chios, Kos, Leros, Lesvos and Samos) and Evros, which was later replaced by a hot-spot policy to be aligned with the European Parliament Agenda on Migration of April 2015 *(8,9)*.[12] Both policies had been widely criticized for a range of reasons and the actors involved reacted differently to them. Responsibility for implementing the policies lay at national level, but the complexities arose from the need to understand local roles and to engage with local actors. For example, mayors on the islands reacted very differently to the policies, partly because of their different political and ideological backgrounds.

Transparency and adequate communication as governance principles became key to managing these relationships and to ensuring that the mayors supported the given policy. The situation was made more complex by the relationship of the mayors with the two regional governors – based in Lesbos

[12] Hotspots are facilities set up at the EU's external borders in Greece and Italy for the initial reception, identification and registration of asylum seekers and other migrants coming to the EU by sea. They also serve to channel newly arrived people into international protection, return or other procedures. There are currently five hotspots in Greece (on the islands of Chios, Kos, Leros, Lesvos and Samos).

for the North Aegean islands and in Syros for the South Aegean islands – who are the competence holders of hygiene and health. The coastguard, police and fishermen also influenced the response, particularly when it came to rescue at sea.

The church is an additional influential actor, in particular because there is no de facto separation of church and state and its outreach through local church associations was essential for an effective response (e.g. providing legal assistance and social support to asylum seekers). Other actors at local level included the army (responsible for catering, provision of health services through military personnel and construction of the reception identification centres) and the ombudsman (monitoring and assessing the protection of citizens' social rights in the fields of social policy, social security and welfare, with a focus on protection of the rights of vulnerable groups, such as refugees and migrants).

The fourth issue was that Greece's relationship with the EU and its Member States determined not only the wider political response but also the specific health response. The influx of refugees and migrants into Greece meant not only entry into a specific country but also entry into the EU as a whole as Greece is part of the Schengen Area. The political dynamics in many EU Member States, with populism and nationalism on the rise, combined with Greece's overstretched capacities meant that Greece had to press hard for the interpretation of the principle of solidarity to encompass burden sharing among EU Member States.

Nevertheless, the EU response was rather slow despite the fact that Member States generally agreed that Greece needed help in its response. The original solution was to release funds, partly also from international organizations such as IOM and UNHCR, which then became the primary implementing partners in the response. Despite the fact that the primary relationship with the EU was managed through the Ministry of Foreign Affairs and the Ministry of Interior in 2015, the Ministry of Health was directly engaged in addressing its main challenge of restoring and reconstructing a functioning public health system with the right to universal access to health care for the whole population, including refugees and migrants. The Ministry of Health, therefore, had to negotiate permission to recruit health professionals in all public health units, at the camps in the mainland and at the points of entry.

This demand was indeed part of a lengthier diplomatic process because the EU argued that health service delivery is the competence of each EU Member State.

The need to promote the good practice being followed in the EU concerning the prevention of disease transmission and respect for the human right to health finally enabled the successful conclusion of these negotiations *(10)*. As a result, the first phase of the PHILOS programme was established and the Ministry of Health could recruit health personnel, including medical doctors, psychologists, nurses, social workers and intercultural mediators, to staff the health units at the points of entry and at a later stage also on the mainland.

The EU–Turkey Statement

The negotiations that led to the EU–Turkey Statement were embedded within the wider diplomatic efforts of the Ministry of Foreign Affairs and the Ministry of Migration Policy, the latter being established in 2016 in response to the refugee crisis to find a common policy to deal with the influx. After an initial period of arguments about responsibilities and six months of lengthy negotiations about the relocation and resettlement of refugees and migrants, family reunification and return to the country of origin, EU ministers approved a plan in September 2015 to share the burden of relocating up to 120 000 people from the front-line states of Greece and Italy *(11,12)*. These negotiations involved, among others, the President of the European Commission, Jean-Claude Juncker, the German Chancellor, Angela Merkel, and the French President, Emmanuel Macron. The end result was that around half of the refugees and migrants (some 60 000 people) were relocated from Greece. This temporary measure – which was to be implemented until mid-2017 – assigned each EU Member State a specific quota of refugees and migrants based on the country's economic strength, population size and unemployment rate. However, an alliance of four eastern and central European Member States, known as the Visegrad Group (Czechia, Hungary, Poland and Slovakia), rejected the agreement *(13)*. The slow implementation of the relocation plan resulted in the EU–Turkey Statement (also known as the Turkey deal), which was signed on 18 March 2016 *(14)*.

Under the terms of the EU–Turkey Statement, all new irregular migrants crossing from Turkey to the Greek islands would be returned to Turkey. For every Syrian being returned to Turkey from the Greek islands, another Syrian would be resettled to the EU *(15)*. In addition, Turkey received €6 billion in financial assistance from the EU in two tranches of €3 billion *(16)*, while visa restrictions for Turkish citizens would be eased within the context of Turkey's negotiation to access the EU.

The EU–Turkey Statement had an immediate impact on the flow of refugees and migrants to the Greek islands: within a week, the number of arrivals dropped to 80 people a day. Despite much criticism, the EU–Turkey Statement created a legal pathway for irregular migrants from the Syrian Arab Republic to enter the EU, and it also meant that the hotspots and many facilities that had been established earlier were closed. Following the EU–Turkey Statement, the European Commission gradually reduced funding for NGOs in Greece, which eventually led to some NGOs leaving. There was a major shift towards funding government authorities in order for them to assume the role of the primary service provider. Nevertheless, the Greek Government valued the contribution of the NGOs and continued the collaboration in specific areas such as vaccinations, mental health, family planning and reproductive health.

Positive health-related developments

The PHILOS programme is funded by the Asylum, Migration and Integration Fund of the EU's Directorate General of Migration and Home Affairs to the value of €24 180 928. It was launched in November 2016, eight months after the EU–Turkey Statement was signed. The programme was created to ensure the sanitary and psychosocial needs of refugees and migrants living in open camps but also to introduce a comprehensive approach towards the provision of health services for refugees and migrants, thus reinforcing the capacity of the national health system *(6)*. (PHILOS II has been allocated nearly double this amount for going forward in 2019.) The PHILOS approach also includes the recruitment of health personnel; the provision of primary health care to the refugee and migrant population, including vaccinations; the development of a syndromic surveillance system; and vulnerability assessment during the

identification procedure in the reception identification centres of the five islands. This last element, in itself, has required health diplomacy. Developing a vulnerability template involved a year-long negotiation with the EU in order to agree on the tool itself, the collection of personal medical data in the medical history and the protection of this personal data from third parties. The representative from the Hellenic Centre for Disease Control and Prevention insisted that the person concerned must first consent to their personal data being shared according to the law, irrespective of their legal status. The negotiation was only successful thanks to constant dialogue between members of the PHILOS Steering Committee, EU counterparts involved in the EU–Turkey Statement and all other actors involved. Persistence ensured that the principle of data protection as part of the human rights framework was applicable to all people, regardless of their legal status. Dr Chrysoula Botsi, a negotiator from the Hellenic Centre for Disease Control and Prevention, and a medical doctor, reflected on her role:

> Every medical intervention is a political one. When you have to face poverty, when you have to face an epidemic because 20 people [are] living in one room, it is in itself a very political issue. You cannot say it is not political. Doctors are the first who see the reality and what comes from policy. Doctors are a result of policy.

A second development, which coincided with the EU–Turkey Statement, was the introduction of Article 33 of Law 4368/2016 by the Ministry of Health, which was passed in the Greek Parliament *(17)*. It provides for:

> the right of free access to the services of the Greek Public Health System by all refugees, asylum-seekers and beneficiaries of international protection, as well as those residing in Greece on humanitarian grounds or for exceptional health reasons. More broadly, the new law aims to ensure free access to health services by members of vulnerable groups in general, such as minors, pregnant women and individuals with disabilities.

The importance of this law has to be understood in the wider political, economic and social context of the country. The provision was passed one month after the EU–Turkey Statement was signed but also, and more importantly, it was passed against the background of the economic crisis and austerity measures at a time when Greeks without a social security number, such as pensioners, the unemployed and family members without a formal salary, were excluded from accessing free health services. Reclassifying these

groups as vulnerable and explicitly mentioning that refugees and migrants are also one of the vulnerable groups, enabled them to be reintegrated into the national health system. As a result, more than 2 million Greeks without health insurance (out of a total population of 11 million) benefited from this new provision. Approximately 80 000 refugees also received free access to health services. In this way, the Greek Government was able to introduce UHC for its population irrespective of social or legal status. In addition, Article 33 in itself provides a good example of interministerial collaboration as it specifies that the Ministry of Health, the Ministry of Labour, Social Security and Social Solidarity and the Ministry of Finance will define the conditions and details of how it is implemented.

The Secretary-General of Public Health, Ioannis Baskozos, contextualized and summarized the relevance and achievements in public health in the following way:

> Of special interest was that we kept the country, from a healthcare standpoint, safe and that no "healthcare bomb" has gone off. We did not allow the refugee issue to become a public health problem: we relied on the country's exceptional scientific personnel; we collaborated with international organizations and legitimate NGOs; we substantially improved the quality of healthcare; we have reinforced the epidemiological surveillance of infections and prevented the spread of sporadic outbreaks that were expected to occur. Emphasizing on prevention actions, universal children vaccination, public health interventions, we are strengthening society's health security and we are eliminating the influence of racism, xenophobia and intolerance.

Finally, the Ministry of Health also established intercultural mediation units as an integral part of the policy to protect and promote refugee and migrant health, for addressing the needs of culturally diverse populations and bridging cultural gaps between health staff and patients. Even though there are insufficient cultural health mediators, intercultural mediation in itself has become part of a locally embedded diplomatic process to build understanding and trust between different communities.

The situation in 2017 and beyond

The number of refugees and migrants arriving in Greece increased again throughout 2017 and 2018, amounting to approximately 200 people a day so far in 2019 *(2)*. The political context in the EU is still of concern, particularly since the Visegrad Group and Austria Summit, which was held in Budapest on 21 June 2018, issued a declaration (Setting up a mechanism for assistance in protecting the borders of the western Balkan countries) in which the five countries agreed to "provide the necessary human resources and technical support pool in order to implement targeted border policing activities with the countries of the Western Balkans" *(18)*.

This declaration introduces a clear division between the western and the central and eastern European Members States of the EU and has a direct impact on Greece. In addition, the Dublin Regulation places a disproportionately high burden on EU countries that are first-entry points, such as Greece, especially if there are high numbers of arrivals *(19)*. Therefore, an efficient and fair solution – based on the European values of respect for human dignity and human rights, freedom, democracy, equality and the rule of law – has yet to materialize. In Greece, these values have been upheld by the Greek Government since the massive influx of refugees and migrants began, while diplomatic efforts have been made at different levels to stress these principles. In early 2019, Prime Minister Alexis Tsipras underlined these principles in his vision for the future.

Now, we are at a standing point where key issues related to [the] refugee population residing in Greece shift to matters of integration, inclusion and social participation. At the same time, we need a global understanding that protecting health care and human dignity and meeting the SDGs is not a privilege or a luxury; it is one of the most important tools we have in order to confront the challenges of our time.

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20. Health service access and utilization among Syrian refugees in Jordan

Ministry of Health of Jordan, in collaboration with the WHO Country Office in Jordan

Introduction

The Hashemite Kingdom of Jordan is a relatively small country, which borders Iraq, Israel and the West Bank and Gaza Strip, Saudi Arabia and the Syrian Arab Republic. In 2018, the World Bank reclassified Jordan as an upper-middle-income country, having previously ranked it as lower middle income.

Jordan is a stable nation situated in a volatile region marked by conflicts and crises, and it remains a safe haven for people fleeing violence and insecurity. For decades, Jordan has hosted and protected Iraqis, Palestinians, Somali, Sudanese, Yemeni, and people of other nationalities.

The Syrian conflict, triggered by national protests in mid-March 2011, has resulted in one of the most complex and protracted humanitarian crises of our time and the largest ever displacement of people, both inside and outside the country. It is estimated that 6.6 million people have been displaced within the Syrian Arab Republic and more than 5.6 million have sought refuge in neighbouring countries, particularly Jordan, Lebanon and Turkey *(1)*.

Since 2011, Jordan has provided refuge to almost 1.3 million Syrians, 51% of whom are children.[13] In 2018, 761 100 refugees were registered with UNHCR (Table 20.1) *(3)*. According to the 2015 census, Jordan's population is estimated at 9 531 000, of whom 13.2% are Syrians. This makes Jordan one of the countries most affected by the Syrian crisis, with the second highest share of refugees compared with its population – 89 refugees per 1000 inhabitants. The majority of Syrian refugees (83%) live in urban areas and of these, 85% live below the poverty line *(3)*. Registration and identification of refugees and migrants is key for the people concerned, as well as for states to know who has arrived and to facilitate access to basic assistance and protection *(4)*. In Jordan, the process of registration enables the early identification of individuals with specific needs within a population and their referral to an available protection response. Asylum seekers and refugees who are registered with UNHCR Jordan can benefit from certain services provided by UNHCR and its partners, as well as by the Government of Jordan *(5)*. Approximately 129 400 UNHCR-registered refugees (17%) live in three camps: Azraq, Emirati Jordanian and Zaatari *(3,6,7)*.

The Jordanian Government maintained an open border with the Syrian Arab Republic until April 2015, when the last formal crossing, Jaber–Nasib, was effectively closed after Syrian rebel fighters took control of the Syrian side of the border.

The many conflicts in the region have had a significant impact on Jordan's socioeconomic situation and stability. The country's resources, infrastructure, and social and health services have been overstretched. Rising unemployment, a lack of economic growth and poor job prospects have increased tensions between host communities and refugees and migrants.

It is important to note that Jordan did not sign the 1951 Refugee Convention or its 1967 Protocol. It is, therefore, relevant to document the Jordanian experience in responding to a long-running humanitarian migration crisis, respecting the right to seek asylum and providing protection and access to

[13] The United Nations Convention on the Rights of the Child (1989) defines a child as "every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier" *(2)*.

Table 20.1. Nationality of the 761 100 refugees registered as refugees with the UNHCR in Jordan in 2018

Nationality	Number
Syrian	671 074
Iraqis	67 425
Yemeni	14 104
Sudanese	5 885
Somali	799
Other	1 813

Source: UNHCR, 2018 *(3)*.

health care to millions of refugees and migrants from neighbouring countries in accordance with the principles of humanitarian assistance.

The challenges and triumphs of Jordan's ongoing response should help to inform and improve current and future international migration crises. The lessons learned from Jordan should benefit health systems in other host countries, ensure transparency and influence policy-makers and health diplomacy strategies.

Jordan's health system and health response

The Jordanian health sector is a relatively modern health system that provides basic primary health care and can also provide advanced medical services to most citizens. The health sector in Jordan comprises various service providers – from the public, private, military, international and charity sectors – as well as councils and international institutions that work with the government to develop health policy.

The Jordanian Ministry of Health leads the health sector response for the Syrian crisis, assisted by the United Nations and the international community. The aim of the health response has been to ensure that Syrians have access to comprehensive primary health care (including sexual, reproductive and mental health), secondary care and tertiary care, while protecting all of Jordan's residents from disease outbreaks *(8)*. In order to improve the country's capacity to detect potential disease outbreaks, the Ministry of Health, in partnership with the WHO Country Office, launched a national programme of public health surveillance implemented in 543 outpatient clinics. The Jordan Public Health Surveillance programme uses an integrated electronic reporting system for case-based, integrated disease surveillance of priority diseases for everyone, regardless of their nationality.

Before November 2014, Syrian refugees registered with UNHCR and so holders of asylum seeker certificates received medical care free of charge *(5)*. The card provided Syrian refugees with the proof of registration as a person of concern, as well as access to all UNHCR services in urban areas. It allowed access to services such as cash and food assistance from UNHCR and its implementing partners. The asylum seeker certificate was indispensable for obtaining a Ministry of Interior service card for refugee access to public health care and education services in host communities *(9)*. More than 30 health ministry hospitals and 650 primary health-care centres welcomed refugees. It should be noted that, at the same time, uninsured Jordanians had to pay a fee to access government health facilities. Refugees living in the camps accessed in-camp primary health-care services provided by humanitarian actors under the supervision of the Ministry of Health. Humanitarian actors also coordinated referrals to secondary and tertiary care facilities outside the camps, through the financial contribution of the Jordanian Government.

