World Health Organization

REGIONAL OFFICE FOR Europe

Background document

For the High-level Meeting on Health and Migration in the WHO European Region
17–18 March 2022

Jointly shaping the vision for the health of refugees and migrants

Abstract

The Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region 2016–2022 was adopted in 2016 by the WHO Regional Committee for Europe. In March 2022, a high-level meeting will discuss strategic priorities for moving beyond 2022. This background document will support discussions at this meeting. It outlines the current status and determinants of refugee and migrant health in the Region, the policy background, progress and achievements to date against key indicators, and the critical gaps that remain. Five salient lessons are identified to help in charting a vision for health and migration beyond 2022 that is inclusive, comprehensive and collaborative, and aligned with existing international global health frameworks and mechanisms. Five pillars of action are proposed: ensure refugees and migrants benefit from universal health coverage; implement inclusive emergency and disaster risk reduction policies; develop inclusive environments that promote social inclusion, health and well-being; strengthen migration health governance and data-driven policy-making; and explore innovative ways of working and develop partnerships as an enabling tool.

Keywords

MIGRATION

DISPLACEMENT

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Abbreviations and acronyms

EPW	the European Programme of Work 2020–2025
EU	European Union
GCM	Global Compact on Safe, Orderly and Regular Migration
GPW 13	Thirteenth General Programme of Work
IHR	International Health Regulations 2005
IOM	International Organization for Migration
IPCC	Intergovernmental Panel on Climate Change
MIPEX	Migration Integration Policy Index
NCDs	noncommunicable diseases
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
PHAME	Public Health Aspects of Migration Programme
SDG	Sustainable Development Goal
TB	tuberculosis
UHC	universal health coverage
UNDESA	United Nations Department of Economic and Social Affairs
UNHCR	United Nations High Commissioner for Refugees

1. Introduction, scope and objectives

Human mobility has been, and will continue to be, a fundamental aspect of our societies *(1,2)*. By the end of 2020, there were almost 281 million international migrants living outside their country of origin globally, with 101 million, 22 million and 47 million residing in the WHO European, African and Eastern Mediterranean Regions, respectively *(3)*. Intraregional migration constitutes a significant portion of international migration; for example, most migrants emigrating from countries in Europe or Africa remain within their region of origin, migrating to neighbouring countries *(4)*. Globally, over 89 million people were living in displacement in 2020, including refugees, asylum seekers and internally displaced people *(4)*. The movement of people into and within the WHO European Region will continue into the foreseeable future *(5)*.

Health is a vital dimension of global, regional and national policy responses. The public health aspects of migration have been on the agenda of the WHO Regional Office for Europe for many years, supporting Member States and other stakeholders in advocating for and promoting the health of refugees and migrants in the Region. In recognition of the need for a framework for a consolidated and coordinated response and to help to guide progress on the health aspects of migration, the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region (Strategy and Action Plan) was adopted in September 2016 for the period until 2022 *(6)* and has guided the WHO Regional Office for Europe and Member States in their work to address health and migration over the last several years. This sits within a broader global policy framework on refugee and migrant health, notably Promoting the health of refugees and migrants: draft global action plan, 2019–2023 (GAP) *(7)*, the World Health Assembly resolution WHA70.15 on promoting the health of refugees and migrants, the Global Compact on Refugees and the Global Compact on Safe, Orderly and Regular Migration (GCM).

A high-level meeting will be held in March 2022 to consolidate progress to date, generate political leadership and momentum and strengthen critical partnerships for health and migration. Building on the achievements and the lessons learned during implementation of the Strategy and Action Plan, the meeting will look to agree on new and emerging priorities for health and migration moving forward in the context of the WHO Thirteenth General Programme of Work (GPW 13), the European Programme of Work 2020–2025 (EPW) and the continuing COVID-19 pandemic. It will also further explore new modalities of work and outline the parameters and guiding principles for collaborative action on refugee and migrant health for 2022 and beyond.

This background document serves as a starting point to progress discussions among government ministries and their technical focal points for health and migration during this high-level meeting. The document will begin with a reflection and overview of health and migration in the WHO European Region[1] over recent years, particularly since 2015 with the development of the Strategy and Action Plan, and will provide an overview of the implementation of the plan to date. This section will also highlight the impact of the current COVID-19 pandemic on the health of refugees and migrants, and the potential

[1] This document has tried to capture an overview of health and migration as it pertains to all 53 Member States of the WHO European Region. However, as literature in Russian was not utilized, many of the references focus on countries of the European Union and Council of Europe area.

implications for a future agenda in the Region. It will then discuss five key lessons for a common vision for health and migration and conclude by putting forward five pillars of action proposed as priority areas going forward.

It should be noted from the outset that the scope of this paper is largely on international migration, reflecting the existing mandate of the WHO Regional Office for Europe's Migration and Health Programme. The paper uses the term refugees and migrants to refer to international migrants including refugees, asylum seekers, irregular migrants and labour migrants, unless one specific subgroup is intended. It is beyond the scope of this paper to address issues pertaining to all migrant typologies, such as internally displaced or stateless people. The Programme does emphasize that many of the areas for action are nevertheless also relevant to these groups.

2. Taking stock: policy background

Migration has been a fundamental aspect of European society throughout history and will continue to be in the future. It is a core part of to the sociocultural, civic–political and economic vitality of the Region, and refugees and migrants contribute to their home and host communities in countless ways *(8)*. The health of refugees and migrants, and indeed the health aspects of migration and displacement, are crucial public health issues faced by all governments and societies in an increasingly globalized world *(9)*. The recognition of this, and the multidimensional aspects of migration and development more broadly, paved the way for the resolution WHA61.17 on the health of migrants, which was endorsed by the Sixty-first World Health Assembly in 2008 *(9,10)*. The resolution called for Member States to promote migrant-sensitive health policies and inclusive access to health care, and it requested that WHO advance interagency, international and interregional cooperation on health and migration *(10)*. It was grounded in the understanding that approaches to managing the health aspects of migration and displacement were not keeping up with increasing volume, speed and diversity of global patterns of mobility, nor were they able to sufficiently address existing health inequalities or fully meet refugees' and migrants' right to health *(9)*. The global economic crisis at the time also generated further concerns about the living and working conditions of refugees and migrants and their general well-being *(9)*.

Guided by the action points of the Resolution, WHO together with the International Organization for Migration (IOM) and the Government of Spain organized a global consultation on the health of migrants in 2010, which brought together participants from all geographical regions, representing various sectors of government, nongovernmental organizations (NGOs), international organizations, regional institutions and civil society, including professional and migrant associations *(9)*. The consultation aimed to identify key gaps and priority areas, creating the foundations for an operational framework to help to coordinate and harmonize actions to improve the health of migrants *(9)*. Priorities and actions included in the framework related to monitoring the health of refugees and migrants; improving policy and legal standards; enhancing refugee- and migrant-sensitive health systems; and establishing partnerships, networks and multicountry frameworks *(9)*.

In 2010 the WHO Regional Office for Europe received a clear mandate from Member States to work closely with health and foreign ministries in the Region to establish policy links and better consider the health diplomacy implications of refugee and migrant health *(2)*. The 60th session of the WHO Regional Committee for Europe in 2010 approved the resolution on health in foreign policy and development cooperation: public health is global health. This paved the way for increased integration of global health in foreign policy and development cooperation in the Region *(2)*, which is understood as being a key

prerequisite for the interpretation of health and migration in a broader context *(10)*. In 2012 the WHO Regional Office for Europe established the Public Health Aspects of Migration Programme (PHAME; now the Migration and Health Programme), taking a leading role in assisting Member States in promoting and protecting the health of refugees and migrants *(2)*.

Since then, global processes related to economics, development, trade and environmental degradation, as well as worsening conflicts, have continued to bring about complex and diverse flows of people across the globe and the WHO European Region alike. According to the United Nations Department of Economic and Social Affairs (UNDESA), the number of international migrants worldwide reached 281 million in 2020 *(8)*.[2] In the WHO European Region, international migrants accounted for more than 13% of the population *(8)*. At the end of 2020, the United Nations High Commissioner for Refugees (UNHCR) recorded 82.4 million forcibly displaced people worldwide (of which 11.2 million were new displacements in 2020), including 26.4 million refugees, 4.1 million asylum seekers and 48.0 million internally displaced people *(11)*. In 2015 at the height of the so-called refugee crisis in the WHO European Region, over 1 million refugees and migrants entered the Region via the Mediterranean[3] alone, while more than 4000 were known to have died or were missing in transit *(12)*. At this time, migration and displacement were often seen as a crisis for transit and host countries, and the focus of intense political debate.

The sudden large influx of refugees and migrants around this period demonstrated clear deficiencies in asylum policy in the Region, and that the capacity of Member States to respond to the health needs of refugees and migrants had been stretched. In response to this situation, and to address the public health and health system aspects of migration and displacement, the WHO Regional Committee for Europe adopted the Strategy and Action Plan in 2016. The need for the development of durable solutions and increased resilience was also recognized by individual governments, other United Nations agencies and the European Union (EU) *(6)*. The EU has been a key driver for action on migration governance, continuing to reform the Common European Asylum System, establishing the European Agenda on Migration (2015–2020) and, more recently, the New Pact on Migration and Asylum.[4] A number of agencies act as implementing bodies, including the European Union Agency for Asylum (previously the European Asylum Support Office) and FRONTEX, the European Border and Coast Guard Agency. These legislative instruments, among others, are intended to achieve more effective and

[2] International migrants are defined by UNDESA as people living outside their country of birth or citizenship. The number of international migrants in 2020 increased to 281 million, from 173 million in 2000 and 221 million in 2010. These figures do not reflect any breakdown in immigration status or legal categories such as students, skilled migrants or refugees.

[3] Includes sea arrivals to Cyprus, Italy and Malta, and both sea and land arrivals to Greece and Spain, including the Canary Islands.

[4] The New Pact sets out a compulsory screening regulation applicable to persons entering the EU without fulfilling entry obligations including health checks at external EU borders. The Screening Regulation will also apply to people who, while not fulfilling the conditions for entry into the EU, request international protection during border checks, people brought ashore in search and rescue operations at sea and people apprehended within the territory if they have eluded controls at the external borders in the first place.

humane responses to migration and asylum, shaping the policy context and setting the scene for action on health and migration[5] in countries within and beyond the EU.

In calling for a renewed and strengthened vision for health and migration, the WHO Regional Office for Europe underscores that migration and displacement should no longer be approached as a crisis or series of emergencies, but rather should be considered as a structural phenomenon that will continue and that will demand sustained commitments and adaptive systems. As the Region continues to deal with and recover from the COVID-19 pandemic, and in light of the various other health, environmental and humanitarian situations presenting across the Region and globally, there is a need to change the discourse around migration. The years since the 2015 High-Level Meeting have served as a reminder that migration is not a distinct phenomenon or crisis, but an enduring and enriching part of our societies. People will always need to be on the move and if managed well and with respect to safety and dignity, migration stands to benefit all people *(13)*. Consequently, advocating for a more inclusive narrative and approach to health and migration is critical. This 2022 High-level Meeting is a key opportunity to build on achievements to date and look to addressing not only the short-term but also the longer-term public health challenges that are associated with the migratory cycle.

2.1 The Strategy and Action Plan

The WHO Regional Committee for Europe adopted the Strategy and Action Plan in 2016 to address refugee and migrant movements in the Region at the time and for the following years. It was based on resolution WHA61.17, the priorities and proposed actions from the first global consultation on the health of migrants, the Sustainable Development Goals (SDGs) and European health policy framework at the time, Health 2020. Planned as a framework for the period 2016–2022, the Strategy and Action Plan contained nine key strategic priority areas for action, as well as five core indicators for measuring and reporting on progress in its implementation *(1)*. A summary of the action areas and indicators are included in Annex 1.

Progress on the implementation of the Strategy and Action Plan at the country level have been captured and reported to the 68th (2018) and the 70th (2020) sessions of the WHO Regional Committee, and a final report is expected to be delivered at the 72nd session in 2022 *(6)*. Reports to date indicate that implementation is progressing, but that much work still remains. A summary of the second round of monitoring of the implementation of the Strategy and Action Plan (2020) is included below, based on the five indicators (see Annex 1). Monitoring was conducted using a questionnaire sent to all 53 Member States. Although 32 Member States completed the questionnaire, not all Member States responded to all questions.

Indicator 1: evaluating national health policies, strategies and plans. Over 80% of responding Member States (26 of 32) had at least one explicit component on migration and health in

[5] Through various instruments, not least the Council Directive 2013/33/EC Laying down standards for the reception of applicants for international protection (recast), the EU has also established minimum standards of health care for third-country nationals. In regard to asylum seekers, this includes access to emergency care, essential treatment of illnesses and serious mental disorders, and any necessary medical or other assistance to applicants that have special needs. However, entitlement of asylum seekers to health care depends on national legislation and, therefore, varies among Member States.

their national policy, strategy or plan. Access to health-care services and social protection were the main aspects addressed. Only one of the six Member States that did not have an explicit component had intentions to add one.

Indicator 2: evaluating the assessments of the health needs of refugees, asylum seekers and migrants. Just over half of responding Member States (17 of 31) had conducted at least one national or regional assessment on the health needs of refugees and migrants. Only five of the 14 that had not yet done so were planning to. Assessments mainly covered communicable diseases among refugees and migrants. Only 11 of the 31 responding Member States had conducted at least one assessment of health service coverage for refugees and migrants.

Indicator 3: evaluating contingency planning and preparedness. Just over half of responding Member States (19 of 32) reported developing a regional or national contingency plan for large arrivals of refugees and migrants. Of the 13 that did not have one, four had intentions to develop a contingency plan.

Indicator 4: evaluating health information and communication to prevent communicable diseases and reduce the risks posed by noncommunicable diseases (NCDs). Just over half of responding Member States (18 of 32) routinely collected and include data on migration-related variables in existing local, regional or national datasets. Main sources of data were medical or utilization records and health interview surveys. Of the 14 that did not conduct routine data collection, 10 had plans to start.

Indicator 5: evaluating social determinants of health. Only 34% responding Member States (11 of 32) had conducted at least one assessment to evaluate the social determinants of health among refugees and migrants. Only seven of the remaining 21 Member States had plans to conduct such an assessment.

Following the adoption of the Strategy and Action Plan, countries have worked together over recent years to take refugee and migrant health forward as a common goal through several resolutions, action plans and international frameworks *(14)*. In 2017 the Executive Board of WHO at its 140th session, and with the contribution of all WHO Regions, requested the development of a framework of priorities and guiding principles to promote the health of refugees and migrants. The Framework of Priorities and Guiding Principles was put forward for consideration at the Seventieth World Health Assembly *(15)*. The Framework served as the foundation for the development of the five-year WHO GAP, developed in close collaboration with Member States, the IOM, UNHCR, other partner organizations and relevant stakeholders, as well as refugee and migrant communities. The GAP was adopted in May 2019, with an overarching aim to achieve universal health coverage (UHC) and the highest attainable standard of health *(7)*. The Framework also informed the health-related components within the development of the Global Compact on Refugees and the GCM. The Global Compacts, negotiated in 2018–2019 with the involvement of WHO and adopted by the United Nations General Assembly, were important steps forward in strengthening governance for refugees and migrants. However, as non-binding instruments, they rely on adoption and effective implementation by Member States, which requires bringing refugee and migrant health into the mainstream *(2)*. The United Nations Network on Migration was established in 2018 to ensure effectively, timely and coordinated United Nations systemwide support to Member

States in their implementation, follow-up and review of the GCM. The negotiations for these documents underscore the importance of the tools of health diplomacy, multilateralism and interagency cooperation, which will be discussed in a later section.

The GPW 13 and the EPW, both working to deliver on the health-related goals of the SDGs, also recognize WHO's commitment to the health of refugee and migrants. The pillars of the GPW 13 are anchored in the SDGs and linked to the Triple Billion Targets for the health sector's contribution to the SDGs: one billion more people benefiting from UHC; one billion more people better protected from health emergencies; and one billion more people enjoying better health and well-being.

The Targets function as both a measurement for progress and as a policy strategy. The EPW, reflecting the WHO Regional Office for Europe's determination to strengthen the leadership of health authorities in the Region, shapes the Regional contribution to the GPW 13 and these global Targets *(16)*. It places a strong emphasis on addressing both health and social inequalities, both of which remain persistent challenges in the Region as they do globally. The core priorities of the EPW are also complemented by four Flagship Initiatives on mental health, digital health, immunization and promoting healthy behaviours *(16)*. They are intended as accelerators of change, mobilizing around critical issues that feature prominently on the agendas of Member States, and for which highly visible, high-level political commitment can be transformative *(16)*. Protecting the human right to health, serving the most vulnerable and leaving no one behind are key principles of the GPW 13 and EPW that cannot be achieved without a strong focus and commitment to refugee and migrant health.

2.2 Work on migration and health within the WHO Regional Office for Europe

The WHO Migration and Health Programme (previously PHAME), was established in 2011 as the first fully fledged WHO programme on migration *(2)*. The Programme works closely with other key stakeholders, particularly the IOM and UNHCR, to promote health as a core aspect of refugee and migration management. The IOM and WHO have worked in close collaboration for decades, including through a formal interagency memorandum of understanding since 1999, which was updated in January 2019. Since its establishment, the Programme has focused on leading Member States to develop capacity for durable and sustainable solutions. The programme works across four main areas.

- Policy development to progress the Strategy and Action Plan and support Member States to align national policies with commitments and obligations contained in regional and global compacts, frameworks and guidelines on refugee and migrant health, as outlined above.

- Technical assistance to conduct in-country work to support robust refugee- and migrant-sensitive health systems and develop contingency plans *(17)*. In collaboration with the IOM and UNHCR, the WHO Regional Office for Europe developed the first toolkit for assessing health system capacity to manage large arrivals of refugees, asylum seekers and migrants *(18)*.

- Advocacy and communication to promote joint action between countries, facilitating timely and transparent knowledge sharing, including on best practices, and engaging with civil society to increase awareness about the positive aspects of migration and counter xenophobia. The Knowledge Hub on Health and Migration – a joint effort between the WHO Regional Office for

Europe, the Ministry of Health of Italy, the Regional Health Council of Sicily and the European Commission – has been developed as a platform for governments, practitioners, researchers and civil society to engage in critical dialogue in this area. Through the Knowledge Hub, the programme has hosted numerous webinars, high-level summits and three summer schools on refugee and migrant health.

- Health information, research and training to develop competency across all relevant stakeholders and provide up-to-date and evidence-informed responses to public health and health system challenges. There are currently three WHO collaborating centres involved with health and migration in the Region,[6] serving as key technical and scientific resources.

3. Current situation as it relates to refugee and migrant health

3.1 Status and determinants of refugee and migrant health

Refugees and migrants are a diverse and heterogeneous group, facing varying challenges related to their health and well-being, and with different individual and particular health-care needs. An individual's health outcomes are often a result of an entire lifetime of risks and exposures, both harmful and protective, which may have occurred before, during or after migration, and health differences may appear different across the life course *(17)*. Consequently, it is also difficult to generalize findings about health status and such findings must be interpreted with caution. The health status of refugees and migrants is also not easy to discern, largely owing to fragmented data.

However, the available evidence shows that, overall, refugees and migrants are likely to have good general health, and many are often healthier than host populations, particularly during the initial period following migration *(17,19)*. However, as refugees and migrants spend longer in the country of destination, their health status tends to converge with that of the host population *(17)*.