By 2014, the number of Syrians accessing health services at health ministry facilities was increasing at an alarming rate. Government facilities were under pressure, and there was a shortage of hospital beds, health staff, essential medicines and supplies. A sector vulnerability assessment found that 22 new comprehensive health centres were needed in order to meet the national minimum ratio of one centre per 60 000 people (Table 20.2) *(8)*.

With no budget to cover these rapidly increasing costs, the Government revised its policy in November 2014, ruling that registered Syrian refugees

Table 20.2. Health staff ratio and health facilities capacity

Health variable	2017	As of mid-2012
Ministry of Health staff ratio (per 10 000 population)		
Doctors	27.1	22.6
Dentists	10.0	7.1
Nurses (all categories)	46.6	29.2
Pharmacists	16.3	15.6
Capacity of Ministry of Health health facilities		
Total number of beds in health facilities (% of beds in all health facilities)	4572 (38%)	570 (35%)
Hospital beds per 10 000 population	18	15

Source: data from the Ministry of Health of Jordan.

living outside the camps were to be treated like uninsured Jordanians, who paid a nominal fee for most health-care services (20% of the foreigner rate) at government facilities. Immunization services offered as part of the national routine vaccination schedule and maternal health (antenatal and postnatal care) were (and still are) provided free of charge regardless of registration status. Unregistered refugees could also access health-care facilities established by NGOs.

Health services remained heavily subsidized, and the new policy introduced equity between Syrians and vulnerable Jordanians without health insurance (approximately 2.2 million people). Nevertheless, vulnerable refugees struggled to obtain medicines and health services because of their inability to pay the fees *(7)*.

Refugees living in camps still benefited from free primary health-care services, but the Government no longer fully covered the cost of secondary or tertiary care. Humanitarian actors, particularly UNHCR, stepped in to cover these costs. UNHCR, through its implementing partners, provides comprehensive health-care services free of charge for refugees in the Azraq and Zaatari camps, for vulnerable Syrians and for all non-Syrians living in urban areas.

Jordan's health-care system was one of the sectors most negatively affected by the crisis, struggling to meet needs and cope with the disease burden of the Jordanian and refugee and migrant population. The issue of Jordanian nationals having to compete for health services, especially within the non-insured group, led to a further policy change in January 2018. A radical change in Government regulations resulted in the rights of urban Syrian refugees to access health care being restricted. This policy change increased prices considerably (to 80% of the foreigner rate), putting health-care services out of the reach of many *(9,10)*.

Impact on Jordan's health system

The health sector vulnerability assessment in 2017 – part of the comprehensive vulnerability assessment led by the Ministry of Planning and International Cooperation – found that services provided to 39% of the population could be inadequate because local comprehensive health centres were required to serve more people than the national minimum ratio of one centre per 60 000 people. This was partly attributed to the influx of Syrian refugees and migrants. Data suggest that only 40% of refugees living outside the refugee camps are covered by health services, leaving over 300 000 people with uncertain access.

The vulnerability assessment framework found that 41% of Syrians are part of households with severe health vulnerability, with 15% vulnerable in terms of access to health services. Pre-existing medical conditions that negatively impact day-to-day life are present in 16% of households, while 10% of Syrian refugee households reported spending over 25% of their income on health care *(7)*.

The change in population demographics and the influx of refugees and migrants have contributed to an overall rise in rates of NCDs and disability, particularly mental disorders *(7)*. In recent years, NCDs have been the major cause of mortality and morbidity among the Jordanian population, refugees and migrants, accounting for 76% of all deaths.

TB also remains a major concern among the Syrian refugee population *(11)*; TB prevalence in Syrians was three times higher than among Jordanians in 2011. As a result, in 2013, IOM, the Centers for Disease Control and Prevention of the United States and the National Tuberculosis Programme developed an approach to reduce drug-susceptible and drug-resistant TB transmission, morbidity and mortality among Syrian refugees in Jordan *(12)*.

Studies have shown that rising social tensions have the potential to generate secondary conflicts in host countries; they hamper access to basic goods, services and livelihoods opportunities that, ultimately, result in inappropriate coping mechanisms in displaced populations *(13)*.

In Jordan, it has been documented that some of the negative coping mechanisms that refugees and migrants use to survive include child labour, early marriage, restriction of movement and domestic violence resulting from increased stress. For example, a study by ILO reported that almost half of the families had one working child. The implications of these coping mechanisms in health indicators and outcomes are enormous *(10)*. A lack of access to equitable employment, along with economic competition, may lead to frustration and discrimination, which can contribute to domestic violence, drug abuse and participation in radical collective action and crime *(13)*.

People with special needs in the Syrian Arab Republic and the wider region remain of concern. Reports from Syrian refugees in the region show that 30% of refugees have specific needs. One in 15 Syrian refugees in Jordan has been injured as a result of the war *(14)*. Despite efforts by the Ministry of Health and the fact that the Mental Health Department has been upgraded to the Directorate of Disabilities and Mental Health, a joint assessment carried out by the Jordanian Government in collaboration with Humanity & Inclusion and WHO found limited intersectoral or interministerial coordination for rehabilitation, particularly as rehabilitation is not defined in health legislation and in the national health strategy.

The impact of the Syrian crisis has exacerbated the existing limitations of the health system and has overwhelmed government capacities. The Jordanian Government focused on the response to the crisis and delayed implementing reforms – such as the national health climate change adaptation strategy and the early warning system for slow- and sudden-onset disasters – potentially exposing the population as a whole to other health risks *(15)*.

Implications of health diplomacy in Jordan's response to the Syrian crisis

The world is witnessing a growing number of refugee and migration crises resulting from conflict, climate change and disasters. Health diplomacy is crucial when governments, civil society and stakeholders are attempting to address the challenges of ensuring the availability, adequacy, accessibility, affordability and appropriateness of health-care services for refugee and migrant populations *(16)*. These activities should be accompanied by a research agenda to strengthen evidence-informed findings, and the potential to progress global health and/or foreign policy objectives *(17)*.

The international community has been involved almost from the beginning of Jordan's response, with several initiatives supporting the Jordanian Government in its efforts to respond to the ongoing Syrian crisis.

In 2015, the Regional Refugee and Resilience Plan brought together governments, United Nations organizations, NGOs and the private sector to support countries neighbouring the Syrian Arab Republic, anticipating the needs of refugees and migrants in host countries. The Plan incorporated the Jordan Response Plan, the Lebanon Crisis Response Plan, and responses in Egypt, Iraq and Turkey that have been developed with the involvement of their respective governments *(18)*.

Currently, the Jordan Response Plan continues to operate, building on the need to integrate humanitarian assistance, resilience and development into a nationally owned, and regionally coherent, plan that meets protection and basic needs while reinforcing resilience and enhancing national capacities

(7,18). The Ministry of Health, together with WHO and UNHCR, is overseeing the health component of this multimillion-dollar support plan.

At the London Conference in February 2016 *(19)*, Jordan issued a strong statement regarding the heavy burden of hosting refugees and migrants and shouldering a global responsibility on behalf of the international community. The proposal for an integrated humanitarian and resilience response led the EU–Jordan partnership to draft the Jordan Compact, an agreement aimed at improving living conditions for Syrian refugees in Jordan and vulnerable host communities alike by improving socioeconomic prospects, security, stability and resilience in Jordan *(20)*.

In addition, the World Bank approved the Jordan Emergency Health Project (2017–2019), aimed at supporting the Jordanian Government in maintaining the delivery of primary and secondary health services to poor uninsured Jordanians and Syrian refugees *(21)*.

Despite the policy change in 2014, the Ministry of Health issued a new directive in January 2018, changing health-care entitlements for urban Syrian refugees. Refugees, who were previously able to access health care at Ministry of Health facilities for the same fee as uninsured Jordanians (20% of the foreigner rate), now had to pay 80% of the foreigner rate.

At the Brussels II Conference in April 2018 *(22)*, following the policy change, the Jordanian Government and the international community remained committed to finding practical solutions to the multifaceted issues, particularly in the areas of inclusive and equitable economic growth, livelihoods, education and social protection. The commitment for the health sector was to review the health system approach and to develop a long-term and cost-effective strategy aimed at ensuring equitable access to health-care systems for Syrian refugees, and to provide life-saving interventions for all *(22)*.

However, after more than eight years of crisis, the traditional short-term approaches led by humanitarian actors were no longer seen as effective *(9)*. The United States Agency for International Development,[14] in collaboration

[14] This is the principal bilateral donor to the Jordanian Government and is supporting its long-term development plans, including for the health sector.

with the World Bank, assisted the health ministry to establish a Jordan Health Fund for Refugees. The Fund aims to support joint efforts by the Jordanian Government and the international community to provide all Syrian refugees with equitable access to national health-care systems (primary and secondary care) and life-saving interventions, as framed in the Jordan partnership paper, which was prepared for the Brussels II Conference. The Fund was initially designed to be operational for three years, from late 2018 until 2021, through a multidonor account *(23)*.

The Brussels III Conference, in March 2019, renewed and strengthened the political, humanitarian and financial commitment of the international community to support the Syrian people, neighbouring countries and communities affected by the conflict *(24)*. Pledges were announced for both the Syrian Arab Republic and the region: US$ 7 billion (€6.2 billion) for 2019 and multiyear pledges of US$ 2.4 billion (€2.1 billion) for 2020 and beyond.

Lastly, as a consequence of the continuing support and commitment from the international community for the Jordanian Government in its ongoing response to the Syrian crisis, and the realization of the multidonor account, the Minister of Health announced on 28 March 2019 the rolling back of the policy reducing entitlements for Syrian refugees, thereby changing their entitlements for accessing health services to the more affordable conditions that were in place before January 2018.

Constraints and opportunities: how to improve health diplomacy strategies

Humanitarian assistance in Jordan – addressing the immediate needs for refugees and migrants – and development interventions have been focused on longer-term recovery and capacity-strengthening activities, managed by the international community through various programme strategies, implementing partners and funding mechanisms. However, the colossal effects of the Syrian crisis have challenged standard aid responses and coordination mechanisms, highlighting the divergence and contradiction between the humanitarian and development systems, and producing gaps in policy, assessment, response capacity and funding *(7)*.

It is important to acknowledge that global norms and standards will never fully fit the contexts in individual countries, which does not imply a failure of global health diplomacy. Consequently, an important part of conducting and evaluating global health diplomacy includes taking into account barriers and specific issues for national action *(25)*. Policies need to adapt and evolve within a specific country context.

In Jordan's case, detrimental consequences could be identified after policy changes in 2014 and 2018. Urban Syrian refugees were negatively affected, specifically in terms of access to health care and protection. Now that these policy changes regarding the entitlements of Syrian refugees have been reversed, it is imperative to gather prospective epidemiological data that will help to understand the health outcomes in the two policy regimes, identify valuable lessons and evaluate the efficiency of health diplomacy strategies.

Health diplomacy can also bring together different disciplines beyond health. This is crucial for complex crises like the Syrian refugee crisis, where sustainable solutions are needed for refugees and migrants and for vulnerable host communities so that social inequalities, instability and public health risks are minimized for all. The humanitarian needs of vulnerable host populations should and must be addressed in parallel to those of refugee and migrant populations. In Jordan, even if access to health-care services and accompanying health indicators have improved, the challenges of unacceptable vulnerabilities and inequalities between different groups remain, for example levels of education, wealth and regional residency *(26)*. To acknowledge and tackle contemporaneously these inequalities will help to decrease feelings of resentment and instability.

The Migrants in Countries in Crisis Initiative highlighted the importance of interventions to address the impact on transit and host communities; many communities lack the resources, services and infrastructure to support refugees and migrants. Assistance for refugees and migrants that excludes local communities is likely to be perceived as preferential treatment, and it will create or exacerbate tensions and lead to discrimination, stigmatization or social exclusion. An inclusive approach fosters social cohesiveness and stability in the long term *(27)*.

Sharing knowledge and experience among the countries of the WHO Eastern Mediterranean Region that are responding to the Syrian crisis can enrich local strategies. A good example of fostering social cohesiveness and integration

is the experience of the Turkish Government, in association with the WHO Regional Office for Europe, in providing training and job opportunities for Syrian health professionals to work as health providers for Syrian refugees and migrants *(28)*. This type of strategy could be introduced by the Jordanian Government in order to address the lack of health professionals.

Conclusions

There is an imperative to bridge the gap between humanitarian assistance and development in Jordan and other countries in the region responding to the Syrian refugee crisis. This is essential to mitigate the impact of the current crisis and to prevent further fragility. The increased momentum to bridge the humanitarian–development gap has led to a new way of working, which was agreed at the World Humanitarian Summit in Istanbul in 2016 *(29)*. The Grand Bargain aims to increase collaborative humanitarian multiyear planning and funding and enhance engagement between humanitarian and development actors *(30)*. It offers the possibility of multiyear grants to humanitarian agencies that could allow for longer-term planning, with opportunities for strengthening health systems and building resilience.

Global health diplomacy will be needed to continue to find ways to take advantage of the skills and experiences of different disciplines, to evaluate the appropriate range of accepted outcomes and to determine when evaluation needs to take place *(25)*.

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21. *Migrant health in Malta: health diplomacy through a multisectoral approach for the control of communicable diseases*

Charmaine Gauci

Introduction

Because of its position on the main migration routes from Africa to Europe, Malta has received a large number of refugees and migrants seeking asylum. This situation, coupled with the fact that Malta is the smallest island state in Europe, with an extremely high population density and a small geographical footprint, means that it bears a burden significantly disproportionate to its size. Malta has risen to the challenge, which has affected many sectors. The health authorities have worked with other sectors, following the principles of health diplomacy, to enable public health, international affairs, management, law and economics to come together to shape and manage policy and action. These actions are founded on years of experience working across different sectors.

Given that the greatest influences on a population's health are known to lie outside the health sector, it follows that solving the issue of refugee and migrant health requires collaboration across government and society. Diplomacy in Malta derives from the simple fact that its size has been transformed into an asset. In particular, diplomatic methods have been developed to address the economic constraints, security threats and vulnerabilities that shape this small country.

Even though it is one of the smallest Member States in the WHO European Region, Malta has been involved in many WHO programmes, often taking an active part in developing policies, guidelines and initiatives. In a small country, there are often fewer resources but, at the same time, it is easier to integrate different roles. Health officials, therefore, often have a broader view of the health situation in the country and this enables them to find pragmatic solutions and to negotiate to address a particular problem.

Health problems for refugees and migrants arriving in Malta

Over the years, a significant number of refugees and migrants have reached Malta's shores by boat. These populations have a range of health needs. While refugees and migrants in general are often healthy, as they tend to be younger, they still face health challenges and are vulnerable to threats to their physical and mental health. They may come from countries that have less-developed health-care systems and they may have had a traumatic transit with poor-quality health care and stress, which makes them more vulnerable to infectious diseases; consequently, on arrival, there may be a gap between their health status and that of the resident population.

Since health is a public good, it is fundamental that countries guarantee all residents the right to enjoy good health. In order to assess the health of refugee and migrant populations, three factors need to be considered: health status, health determinants and access to health services *(1)*. The most common health problems affecting newly arriving refugees and migrants are accidental injury, hypothermia, burns, pregnancy and birth complications,

skin infections, infectious diseases and mental health issues. Refugees and migrants may also face specific risks associated with migration, such as exposure to violence, psychosocial disorders, interruption of care and treatment for NCDs, infectious diseases and drug or alcohol abuse. Children are prone to respiratory infections, skin infections and diarrhoea because of their living conditions, as well as to preventable childhood infections due to a lack of vaccination.