Refugees and migrants can be more susceptible and vulnerable to infectious diseases through exposure to infections during migration and poor living conditions during migration, as well as lack of access to care or interrupted care. For example, in many countries in the Region, refugees and migrants experience an unequal burden of tuberculosis (TB), and multidrug-resistant TB is more prevalent among refugees and migrants than in host populations, linked to health system failures in terms of latent TB, late initiation of treatment and incomplete treatment courses *(17)*. Similarly, while migration itself is not a risk factor for HIV, migration and displacement may place people in situations that increase vulnerability to HIV, or worsen outcomes when infected *(20)*. A significant proportion of refugees and migrants living with HIV acquired infection after arriving in the Region, including those moving from countries with high HIV endemicity *(17)*. Refugees and migrants may also have lower uptake of immunizations depending on health system functioning in countries of origin, and low immunity to

[6] The three collaborating centres are the Department of Operational Medicine of the University of Pécs in Hungary (since 2017), the Public and Patient Involvement Research Unit at the University of Limerick (since 2019) and the National Institute for Health, Migration and Poverty of Italy (also since 2019, formalizing a long-standing cooperation between WHO and the Ministry of Health of Italy).

diseases circulating in transit or destination countries that they had not previously been exposed to *(17)*. Overall, these populations do not pose an increased risk for transmitting communicable diseases to host communities.

While prevalence rates for NCDs among refugees and migrants appear to be lower on arrival compared with host populations, prevalence rates tend to converge over time with longer duration of stay in the host country, especially for obesity *(17)*. Refugees and migrants in the Region also generally have higher incidence, prevalence and mortality for diabetes, as well as higher risk of ischaemic heart disease and stroke *(17)*. However, there are no clear patterns for cardiovascular diseases, and prevalence may be associated as much with socioeconomic factors as migration-specific factors *(17)*. Refugees and migrants have a lower risk for all neoplasms except cervical cancer; however, they are more likely to be diagnosed at a later stage in their disease than host populations *(17)*.

Prevalence of mental disorders in refugees and migrants shows considerable variation, and risk factors may be experienced during all phases of migration. Post-traumatic stress disorder and mood disorders such depression and anxiety are the most frequently reported conditions, mainly for refugees and recently arrived asylum seekers *(17)*. For migrant workers, conditions of employment vary drastically, as do the occupational hazards faced and their access to health and social protections. Male migrants experience significantly more work-related injuries than non-migrant workers *(17)*. For female refugees and migrants, there is a marked trend for worse pregnancy-related indicators, including maternal morbidity and mortality, postpartum depression and perinatal and neonatal mortality *(17,21)*. Women and girls are also overrepresented in high-risk migrant groups such as those who have experienced violence, including sexual and gender-based violence, or those who are victims of human trafficking, and they may be exposed to a range of specific dangers and health risks related to these circumstances, including for mental health *(17,22)*.

Care for chronic disorders and rehabilitation for disabilities are often the most pressing needs of refugee and migrant children, with dental issues the most common need for care *(23)*. They may also have increased vulnerability to diet-related health issues (both malnutrition and overweight/obesity), and migration is also a potential risk factor for mental disorders in children, especially for unaccompanied minors *(17,23)*. For older refugees and migrants, patterns of health and morbidity vary greatly according to a range of risk factors over the life course of the individual. However, whereas host populations may benefit from a delayed onset of morbidity to older ages (compression of morbidity), migrant populations may not benefit in the same way, contributing to growing differentials in health between older population groups *(24)*. Self-rated health, well-being and mental health status tend to be lower among older refugees and migrants than in host populations of similar age, with deterioration over time in the host country *(24)*.

The social determinants of health describe the conditions in which people are born, grow, live, work and age; they are major determinants of health for all people, and indeed bear the major responsibility for differences and inequalities in health across groups. The processes and exposures associated with migration and displacement can also be understood as key social determinants of health, which can place these populations at increased risk for poor health *(17,19)*. These include conditions experienced in countries of origin, during transit and after arrival, including their migration status (linked to their stage of migration and the outcome of asylum procedures), the policies that grant or deny access to health and social services, their living and working situations, and mechanisms for social inclusion *(19)*. Evidence suggests that the link between sociodemographic conditions is potentially stronger for

migrants than for native populations *(25)*. Therefore, while refugees and migrants should not be considered as separate to mainstream populations, the risks faced during and after migration mean they may have some additional and unique needs that receiving countries should be aware of.

In terms of entitlement and access to health care for refugees and migrants, there are significant discrepancies across the WHO European Region, and even within the national boundaries of some Member States *(17)*. Different countries not only stipulate different conditions for inclusion (largely based on migration status), but also the extent and level of care services provided, as well as whether any special exemptions are granted for certain conditions or services *(17)*. The Migration Integration Policy Index (MIPEX), which monitors policies affecting migrant integration across the globe, including in 34 Member States of the WHO European Region,[7] conducted a questionnaire in 2017 to measure and score the equitability of policies relating to entitlement and accessibility of health services, and responsiveness to migrants' needs. On the MIPEX scale, a score of 100 defines complete parity with nationals *(26)*. The 2017 questionnaire found that regarding legal entitlements and accounting for administrative barriers that make it difficult for migrants to actually obtain coverage, migrant workers scored 71, asylum seekers scored 60 and irregular migrants scored only 35. It is noted that in most of the Member States in the Region included in the survey, health service coverage for undocumented migrants was well below the standard required by international law, largely due to the widespread use of discretionary judgements and the emphasis on emergency rather than primary care *(26,27)*. Even where there are legal entitlements to care, differences and inequalities still exist in terms of accessibility.

Administrative requirements, knowledge of host country health system, cultural and linguistic differences, and discriminatory practices are all major barriers to utilization of care services *(17,25)*. A review of the MIPEX Health Strand in 34 Member States in the Region showed that countries differed greatly in efforts that were made to inform migrants about their rights to care and how to exercise them, as well as other measures to help them to find their way into care *(26)*. It found that health information is often meagre, inaccurate and/or poorly targeted *(27)*. Regarding accessibility, six countries require undocumented migrants who receive treatment to be reported to immigration authorities, while four may in principle apply sanctions to health workers who provide treatment *(27)*. In terms of responsiveness of services to migrants' needs, almost one quarter of countries scored zero, while only about half of all countries included have standards or guidelines for so-called culturally competent or diversity-sensitive care or relevant training programmes. Most countries do not involve migrants in health service delivery *(27)*.

In 2020, MIPEX was expanded to measure integration policies in 56 countries, including 39 countries of the WHO European Region. While many countries included across both studies showed improved scores related to health policies between 2015 and 2020, there remains considerable variation in the Region in terms of entitlements to health care among migrant groups (migrants with clear legal status, asylum seekers and undocumented migrants) and associated administrative requirements, availability of

[7] The MIPEX Health Strand is a collaborative project funded by the EU and co-developed by the IOM together with the EU research network European Cooperation in Science and Technology (COST) Action IS1103 ADAPT (Adapting European Health Systems to Diversity), the Migration Policy Group, and the Barcelona Centre for International Affairs. The project was carried out between 2013 and 2017 in 38 countries, including 34 countries in the WHO European Region.

information and support, as well as involvement of migrants in information provision, service design and delivery.

Recognizing the status of health and health-care access for refugees and migrants is essential to moving forward the agenda, and for laying out opportunities for action on health and migration into the future.

3.2 Impact of the COVID-19 pandemic on refugee and migrant health and the health and migration agenda in the Region

The COVID-19 pandemic and the situation still unfolding in the Region and across the globe has simultaneously highlighted and reinforced both how much human mobility has been an essential foundation of our societies and the precariousness and vulnerability of refugee and migrant populations to this day *(28)*. As the European Commissioner for Home Affairs Ylva Johansson stated, "the pandemic had a significant impact on migration and on migrants themselves who often played a vital role in the EU's response to COVID-19, while also facing disproportionate risks" *(29)*. While refugees and migrants face similar health threats from COVID-19 as their host population, the pandemic has exacerbated pre-existing vulnerabilities and generated new forms of vulnerability *(30)*. It has not only significantly impacted refugees and migrants in terms of health and livelihoods but also responses to the pandemic in many cases have compounded risks and further driven inequalities. Particular areas of concern relate to risk for SARS-CoV-2 infection, loss of income and exclusion from social support and welfare, as well as ability to move across borders and seek protection. These will be addressed further in a later section regarding public health emergencies.

It is yet to be fully seen what impact the COVID-19 pandemic may have on migration governance moving forward, or the health and migration agenda specifically. The pandemic has been observed to fuel the increasing hostility that surrounds migration debates. In many ways, the pandemic has strengthened the increasing problematization of migration and the toxic and misinformed political and public rhetoric around refugees and migrants as security threats and spreaders of infectious diseases, as well as exacerbating already high levels of discrimination and xenophobia *(31–33)*. There is also a risk to the level of ambition and capacity for countries in the Region to prioritize refugee and migrant health in the face of pressing national economic and health sector constraints *(34)*. It is conceivable that, while the world is occupied by COVID-19, the momentum to meet existing goals and obligations will fall behind.

In contrast to these negative aspects, the pandemic period has also seen public health and the well-being and protection of vulnerable populations at the forefront of discussions in multilateral fora, including among both WHO and EU agencies *(16)*. The political mandate for the EPW recognizes that the COVID-19 pandemic has hit the poor and most vulnerable severely and has exacerbated existing inequalities *(16)*. The pandemic also provided compelling insight regarding the critical role refugees and migrants have played in efforts to fight COVID-19 and to support health systems and communities more broadly. Refugees and migrants have been involved in response efforts in a myriad of ways, including working in essential and frontline service roles, working as cultural mediators and translators, and taking up other community support roles *(35)*. In particular, the pandemic has demonstrated how reliant the Region is on migrant workers, especially in essential sectors such as agriculture, domestic work and health care, including elder and home care. An EU Joint Research Centre publication in 2020 on migrant workers in the COVID-19 pandemic reported that migrants accounted for 13% of the essential workforce

in the EU *(36)*. In the health sector specifically, an assessment of the role of migrant workers across 31 European countries in 2020 by the Organisation for Economic Co-operation and Development (OECD) found that 23% of doctors and 14% of nurses were foreign born, and migrant women in particular constituted a significant proportion of the care sector *(37)*. In key cities such as London and Brussels, around half of all doctors and nurses are migrants *(37)*. Migrants also make up a large proportion of low-skilled occupations, where they constitute up to 25% of workers in capital regions *(37)*. At the same time, general restrictions on movement of refugees and migrants and their access to health and social services were seen, although some countries across the Region have also implemented specific measures and fast-tracked the movement of certain migrant groups as a means of addressing critical labour shortages.