Among the key health status determinants for refugees and migrants are their individual characteristics and their country of origin. Despite the common perception that there is a link between migration and the importation of infectious diseases, there is actually no systematic connection between the two. There are indications that there is only a very low risk of transmitting communicable diseases from the refugee and migrant population to the host population in the WHO European Region *(2)*. However, it is possible that refugees and migrants arriving from countries with a high prevalence of communicable diseases may also reflect this prevalence and so actions to control such communicable diseases are important. The relationship between migration and communicable diseases is complicated and a scientific approach has been called for in the study of infectious diseases in refugees and migrants *(3)*.

The number of refugees and migrants arriving in Malta by boat, or rescued at sea, increased in the early 2000s (Table 21.1). Most came from African countries (Table 21.2) where there is one of the highest levels of TB and HIV in the world. This exposed Malta, with a low estimated TB and HIV incidence of 11 cases per 100 000 people *(4)*, to people coming from high-prevalence countries, such as Somalia, with an estimated 266 cases per 100 000 *(5)*, and Ethiopia, with an estimated 164 cases per 100 000 *(6)*.

International data have shown an increase in the number of cases of TB, malaria and HIV infection among refugees and migrants travelling from areas of high rates of these diseases to areas of lower prevalence, but transmission rates from the refugee and migrant population to the host population is considered to be low and mostly related to poor living conditions *(2)*. TB control is a priority and may be particularly problematic in reception centres, where people from diverse backgrounds are living in close proximity. Because TB is spread through the air, one infectious patient can easily infect others,

Table 21.1. Irregular migrants arriving in Malta by boat and/or rescued, 2000–2019

Year	Total
2000	24
2001	57
2002	1 686
2003	520
2004	1 388
2005	1 822
2006	1 780
2007	1 702
2008	2 775
2009	1 475
2010	47
2011	1 579
2012	1 890
2013	2 008
2014	569
2015	106
2016	24
2017	20
2018	1 445
2019	49
Total	20 966

Source: data provided by the Disease Surveillance Unit of the Ministry for Health of Malta.

Table 21.2. Countries of origin for irregular migrants arriving in Malta by boat and/or rescued, 2000–2018

Country of origina	2000–2003	2004–2006	2007–2009	2010–2012	2013–2015	2016–2018	Total
Bangladesh	20	5	24	31	4	243	327
Burkina Faso	0	25	49	11	2	7	95
Cameroon	9	5	8	14	7	16	59
Chad	17	30	15	16	6	11	95
Congo	101	119	4	2	0	0	226
Côte d'Ivoire	32	185	331	114	21	133	816
Egypt	309	869	62	78	15	23	1356
Eritrea	335	939	519	735	502	215	3245
Ethiopia	63	537	144	125	26	7	902
Gambia	4	1	62	10	115	12	204
Ghana	49	111	244	76	45	6	531
Guinea (Republic of)	5	4	54	2	1	30	96
India	5	13	47	0	0	0	65
Iraq	146	54	2	0	20	0	222
Liberia	170	44	13	2	2	0	231
Libya	2	0	1	8	0	72	83

(Continued)

Table 21.2. Countries of origin for irregular migrants arriving in Malta by boat and/or rescued, 2000–2018 (Continued)

Country of origina	2000–2003	2004–2006	2007–2009	2010–2012	2013–2015	2016–2018	Total
Mali	8	43	352	88	93	40	624
Morocco	161	182	17	2	7	53	422
Niger	0	82	68	20	1	0	171
Nigeria	25	104	552	318	108	20	1127
Pakistan	25	42	7	52	0	12	138
Palestine	24	148	5	3	83	8	271
Senegal	1	2	29	4	71	18	125
Sierra Leone	10	29	9	5	3	6	62
Somalia	338	990	2954	1716	1118	118	7234
Sudan	126	551	109	61	84	399	1330
Syrian Arab Republic	10	1	2	303	168	19	503
Togo	2	42	74	11		4	133
Tunisia	37	45	22	4	2	2	112

[a] Only countries with more than 50 arrivals over the period are listed.
Source: data provided by the Disease Surveillance Unit of the Ministry for Health of Malta.

whether refugees and migrants or staff. By quickly identifying and isolating an infectious patient, the spread of TB in reception centres can be prevented.

Quickly starting the directly observed treatment, short-course (DOTS) strategy for TB also helps to ensure that the patient adheres to the treatment. This decreases infectiousness, reduces the risk of relapse and helps to prevent the development of drug resistance. Meeting the demand of providing DOTS for patients with TB was a challenge, and the support of social workers – trained by the public health authorities – proved crucial. The centralized procurement service for medicines and medical devices responded quickly to meet the demand for additional medicines and vaccines.

Unions for staff at reception centres took part in high-level diplomatic and technical meetings to outline the risks. This was followed by intensive training of all staff working with refugees and migrants. Social media posts by the general public often referred to an increased risk of infectious diseases from refugees and migrants, but this was countered and mitigated by providing the facts about disease transmission through the mainstream media.

Disease control: a collaborative response

National health systems are under pressure to respond to an influx of refugees and migrants and health diplomacy has an important role to play in finding collective solutions that involve various sectors. In Malta, close collaboration between different entities led to focal points being identified and the immediate establishment of an emergency response team to provide for the needs of arriving refugees and migrants, with back-up as required. The team included health-care staff from emergency and response departments, primary care and public health. Medical and other health-care student associations also provided support.

The Ministry for Home Affairs and National Security is responsible for managing the response to refugees and migrants who arrive by boat using a collaborative approach between the different entities that come under its jurisdiction, including the armed forces, the police, civil protection and immigration authorities. Since the influx of boats carrying refugees and migrants began,

close collaboration between these entities and those that come under the Ministry for Health have ensured a timely response to the arising needs. This has been achieved despite the pressure on all parties to maintain business as usual yet also be part of the response team. The Ministry for Home Affairs and National Security established a local coordination team, with responsibility for coordinating communications, setting up an initial triage system, creating identification processes, identifying clinical needs, public health screening, providing food and shelter and conducting an ongoing review.

As soon as an alert about a boat's arrival in Maltese territorial waters has been issued, key people work around the clock to ensure a timely and coordinated response, with support teams from all sectors responding quickly. Malta's public health authorities have a limited number of public health specialists working on infectious diseases; however, other public health specialists were engaged in the response. The main responders came from the Superintendence of Public Health. As the numbers arriving began to increase, other public health doctors working in other areas (e.g. the policy department) were recruited and trained on a voluntary basis. The clinical needs aspect of the response required nurses and medical teams to carry out an on-site assessment, which was achieved by coordinating the efforts of both the primary care system and the main state hospital in Malta, which receives and admits all the arrivals.

The alert about a boat triggers the standard operating procedure, alerting the health authorities. A team from the Ministry for Health – which includes public health, port health, accident and emergency, and primary care – provides an immediate response and gathers information about the health status of the refugees and migrants. Their immediate clinical needs are met and then any who need further care are referred to primary care or secondary care in hospital. Screening for infectious diseases is carried out straight away in order to contain and manage any risks. All incoming refugees and migrants are screened for symptoms of TB in order to identify anyone with active disease at an early stage so that investigations and appropriate treatment are started. This complements and does not replace chest radiography, which is the most effective means of detecting cases of active TB.

Refugees and migrants are also examined for any other obvious infectious diseases. Further screening for active TB is carried out at the reception centre using chest radiography for adults and the Mantoux test for children and pregnant women. Those with confirmed TB are admitted to hospital for treatment and followed up by TB specialists. Different parties, from both the health care and social care sectors, work closely together on providing DOTS for TB and on the procurement of TB medication to ensure that patients adhere to their treatment.

Vaccine-preventable diseases are likely to be transmitted among refugees and migrants where there are gaps in their immunity *(7)*. WHO recommends that refugees and migrants should be eligible to access appropriate vaccination services and information *(8)*. Once they arrive in Malta, all refugees and migrants over 10 years of age receive vaccinations for diphtheria, tetanus and polio. They also receive MMR vaccine, except for pregnant women, who only receive the diphtheria, tetanus and polio vaccine. Children aged 2–10 years receive pentavalent vaccine (diphtheria, tetanus, pertussis, hepatitis B and *H. influenzae* type b), plus the hepatitis B and MMR vaccines. Infants under 2 years of age get a full course of the pentavalent vaccine, two doses of the MMR vaccine with the first at 1 year of age, and three doses of the hepatitis B vaccine, also with the first at 1 year of age. All children under 5 years of age who are at high risk of contracting TB are given the BCG (Bacillus Calmette–Guérin) vaccine.

Coordinating the efforts of the different entities required close cooperation to ensure that work in each sector was carried out within the shortest possible time frame and with the minimum of disruption to refugees and migrants, who were already stressed from their long journeys. A reception centre was set up where all new migrants were provided with food and secure accommodation and where their health needs were met. Initially, screening for active TB was carried out at the main state hospital in Malta and at health centres. This meant that the refugees and migrants had to be transferred from the reception centre, which inconvenienced them, created additional work for reception centre staff and increased the risk of TB transmission. Later such screening could occur at the reception centres (see below).

Multisectoral collaboration

The Ministry for Health, the Ministry for Home Affairs and National Security, the Funds and Programmes Division and the Department of Contracts worked together and successfully secured over €700 000 in emergency measures under the European Refugee Fund 2012 Annual Programme. Some of the funds were used to set up a digital radiography unit and isolation units at the reception centre. This enabled health screening to occur quickly on arrival of the refugees and migrants, which reduced the burden on the already overstretched and only state hospital. It also eliminated the need for refugees and migrants to be transferred for screening, which effectively contained any infectious diseases. It was considered appropriate for refugees and migrants to remain in the reception centre until they had been screened.

To deal with the possibility that a refugee or migrant might refuse to remain in the centre until the screening process was completed, the Office of the Superintendent of Public Health, based on the advice of the Office of the Attorney General, can issue a restriction of movement order for public health reasons. This restriction of movement is issued under Article 13 of the Prevention of Disease Ordinance if there are reasonable grounds to suspect that a person might spread disease and, therefore, needs to be screened. Containment is kept as short as possible by speeding up the screening process, thereby ensuring that the rights of the refugees and migrants are respected while protecting public health.

The application of health diplomacy in terms of cross-sectoral cooperation and dialogue resulted in strengthening collaboration between the Ministry for Health, the Ministry for Home Affairs and National Security and the trade unions to develop and support continuous training and education for the staff at the reception centre. Training is intended for all staff working with refugees and migrants and covers the signs and symptoms for common communicable diseases, plus transmission and infection control policies. Training became crucial as staff working at the reception centre were raising concerns about the risk of catching infectious diseases from refugees and migrants and passing the infection on to their families. Trade unions were a key stakeholder in organizing the training programme, as many members of staff who were concerned about their safety had turned to them, leading to industrial disputes with the government. Trade unions were instrumental in allaying

staff fears during the training programme. Now, all staff coming into close contact with refugees and migrants undergo a risk assessment to determine the level of personal protective equipment needed, which is provided along with training in its proper use.

The following measures, based on a multisectoral approach, have proved to be effective in the control of TB *(9)*:

- identifying people with TB disease early on
- preventing transmission within the reception centre
- treating patients with active and latent TB
- assessing and evaluating screening and containment procedures
- educating refugees and migrants and staff working with them.

Table 21.3 shows the overall number of identified patients with pulmonary TB among irregular migrants arriving in Malta between 2002 and 2018 and the proportion of the total number screened. The table shows an effective detection rate, which can inform a follow-on strategy for appropriate and timely action in order to control active TB disease through a coordinated intersectoral approach.

Preparedness and planning

The arrival of large numbers of refugees and migrants represents a real threat for Malta, which is concerned about its limited capacity to deal with a sudden influx. The current picture of migration flows in the Mediterranean – with an estimated 177 000 asylum seekers reaching Europe in 2016 – means that the possibility of a mass influx to Malta is a very real one. When an influx of refugees and migrants occurs over a short period of time and/or involves large numbers of people, the effect on the receiving country can be dramatic, particularly for a small island state such as Malta.

In terms of an immediate public health response, WHO recommends a triage approach, followed by diagnosis and treatment targeted at specific groups. It advocates full access to high-quality care for all refugees and migrants, regardless of their legal status. In the longer term, it stresses the need to ensure that national health systems are adequately prepared. The European

Parliament has repeatedly emphasized the importance of providing health care to vulnerable groups such as refugees and migrants, regardless of their legal status.

An assessment carried out by the WHO Regional Office for Europe in 2013 concluded that Malta had limited capacity to implement the measures needed

Table 21.3. Number of cases of pulmonary TB among irregular migrants arriving in Malta, 2002–2018

Year	No. screened	No. cases of pulmonary TB	Percentage with TB on arrival
2002	1686	8	0.47
2003	520	0	0
2004	1388	8	0.58
2005	1822	7	0.38
2006	1780	12	0.67
2007	1702	4	0.24
2008	2775	11	0.40
2009	1474	6	0.41
2010	47	0	0.0
2011	1579	7	0.44
2012	1980	19	0.96
2013	2008	11	0.55
2014	569	3	0.53
2015	106	2	1.89
2016	24	0	0
2017	20	2	10.0
2018	1445	9	0.62

Source: data provided by the Disease Surveillance Unit of the Ministry for Health of Malta.

to cope with a mass influx *(10)*. However, contingency plans to deal with an exceptional influx of refugees and migrants are in place. These plans include an emergency facility to deal with a large influx of people with medical needs, which avoids emergency hospital admissions. The emergency facility will include a sturdy portable mass triage sheltering system that provides services to care for patients, including diagnostic and monitoring equipment. The health authorities, with support from the Ministry for European Affairs and Equality (responsible for EU funding), has secured funds to upgrade the main state hospital in Malta with a facility to manage infectious diseases, which was identified as a gap in Malta's response plans.

Conclusions

Health diplomacy has been utilized as a tool to support responses to the issues related to migration when limited capacity is available. Action on a global level is required to address the gaps that are detrimental to refugee and migrant health and it is vital to develop efficient information systems with indicators to assess health status and needs for this group. Research on health problems linked to migration and their epidemiology is required in order to identify effective interventions. Preparedness across countries is also critical: health systems need to be prepared and equipped to deal with common infections and NCDs in a large refugee and migrant population. Under the International Health Regulations (2005) *(11)*, all WHO Member States are obliged to have an effective disease surveillance and reporting system in place and have outbreak investigation, case management and response capacities.

However, not all Member States of the WHO European Region are prepared to respond to all the health challenges presented by large numbers of refugees and migrants. Some do not have the laboratory capabilities to detect such diseases, and, consequently, collaboration between Member States is essential, together with expert advice when required. Malta, as a small country, has limited laboratory capacity, and memoranda of understanding are in place with reference laboratories in other EU Member States for support when needed and for sample analysis. The European Centre for Disease Prevention and Control has been very supportive during disease outbreaks in helping to identify laboratories that can provide support.

Effective coordination and collaboration among a number of bodies, both within and outside the health sector, are needed in order to respond efficiently to an influx of refugees and migrants. Countries need to have robust plans prepared to face the challenges of receiving large numbers of people. Such plans should contain an effective surveillance system for the early detection of infectious diseases, together with robust systems to collect and analyse epidemiological data. Preparedness also involves regular staff training on infection control and the use of personal protective clothing, as well as systems to prevent the spread of infectious diseases in health-care settings.

Malta strives to enhance the health of refugees and migrants and to ensure that communicable diseases are controlled. Addressing the health of refugees and migrants is fundamental; being displaced is a stressful, sometimes dangerous, situation that may pose a range of risks to the health and well-being of refugees and migrants. A multisectoral approach that follows the principles of health diplomacy is essential in order to ensure their health.

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22. Refugee and migrant health in Bosnia and Herzegovina: the role of WHO in complex political environments

Victor Stefan Olsavszky and Palmira Immordino

Introduction

Bosnia and Herzegovina (BiH) is an independent state and one of six republics that made up the former Yugoslavia. As result of the 1992–1995 civil war, the country has a very complex and multilayered political structure and system of governance for health. This provides fertile ground for fragmented and duplicated functions and responsibilities, inefficiencies in the functioning of health systems, inequalities in health and hindered coordination in the health sector.