The pandemic has also resulted in important acts of solidarity with refugees and migrants, and many governments in the Region have adopted inclusive and migrant-sensitive policies to respond to their needs and protect them in accordance with international law *(38)*. When a state of emergency was declared in Portugal in March 2020, the Government granted temporary residence to all migrants and asylum seekers whose residence permits were pending, and did so again in November 2020 when the second state of emergency was declared. This allowed these groups to access health care and to the public services critical during a global health crisis. Governments in Italy, Spain and other countries have also implemented mechanisms to extend residency permits and approve pathways for regularization of the status of migrant workers in key sectors, not only addressing employment insecurity and labour shortages but also working to prevent the spread of the virus. The United Kingdom announced that all migrants were eligible for the COVID-19 vaccine, regardless of whether they had the legal right to be in the country. Certainly, the pandemic has demonstrated important progress in terms of recognizing the needs of refugees and migrants and the vulnerable situation they are often forced into. It has also reinforced that protecting the health of mobile populations is also essential to ensuring the safety and well-being of the broader community.

This High-level Meeting, therefore, serves as a critical opportunity to bring together a coalition of the WHO Regional Offices for Europe, Africa and the Eastern Mediterranean, the EU, the Commonwealth of Independent States and other key regional stakeholders. It will reflect on these positive developments, reaffirm existing commitments and partnerships and build consensus on next steps. It will also be a key opportunity to mobilize political and public support to change the negative rhetoric around refugees and migrants and ensure that the COVID-19 pandemic and recovery efforts do not hamper international cooperation on refugee and migrant health. It is essential that health and migration remains high on national and international agendas as a shared priority across all sectors of government and society alike.

4. A fit-for-purpose approach to health and migration

To fully realize the potential of migration for thriving, healthy populations and an economy of well-being for all, there needs to be a renewed public health approach. Such an approach must be fit for purpose; build upon the experiences, achievements and lessons learned during the implementation of the Strategy and Action Plan; and be able to respond to the various challenges and opportunities facing the Region. It must also be aligned with global policies, strategies and guiding principles.

In collaboration with its informal advisory group, the WHO Regional Office for Europe has identified five salient lessons going forward. These are:

1. Working across sectors, and including the voices of refugees and migrants
2. Societal transformation and recognizing migration as an asset
3. Strengthening cooperation within a whole-of-route approach
4. Building on inclusive health systems that are people centred and refugee, migrant and gender sensitive
5. Recognizing One Health and its intersection with migration.

4.1 Working across sectors and including the voices of refugees and migrants

It is well established that health, disease and mortality are determined by complex interactions of various nonmedical social, political, economic and environmental conditions that generate health inequities *(19)*. The processes of migration and displacement themselves are also considered social determinants of health in so far as the health of refugees and migrants is greatly influenced by conditions experienced during the different phases of migration and their migration status, which determine access and entitlement to health care and the quality of care available *(19)*. It is essential that a social determinants of health approach underscores all future work and collaboration regarding refugee and migrant health. Critically, this also means adopting an intersectoral approach: a foundational principle that guides all of WHO's policies and programmes.

While the health and well-being of refugees and migrants is influenced by multiple sectors (such as home and foreign affairs, immigration, security, trade, justice, finance, social affairs and labour), policy-making on migration issues has typically been conducted in isolation and siloed within these sectors *(19,39)*. Moreover, policy-making on migration from these sectors has typically not included the health sector, nor routinely considered the health impacts or outcomes of such policies *(19)*. These sectors may have differing goals and these may even be incompatible with health goals *(19,39)*. The public health implications of migration are still widely considered as side-effects of population mobility that only call for ad hoc health interventions as required *(2)*. The risk of siloed approaches is that public health perspectives may be lost or subordinated to law enforcement or other considerations, with consequences for the health and social well-being of both refugees and migrants and of host communities *(2)*. The policy measures widely implemented across the Region during the COVID-19 pandemic have demonstrated that this remains an issue. While some Member States recognized the inextricable link between refugee and migrant health and public health, as well as the moral imperative for ensuring the human right to health, in other cases, unilateral and uncoordinated responses have negatively impacted health and well-being.

Overcoming these issues will require a whole-of-government and whole-of-society mindset and approach, one that facilitates the mainstreaming of migration into health governance and health into migration governance *(33)*. Such an encompassing approach will require alliance building and engagement of all key constituencies and stakeholders with a role or responsibility in tackling health and migration. A strong collective programme of action on health and migration will need to bring together health with non-health ministries across all levels of government as well as NGOs and civil society

organizations. Exploring ways to engage with other United Nations agencies, the European Commission and other relevant actors, not least through existing global and regional frameworks, is a priority. These actors include academic and research institutions, humanitarian organizations, the private sector, health and migration practitioners and, importantly, refugee, migrant and diaspora communities *(33)*. Refugees and migrants must be included in decision-making and programming efforts as their voices are crucial to identifying challenges and solutions for refugee and migrant health. Governments, NGOs and institutions will need to rethink the predominance of vertical structures and address the lack of susceptibility and commitment towards more horizontal and collaborative governance mechanisms *(2,40)*. It will be important for focus to be placed on shared responsibility for refugee and migrant health.

An intersectoral approach to health and migration will need to recognize that not only do non-health sectors greatly influence overall health and well-being but also that much of the information and services required to make informed and health-conducive choices may also be outside the realm of the health sector *(19)*. Therefore, it will be important to consider ways of adopting a Health in All Policies approach, one that focuses not just on public health policies but also on healthy public policies. Drawing on the Helsinki Statement on Health in All Policies, this approach is grounded in the intersectoral development of public policies that promote a social determinants of health approach, rather than merely public health policies, which may focus too narrowly on health care and/or disease management *(19)*. Health in all migration policies specifically should also be a focus in this context. Notably, stratification of responsibilities between various ministries and government agencies and suboptimal collaboration between them were noted by some Member States as reasons for failing to implement key actions under the Strategy and Action Plan *(5)*. Building alliances across key sectors is necessary to support effective health and migration governance *(33)*. WHO and its international partners, within their respective mandates, have a key role in supporting Member States in this regard.

A more holistic and integrated approach to refugee and migrant health care could also go some way to alleviating concerns regarding the development of migrant health services or even migrant-sensitive health programming, in terms of the risk of further (inadvertently) stigmatising or separating refugee and migrant populations *(33)*.

4.2 Societal transformation and recognizing migration as an asset

Migration offers significant positive social, economic, cultural, developmental and other benefits to the Member States of the WHO European Region and beyond. A strong and inclusive approach to health and migration recognizes this and understands that safe and inclusive migration is an overwhelmingly positive reality and an enormous asset for the Region *(4,13)*. Migration helps to strengthen social connections, expand transmission of knowledge and ideas and promote political engagement, among other important benefits. Refugees and migrants also have an overall net positive effect on economies of host countries, help to fill labour shortages and send remittances[8] to home communities (including

[8] Global international remittances totalled around US$ 702 billion in 2020, an increase from around US$ 128 billion in 2000 *(41)*. This is, however, likely to be underestimated as data do not capture unrecorded flows through formal or informal channels *(42)*. Remittances to Europe and central Asia totalled US$ 65 billion in 2019, and fell to approximately US$ 56 billion in 2020 owing to the COVID-19 pandemic and weak oil prices *(43,44)*. However, globally, remittances have stayed relatively resilient

within the WHO European Region), underscoring the influence of international migration on development outcomes *(32,42,45)*. Ensuring the health of refugees and migrants is an important part of realizing these benefits; populations in good health are better able to contribute socially and economically in their communities in both countries of origin and destination, promoting social integration and cohesion *(46,47)*.

The benefits of migration are equally relevant globally and in the context of the social and demographic transitions currently underway in the WHO European Region. Ageing populations, declining fertility rates and diverse migration flows are major drivers of the demographic shifts currently being experienced in part of the Region *(48)*. These distinct but intertwined phenomena have important implications for public health and well-being in the future, including refugee and migrant health.

An increasingly ageing population is currently being observed across much of the Region and other high-income countries around the world, largely owing to declining fertility rates and increased life expectancies. As such, the Region is seeing an increasing old-age dependency ratio; that is, the ratio of the population aged 65 years and over to the working population (15–64 years) *(48)*. The proportion of Europeans over the age of 65 is expected to be more than 20% in 2025, and around 30% in 2050 *(49,50)*. The WHO European Region is the only region in the world expected to experience a decline in population by 2050 *(48)*. While a decline in population growth in and of itself is not necessarily a negative phenomenon, there are significant economic, social and public health implications *(48,49)*.

Ageing populations mean shrinking labour forces and many countries in the Region will become more reliant on migrants to support their labour forces and sustain welfare models *(51)*. In this regard, immigration will become a necessity for many countries *(52)*. It is already apparent how reliant the WHO European Region is on migrant workers and the essential contribution thatrefugees and migrants make to our societies, including in health and long-term care sectors, which are expected to feel increasing pressure due to the ageing population in the years to come. In 2018 in the EU alone, there were almost two million long-term health-care workers working in a different country to that of birth, the majority originating either from other European countries or from north Africa and the Middle East *(53)*. As demographic changes continue to put pressure on labour markets, ensuring mechanisms to minimize health inequalities for migrant workers, including legal pathways for safe and dignified work, is essential. This has the potential to improve the health and wealth of refugees and migrants and broader host populations alike *(52)*. Ultimately, health is both a prerequisite and an outcome of safe and successful migration and integration *(51)*. In the context of continued population ageing in the Region, lack of such planning risks an exacerbation of existing inequalities and the expanding of an underclass of imported labour lacking social security or entitlements *(52)*. While not only a strictly demographic issue, ultimately migration will play a large part in ensuring future productivity and welfare in the Region and, consequently, there are very good economic, social and political reasons to support full provision of services to ensure the health and wealth of migrant populations *(51)*.

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throughout the COVID-19 pandemic, despite predictions of significant declines *(44)*. The largest recipient of remittances in the Region was Ukraine, largely from Czechia, Poland, the Russian Federation, the United States and the United Kingdom *(43)*. Kyrgyzstan, Tajikistan and Uzbekistan are other smaller remittance-dependent economies *(43)*.

It is important to note here too that better-regulated migration can help to support resilience and capacity-building in countries of both origin and arrival, including in the context of intraregional migration. For example, the EU New Pact on Migration and Asylum is part of a broader approach to not only develop legal pathways for those in need of protection but also to attract workforce talent to the EU. Critical shortages of skilled health professionals are a global challenge and must be factored into the global race for talent. There is an imperative to ensure that efforts to achieve UHC and improve health outcomes in migrant-origin countries are not undermined by the EU's active recruitment of health workers. Effective management of health worker migration, health capacity-building in migrant origin countries and skills and knowledge transfer should be considered when implementing recruitment strategies, policies and action plans. The WHO global code of practice on the international recruitment of health personnel *(54)*, the Global strategy on human resources for health: Workforce 2030 *(55)* and resolution WHA61.17 on the health of migrants *(10)* provide an evidence-informed framework to promote good practices and mitigate the negative global impacts associated with health workforce migration (so-called brain drain).

Finally, migration and ageing have intertwined trajectories, and migration adds an additional layer of complexity to the already great diversity in health and well-being in older populations in general *(26)*. Consequently, diversity-sensitive health-care policies and practices must seek to address the health and social needs of both older refugees and migrants who are newly arrived and those who have been settled in the Region for some time and are ageing in their new country *(26)*. While older adults do share a range of similar experiences and needs, refugee and migrant populations often have a different trajectory when ageing compared with majority populations, influenced by disadvantaged socioeconomic positions, long-term effects of traumatic experiences and different exposures to risk factors *(26)*. Responding to the needs of older refugees and migrants should be integrated into all dimensions of ageing policies and practices across the Region *(26)*.

4.3 Strengthen cooperation within a whole-of-route approach

While recognizing that health and migration governance is an issue of state sovereignty, the health and well-being of refugees and migrants as a transnational issue can only be addressed in a robust and sustainable way by building international solidarity and cooperation. The COVID-19 pandemic has seen many States look further inward and reconsider their interconnectedness and dependency on other countries, while at the same time the pandemic has underscored the futility of States trying to manage such issues on their own *(34)*. It has also demonstrated decisively that not only is the health of all people only as secure as the health of those most vulnerable among them but also that, despite restrictions, people will always need to migrate. This may be to escape insecure situations or to fill labour gaps in destination countries and reach occupational opportunities to be able to provide for themselves and their families. Migration will always remain essential, and international cooperation is necessary perhaps now more than ever to ensure the health and well-being of refugee and migrant populations and host populations alike, including in the context of prolonged border closures and travel restrictions. This will continue to be the case as we look to addressing global challenges such as climate change, future health and humanitarian emergencies and changing demographics. Single-country solutions will fall short in meeting regional and global commitments.

It is evident that the guiding principle that set the Strategy and Action Plan (and subsequent global compacts) in motion still holds: Member States need to work together in the spirit of international and

interagency cooperation to find effective ways to address health and migration. Member States in the WHO European Region must reaffirm commitments not only to intersectoral ways of working but also to whole-of-route ways of working that can address refugee and migrant health in countries of destination, transit and origin. In particular, there is a strategic need to look towards a coalition of the countries and the Regional Offices of Europe, Africa and the Eastern Mediterranean in order to better tackle current and future challenges. In addition to the regional commitments already set out in this document, the International Health Regulations 2005 (IHR)[9] provide a framework for promoting such cooperation to build capacities and health system resilience in this context.

Different stages of the migration trajectory present differing health needs and challenges involving different government and nongovernmental actors along the way. Interrupted care or immunization services in countries of origin may mean that refugees and migrants are vulnerable to different disease risks or stressors in transit and destination countries *(17)*. In transit settings, challenges may include hesitancy to seek and complete treatment if this might delay onward travel, as well as lack of consistent cross-border medical records *(17,56)*. In stages of arrival, limited time and resources have seen mental health and psychosocial support or treatment for chronic conditions often omitted where infectious diseases are prioritized and coordination between service providers is fragmented and chaotic *(56)*. In countries of destination, it has been reported that integration of refugees and migrants into national health systems can be difficult as they often lose the support (including financial) they may have received during previous phases and are expected to use mainstream services unassisted *(56)*. An interregional perspective focuses not just on provision of health care within the WHO European Region but also on preventing poor health outcomes for refugees and migrants en route to the Region, at borders and in closed settings where the risk to health of these populations is often increased. The health issues and challenges at each phase of migration do not present in isolation from the next, and coordination between actors across the entire migration trajectory is essential for meaningful health outcomes.

Whole-of-route approaches importantly do not only mean interregional collaboration but also intraregional collaboration. UNDESA reported in 2020 that the WHO European Region had the largest share of intraregional migration globally; according to the IOM, nearly 51% of international migrants living in Europe[10] in 2020 were intraregional migrants: born in Europe but living elsewhere in the Region *(4,8)*. Of the main migration corridors that include WHO European Member States, most are intraregional, representing significant flows of mobility *(42)*. Migration between the Russian Federation and former States of the Soviet Union, including Ukraine and countries in central Asia, represented

[9] The IHR, first adopted by the World Health Assembly in 1969 and last revised in 2005, provide an overarching international legal framework that defines countries' rights and obligations in handling public health events and emergencies that have the potential to cross borders. The IHR are legally binding on 196 countries, including the 194 WHO Member States.

[10] The composition of Europe used by the IOM differs from the totality of WHO European Member States. IOM data excludes countries of central and western Asia: Armenia, Azerbaijan, Cyprus, Georgia, Israel, Kazakhstan, Kyrgyzstan, Tajikistan, Turkey, Turkmenistan and Uzbekistan. As such, the proportion of intraregional migration (including between the EU and the wider WHO European Region) is underestimated.

some of the largest migration corridors[11] involving European countries in 2020. The eastern borders, western Balkan and Mediterranean routes are other key corridors into and within the Region *(42,57)*.

Intraregional migration has important implications for health care across the Region, especially regarding entitlements that exist for nationals within the EU[12] but which do not extend to other countries in the Region, including those along routes with increased migratory pressures across eastern Europe. Cross-border care for TB, for example remains a consistent challenge with high burdens of TB (including multidrug-resistant TB) in countries within the Region but outside the EU, such as countries in eastern Europe and central Asia *(17)*.[13] The WHO European Region has established a minimum package of cross-border TB control and care, with the aim of fostering whole-of-route coordination between EU and non-EU countries within and outside of the WHO European Region, protecting the right to health and continuity of care regardless of migration status *(17)*. Similarly, initiatives to ensure continuity of care for HIV, including access to antiretroviral therapies and harm-reduction interventions, are critical as migrants living with HIV have notably greater gaps along the HIV treatment cascade than non-migrants living with HIV *(20)*. Digital and portable health records are potentially a key intervention in this context *(20)*.

Systematic cooperation of this kind serves as a useful example and entry point for continued and strengthened intra- and interregional collaboration on refugee and migrant health. Other key opportunities include the provision and access to health care in transit countries, reciprocity of public health norms and standards between neighbouring countries, and improved cross-border continuity and portability of care with respect to immunization schedules. Careful information sharing, including cross-border surveillance data, is another aspect. As migration corridors and routes are generally well defined and predictable, strengthened engagement between Member States across the whole migration trajectory will be important. Cooperation across levels of levels of government is also critical in this context, particularly recognizing the role of cities and local municipalities in addressing the needs of refugees and migrants along migration routes *(13,60)*.

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[11] Calculated in terms of millions of migrants. It is important to note, as highlighted by the IOM, that Russian-born populations only became international migrants after the dissolution of the Soviet Union in 1991; prior to this, they were internal migrants within the Soviet Union *(42)*.

[12] The European Health Insurance Card, for example, is a free card that gives people access to medically necessary, State-provided health care during a temporary stay in any of the EU countries plus Iceland, Liechtenstein, Norway and Switzerland under the same conditions and at the same cost (free in some countries) as people insured in that country. The benefits covered include those provided in conjunction with chronic or existing illnesses as well as in conjunction with pregnancy and childbirth *(58)*.

[13] According to 2019 data, 83% of the estimated cases of TB in the Region occur in the 18 high-priority countries; here estimated TB incidence was 50 cases per 100 000 population, which was almost five times higher than the EU/European Economic Area average *(59)*. The six countries with the absolute highest number of incident TB cases were Kazakhstan, Romania, the Russian Federation, Turkey, Ukraine and Uzbekistan *(59)*. It is important to emphasize that all the high-priority countries in the Region have experienced a decline in TB incident rates during the period 2010–2019.

4.4 Building inclusive health systems that are people centred and refugee, migrant and gender sensitive

Recognizing that refugee and migrant populations are primarily rights holders under international human rights laws, the vision for a future agenda for action on health and migration must ensure an approach that is firmly grounded in universal human rights *(2,32)*. As for all people, refugees and migrants are equally entitled to the right to the highest attainable standard of health and to equal access to health care; they have rights to the underlying determinants of health such as non-discriminatory treatment and safe living and working conditions *(32)*. Upholding human rights and safeguarding the health and well-being of people in vulnerable situations are not only critical for meeting our commitments under the GPW 3 and EPW but go to the heart of equity, fairness, humanity and public health *(2,6)*. Capacity-building at the country level to implement rights-based approaches and to strengthen the ways in which health issues are considered by existing human rights mechanisms could be considered moving forward.