Indeed, the country could still be considered as being in the aftermath of war, since its Constitution remains an annex of the Dayton Peace Agreement, while peace-building and reconciliation are ongoing processes. The 10 years from 2008, and particularly 2018, reflect a deteriorating political situation in BiH, which is making slow but steady progress towards membership of the EU. Structural and functional challenges from the end of the conflict, 24 years ago, have yet to be resolved – and they are getting worse. These include a weak rule of law,

lack of political accountability, widespread corruption and a ruling class that ignores citizens' needs. Of equal concern is the fact that BiH is being weakened by increasingly contested narratives about the past, present and future of the country. More than two decades after the war, a lack of reconciliation still allows nationalist leaders to pursue wartime policies.

The Dayton Peace Agreement, which was signed in 1995, achieved its immediate aim of ending the Bosnian War. The agreement also left an extremely complex system of government, which has made governance very complicated. Constitutionally, four levels of administration, including health system governance, have been recognized:

- state-level entities, consisting of the Federation of Bosnia and Herzegovina (FBiH), Republika Srpska and the Brčko District;
- sub-state entities, consisting of 10 formal administrative jurisdictions/ cantons in FBiH and five geographical regions in Republika Srpska; and
- community-level entities, represented by over 140 municipalities in BiH.

The country, therefore, has 13 constitutions, 14 legal systems, 13 prime ministers and some 140 different ministries. The organization, finance and delivery of health care are the responsibilities of each state-level entity: Republika Srpska, FBiH and the Brčko District. State competencies in health are defined in Article 15 of the Law on Ministries and Other Bodies of Administration of Bosnia and Herzegovina *(1)*, which states that the Ministry of Civil Affairs of BiH "shall be responsible for carrying out tasks and discharging duties which are within the competence of BiH and relate to defining basic principles, co-ordinating activities and harmonising plans of the Entity authorities and defining a strategy at the international level in the fields of health and social care". As a result, there is a total of 14 government/health ministries responsible for health sector governance in BiH: one at state level, three at sub-state level and 10 at sub-entity level (only in FBiH).

The process of implementing reforms, including those related to health and that have a direct impact on the population, has been slow. Negotiating compromises and finding solutions to various political, economic, health and social issues linked to migration are proving to be very demanding.

This chapter aims to provide insights into the negotiation processes led by WHO to deal with the challenges of migration and health issues within the context

of a complex political organization and governance for health. It also aims to highlight how migration-related health issues have subsequently successfully guided current actions in BiH at country level.

Migration flows

By 2015 and early 2016, the western Balkans was already established as one of the main migration routes into Europe, with a dramatic increase in migrant numbers compared with previous years. In 2015, the number of refugees and migrants arriving in Greece had an impact on the western Balkan route, as people who entered the EU in Greece then tried to pass through North Macedonia, then Serbia, before passing into Hungary or Croatia; from here, they continued towards western Europe. This led to unprecedented numbers of refugees and migrants seeking to re-enter the EU through the Serbian–Croatian–Hungarian border. In 2015, the western Balkan region recorded 764 033 illegal border crossings by refugees and migrants fleeing war and persecution, with the main country of origin being the Syrian Arab Republic, followed by Afghanistan and Iraq *(2)*.

In November 2015, countries along the route began implementing restrictive policies and measures, limiting entry to certain nationalities and for certain destinations, until the western Balkan route closed completely in early March 2016, when the EU–Turkey Statement took effect. Despite the mass movement of refugees and migrants through the region in 2015, BiH did not register an increase in the number of foreigners passing through its territory. BiH received just 45 asylum seekers in 2014 and 46 in 2015 *(3)*.

In February 2016, a new Law on Foreigners was adopted, and a new Law on Asylum entered into force, which aligned more closely with EU regulations. By the end of July 2016, some 22 asylum applications had been recorded. As the asylum centre in Delijaš has a normal capacity of 150 people, which can be increased by another 150 to a maximum of 300 people, the Sector for Asylum's ability to process claims was unchallenged by any significant increase in numbers.

Up until March 2016, the western Balkan route continued through North Macedonia to Serbia, and then onwards through Croatia and Slovenia, which

registered 95% of migrants who transited the region. In 2018, when the western Balkan route became more difficult or impossible to pass through, refugees and migrants searched for alternative routes through BiH, which then became the prominent country of passage, registering 80% of the total number of refugees and migrants who transited in the western Balkans *(4)*.

The authorities in BiH recorded the arrival of 24 067 refugees and migrants in the country between 1 January 2018 and 31 December 2018, compared with 755 recorded arrivals in 2017 *(5)*. The majority arrive irregularly by land through unofficial border crossings. Increasing numbers then arrived from Greece via Albania and Montenegro. It is estimated that between 4500 and 5000 refugees and migrants have remained in BiH and are in need of humanitarian assistance at various locations, particularly in the capital, Sarajevo, and in Una-Sana Canton. The latter location is used by people attempting to enter Croatia and the EU.

The composition of the migration flows is mixed, with the top declared countries of origin in early 2019 being Afghanistan, Iran (Islamic Republic of), Iraq, Pakistan and the Syrian Arab Republic. In the period January 2018 to February 2019, out of 25 299 arrivals, 23 176 had expressed the intention to seek asylum. Of these, only 1590 had submitted asylum claims and 875 were awaiting registration of their asylum claim with the Ministry of Security, as the Sector for Asylum cannot schedule an interview if those wishing to apply have not registered an address *(6)*. Legal status is one of the most important factors when determining whether migrants are able to access affordable and adequate health services. Their access to health care and the level of care provided varies, depending on their location and legal status.

Many refugees and migrants arrive without documents and it can be difficult to verify their citizenship. In the event that a refugee or migrant expresses an intention to seek asylum in BiH, according to the Law on Aliens, the border police will offer them transportation to a single reception centre: the Centre for Foreigners in Sarajevo. The Centre is part of the Service for Foreign Affairs, which comes under the Ministry of Security. After making contact with the Service for Foreigners' Affairs, refugees and migrants are then transferred to one of the five reception centres in BiH: Bira or Dorm Borići (in Bihać), Sedra (Cazin), Miral (Velika Kladuša) or Ušivak (Hadžići, Sarajevo Canton).

Registered migrants are allowed to stay in BiH for 14 days. However, only a few of the refugees and migrants currently formally applying for asylum in BiH do so by the given deadline. In theory, if a refugee or migrant remains in BiH after 14 days have elapsed without submitting an asylum claim, then they are considered to be in the country illegally. However, no active steps are taken to deport those who remain, nor are there any effective readmission agreements with the countries of origin. This is important as, under the country's laws, only asylum seekers are entitled to the same access to health care as BiH citizens.

Because the situation is so complex, the response to the challenges posed by migration-related health issues consists of a patchwork of systematic and ad hoc measures. In response to an increase in the number of refugees, migrants and asylum seekers in need of humanitarian assistance and protection, and with support primarily from the EU, the Council of Europe Development Bank and the internal funding mechanisms of United Nations agencies in BiH, significant efforts were made to support the Council of Ministers of BiH in expanding the country's capacity to provide accommodation, humanitarian assistance, protection and health services to refugees and migrants on its territory.

A window for health diplomacy

In June 2018, WHO received a letter from the BiH Minister of Civil Affairs describing briefly the difficulties that health providers were facing in delivering health services for refugees and migrants, particularly in Una-Sana Canton, the most affected area. Since the health system in BiH was unable to deal with the situation, the Minister asked WHO to provide any support that it could offer.

In response to the Minister's request, the WHO Country Office in BiH, with the support of the WHO Regional Office for Europe, immediately began talks and organized a short mission in July 2018, which involved health-care providers and health authorities, in an effort to understand the nature and the scale of the problem.

The mission revealed a lack of coordination among various stakeholders in the way they handled the newly emerging issue of the rising number of refugees and migrants in two locations in Una-Sana Canton: Bihać, the administrative centre of the Canton, and Velika Kladuša. Because of the country's decentralized administrative and political system, there was no communication between various authority levels, particularly in the health system.

Health services are provided by local health facilities under the supervision of the local health ministry and are financed by the local health insurance fund. Most funding for health comes from health insurance funds, which provide reimbursement financing for services provided to insured citizens of BiH.

At the level of the FBiH, there is a solidarity fund to cover some costly treatments abroad. Tourists and foreign citizens from countries with which the health insurance funds have bilateral agreements also have access to health services at no charge, with invoices being sent to their home countries for reimbursement. Registered asylum seekers will have access to health care that is reimbursed from the state, while for refugees and migrants who have not claimed asylum and who come from countries with no bilateral agreements, it is not possible to identify any sources of funding because of their legal status. In fact, those refugees and migrants come under the responsibility of the state-level Ministry of Security, which has no administrative branches at canton level. Financial resources from health insurance funds cannot be used to provide health care for those refugees and migrants, and health-care services have to be financed by the Ministry of Security or by local or international donors.

The Danish Refugee Council – funded by the European Civil Protection and Humanitarian Aid Operations through local health institutions – manages the primary and secondary health care for refugees and migrants. The Danish Refugee Council has engaged mobile medical teams to provide primary health care in the camps. Secondary health care is provided in hospitals in Una-Sana Canton on an individual basis in urgent and life-threatening situations. The supporting international organizations have highlighted the pressure and strain the medical teams were under as a result of increased numbers of refugees and migrants and the large number of medical screenings and check-ups that took place, particularly in Una-Sana Canton during the winter months in 2018 and in the first three months of 2019. The local health authorities increased their efforts to expand medical teams and increased working hours.

Several key issues remain, however, including funding limitations as well as longer-term health care and the lack of properly defined referral pathways for more complex medical issues.

In such decentralized administrative and political systems, the role of the WHO Country Office is even more crucial because, at country level, WHO is seen as either a technical or a policy expert and benefits from a closer advisory and supportive role with the ministries. Despite this complexity, it is always viewed as a neutral negotiator between health sector stakeholders.

The July 2018 mission confirmed the important role that WHO could play, and, as a result, WHO organized the first health coordination meeting at local level in Una-Sana Canton and at entity level (FBiH) in Sarajevo, involving all health system stakeholders. The meetings were important as they highlighted the ways in which local authorities were addressing the health of refugees and migrants, while providing an opportunity to better prepare for the next meeting between the WHO Regional Director and the Minister of Civil Affairs. WHO played a convening role in health policy dialogue by facilitating and negotiating between stakeholders from the different sectors and levels. This allowed representatives to identify and understand the common health issues, to visualize their own roles and to set a joint vision for health.

The mission also concluded with the idea of sending a WHO expert team from the Regional Office to conduct a rapid assessment at the beginning of September 2018. The rapid assessment included meetings with health ministries at all three levels (state, entity and canton) and visits to the field and refugee camps, as well as participation in one of the health coordination meetings organized by the WHO Country Office.

Without WHO's help, it was clear that it would have been difficult to overcome the challenges in reaching agreement on the issue of refugee and migrant health. However, the visit in September strategically positioned WHO in the local migration health dialogue, where it could help to identify priority areas of intervention in support of the BiH Minister of Civil Affairs and to stimulate a dialogue with donors and other organizations operating in BiH, with the aim of finding synergies as well as areas and modalities of potential collaboration.

One of main problems was a lack of coordination and communication among the various health-care providers, health authorities and international organizations (the Danish Refugee Council, International Rescue Committee,

IOM, MSF and UNHCR) that were responsible for organizing the care, shelter and protection of refugees and migrants. For example, representatives from the Federal Ministry of Health acknowledged that the first time they met the representatives of these international organizations was when the WHO Country Office organized the first health coordination meeting. In addition, they commented that communication was lacking even with the Ministry of Security, which is responsible for refugee and migrant issues. There was also no vertical collaboration and communication between the Federal Ministry of Health and cantonal health authorities.

Compared with other European countries, public attitudes were less negative, mainly because many people in the region had also been refugees during the Yugoslav wars in the 1990s. However, politicians mainly used the refugee and migrant issue to shift responsibility from an organizational and administrative level to a political one, questioning the EU's involvement and support, demanding that the burden be shared equally among the cantons or simply avoiding the issue.

Outcome of the negotiations and lessons learned

From the outset, it was quite clear that the Ministry of Civil Affairs had no competencies or responsibilities in either health care or refugee and migrant issues but it fulfilled its constitutional role of coordination and representation towards the international organizations. Furthermore, the various meetings also revealed the political aspects of the refugee and migrant issue in BiH: 2018 was an election year and some political parties used discussions on refugees and migrants as an opportunity to reclaim their electoral territories by presenting the issue as a security threat.

The mission in September 2018 provided an opportunity for WHO to propose a roadmap of interventions aimed at promoting the health of refugees and migrants. It also seized an opportunity to promote information sharing and to help to develop an integrated and coordinated approach. The WHO Regional Office further assisted BiH through the Country Office in BiH, in particular by supporting the coordination efforts of health interventions in the city of

Bihać and by providing technical advice to local authorities for creating health profiles and epidemiological reports of the refugee and migrant populations. Other recommendations that came from the short mission in 2018 were for capacity-building activities and reinforcing the health workforce.

WHO supported the participation of the Director of the Public Health Institute of Sarajevo Canton at the second annual WHO School on Refugee and Migrant Health. It also helped to promote collaboration and interaction between the University of Sarajevo and the University of Pécs, Hungary (WHO Collaborating Centre for Migration Health Training and Research), thus facilitating the organization of a short, intensive and comprehensive training course for health-care workers to provide support in the field of intercultural mediation.

While the regular health coordination meetings continued, the first fully WHO-driven coordination meeting, at UN House, Sarajevo, took place. All the stakeholders invited attended and contributed to the discussions. At the time, WHO began to coordinate the approach on migration-related health matters on behalf of the United Nations country team. One of the outcomes of the meeting was the willingness of other international organizations to communicate with the FBiH Ministry of Health. The other important agreement that came out of the meeting was to proceed with a request by all participants to draft standard operating procedures on health checks for refugees and migrants.

In February 2019, experts from the Rome-based National Institute for Health, Migration and Poverty (WHO Collaborating Centre on Health and Migration Evidence and Capacity Building) were invited to present the key clinical organizational guidelines for the health protection and the social and health care of refugees and migrants *(7)*. The workshop, consisting of lectures and first-hand experience sharing by policy-makers, experts, health workers and civil society representatives, was organized by the WHO Country Office in BiH with the support of the WHO Regional Office. In addition to the specific request to develop standard operating procedures on health checks for refugees and migrants, the workshop provided an opportunity to facilitate a dialogue between the different stakeholders at federation and canton level, as well as at municipality level, to discuss possible ways forward.

One of the outcomes of the workshop was the creation of a working group to liaise with the WHO Country Office, the WHO Regional Office for Europe and

international experts from the National Institute for Health, Migration and Poverty to draft and finalize the standard operating procedures document. At the same time, participants acknowledged there was still a lack of information internally about the roles and responsibilities of each actor. Therefore, all the stakeholders agreed on the need for, and indeed requested, a comprehensive refugee and migrant health country assessment of the health system's capacity to manage a large influx of refugees and migrants, which was conducted in April 2019.

The subsequent coordination meetings, which take place monthly at both canton level and the level of the FBiH, were organized by the Federal Ministry of Health and supported by the WHO Country Office. One of the main outcomes of the meetings was the call for health authorities to be more involved, despite the fact that, legally, they were not obliged to be. The meetings offered the best platform for finding solutions. Health-care providers had to deal with a lack of regulation concerning tariffs and the financing of the health care they provided. Donors were receiving financing requests of varying amounts for the same types of service in different settings. During the meetings, a set of common rules were agreed. For example, health-care providers agreed to invoice their services on the same basis as for BiH citizens, rather than for foreigners, who are usually charged a higher rate.

One of the most valuable inputs provided by WHO was to mobilize staff to the field in Bihać to continue to support the health ministry at local level in organizing health coordination meetings with international donors, local authorities and health-care providers. A four-way flow of information was established between Una-Sana Canton, the WHO Country Office, the FBiH Health Ministry and the WHO Regional Office for Europe. Real-time problems benefited from real-time technical advice. When communication among health authorities was slow or protracted, WHO raised the issue at FBiH or state level, at the WHO Country Office or at the country offices of other international organizations. This way, better and more coordinated interventions in health were possible.

One example that illustrates the benefit of a so-called coordination catalyst is worth mentioning: in one of the camps, a patient with TB was reported. No TB contact investigation was carried out because of the diffused responsibility between health-care providers. WHO staff in the field informed the WHO Country Office and acted as a communications mediator between the cantonal

Institute of Public Health, the federal Institute of Public Health and the federal coordinator of the TB programme. As a result, the cantonal Institute of Public Health carried out the TB contact investigation and screening.

From a health diplomacy perspective, the most important lesson learned is that WHO, as a highly regarded authority on health issues, can step in and bring stakeholders together when the health of vulnerable people falls into a constitutional gap and is neglected because of local political issues. By promoting and encouraging blunt and open dialogue, WHO catalysed a coordinated effort to provide adequate health care to refugees and migrants. It played a convening role in the policy discussions on health and migration by facilitating meetings and negotiating between stakeholders from different sectors.

This shows that even without providing financial or material support for health authorities at state, entity or local level, improvements can still be generated. WHO does not run operations to support refugee and migrant health in BiH at any level, but its involvement in leading the task of coordination was very well received and much appreciated. Trust in WHO's technical excellence, as well as its good record of cooperation with all health authorities, paved the way for it to become a mediator on the issue of refugee and migrant health in a year marked by general elections (in November 2018), when refugees and migrants became the subject of election debates.

Conclusions

The challenges posed by migration and health issues can be intensified by the local context and by the history of the country, but, equally, they can be seen as an opportunity to find common ground. Another lesson is that no health diplomacy strategy can succeed alone without very committed individuals pushing forward the global health agenda.

Finally, coordination and a thorough understanding of the roles and responsibilities of the different international organizations and agencies are crucial in achieving common goals, particularly when related to issues as sensitive as migration.

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23. Negotiating access to health care for asylum seekers in Germany

Kayvan Bozorgmehr and Oliver Razum

Introduction

Germany is a country of immigration and has been receiving large numbers of asylum seekers since the 1990s.[15] Between 2013 and 2016, it was the largest single recipient of new asylum claims among industrialized countries *(1,2)* and, in 2017, the second largest after the United States *(3)*.

During the first 15 months of an asylum seeker's stay in Germany, access to health care is limited by national law: asylum seekers are entitled to treatment for acute and painful conditions, vaccinations, preventive care and check-ups for children, as well as services during pregnancy and childbirth. Further essential services may be offered on request and on a case-by-case basis, depending on individual assessments carried out by welfare agencies and public health authorities. As there is no explicit national list defining what these essential health-care services include, it is left to the relevant local authorities to determine the precise package of services available to asylum seekers *(4)*.

[15] This chapter specifically considers the situation for asylum seekers.

As well as entitlement restrictions, asylum seekers face further barriers in accessing health care: they need a health-care voucher to visit a doctor (except in emergencies), which they must personally apply for at the local welfare agency or state-level authority. The voucher is valid either for a specific visit to a doctor or for a period of three months. Health-care providers then use the voucher to obtain reimbursement from the cost bearer, that is, the welfare agency. After 15 months, all asylum seekers with an approved asylum claim are entitled to an electronic health card and are covered by the same service package provided to residents who are insured under the statutory health insurance system.

Since 2015, however, several federal states and local authorities have been introducing electronic health cards for asylum seekers immediately or shortly after their arrival to replace the bureaucratic voucher system. This policy change has been accompanied by extensive discussions and negotiations between multiple actors at the national, state and local levels in districts and municipalities. This chapter aims to provide insights into the negotiation process and outcomes and concludes with lessons learned from the perspective of health diplomacy. It is a narrative report based on the literature, media reports and the authors' involvement in the process as evidence-brokers and representatives of academia, who provided expertise and scientific knowledge to decision-makers at different levels.

Electronic health cards for asylum seekers

The use of health-care vouchers has been criticized since the 1990s – mainly by civil society organizations working in health and human rights – for potentially delaying access to health care and creating an unnecessary administrative barrier for asylum seekers *(5)*. In order to overcome the cumbersome voucher system, the federal state of Bremen, one of the smallest German states, first introduced electronic health cards for asylum seekers in 2005 when it was governed by a coalition between the Social Democratic Party and the Christian Democratic Union. Based on national legislation of Social Security Code V (Sozialgesetzbuch V), the state welfare agency registers asylum seekers with a local sickness fund (AOK Bremen/Bremerhaven) and pays a lump sum per person to cover administrative costs *(6)*.

The state thereby continues to act as cost bearer, with payments being channelled through the efficient sickness fund system. As with welfare payments for unemployed residents, the sickness fund reimburses health-care providers for services provided to asylum seekers and charges the authorities at regular intervals, as is the case with the reimbursement scheme of the general health-care system. Entitlement restrictions are, thus, reduced to a minimum, and the service package offered to asylum seekers differs only slightly from that offered to residents.

In 2012, the neighbouring federal state of Hamburg adopted the so-called Bremen Model and also introduced electronic health cards for asylum seekers. The contract, however, was set up with AOK Bremen/Bremerhaven, as the sickness funds in Hamburg declined to register asylum seekers and administer the scheme. Following the introduction of the electronic health card, the state authority in Hamburg carried out an internal evaluation and concluded that administrative costs had been substantially reduced. The cost savings were over €1 million a year, yet per capita health-care expenditure for asylum seekers remained largely unchanged *(7,8)*.

A window for policy reform

At the same time, the public debate on the need to reform the Asylum Seekers' Benefits Act intensified. This was prompted by a Constitutional Court judgement stating that differences in the level of cash benefits paid to residents and to asylum seekers to cover living costs were unconstitutional unless the difference in benefits payments was based on an objective measure of need *(9,10)*. As this was not the case, the Act was reformed and cash benefits were equalized between residents and asylum seekers. During the course of the debate, entitlement restrictions and inequality in physical access to health care under the voucher system became increasingly a matter of public concern, and civil society organizations and some political parties (e.g. the Greens and the left-leaning Die Linke party) called for the sections of the Act governing entitlement restrictions to be abolished.

The then German Government, formed by a coalition between the Social Democratic Party and the Christian Democratic Union, did not abolish the restrictions completely. However, a reform was passed in March 2015 to reduce the time period before which electronic health cards could be issued and entitlements to health care aligned with those of residents from 36 months (as previously) to 15 months. The public debate about whether to issue electronic health cards to asylum seekers immediately after their arrival in Germany gained further momentum during 2014 (when increasing numbers of refugees and migrants arrived) and during 2015 (when Germany's so-called welcome culture prevailed and 890 000 asylum seekers were registered) *(11)*. Last but not least, new and timely data analysis proved that restricting entitlement to health care for asylum seekers resulted in higher health-care expenditure over 1994–2013 compared with the regular provision of services *(12)*.

National-level negotiations and outcomes

Although the evidence resonated in the German media and informed the national political debate, which included an expert hearing in the German Federal Parliament's health subcommittee in June 2016, discussions about the advantages and disadvantages of the electronic health card were heated. Proponents argued that electronic health cards reduced bureaucracy and related administrative costs and ensured both improved and nondiscriminatory access to health care for asylum seekers. Opponents argued that large federal states may not be in a position to introduce electronic health cards because of the different levels of administrative responsibility for health care immediately after an asylum seeker's arrival (responsibility at state level) compared with during the course of their stay in Germany (responsibility at district and municipal level). Further arguments against the electronic health cards were the (assumed) technical problems of issuing cards to a dynamic population, pull factors encouraging further migration to Germany and exacerbating health-care costs through the (assumed but already disproven) increased use of health care by asylum seekers *(13,14)*.

Overall, the public debate and political negotiations in parliament did not result in legal reform to ensure a nationwide implementation of the electronic health card for asylum seekers. Instead of national legislation, the ruling coalition Government settled on a compromise and initiated a reform in the Social Security Code *(15)* that allowed interested federal states to issue electronic health cards to asylum seekers at state or district level even before the first 15 months had elapsed, while requiring sickness funds in the relevant federal states to enter into a contract with those authorities planning to introduce health cards. The core focus of the policy reform was, therefore, to decentralize the decision to introduce electronic health cards.

This decentralization was accompanied by a nationwide framework governing the details of the implementation process for states that introduced electronic health cards, including efforts to operationalize and specify the restricted package of health services to be provided to asylum seekers. This nationwide framework was negotiated between the German Association of District Authorities (Deutscher Landkreistag), the German Association of Towns and Municipalities (Deutscher Städte- und Gemeindebund), the German Association of City Authorities (Deutscher Städtetag) and the Federal Association of Statutory Sickness Funds (GKV-Spitzenverband). Representatives of these authorities argued for a clear-cut, but limited, package of health services that asylum seekers could access under the framework, especially with regards to long-term treatment or the need for hospital treatment or for treatment that could not be completed because of the anticipated length of stay.

This effort, however, was opposed by the Federal Association of Statutory Sickness Funds, which stated that attempts to generally limit services based on criteria related to residence status, among others, would conflict with everyday medical practice and would by no means provide doctors and sickness funds with a judicial basis on which to approve or decline the provision of medical services *(16)*. As such, attempts to introduce a national list of restricted health-care services patently failed owing to the complex nature of medical practice, while the precise package of services available to asylum seekers remained subject to local decisions of the relevant authorities, regardless of the availability or otherwise of electronic health cards. The

missed opportunity to adopt the Bremen Model (which applies criteria of the statutory sickness funds to determine needed or essential services) on a national level had a significant impact on efforts to make electronic health cards for asylum seekers more widely available at subnational level.

State-level negotiations and outcomes

With the decision on whether to introduce health cards for asylum seekers being devolved to federal states, discussions about the advantages and disadvantages and negotiations relating to potential implementation models continued at subnational level. To date, just four federal states (Berlin, Brandenburg, Schleswig-Holstein and Thuringia) have opted to introduce electronic health cards. These early adopters also initiated reforms in the form of state-level regulatory frameworks to cover all health-care costs at state level.

Three states, however (North Rhine-Westphalia (the most populous federal state), Rhineland-Palatinate and Lower Saxony), decided to leave the decision on whether or not to introduce the card to individual municipalities, the lowest administrative level. They did not implement state-level structures for financing, except for single lump-sum payments and regulations to cover extraordinary high costs for individuals on a case-by-case basis *(17)*.

As a result, 22 out of 396 communities in North Rhine-Westphalia have introduced the health card *(18)*. North Rhine-Westphalia was the first large federal state to adopt the policy, and the evidence in support of the electronic health card *(8,12)* facilitated the policy decision to introduce it. Nevertheless, in early 2019, implementation remains fragmented. The reform was also only partly adopted in the other states, which further devolved the decision: in Rhineland-Palatinate, just one in 2305 municipalities has adopted this reform *(19)*, while, one in 944 municipalities in Lower Saxony have done so *(20)*.

One of the reasons for the limited implementation by municipalities is that the state-level Association of Statutory Sickness Funds managed to enshrine,

in the state-level framework regulations, administrative costs equivalent to 8% of the health expenditure of asylum seekers to be covered by municipalities. This rate is higher than the administrative costs for residents receiving benefits. Small municipalities hosting only a few asylum seekers were, therefore, sceptical about the financial benefits and argued that the regulations could ultimately result in higher administrative costs as no state-wide mechanism to cover costs was envisaged.

In the state of Hessen, negotiations were still ongoing (2019), and implementation at state, district or municipal level remains to be decided. In 2016, six states (Baden-Württemberg, Bavaria, Mecklenburg-Western Pomerania, Saarland, Saxony and Saxony-Anhalt) decided not to introduce electronic health cards for asylum seekers *(21)* and ended negotiations *(13,17)*.

The arguments put forward in these states were often politically motivated rather than supported by evidence. These were as follows: presumed acceleration of the asylum processes, making the introduction of electronic health cards dispensable before a decision on asylum claims is made (Mecklenburg-Western Pomerania); cost (Saarland); concerns that the health card encourages immigration (Saxony); and claims that a high level of access was already ensured by the current voucher system (Bavaria) *(21)*.

Opposition to the electronic health card in Baden-Württemberg – the third largest federal state, which receives about 13% of all asylum seekers in Germany – was particularly surprising. The then governing Greens strongly advocated in favour of introducing the electronic health card before elections to the state parliament in 2016. However, after the election, the Greens formed a coalition with the conservative Christian Democratic Union, and the new coalition government opposed the cards *(13,14)*.

Overall, the main objection put forward by states and municipalities that did not implement the electronic health card scheme was an assumed increase in cost, especially in regions where sickness funds were allowed by state-level regulations to invoice additional administrative costs for asylum seekers. In the six federal states that do not use the electronic health card, asylum seekers must still apply in person at the local welfare agency for a health-care voucher.

Conclusions and lessons learned

From a health diplomacy perspective, several lessons can be learned from this recent example in Germany. First, health diplomacy in this context encompassed complex negotiations between multiple actors at all administrative levels and in different societal spheres, ranging from political fora (national and state parliaments) to civil society and the media. The particular political and social climate at the time – constitutional rights-based discussions on entitlements, intensive public debates on migration, experiences of practicable policy alternatives and political parties adopting a favourable position – and the availability of scientific evidence on alternative approaches opened policy windows and facilitated equity-oriented discussions on health policy reforms for this particular group of people.

However, the complexity of the German health system, as well as political priorities and compromises, affected the outcomes of the negotiation process, resulting in a heterogeneous policy that was fragmented and that was implemented haphazardly at times. Decentralizing the negotiations on access to health care for asylum seekers led to a plethora of implementation models. From an equity perspective, this well-intended policy reform has increased inequalities in access to health care among asylum seekers: it now depends on their place of residence, which itself is determined by a complex dispersal policy and not by individual choice. To what extent the heterogeneous models translate into inequalities in real life, in terms of actual access and health outcomes, will be a matter of ongoing evaluation and empirical study.

Furthermore, as shown in this chapter, health diplomacy and the underlying decision-making processes are highly political undertakings: despite evidence, plausibility and convincing experiences, political objections in many federal states dominated the debate and the outcome of the negotiations *(14)*. Despite welcome calls for evidence-informed health policy and practice *(22)*, public health practitioners must be aware of the political nature of the decision-making process. Most importantly, as shown by comparing the examples of Bremen and Baden-Württemberg, the same political parties may have different priorities in different contexts: while the Christian Democratic Union in Bremen was part of the coalition that introduced the first electronic

health cards in Germany, a coalition in Baden-Württemberg in which they were a partner decided not to adopt the policy.

Another lesson identified is that specific evidence has a widely different meaning for the various actors involved. Based on the authors' experiences, political parties were open to the argument about reducing administrative costs. The same argument, however, appeared unconvincing and even threatening to the administrative bodies concerned: cost savings may result in staff cuts and reduced administrative budgets. In short, it is not just the type of evidence and argument that is put forward in negotiations and health diplomacy that is relevant but also which actor it addresses.

Health diplomacy in the context of migration must, therefore, consider the politics of evidence and argument. In particular, health advocates must be aware that the process and policy debate may, in practice, be decided by migration policy and the desire to deter asylum seekers, refugees and migrants, rather than arguments based on asylum seekers' health and public health outcomes.

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Subnational perspectives

24. Partnership Skåne: establishing a model for health diplomacy at subnational level

Katarina Carlzén, Hope Witmer and Slobodan Zdravkovic

Introduction

Between 2006 and 2014, Sweden had the highest refugee population per capita of any country in Europe *(1,2)*. In the period 2014–2017, Sweden received approximately 220 000 asylum applicants who were over the age of 20 years, around 75% of whom were granted a residence permit. In 2016, approximately 20% of the population was foreign born, and at least half of all the population growth between 2002 and 2015 was from foreign migration, a trend expected to continue until 2020 *(3)*. Changes in Swedish national policies for immigration have been introduced: migrants with a residence permit are now required to attend an introductory programme (Box 24.1 and Fig. 24.1).