Enabling the full enjoyment of health care, however, does not stop at granting formal entitlements but also requires the existence of inclusive and non-discriminatory health services that ensure quality of care *(51)*. Although some vulnerable groups of refugees and migrants such as children and pregnant women often do have some exemptions from restrictions in many countries, barriers remain to accessing specialist care such as maternal and child health care, or mental health care *(56)*. Discrepancies between law and practice occur because of the complex processes involved in granting exemptions, unfamiliarity with legal issues and entitlements among health-care workers, and lack of information on rights and available services for refugees and migrants *(56)*. Institutional biases or discrimination based on race, gender, religion or other factors may still be prevalent. Health services must be prepared for and responsive to the particular and diverse needs of refugees and migrants under differing and demanding contexts. Policies must be in place to support non-discriminatory access to quality health services under UHC, irrespective of age, sex, gender, disability, race, ethnicity, country of origin, religion or economic or other ability to pay; to enable health practitioners to identify and manage health concerns related to processes of migration and displacement; and to minimize to the greatest extent possible the administrative, logistical, cultural, linguistic, gender-based and other barriers to care that refugees and migrants experience daily across the Region. Ultimately, a future agenda for health and migration should be focused on ensuring health policies and systems are inclusive, people centred and diversity and gender sensitive, working to enhance participation, build resilience and empower communities.

Intercultural competence and cultural sensitivity in health systems is an integral part of the provision of equitable and accessible health care *(17)*; this can be particularly evident in mental health care, where there may be a language barrier or poor understanding of cultural nuances by service providers and services such as talking therapies may be less effective. Despite this, basic services such as provision of interpreters and cultural mediators are still limited in many countries due to a lack of enabling policies and financial commitments *(56)*. Evidence shows that inclusive and migrant-sensitive health systems and interventions grounded in the right to health can not only reduce migration-related risks but also increase determinants of good health, including people's access and use of such services *(32)*.

Of particular note, health policies and systems need to work to better advance gender mainstreaming and apply a gender lens to needs analyses and public health programming at large, and in regard to

health and migration. Gender, like migration, is a key social determinant of health and has important intersections with migration. Not only does gender contribute to determinations of who migrates and the kinds of risks and opportunities that may emerge across the migration trajectory, migration also influences the individual and their perceptions of gender and social norms *(61)*. There are, therefore, important implications for health policy and provision of equitable care, including with respect to sexual and reproductive health care and rights *(17)*. Attention must also be paid to refugees and migrants with diverse sexual orientation, gender identity and sex characteristics, who consistently face an array of threats and challenges, including persecution from countries where same-sex relations are criminalized and the trauma associated with facing the burden of proof to justify asylum claims *(42)*. Issues around access to and provision of care should as much as possible also consider other cross-cutting factors that contribute to determining vulnerabilities and resilience. These include age, employment, education and level of integration *(17)*.

Critically, provision of refugee- and migrant-sensitive health systems does not mean parallel programming, but rather aims to reduce the barriers for refugees and migrants in accessing mainstream health services. This should be the primary goal. It is essential, therefore, that consideration of how these groups can be incorporated into broader global health strategies should be part of thinking about further collaborative action for refugee and migrant health: for example, on TB *(62,63)*, HIV/AIDS *(64)*, immunization *(65)*, sexual and reproductive health *(66)*, NCDs *(67,68)*, occupational health *(69)*, mental health *(70)*, and violence prevention, among others. This is not only critical to avoiding separate health and migration services but also fundamental to achieving the goals and targets outlined in those strategies *(2,71)*.

Policy-makers, service providers and civil society organizations have key roles to play in clarifying and harmonizing entitlements in line with human rights frameworks and in improving organization and coordination of services, minimizing barriers to access and increasing knowledge of service providers and refugees and migrants alike about care pathways. Greater collaboration among stakeholders, including with refugee and migrant communities, can help to enhance the cultural, linguistic, gender and religious sensibilities of health services and providers *(17)*. Building partnerships between research institutions in the Region and across the globe, including through WHO collaborating centres, will also go some way in developing the necessary resources and professional competencies in this regard.

4.5 Recognizing One Health and its intersection with migration

One Health is a concept and an approach that recognizes the interconnectedness of the health of people, animals, plants and their shared environment. It is not a new concept, and its relevance to migration and displacement is becoming increasingly recognized around the world, including in terms of the various hazards that may be faced along migration routes. For example, exposure of refugees and migrants around the world to antimicrobial resistance in transit and host countries due to conditions that favour the emergence of drug-resistant pathogens is a key issue *(72)*. A 2018 study among migrants in Europe found increased antibiotic resistance among refugees and asylum seekers, with evidence suggesting that drug-resistant organisms were being acquired during transit and in host countries in community settings with high numbers of migrants, such as refugee camps and detention facilities *(72)*. However, the study also found little evidence of any onward transmission of antimicrobial resistance from migrant to host populations *(72)*. The impacts of environmental contamination of wastewater in refugee camps in particular has also been discussed in terms of implications for drug resistance *(73)*. The

potential risk of zoonoses where there is close interaction between humans and animal populations and livestock is another example of the One Health dimensions of migration *(73–75)*.

In this context, anthropogenic climate change is a significant issue and one of the most pressing challenges currently faced by humankind, with significant implications for migration and public health globally, including within the WHO European Region *(76)*. The 2021 assessment report from the Intergovernmental Panel on Climate Change (IPCC) stated that each of the previous four decades had been successively warmer than any preceding decade since 1850 due to increases in greenhouse gas concentrations caused by human activities *(77)*. The last decade (2011–2020) was the warmest on record, with the global surface temperatures 1.09 °C (range, 0.95–1.20) higher than pre-industrial levels (1850–1900) *(77,78)*. The IPCC noted that global surface temperature will continue to increase until at least the middle of this century under all greenhouse gas emission scenarios considered, and unless deep reductions in emissions occur in the coming decades, warming of 1.5–2.0 °C will be exceed during this century *(77)*.[14] Such scenarios include drastic changes in the functioning of the environments in which people live, and the ecosystem goods and services upon which people's livelihoods and security depend, directly or indirectly leading to human mobility *(79,80)*. Examples of both slow- and rapid-onset impacts of anthropogenic climate change include changes in rainfall patterns, desertification, drought, ocean acidification and rising sea levels, saltwater intrusion, changing distribution in marine fisheries, soil degradation, storms, flooding, tropical cyclones and other disasters, and increased geographical and host spread of vector-borne diseases. Many of these impacts are expected to increase in both frequency and severity in the future, including in the WHO European Region where warming is increasing at a faster rate than global averages.[15]

As a form of adaptation to this and recognizing there may be limits to adaptation measures that can be taken in situ, significant changes in human mobility, both forced and voluntary, are anticipated and already occurring. Forecasts range from 25 million to 1 billion internal and international environmental

[14] According to the IPCC, global warming of 2 °C relative to 1850–1900 would be exceeded during the 21st century under the high and very-high greenhouse gas emissions scenarios. Global warming of 1.5 °C relative to 1850–1900 would be exceeded during the 21st century under the intermediate, high and very-high scenarios *(77)*.

[15] The WHO European Region is warming at a faster rate than the global average, as it has in previous decades, and is already grappling with the effects of climate change *(81)*. Key expected and already-emerging trends include increasing frequency and intensity of hot extremes in all parts of the Region, including maritime heatwaves and wildfires *(77,78)*; increasing agricultural and ecological drought across western and central Europe, the Mediterranean and central Asia; rising sea levels in all coastal areas (except the Baltic Sea) at a rate close to or exceeding global mean sea level increases; increasing frequency and intensity of extreme sea level events, leading to more coastal flooding and retreat of sandy shorelines *(77,82)*; increasing heavy precipitation with extreme precipitation and pluvial flooding projected to increase at global warming levels exceeding 1.5 °C in all regions except the Mediterranean *(77)*; and continued strong declines in glaciers, permafrost, snow cover extent and snow seasonal duration at high latitudes/altitudes *(77)*. Climate change is also altering ecological conditions, with some parts of the Region becoming more suitable for the transmission of certain infectious diseases *(78)*. The environmental suitability for the mosquito vector for dengue transmission, for example, increased by more than 40% in 2018 compared with the baseline of 1950–1954. Since 2015, the proportion of coastline in the Baltic Region suitable for transmission of the *Vibrio* bacteria, which can cause potentially fatal infections through direct exposure and gastroenteritis via consumption of contaminated seafood, has increased by 61% compared with the baseline of the 1980s *(78)*.

migrants[16] by the year 2050, reflecting both the difficulty to accurately predict future migration patterns as well as the magnitude and complexity of the challenge posed by climate change *(84,85)*. Not only will the climate emergency increase (typically involuntary) movements in response to extreme and rapid-onset climatic disasters such as floods, but also more (typically proactive) long-term migration due to slow-onset climatic changes such as drought, which can result in food and water insecurity, and the loss of environmental amenity and livelihood possibilities *(86,87)*. It is noted that slow-onset events are potentially more likely to induce increased migration than rapid-onset events because the latter deplete household resources more rapidly and so can constrain the capacity to migrate.

The importance of different macro-level conditions as mediators of climate-related migration and displacement should also be emphasized *(86)*. Climate change may exacerbate existing vulnerabilities and stressors (for example, inequality, poverty or conflict). and various economic, social and political factors can also reinforce or suppress migration as a response to climate shocks *(86,88)*. Agricultural dependency and income are two such examples that mediate the relationship between climate change and migration, noting that there is always a trade-off between the motivations to migrate and the resources required *(86)*. Indeed, climate-related migration is determined by both individuals' vulnerabilities (exposure and sensitivity to climatic shocks) and their capabilities (material and non-material resources and capacities to mitigate impacts) *(87)*.

Nevertheless, climate migration will occur in various ways, including forced displacement, planned migration and resettlement. It will also result in circumstances of immobility as some populations may become trapped or have minimal resources to move, leading to reduced rather than increased options for mobility. Each of these pathways have different implications for health and well-being depending on the climatic conditions and risks to which they are exposed. Major pathways through which climate change harms health include direct effects, such as from increased heat exposure, extreme weather events and pollution;[17] effects mediated through natural systems such as the patterns of distribution and transmission of vector-borne diseases, food and water security; and effects mediated through socioeconomic systems such as the health consequences of increased impoverishment, conflict over natural resources and, of course, migration *(90)*. Importantly, the health–climate–migration nexus does not only concern migration away from environmentally vulnerable sites but also into sites where climate change impacts have consequences for health *(91)*. Labour migrants moving to places impacted by high temperatures and risk for heat exposure is one example. In this way, climate change may amplify health risks for those that migrate largely for social, economic, political or other reasons *(91)*.