The Skåne Region, in the southern-most part of Sweden and at the Swedish border with Europe, received around 18 000 adults with a residence permit in 2014–2017, which is about 10% of the total number of people granted residency in Sweden. This chapter describes a coordinated effort to develop a holistic introduction process for newly arrived refugees and migrants in Sweden and a model for health diplomacy: Partnership Skåne. This is a multilevel governance and cross-sectoral platform for collaboration and

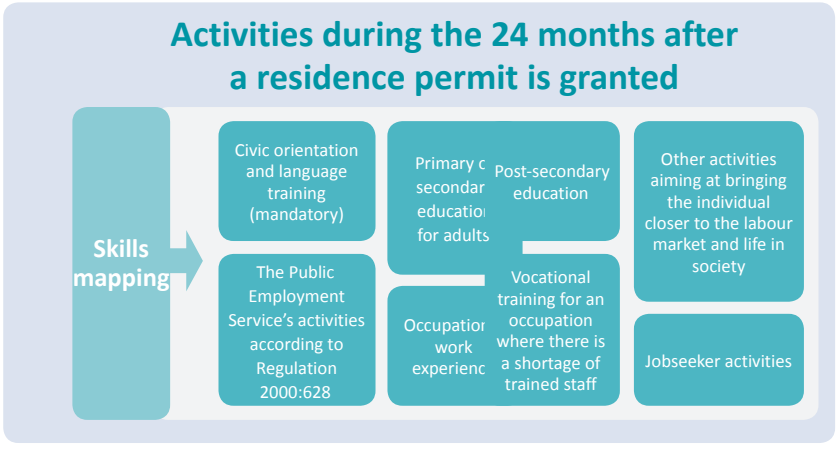
Box 24.1. Reception and introduction of newly arrived migrants in Sweden

In 2016, changes in national immigration policy were introduced, making it harder for migrants to obtain a residence permit; currently, around 35–40% of applications for residence permits are granted, while the opportunities for family reunification have been limited.

It is the responsibility of the Swedish Public Employment Service to provide the newly arrived migrants (i.e. migrants who have secured a residence permit) with a place on a mandatory introduction programme (Fig. 24.1), which runs for two years after a permit has been issued.

The aim is to make it easier for migrants to enter the labour market through a programme adapted to the competences and needs of each individual. The introduction programmes usually focus on language acquisition and practical activities designed to engage individuals in the labour market. A minimum of 60 hours of civic orientation is a mandatory part of the introduction and aims to provide participants with an understanding of how Swedish society works. In 2018, 42% of participants were either employed or studying 90 days after finishing the introduction programme, compared with 32% in 2017 *(4)*.

Fig. 24.1. Swedish introduction programme for newly arrived migrants with residence permits



capacity development, which has been proven to promote health equity and enhance social inclusion for newly arrived refugees and migrants in Sweden *(5)*. The chapter also describes the process of establishing Partnership Skåne and the associated challenges, for example in terms of uniting organizations from different sectors and promoting health and social inclusion in a political context focused on labour market integration (Fig. 24.1).

Health equity and social inclusion: development of Partnership Skåne

The complex interaction between economic and social vulnerability, marginalization and ill health poses serious challenges for the successful integration of newly arrived refugees and migrants into their host societies. Despite this, health has traditionally not been regarded as a pivotal factor within the Swedish system for receiving and integrating refugees and migrants. Hence, the work within Partnership Skåne started out by offering intersectoral seminars that addressed various relevant questions, such as to what extent the integration processes for newly arrived refugees and migrants promoted health and were empowering and conducive to social inclusion. Health-related issues were recognized as crucial but challenging, as the public health sector and other organizations were working separately and from a seemingly different set of rationales.

The seminars were followed by the formulation of joint action plans on prioritized areas of coordinated activities that would benefit from the organizational support of regional actors: areas such as culturally sensitive civic and health communication, coordinated collaboration with civil society and knowledge-based development through collaboration with research partners. These areas have since constituted the essence of Partnership Skåne, resulting in a model for health diplomacy. Partnership Skåne has worked effectively for 10 years in Skåne and its success has led to the model being disseminated nationally.

Health diplomacy – that is, advocating for health equity and social inclusion for all newly arrived refugees and migrants – constitutes the main thrust of the activities within Partnership Skåne. Gaps and related risks in the existing

system have been identified and presented alongside pragmatic tools for use in addressing the gaps. In parallel, actors within the reception and integration fields have been invited to engage in mutual processes of learning and development taking place in an environment created and facilitated through cross-sectoral knowledge alliances. This will be described later in this chapter.

Providing health communication to newly arrived refugees and migrants in their mother tongue – an activity embedded in the general introduction programme in the region through these health diplomacy efforts – is at the very core of Partnership Skåne, as knowledge and information are seen as prerequisites for empowerment and self-efficacy (an individual's belief in his or her own ability to perform a specific action *(6)*). Health communication has, therefore, been prioritized in national advocacy and dissemination processes. This has resulted in those involved in the reception and integration of newly arrived refugees and migrants understanding that health is a relevant factor for successful integration into the labour market.

The main elements of the Partnership Skåne health diplomacy model are now disseminated through MILSA, the national education platform for civic and health communication. This is a national capacity-development programme supporting health equity and the empowerment of newly arrived refugees and migrants *(7)*. The programme is run in collaboration with universities, experts and 200 national, regional and local partners. Its aim is to develop national capacity for culturally sensitive health communication linked to the national introduction programme for newly arrived refugees and migrants (see below). Issues such as mental health and parenting are also addressed in depth through supporting tools and methods, as tasked by the Ministry of Health and Social Affairs. Furthermore, the work focuses on facilitating collaboration across sectors and on jointly developing knowledge around migration and health.

Understanding the health needs of newly arrived refugees and migrants

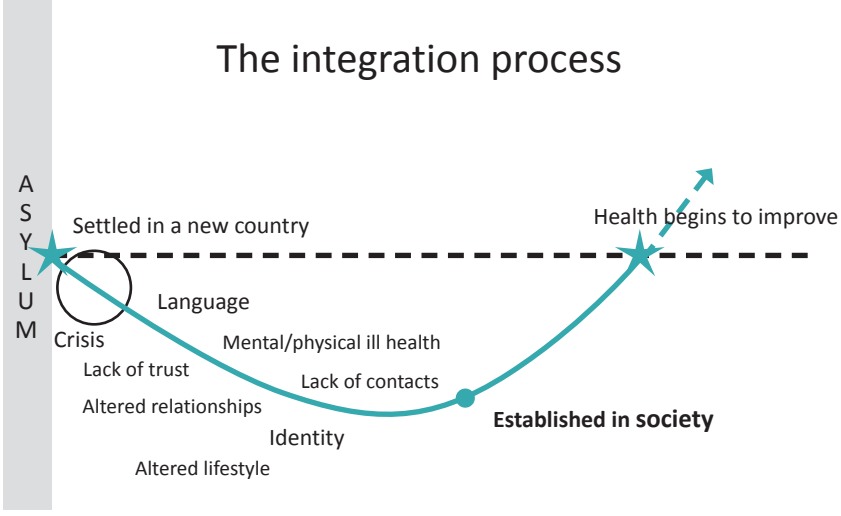
Regardless of the level at which programmes are initiated for the integration of refugees and migrants, all need to be created with an understanding of

the likely health needs. Newly arrived refugees and migrants are more likely to be in poor physical and psychological health compared with native-born Swedes because of their experiences during the migration process *(8,9)*. However, an important factor in their health is also how they initially adjust once they have arrived in the country of destination. Fig. 24.2 illustrates how a number of risk factors may interplay during the initial period, resulting in the gradual deterioration of health. This situation improves only after refugees and migrants have integrated into society. As shown in Fig. 24.2, health is a significant factor in the successful and sustainable integration of newly arrived refugees and migrants.

Health-care provision for newly arrived refugees and migrants in Sweden depends on age and legal status:

- adults seeking asylum or who have no papers have a right to emergency health and dental care; a right to maternity care, including delivery care, abortion and contraceptive advice; and care according to the contagion prevention law;

Fig. 24.2. Relationship of health with the settling process for refugees and migrants



- children under 18 years of age seeking asylum have the same rights to health and dental care as all children in Sweden;
- all adults and children seeking asylum are offered a free health check-up as soon as possible after the asylum application;
- all those with a residence permit have the same rights to health care and dental care as all Swedish citizens; and
- anyone who requires one is entitled to an interpreter when contacting health care or dental care services; health-care staff decide whether there is need for an interpreter, which the care service pays for.

The health-care sector is often seen as having sole responsibility for health. However, since many of the determinants of health and health inequities have social, environmental and economic origins that extend beyond the direct influence of health policies and the health sector, health should be considered across the whole of government when developing integration policies and strategies.

Nevertheless, a central part of the health-care encounter is the communication between health-care staff and patients. Recent studies show that, following a health-care interaction, almost every second patient has not understood what has been said, and this applies even more to people from a lower socioeconomic background or who have not yet mastered the language *(10)*. The inequity of the interventions and results for health care can, therefore, partly be explained by a lack of communication.

This argument is underlined by research conducted within Partnership Skåne, which shows that it is common for newly arrived refugees and migrants not to have sought out public health-care services despite needing them *(11)*. This may partly reflect low levels of trust, in society at large but, notably, regarding the health sector and interpreters. Moreover, even those with higher education may find it difficult to understand the information that is available. Many experience a lack of empowerment with regard to their own integration process, finding it hard to make sense of the new context and feeling that existing efforts within the introduction programme do not meet their needs *(12)*. Poor mental health among newly arrived refugees and migrants is common *(11,13)*.

To conclude, the way in which health is understood, defined and included in the design and implementation of integration processes is crucial. For example,

trust, the transfer of information and health literacy all affect the utilization of health services *(14,15)*. Importantly, the preparedness and openness of health services also affects the ability of refugees and migrants to access health care, as well as the possibilities for health equity and social inclusion.

Health diplomacy through multilevel governance

Capacity-building efforts aimed at promoting health equity and social inclusion are, according to the experiences of Partnership Skåne, enhanced by a support structure that targets not only the separate relevant organizations but also the system as a whole *(16)*. A health-promoting system cannot simply be constituted through the everyday work of each relevant organization but instead requires interorganizational measures, processes and communications that are specifically designed and coordinated to suit the needs and perspectives of the users. This coordination process requires effort to ensure a common understanding of the needs addressed, in this case a recognition of the key elements for supporting health equity. High-quality and relevant support (e.g. quality-assured health communication in the native languages of the refugees and migrants) may be difficult to develop, finance and maintain at local level and can benefit from the existence of a regional structure such as Partnership Skåne or a national structure. The following sections outline the design of Partnership Skåne and the key factors of its success before going on to describe its dissemination to other regions and nationally.

Partnership Skåne: a regional support structure for health diplomacy

Partnership Skåne's work is coordinated by the Skåne County Administrative Board as part of its government mandate to support regional and national capacity in the reception of newly arrived refugees and migrants. Its

partners come from the public sector, academia and civil society, operating with different rationales and responsibilities but all committed to a holistic, inclusive and health-promoting system for integrating newly arrived refugees and migrants.

The platform functions on both an operational and a strategic level, focusing on facilitating an environment in the introduction programme that is conducive to health as well as to trust, empowerment and social cohesion. Partnership Skåne is, moreover, linked to different strategic fora for collaboration. Its activities are financed by national, regional and local funds, as well as by various EU funds.

On a practical level, the main activities of Partnership Skåne are organized and coordinated through five regional hubs in order to facilitate collaboration and reach all newly arrived refugees and migrants.

Spheres of activity

There are three spheres of activity: providing health education through culturally sensitive civic and health communication, improving access for refugees and migrants to tailored activities within civil society and conducting knowledge- and research-based development work (Fig. 24.3). These are briefly outlined below.

Providing health education through culturally sensitive civic and health communication

The civic and health communication elements of Partnership Skåne's activities have been providing quality-assured education about society and health in various languages since 2008. In 2010, Sweden implemented a law that made municipalities responsible for offering civic orientation to newly arrived refugees and migrants. In Skåne, the vast majority of municipalities do this within the framework of Partnership Skåne, thereby making health communication (otherwise not a mandatory part of the introduction in Sweden) available to all newly arrived refugees and migrants within the participating municipalities.

Fig. 24.3. The three spheres of activity of Partnership Skåne

The extended programme consists of 32 different themes, covering both civic orientation and health communication. It provides important information and dialogue about issues in Sweden such as democracy, equality, physical and mental health, and parenting. The communicators are professionals with personal experience of migration and of being a newcomer in Sweden. They are highly trusted by newly arrived refugees and migrants and serve as a crucial communication channel between them and Partnership Skåne's collective work.

The programme is offered to all municipalities and organized in collaboration with municipal coordinators responsible for the regional hubs. Various inclusive activities, provided by civil society organizations and other associations, are also offered to newly arrived refugees and migrants through the programme. Ongoing evaluations indicate that the programme has an immediate positive

impact on feelings of trust regarding, for example, societal institutions, as well as on self-perceived health and perceived possibilities for entering the labour market.

Improving access for refugees and migrants to tailored activities within civil society

Civil society organizations play a key collaborative role in Partnership Skåne. The collaboration is channelled through the introduction programme, where newly arrived refugees and migrants are offered individually designed programmes, organized around the regional hubs and with coordinators from civil society responsible for each hub. The coordinators work with partners from the public and civil sector to create both general programmes and carefully planned, high-quality, tailored activities within civil society organizations, aimed at directly supporting language acquisition, health promotion and network building. This enables all newly arrived refugees and migrants in the region to gain access into society at large, which can otherwise be difficult to achieve.

Conducting knowledge- and research-based development work

MILSA is a collaboration between practitioners and researchers that aims to increase knowledge and understanding of the health and health needs of newly arrived refugees and migrants, and of their experiences. Through surveys and collaborative activities, MILSA links the work of practitioners and researchers from different disciplines.

The work, which is jointly coordinated by Malmö University and the Skåne County Administrative Board, contributes to the ongoing development of inclusive systems at both the regional and national levels through the formal and informal structures interlinked with Partnership Skåne. The work currently being conducted within MILSA is funded by the EU's Asylum, Migration and Integration Fund, the European Social Fund and the Swedish Ministry of Health and Social Affairs.

Challenges and key factors for success in establishing a regional structure for health diplomacy

Over the years, Partnership Skåne has been studied, analysed and evaluated by various external actors. Like many other cooperation processes, Partnership Skåne was initially characterized by uncertainty, the absence of a unified vision among the stakeholders and difficulty in maintaining commitment. The external studies and evaluations played a crucial role in strengthening the working model for health diplomacy. Moreover, a constant challenge was posed by integration policies focused on employment-promoting measures, where limited attention was given to the health-promoting perspective. The fact that the development work carried out by Partnership Skåne has, nevertheless, been successful results from several factors.

First, the development work focuses on advocating for the right to health and social inclusion for all newly arrived refugees and migrants. This is led by a cooperation leader employed at the County Administrative Board in Skåne, who is responsible for identifying the shared needs of development from a systemic perspective, as well as for leading process-oriented development work promoting ownership, trust and a unified vision among the cooperating parties.

Second, the development work was designed by taking into account the varying mandates and assignments of the actors, which gave them different entry points into the collaborative process. Great importance was attached to making the context visible to the different actors, as well as focusing on areas of cooperation and opportunities for shared leadership with overlapping benefits for newly arrived refugees and migrants, actors and society.

Third, the development work was borne out of a shared understanding about Partnership Skåne and its key principles – to be inclusive, holistic, and needs and knowledge based – which act as a convincing and binding element. A fourth success factor was development work being allowed to run its course, thanks to the Skåne County Administrative Board continuing to allocate resources even after the initial project period had ended (among other reasons).

Advocacy for the right to health and social inclusion has been constant throughout the process. Through concerned intersectoral fora at the regional and national levels, much effort has, therefore, been devoted to producing evidence for the relevance of an integrated health perspective in the context of labour market policies.