The impact of climate-related migration and displacement on health is complex and varied according to country and geographical contexts and the circumstances of migration and immobility. On one hand,

[16] The IOM defines an environmental migrant as a person or group of people who, predominately for reasons of sudden or progressive changes in the environment that adversely affect their lives or living conditions, are forced to leave their places of habitual residence, or choose to do so, either temporarily or permanently, and who move within or outside their country of origin or habitual residence *(83)*. Note: the definitions of environmental migrant or climate refugee are not legal categories, and there is currently no international agreement on a term to describe people who move for environment- or climate-related reasons *(83)*.

[17] Air pollution, a key contributor to climate change, is also a major health hazard in and of itself. It is estimated to have increased COVID-19 mortality by 19% in the WHO European Region *(89)*.

migrating to avoid extreme climatic hazards and depleted environments may improve health, such as through relieving nutritional stress or providing increased opportunities for health care *(92,93)*. In such cases, migration can increase human security and, therefore, constitute a form of health-seeking behaviour, also helping to reduce local vulnerabilities *(93)*. On the other hand, climate-related displacement may increase the risk of adverse health outcomes, particularly for more vulnerable groups such as children, older people and those suffering chronic illnesses *(93)*. This may include exposure to new infections for which migrants have little immunity, or other new climate-related health risks that present in transit and destination contexts *(92,94)*. Climate-related displacement can impact experiences of physical and mental trauma and stress; access to basic water, sanitation and hygiene services; and access to needed health care *(92,95)*. Overall, research suggests that the health risks posed by climate change and climate-related migration may become a key source of disability, morbidity and mortality *(93)*.

Important to note also is that according to available literature there is an important gender dimension to the climate–health–migration nexus, and women are generally understood to be more vulnerable to the health and other impacts of climate emergencies *(96)*. Climate change is expected to disproportionately affect women, who often have the least resources to adapt and manage risk, largely due to sociocultural factors and gender-specific norms in different contexts. Where the effects of climate emergencies will be most felt, women tend to be poorer, less educated, have lower health status and limited access to or ownership of resources *(97)*. Further to this, both the processes and outcomes of climate-related migration are likely to be gendered. Men tend to dominate temporary migration patterns, such as seasonal labour migration and certain flows of outward migration; women, children and elderly people tend to be left behind in environmentally vulnerable areas *(97,98)*. Some research, however, has also shown that male outward migration due to climate change can have some positive impacts, such as increased decision-making power and autonomy for women *(99)*. Importantly, gender is not the only aspect of inequity that influences the dynamics between climate change, health and migration. Vulnerabilities that may be exacerbated by age, class and ethnicity are also relevant considerations, and addressing these inequities from a broader social development perspective will go a long way to managing the impacts of climate change on health and migration.

Mechanisms and workplans on the intersection between climate change, health, migration and displacement are partially already in place, including WHO's work on climate change that is aligned with and supports the implementation of a range of regional and global policy commitments.[18] However, further work and strengthened engagement on climate change and the health aspects of climate migration are needed to fully meet the scope and gravity of the challenge. The urgency to act on climate change – and to include health and migration in related policies – was reiterated during the 2021 COP26 discussions, where the direct linkages between climate change, migration and health were highlighted. In acknowledging the intersections of human and environmental health, a One Health approach can help to advance more effective policy development in this area.

[18] Key policy commitments on climate change and health include the 2008 World Health Assembly resolution WHA61.19 on climate change and health *(100)*, the 2019 WHO Global Strategy on Health, Environment, and Climate Change *(101)*, the 2017 Declaration of the Sixth Ministerial Conference on Environment and Health *(102)* and the EPW *(16)*.

5. Pillars of action for moving forward in refugee and migrant health

Acknowledging these lessons, and in a rapidly changing and interconnected world, there is a need to better understand the challenges and opportunities facing the Region now and into the future. Achieving collective health and well-being and the SDG mantra of leaving no one behind is impossible if refugee and migrant populations continue to be excluded or restricted in their abilities and rights to enjoy the highest attainable standard of health *(103)*. A clear and common vision for health and migration post-2022 is needed. In collaboration with WHO headquarters and the WHO African and Mediterranean Regions, and supported though expert consultation with an informal advisory group, Member States, civil society, development partners, academia, and refugee and migrant groups, five transformative objectives or action pillars have emerged.

Action pillar 1: ensure refugees and migrants benefit from UHC regardless of migration status or level or health insurance.

Action pillar 2: implement inclusive emergency and disaster risk reduction policies and actions to increase resilience of refugee and migrant populations, bolster the preparedness of host countries and maintain safe cross-border mobility.

Action pillar 3: develop inclusive environments that promote social inclusion, health and well-being and reduce inequalities between people.

Action pillar 4: strengthen migration health governance, and evidence- and data-driven policy-making.

Action pillar 5: explore innovative ways of working to implement an ambitious future agenda and develop partnerships as a vital enabling tool.

These pillars of action reflect current gaps and future challenges for refugee and migrant health in the coming years, in line with the standing priorities of the EPW and its Flagship Initiatives, as well as the global priorities outlined in the GPW 13, the GAP and the SDGs. As a foundation principle of the Strategy and Action Plan, it is essential that future action on refugee and migrant health is situated within and closely aligned to these existing regional and global frameworks. Achieving the goals and targets set out under these instruments remains impossible if refugees and migrants are restricted in their abilities and rights to enjoy the highest attainable standard of health. The World Health Assembly resolution WHA70.15 and the two global compacts provide further parameters for ongoing collaborative action, as do existing regional commitments set out in the 68th session of the Regional Committee for Africa in 2018, the 66th session of the WHO Regional Committee for the Eastern Mediterranean in 2019 and the 66th session of the Regional Committee for Europe in 2016, with its European Strategy and Action Plan 2016–2022.

It will also be critical to ensure that mechanisms of monitoring, reporting and accountability are effective. The 2016–2022 Strategy and Action Plan includes indicators that are working well. Going forward it will be important that a future action plan has the same.

5.1 Action pillar 1: ensure refugees and migrants benefit from UHC

Throughout the WHO European Region, people expect their governments to secure their right to UHC. UHC means that all people and communities have universal access to quality health care, medicines and vaccines, without being exposed to financial hardship *(16)*. Importantly, UHC is about ensuring accessibility of existing mainstream systems for refugees and migrants rather than creating duplicate pathways to care. Moving towards UHC has been a long-standing priority of the global health agenda, captured within various regional and global frameworks and instruments, including as core priorities of the GPW 13, the EPW, the SDGs (SDG 3.8, achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all), the Framework of Priorities and Guiding Principles *(15)*, the GAP and the GCM, under which Member States have committed to ensure that all migrants, regardless of status, can exercise their human rights through safe access to basic services *(30)*. It is also enshrined in international law: the 1951 Refugee Convention and the 1966 International Covenant on Economic, Social and Cultural Rights both state that all individuals should have access to necessary health-care services regardless of legal status.

While in principle all Member States in the Region subscribe to the principles of UHC and recognize the right of every individual to the highest attainable standard of physical, mental and social well-being, in practice, not everyone has this universal access to quality care, or at least not without significant financial hardship. Political and financial sensitivities surrounding migration have a direct influence on how Member States define and prioritize target groups for UHC interventions. Non-citizens are often either overtly excluded or simply ignored in the application of UHC standards and commitments. Reports on achievements towards UHC at the country level in the Region demonstrate that refugee and migrant inclusion is still lacking *(103)*. As described above, restrictions and levels of entitlement for refugees and migrants do also vary considerably within the Region and are usually based on migration status. Asylum seekers and irregular migrants[19] generally have the strictest entitlement rules, for example, in some cases only receiving emergency care or in other cases requiring co-payments or residence in state accommodation *(17,104)*. Critically, where key services such as mental health care are only offered at secondary and tertiary levels (in most countries in the Region), those only entitled to primary and/or emergency care are left behind.

The impact of the COVID-19 pandemic on refugees and migrants highlights the importance of UHC, not only for the safety and well-being of these populations themselves but also for the broader population. While refugees and migrants do not constitute a threat to host populations, the conditions that may be experienced during travel and transit mean that denial of preventive and curative services, especially in an outbreak scenario, creates risks for all people. That there is no public health without refugee and migrant health has been demonstrated repeatedly over recent years. Ensuring that refugees and

[19] The IOM notes that a person's immigration status can be fluid and change quickly, arising from changing circumstances and policy settings. There are also many pathways to irregularity. For example, some may enter countries on valid visas, which come with certain entitlements to health and other services, but then stay in contravention of one or more visa conditions, such as overstaying the visa period or taking up employment where this is not permitted.

migrants are included in provision of UHC not only reduces risks for all people and communities, but also reduces pressure and costs to health systems *(103)*.

While the argument for restricting health care is usually that it is a financial burden for host countries, any short-term savings linked to limited access to preventive and curative care, including early diagnosis, are often lost within the greater costs for treatment for late presentation and emergency care *(17)*. It is indeed widely documented that providing basic health care for refugees and migrants is economically advantageous for host countries and generally results in both direct and indirect medical and nonmedical cost savings *(104)*. A study on the effect of restricting access to health care on health expenditures among asylum seekers and refugees over a 20-year period in one European country found the cost of excluding these groups from health services was ultimately higher than granting regular access to care *(105)*. Similarly, a report from the EU's Agency for Fundamental Rights estimated the economic cost of providing access to health care for irregular migrants compared with the cost of providing emergency treatment only *(90)*. It found that providing regular preventive care for this group would be cost-saving for governments *(90)*. This cost saving was also suggested to be underestimated since it only included costs incurred by the health system and did not quantify costs incurred by the patient or society at large *(90)*. Provision of primary health care to refugees and migrants reduces the risk of health conditions that could be treated cheaply and efficiently from progressing into complex and expensive illnesses *(46)*. A study using primary health-care provider data in four EU Member States as part of the IOM/European Commission Equi-Health project on fostering health provision for migrants, Roma and other vulnerable groups also found that timely treatment in a primary health-care setting was always cost-saving compared with treatment in a hospital or emergency setting *(51)*. It found that at least 49% and up to 100% of direct medical and nonmedical costs of hospitalization could be saved if timely primary health care is provided to those who would otherwise not be entitled *(51)*. Inequalities in health care lead to non-recourse or delayed recourse to care, negatively impacting individual and public health and increasing health system expenditure *(51)*. As noted in section 4, ensuring refugees and migrants benefit from UHC also has important broader benefits as people in good health are able to contribute socially and economically in their communities.