Some other key factors for establishing a regional model of health diplomacy are as follows: anchoring the model at a strategic level in addition to its operational-level activities, having research-based practice, having shared leadership and creating trust. These four areas were identified using data gathered as part of a research project. The analysis of Partnership Skåne in 2018 then identified key organizational and leadership aspects contributing to the sustained effectiveness of the collaboration *(17)*.

Anchoring the model at a strategic level

The strategic anchoring of Partnership Skåne ensures mandate and legitimacy, which contributes to the partnership's sustainability and impact *(18)*. Such strategic anchoring is achieved through different high-level steering committees with senior representatives of the collaborating actors as members and led by the County Governor of Skåne. They are in close collaboration with the political decision-making bodies of Region Skåne, which are, in turn, responsible for the adoption of the regional development strategy linked to the SDGs.

The results of Partnership Skåne, and its activities on a practical level, ensure that commitment among the collaborating actors is maintained over time. Furthermore, the strategic and knowledge-based approach within Partnership Skåne means that new initiatives are relevant from an inclusive and health-promoting system perspective and not just from the perspective of the individual organizations. The analysis of Partnership Skåne in 2018 identified organizational and leadership aspects as contributing to the sustained effectiveness of the collaboration *(17)*.

Research-based practice

The work on research and knowledge generation within Partnership Skåne can be described as knowledge alliances, in that research-based facts are combined with the knowledge of practitioners and the tacit knowledge of those closest to the experience – in this case, newly arrived refugees and migrants – in order to identify both outcomes and causes *(19)*. Knowledge alliances consequently approach knowledge from a broad and inclusive perspective, encouraging questions and engagement from practitioners as well as from the refugees and migrants themselves. This knowledge informs actions that are evaluated through feedback in a double-loop learning process in which information is received and analysed and changes to practice are implemented based on this input. Through the process, decisions are shaped, potential interventions are identified and conflicts (e.g. resulting from different political agendas and increased competition for resources) are explored for hidden opportunities. One example of such a hidden opportunity in these conflicts is that they have become a catalyst for the need to produce evidence-informed research to support the value of health-promoting activities. The combination of pragmatic solutions and MILSA's strong research platform further legitimizes the value of those health-promoting activities that were originally being challenged.

Embedded in the health diplomacy model of Partnership Skåne is a form of circular adaptive learning. On an operational level, the process includes fact-based decision-making that looks for opportunities and systems where feedback can be received from multiple parties. By-products of such a focus are that it can safeguard against an individual agenda dominating the debate and it can maintain the focus on providing adaptive interventions based on the data gathered, the knowledge acquired, the actual experiences of the refugees and migrants and verified outcomes. From a leadership perspective, strategic decisions are made, and opportunities pursued, based on facts from different sources. From an organizational point of view, processes are in place that allow for feedback and adaptation in order to stay relevant to the needs of the refugee and migrant population.

Shared leadership

Partnership Skåne utilizes a shared leadership process that encompasses a wide range of actors whose influence varies depending on how their contribution aligns with the immediate strategic focus *(20)*. Partners are connected according to their shared commitment to the mission, using research-informed knowledge as the foundation for decision-making and viewing their role in the context of the value of their contribution. This process has included the addition of partners and the reallocation of resources in line with the strategic focus.

Shared leadership is an agile and adaptive form of leadership that has the flexibility to adapt to new information and a shifting external environment involving multiple operators. Partnership Skåne does have a director, appointed by the Skåne County Administrative Board, but the director is committed to facilitating the shared leadership process while also acting as gatekeeper for the mission, a facilitator of learning-loop processes and a connector for strategic engagement.

Trust

The introduction programme for newly arrived refugees and migrants encompasses different actors, such as municipalities, government institutions and civil society. Collaboration is, therefore, key for successful regional development aimed at promoting health and social inclusion. A unique quality of the collaboration is that no participant has a mandate to make decisions over another, and that the possibilities for entry and exit are extensive.

Experience from Partnership Skåne demonstrates that trust plays an important role in maintaining the stability of regional cooperation over time, as well as ensuring that participants work together towards a joint objective instead of using the collaboration as a platform for negotiation, positioning and the dislocation of responsibilities. Trust is built on accountability for actions and for shared outcomes, and allows for a diversity of opinions and robust dialogue concerning strategy and implementation.

The most recent research on this collaboration identified high levels of trust due to the credibility of consistent actions, transparency in the processes and a belief in the trustworthiness of the director in keeping Partnership Skåne focused on its mission *(17)*. All these aspects of trust are connected to the joint commitment of the individual organizations to health equity.

The development of national capacity

The need for a holistic, health-promoting introduction system for newly arrived refugees and migrants has gained increasing attention in recent years *(9)*. As a result, the practices developed by Partnership Skåne have been

Fig. 24.4. The experiences made within Partnership Skåne's regional work are now used nationally through MILSA

disseminated to other regions and nationally, while various international networks linked to migration have expressed an interest in collaboration.

The education of civic and health communicators across the whole country is an important aspect of the ongoing national development work, complemented by activities supporting intersectoral collaboration and knowledge development around migration and health. Partnership Skåne, developed in one small region, has informed the work of MILSA nationally (Fig. 24.4). The work is conducted in collaboration with a number of universities and experts in different fields, as well as with public and civic organizations at the local, regional and national levels. Furthermore, evaluations are made on different levels in relation to the overall goals of supporting increased health equity and ensuring a quality integration process for newly arrived refugees and migrants into Swedish society.

Model for health diplomacy

Migration, particularly if forced, means not only that many basic needs may not be met during transit but also that certain needs can become critically intensified. Unaddressed, the negative impacts of forced migration on health will increase over time, affecting the wider community and, eventually, the world as a whole. In order to minimize negative impacts on health and to support integration for refugees and migrants, a health-promoting element should be incorporated into introduction programmes for newly arrived refugees and migrants, addressing social participation, health communication and empowerment. This requires authorities and organizations to recognize health promotion as an area relevant to the whole process, regardless of any other specific focus.

Global migration poses many challenges for societies, regions and countries. Sweden is a country with a deep and strong commitment to human rights, equality and equity in health, as well as being committed to implementing the SDGs. A national action plan for the 2030 Agenda was adopted by the Swedish Government in 2017, underlining the need for strategic work towards health equity *(21)*.

The Swedish Association of Local Authorities and Regions stated in its 2017 agenda for integration that the health aspects of the reception of refugees and migrants need to be further emphasized, and it proposed that accessibility of health care, according to the needs of newly arrived refugees and migrants, should be prioritized *(22)*.

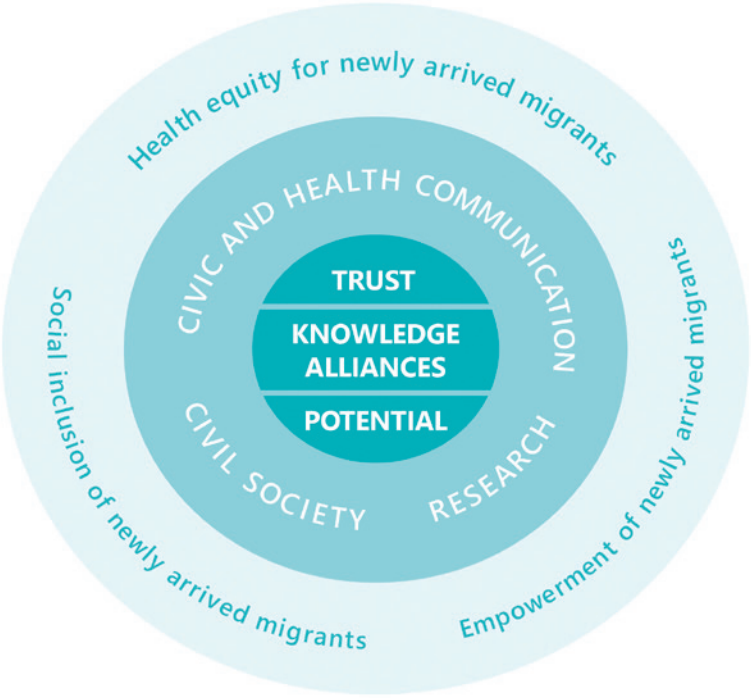
It is, however, crucial that the relevant commitments are implemented on a systemic level. In 2016, national agencies in Sweden were presented with analyses of the need for health-promoting measures for newly arrived refugees and migrants, along with recommendations for the development of a holistic introduction programme that promotes health *(9,23)*. Based on the model of Partnership Skåne, health communication in the native language of newly arrived refugees and migrants and activities arranged by civil society organizations and carried out within the introduction programme were recommended as a basis for achieving health equity for refugees and migrants.

In order to further develop civic orientation programmes, county administrative boards have prioritized health communication relating to civic orientation, and, currently, both of the recommendations are being implemented throughout Sweden. The county administrative boards play an important role in supporting regional collaboration and capacity for the integration of newly arrived refugees and migrants; they also support the development of knowledge regarding migration and health, as undertaken by MILSA. The tools and methods developed within Partnership Skåne and the MILSA platform (e.g. toolboxes regarding sexual and reproductive health and rights, mental health and well-being, and parenting) are linked to other national, regional and local strategies.

Conclusions

This chapter has presented a health diplomacy model promoting health and social inclusion for newly arrived refugees and migrants that is conducted within a multilevel governance support system (Fig. 24.5). Despite addressing

Fig. 24.5. The core dimensions of health diplomacy used within Partnership Skåne



complex issues, the model offers some fundamental, pragmatic and effective solutions that are transferable as they can be adapted to suit specific regional or national conditions in order to better meet global challenges regarding health equity and migration.

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25. New structures for acute medical care, mental health, initial medical screening and vaccination for refugees in the state of Berlin

Joachim Seybold and Malek Bajbouj

Introduction

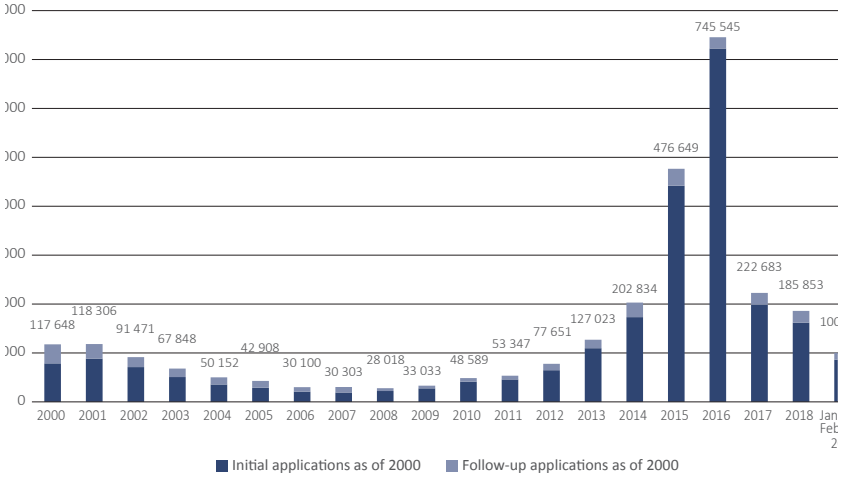
Refugees and migrants face immense health risks as a result of exposure to morbidogenic environments (conducive to illness) both in their countries of origin and during migration. They may also suffer from individually perceived and structurally reinforced postmigration stress *(1)*; however, the associated health consequences they face are often underestimated at the national and global levels. Moreover, the institutional responses of national health systems *(2)* often fall short in responding adequately to their specific needs and to the increased diversity of refugee and migrant populations *(3)*.

Population movements and the related health consequences for individuals and health systems have always been a relevant topic *(4)*. However, the movement of an increased number of refugees and migrants in recent years

have made it an urgent issue. Significant numbers of asylum seekers started to arrive in Germany, with numbers reaching a peak at the end of 2015 and the beginning of 2016. Overall, the total number of asylum seekers (first application) was 441 899 in 2015 and 722 370 in 2016 (Fig. 25.1). In the state of Berlin (3.5 million inhabitants), 55 001 asylum seekers were registered in 2015, 16 889 in 2016 and 8285 in 2017. At 30 June 2018, 3771 asylum seekers were registered.

This spike in arrivals of refugees and migrants in 2015 and 2016 posed an unprecedented challenge for the European and German health-care systems, which were mostly insufficiently prepared *(6)*. Within an exceptionally short time frame, additional professional medical resources had to be put in place across Germany. This essential yet complex task was not always successfully implemented in every German region, city and local authority at the outset.

Fig. 25.1. Applications for asylum in Germany from 2000 to February 2019



Notes: first application, dark blue; follow-up application, light blue; numbers over bars are the total numbers.

Source: Federal Office for Migration and Refugees, 2019 *(5)*.

Developing a health-care structure for refugees and migrants: from initial response to lasting concepts

Many asylum seekers were not only exhausted when they arrived in Germany but also ill and in need of immediate access to health care despite being unregistered. The health screening of all asylum seekers is a legal requirement and working structures had to be set up quickly. During the refugee and migrant influx in 2015 and 2016, the initial response could only come from existing health-care structures, which, normally, would only be accessible to people in possession of the relevant documents or who have been registered. The inability of existing public health structures to cope with such an unprecedented situation was overcome by using volunteers – who were initially unorganized – and through existing health-care organizations, which did not wait for an official mandate to begin providing health care in what was a rather chaotic situation.

Charité – Universitätsmedizin Berlin (referred to here as Charité), a public hospital belonging to the state of Berlin and Europe's largest university clinic, became involved because it was felt that the size of the organization, the motivation of its employees and its ability to put the required structures in place would enable it to serve refugee and migrant patients outside the hospital buildings. Despite being a public hospital, it did not inform the state of Berlin, or any other public authority, before launching medical activities in refugee shelters. Following this self-appointed activity, Charité was asked by the public authorities to extend its support and for its staff to help at other sites. Once the initial crisis had passed and the authorities were better able to respond, new solutions were found to improve the vaccination coverage and mental health care coverage for refugees and migrants.

By early summer 2015, it had become clear that a sizeable proportion of refugees and migrants were showing significant psychological symptoms as a consequence of the traumatic and stressful events they had experienced in their home countries, during their journey and in their first few months in Germany *(7)*. As a result, the provision of additional mental health services became mandatory, which led to the establishment of a central clearing clinic,

a port of call for all refugees and migrants in Berlin needing psychosocial support. This mental health clinic began operating in February 2016 and is discussed later in this chapter.

At the same time, Charité established the health screening centre for all arriving asylum seekers, which was housed in a building together with the authorities involved in the initial registration process. The screening centre came into operation in March 2016, by which time the number of new arrivals had already begun to fall. In addition, vaccinations for all asylum seekers became an integrated step in the initial medical screening process, and, shortly afterwards, this was complemented by a mobile vaccination programme. This aimed to reach all refugees and migrants who had arrived before the first refugee medical screening centre existed in Berlin and who may have had to manage without the required vaccinations. A vaccination shuttle was established, which took refugees from their residence to the medical screening centre. The vaccination shuttle was replaced by the vaccination bus, a mobile medical practice offering vaccinations and examinations that can be parked near the refugee accommodation.

All these activities were planned and gradually implemented by Charité at a time when the need to provide health care for refugees and migrants was combined with an unprepared public health system. The structures created for the medical care of refugees and migrants will be briefly presented in terms of (i) the establishment of basic health-care structures within a short time frame, (ii) a solution for central mental health services, (iii) the organization of the required initial health screening and (iv) innovative mobile health-care solutions. These will be evaluated for their effectiveness, subsequent results and implications for health diplomacy.

Acute response: establishing clinics in emergency refugee shelters

Medical contact points were gradually established at various locations throughout Berlin in order to treat acute diseases affecting the initially high number of refugees and migrants in the city. At first, and mainly with the help of volunteers, these contact points were set up in emergency shelters and on the site of the State Office for Health and Social Affairs (Landesamt

für Gesundheit und Soziales, the authority responsible for asylum seekers). Because of the many donated items and medicines, the considerable need for medical care could be met, at least partially, through associations of local citizens, churches, various initiatives and volunteers over a significant period.

The medical care crisis deepened with the establishment of every additional emergency shelter. In September 2015, Charité was the first hospital in Berlin to set up an outpatient clinic in an emergency shelter. This was initiated in the largest emergency shelter at the time, with more than 1700 residents, and the clinic was staffed six days a week by volunteer doctors from Charité (Fig. 25.2).

Items such as medicines, along with logistics services, were provided by Charité. Also in September 2015, another outpatient clinic was set up in an emergency shelter for 1000 residents in the Berlin Olympic Centre gymnasiums in the district of Wilmersdorf. This shelter served as a hub in which almost all incoming refugees and migrants were accommodated at short notice, before being transferred to other accommodation after two or three days. Owing to the large number of ill and exhausted people, this outpatient clinic was initially staffed in two shifts and staffed at weekends with the help of volunteers.

Both clinics were established solely in agreement with the private operating companies running the shelters. At the time, Charité was not expecting to receive a formal appointment from the State Office for Health and Social Affairs. When establishing clinics in refugee shelters, Charité had begun operating without a mandate from any official institution or public authority. Charité employees helped as volunteers, albeit with the full support of the hospital management and with the reassurance that all the hours worked in refugee health would be counted as working hours.

In November 2015, two months after the first clinic was opened, Charité received a request from the State Office for Health and Social Affairs to open a clinic on the State Office's own premises, adjacent to the registration building. This was Charité's first formal appointment and resulted from the fact that the large number of volunteer doctors, midwives, dentists and other medical staff, together with interpreters from diverse backgrounds and other volunteers, clearly lacked the necessary organizational structures and consistent functioning processes. Charité faced, and subsequently solved, the challenge of establishing a mixed organizational structure consisting of Charité-employed staff together with volunteers, whose previous work was acknowledged by including them in Charité's professional team. Doctors

Fig. 25.2. Charité medical staff screen and vaccinate a refugee family

from the German armed forces (Bundeswehr) were also part of the team. Altogether, every day, over 100 patients of all ages were examined, treated and vaccinated until December 2016.

In hindsight, it is clear that quickly establishing outpatient clinics in the largest emergency shelters was a significant step, as all the unregistered residents of these shelters had no other access to medical care. Outpatient clinics located in shelters relieved the pressure on hospitals, panel doctors and emergency medical services. Other hospitals and aid organizations joined in, opening more outpatient clinics in emergency shelters, which were able to ensure an increasingly stable basic service provision on-site with their own staff, organization, materials and logistics.

Providing mental health services for refugees and migrants

From the very beginning, psychologists and psychiatrists from Charité offered consultations in three of the outpatient clinics. Based on the experiences gathered in the clinics and in the psychiatric departments involved, the

concept of a central clearing clinic to provide mental health-care services was developed. The basic idea was to provide a mental health assessment within 14 days and to refer the patient to a social worker, an immediate intervention or an external expert intervention. In order to achieve this, the central clearing clinic addressed four barriers that had been identified as critical.

Language barriers. Professional interpreting is key in mental health care. It is the prerequisite for a professional relationship between the therapist and the patient. Given the fact that the refugee and migrant population in Berlin was highly diverse, the issue of interpreting needed to be addressed innovatively. To this end, a complex interpreting system was used based on four interlinked approaches, including doctors with Arabic language competence, two permanently available interpreters for Farsi, on-demand interpreters for the less frequently requested languages and an online system where trained interpreters were consulted in the treatment room via a videoconference link, available on demand and within minutes.

Cultural and stigma barriers. Psychologists and psychiatrists working in the central clearing clinic were either experienced and trained in transcultural psychiatry or were from the same cultural background as the majority of refugees (mainly Arabic). This reduced the cultural distance between professionals and patients, making it easier for patients to make contact with doctors and psychologists. In addition, the location of the clinic, at a central site away from their own shelter, allowed those in need to seek help without anyone else in the shelter knowing.

Resource barriers. Services of the central clearing clinic were provided from the very beginning to all refugees and migrants, regardless of their place of residence, their health insurance status or their residence or asylum status. In order to manage psychosocial demands, the clinic was sufficiently staffed by three full-time psychiatrists (two psychiatrists dealing with adults and one dealing with children and adolescents).

Knowledge barriers. Many patients lack knowledge about the causes and consequences of stress and trauma; equally, knowledge about cultural differences is often not widespread among staff. Staff members in the clinic conducted regular awareness-training workshops for patients suffering from stress or trauma-related symptoms.

The central clearing clinic came into operation in February 2016 located near the State Office for Health and Social Affairs and in the same building as the physical outpatient clinic for refugees. The central clearing clinic acts as a contact point for all types of mental health issue. As well as a careful, initial diagnostic assessment, short interventions and group therapies can be offered. However, the focus has been on transferring all patients needing treatment to appropriate psychiatric care structures close to the shelters. This coordinating role of the central clearing clinic enables more patients to be treated individually in facilities throughout the city that specialize in the treatment of refugees. On average, the central clearing clinic received between 300 and 350 patient contacts a month up to summer 2018.

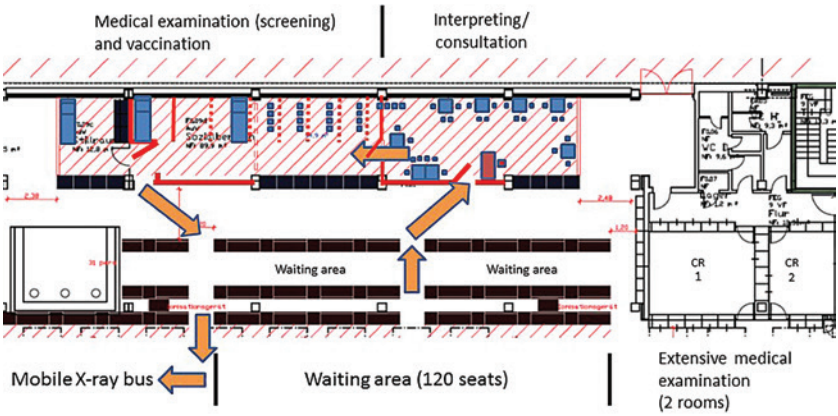
Initial health screening and TB screening

The Asylum Act requires that asylum seekers undergo an initial health screening at the start of the asylum admission process in order to reduce the risk of disease spread, for example in mass housing. For the same reason, the Infection Protection Act provides for screening to rule out any risks from undiagnosed TB.

Ideally, screening and investigations take place as part of the initial registration process, immediately after the asylum seeker's arrival. In Berlin, this could only be achieved following the completion of the central arrival centre, where the administrative functions of the initial registration process are located. The refugee health screening centre was established in the same building, in March 2016 (Fig. 25.3), and is where Charité carries out the initial health screening (on behalf of the State Office for Refugees) and the TB screening. The refugee health screening centre was set up to handle a capacity of 400 asylum seekers a day; however, the maximum number dealt with never exceeded 300 a day.

In the outpatient clinic (right-hand side in Fig. 25.3), sick refugees and migrants can be examined more closely in two consultation rooms if the patient's medical history or the signs or symptoms displayed in the initial screening indicate an acute or chronic illness. Extended diagnostic options are also available, such as electrocardiography, ultrasound scans and laboratory tests. For further diagnostic tests or treatment, patients are transferred to an

Fig. 25.3. Layout and examination process for the refugee health screening and vaccination centre in Berlin run by Charité



Note: CR: consultation room.

outpatient or inpatient clinic at the Charité hospital or to a hospital nearby for follow-up.

Following the health screening, refugees and migrants receive vaccination counselling as recommended by the Permanent Vaccine Commission (Ständige Impfkommission) at the Robert Koch Institute (the federal public health institute). Vaccinations then take place.

During the first part of the screening process, a medical history is taken for the initial screening, and vaccination information and consent – supported by interpreters – is obtained. A quick and comprehensive vaccination process was established by preparing the vaccination information and consent forms in 19 different languages, with five age groups for each language.

The medical history and vaccination information stage is followed by a physical screening and the administration of any missing vaccinations. As part of the integrated TB screening, pregnant women and adolescents under 15 years of age undergo a blood test along with a physical screening and an assessment of lymph node status. From the age of 16 years, thorax examination can be carried out in a special radiology bus. Once the medical examination has

been completed, the patient receives their full examination documentation (including a vaccination certificate) for their personal use, together with confirmation of the compulsory tests that enable them to proceed with the registration process.

Mobile solutions for preventive vaccination: the vaccination shuttle and the vaccination bus

A vaccination service for all newly arrived refugees and migrants was established in March 2016 with the launch of structured initial screening. For those who arrived before this date, Charité devised a method to make up for the missing initial screening and vaccinations. A bus shuttle service was launched that took refugees to the health screening centre for admission, including vaccination. In this way, initial screening, TB screening and missing vaccinations for approximately 11 000 refugees and migrants were carried out in just four months.

In order to reach all unvaccinated asylum seekers, a mobile solution was developed to transport medical staff into the shelters. A bus was converted by the German state railway operator Deutsche Bahn into a mobile medical practice (Fig. 25.4a), which proved to be the ideal solution. The bus was parked near refugee shelters and served throughout the day as a vaccination centre.

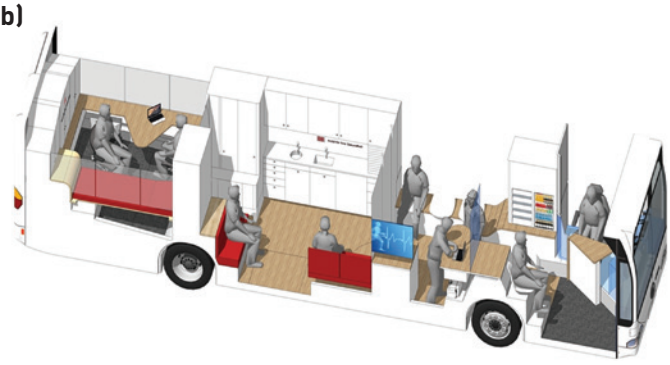
The bus is divided into three separate rooms (Fig. 25.4b). In the front part of the bus, a doctor carries out the medical briefing and patient history interview, using the online video interpreting system. In the middle room, vaccines are prepared and administered. In the rear of the bus, there is a protected screening area with an examination stretcher and a second access point for the online video interpreting system (Fig. 25.4c). It was crucial that the bus be equipped with an online video interpreting system to enable staff to quickly connect (within one or two minutes) to an interpreter for the most common languages spoken by the patients.

Using this mobile and easy-access service, more than 6300 refugees were reached. This benefited school pupils, for example, who could be vaccinated after school or on Saturdays in the bus parked near their shelter.

Fig. 25.4. A mobile solution for taking vaccination services to refugees and migrants in shelters. (a) The vaccination bus, originally developed as the medibus by Deutsche Bahn. (b) Interior view of the bus. (c) A medical consultation using the online video interpreting system inside the vaccination bus.

(a)

(b)



(c)

Conclusions for health diplomacy intelligence

Public health for refugees and migrants: from disarrangement to structure

Existing public health institutions in Berlin were insufficient to meet the needs of the high number of refugees and migrants arriving in 2015 and 2016. Initially, many remained unregistered for weeks and were, therefore, unable to access existing health-care providers. The health-care providers in Berlin had to act independently as there was a lack of coordination. Volunteers, including health-care workers, associations of citizens, churches, and welfare and social initiatives, began to develop an emergency response, such as provision of food supplies, shelter and rudimentary health structures. In terms of health, the early-response phase was driven mainly by individuals such as retired doctors and practitioners, and not by institutional health-care providers.

During this early phase, the state authorities were not very open to the idea of detailed discussions on the appropriate level of health care for asylum seekers. In fact, they were overburdened by the large number of refugees and migrants and were focused instead on building up their own administrative workforce rather than structures for health screening or refugee clinics.

During the second phase, this coordination vacuum was filled by major health-care providers, whose infrastructure, workforce and management enabled them to set up health-care structures even though they had not been mandated by the state authorities. Charité did not receive an official mandate to offer medical care for refugees and migrants beyond the hospital's premises even though there was clearly a need for this. Charité staff decided, at very short notice, to offer free medical care to refugees and migrants in the shelters without waiting for an official mandate. They decided to act because official institutions, at the time, were struggling to register and house the large number of incoming refugees and migrants.

Charité also began to highlight the fact that the existing structures were insufficient to fulfil the legal obligation to provide a medical examination for

all asylum seekers on arrival before they were allocated accommodation. This was also true for vaccinations, which Charité regarded as a necessary component of the first examination. As the state public health sector was unable to process such a high number of asylum seekers, Charité, as a state-owned public hospital, offered to step into the breach on behalf of the public health sector and establish the necessary structures to fulfil this obligation. It is worth mentioning that, at this stage, there was a remarkable openness towards new ideas such as the central clearing clinic for mental health services, although it was not a legal requirement and did not exist anywhere else in Germany.

Such willingness to provide health care beyond its legal obligations was, most likely, the result of trust between the authorities and Charité, a hospital that was effectively performing a dual role as a public health-care provider and an adviser. Trust also resulted from the fact that Charité began its activities on behalf of the state authorities even before any financial arrangements had been agreed. Subsequent remuneration and negotiations were characterized by transparency and a mutual understanding of each party's role.

During the third phase, hospital and other health-care providers received official appointments, contracts and payment for their services. In the case of Charité, this was a welcome development as up to 40 of its employees had been assigned to work with refugees and migrants outside the hospital's premises in clinics throughout the city of Berlin. Furthermore, payment was required to cover significant non-staff costs, for example vaccines and laboratory tests such as the those for TB screening.

Developing preventive care: when urgent need meets pragmatism

In the early phase of the refugee and migrant influx, there was no overview about which refugees and migrants had been vaccinated or who had been screened for TB. The mandatory health screening for refugees did not take place at all early on, and was only established on 1 March 2016. With this legal duty fulfilled, no further action was considered by the authorities, while medical staff felt it was necessary to catch up with the mandatory health screening and vaccination for all refugees and migrants who had arrived before 1 March 2016. With the

idea of sending mobile medical teams on the vaccination bus to more than 120 refugee shelters in Berlin, a very obvious solution was developed by a university hospital that had not offered public health services outside its hospital premises before, but which felt that public health meant reaching everyone in need – albeit in a rather chaotic context.

In addition, mental health-care services for people arriving in Berlin were required urgently. By using the central clearing clinic, Charité quickly established a structure that overcame the classic barriers of health-care provision and that enabled people in need to seek help that was difficult to access in the standard German health system. Meanwhile, the central clearing clinic handles between 300 and 350 contacts a month and has been proven to be a tool to overcome those high barriers and thereby provide immediate access to psychiatric specialists. This service is also regarded as a model for other vulnerable groups requiring easy access to mental health specialists.

The operational context for establishing public health access points for refugees in 2015 and 2016 was challenging. However, it provided stakeholders with a rare opportunity to establish new solutions quickly, which would otherwise have involved time-consuming considerations and negotiations with numerous actors in a health system that, in many respects, is regarded as overregulated. While, on the one hand, the health system appeared paralysed and unable to respond immediately to the high number of arriving asylum seekers, on the other hand, a wider range of actors found solutions, which, under normal circumstances, would have been outside their official role. Interestingly, actors from different backgrounds found themselves in unexpected roles and working in new alliances. For example, health professionals from Charité worked with military doctors, freelance midwives, dentists, social workers and volunteer interpreters – all working on the same corridor in the newly established refugee and migrant clinic near the asylum seeker registration centre.

Under normal circumstances, the German Constitution would not allow military doctors to work in a civilian mandate in the domestic territory, neither would health legislation allow university hospitals to open outpatient clinics at locations in the city other than at the hospitals' own premises. The health diplomacy approach resulted in an improvement in refugee and migrant health care as different institutions identified their role and potential contribution individually

and in agreement with other institutions, without involving the existing frameworks for collaboration.

Overall, crises create opportunities; public health strategies can be developed with the involvement of institutions and individuals who would otherwise not have become so deeply involved in public health issues.

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World Health Organization
Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int