An inclusive approach must emphasize the integration of refugees and migrants into national health policies and health systems; service provision is central to a comprehensive public health response for these populations. Member States need to work to provide, within available resources and aligned to national legislation, access to essential and culturally sensitive health promotion and preventative, curative and palliative health care for all people must continue to be a priority, independent of migration status or level of health insurance. This includes for primary health care, mental health, sexual and reproductive health, and maternal and child health, as well as for management for chronic diseases and disabilities. As highlighted in the GAP, efforts to integrate HIV and TB services for refugees and migrants should be prioritized and are essential to fully achieve UHC *(7,20)*.

Immunization is also a core priority under UHC to ensure vaccination coverage is maximized among all population groups. Suboptimal immunity to various vaccine-preventable diseases among refugees and migrants in the Region has been observed, together with lower vaccination coverage of these groups compared with local host populations; this is often the result of disrupted vaccination services in countries of origin or transit *(106)*. Sustained efforts are needed to increase vaccination rates among refugees and migrants where required to protect them against these vaccine-preventable diseases, including catch-up vaccines according to national immunization schedules *(106)*. It should also be noted

that, as COVID-19 vaccines continue to be distributed around the Region, Member States must ensure that refugees and migrants are included in allocation plans, particularly low-income migrant workers, irregular migrants and those living in camps and camp-like settings; these have been identified as priority groups by SAGE (WHO's Strategic Advisory Group of Experts on Immunization) *(107,108)*. WHO confirmed that only one quarter of national vaccine plans submitted to COVAX (the COVID-19 Vaccines Global Access Facility) by March 2021 included refugee and migrant populations *(109)*. Administrative requirements such as identification documents and residency status have also been documented as significant barriers to equitable access to vaccines *(110–112)*.

Health screening of newly arrived refugees and migrants can potentially be an important tool for protecting the health of these groups and host populations alike. Screening can be a key opportunity to identify the health needs of refugees and migrants crossing borders, as well as any potential public health concerns. In line with the Strategy and Action Plan, the IHR and obligations to UHC, Member States should offer voluntary and non-discriminatory health screening processes that are non-invasive, risk specific and evidence informed. Screening should not be limited to infectious diseases but rather aim to identify also needs related to NCDs and chronic conditions, including related to mental health and sexual and reproductive health. Follow-up and care should also be in place. The purpose of screening must be to ensure the timely management of health issues rather than being utilized as a way to restrict any entitlement; it should be offered regardless of migration status or reason for migration. Therefore, where health screening and checks are conducted, including under the EU New Pact on Migration and Asylum adopted in September 2020, they should lead to treatment and offer pathways to integrate refugees and migrants into health systems under the principles of UHC and the right to health. When conducted appropriately, health screening and checks that serve the needs of refugees and migrants and facilitate pathways to care can be an important instrument in the UHC toolbox, reducing missed opportunities for diagnosis and treatment and optimizing resources.

The financing of health systems is a critical aspect of UHC, and Member States of the Region need to continue to improve health financing arrangements and mechanisms for refugees and migrants. There is a high degree of fragmentation regarding sources of health financing in arrival, transit and destination countries *(104)*. Some countries include these populations in existing social health insurance and taxation schemes, while others have instituted parallel ring-fenced financing schemes, in some cases relying on short-term funding from humanitarian agencies for NGOs *(104)*. Notably, even in tax-based health systems, and where there may be tiered levels of entitlements depending on migration status for example, the MIPEX Health Strand reports that even legal migrants may be excluded from coverage if their stay is not long term or permanent *(27)*. Insurance-based systems are also precarious for those migrants who become unemployed, and who must then finance their own health care at a time when they may be least able to do so *(27)*. Other States have simply restricted access to services on grounds of perceived financial burden as noted above *(104)*. Developing sustainable health financing mechanisms to cover access to UHC for refugees and migrants remains a key priority.

Financial risk-sharing at a Regional level, particularly in the context of sudden or large influxes of refugees and migrants, is another issue that warrants further consideration. While several mechanisms do currently exist in the WHO European Region to disperse funds, they generally offer retroactive solutions to support frontline emergency health services without adequately addressing the protracted nature of humanitarian situations or the protection of the right to health *(104)*. Recent policy solutions have also tended to focus on mitigating or diverting the costs of hosting refugees and migrants *(113)*.

There is a risk that decentralized and fragmented health financing mechanisms can lead to problems with equity, efficiency and transparency in resource distribution *(104)*.

5.1.1 Possible areas for collaboration

- Advocate for UHC as a means for protecting the health of all people, and meeting obligations under regional and global instruments.
- Support cross-border and interagency dialogue and collaboration of WHO European Member States to ensure quality and continuity of care of refugees and migrants.
- Strengthen country-level partnerships within governments to ensure a comprehensive legislative approach to refugee and migrant health as a complex issue that crosses ministries and portfolios. Ministries of health may be well placed to lead such initiatives, noting that health in migration is not easily tackled if handled in a siloed approach. A collaborative approach to health and migration represents mutual success for the health and social and economic outcomes of both refugee and migrant communities and host countries alike.
- Promote the use of frameworks such as cost–benefit analyses to help policy-makers and service providers to better understand the values of key policy objectives, including integration of refugees and migrants into national health and social protection systems within the Region *(114)*. Evidence-informed analysis and budgeting can help to make the case for investment in health that minimizes out-of-pocket expenses and reduces catastrophic expenditures on health.
- Ensure that where border health screenings are imposed, such as under the EU New Pact on Migration and Asylum,[20] they meet ethical and human rights standards, that practices are subject to public health evidence, quality assurance and periodic re-evaluation, and that refugees and migrants are integrated into national health systems on a non-discriminatory basis.
- Work to improve harmonization and systemization of practices in countries across the Region.
- Promote innovative health financing for health and migration to reduce financing gaps and burdens and encourage longer-term multiyear funding to allow for more predictable and sustainable programming at country and regional levels *(115)*.
- Support a collaborative effort to address the issue of supranational and regional health financing mechanisms for UHC at Regional level and find durable solutions for financial risk sharing. Such a solution should be responsive to future changes in the number and composition of refugees and migrants *(104)*.

[20] Note that the undertaking of medical examinations is subject to the relevant provisions set out in the IHR, not least Articles 23, 31, 42, 43 and 45.

5.2 Action pillar 2: implement inclusive health emergency and disaster risk reduction policies and actions

The COVID-19 pandemic has been a transformative experience for the WHO European Region and the world. It has confirmed the widespread consensus on the responsibility of health authorities to protect against health emergencies. The need for coordinated preparedness and prompt response to health emergencies is cemented as a core priority of the GPW 13 and the EPW.

As previously discussed, the pandemic has also highlighted that refugees and migrants are often among the more vulnerable during disasters and health emergencies. Studies in a number of OECD countries, for example, have found a risk for infection with SARS-CoV-2 among refugees and migrants that is at least twice as high as that of native-born populations *(116,117)*. In the early months of the pandemic, those countries in the Region that collected health data by country of birth reported that up to 42% of all those testing positive for SARS-CoV-2 were migrants *(118)*. This is still likely to be an underreporting of the situation *(118)*. Refugees and migrants have been overrepresented in COVID-19-related hospitalizations and deaths *(118)*. The pandemic has also greatly impacted the mental health of refugee and migrant groups. WHO's global survey of refugees and migrants that collected self-reports of the impact of the pandemic[21] found that a large proportion of participants reported a perceived worsening of mental health over the course of the pandemic, with those in insecure housing and living in asylum centres reporting the greatest decline *(31)*.

Although a person's vulnerability during and after emergencies is generally determined by the extent to which their rights, dignity and participation are guaranteed on a day-to-day basis, many refugees and migrants struggle to access the resources, services and opportunities needed to ensure their safety and well-being *(119)*. They may be physically and/or socially marginalized or in hard-to-reach settings; have limited knowledge of local hazards or access to information; have lack of trust in authorities and responders; and experience housing and livelihood insecurity, including poor working conditions *(30,119)*. Migrant workers particularly are disproportionately employed in high-risk and frontline roles in industries such as health care, construction, agriculture, agrofood processing and transport; they are, therefore, at increased risk of exposure to and contracting communicable diseases such as SARS-CoV-2 or influenza *(120)*.[22] Several outbreaks of SARS-CoV-2 infection have been reported among migrant workers in meat factories and other sectors where labour rights and conditions may be poor. Similarly, insecure housing and inadequate sanitation facilities undermine the ability of these groups to follow public health advice, including basic hygiene measures and physical distancing, as many live in close proximity *(38)*. Refugees and migrants are also overrepresented among the homeless in most Member

[21] The ApartTogether survey is the first global enquiry into the social impact of the COVID-19 pandemic on refugees and migrants. More than 30 000 participants from almost all WHO Member States responded to the survey between April and October 2020 *(31)*.

[22] Globally, migrant workers are also overrepresented in agricultural sectors such as poultry farming, where there is an increased likelihood for zoonotic spill over of infection to occur. If workers in these sectors are not reached by prevention services or epidemiological surveillance systems, they may represent a high-risk population for infectious disease outbreaks *(121)*. At a more global level, it is imperative to understand the linkages between formal and informal migration routes with networks of migrant labour in animal husbandry and related industries in order to develop evidence-informed policies that anticipate and prevent the emergence of novel zoonoses *(121)*.

States, a growing trend among certain EU Member States and border and transit countries particularly *(122).* Refugee camps are also a particular cause for concern. Many affected by humanitarian crises and seeking asylum live in camps or camp-like settings within or on the borders of the WHO European Region, including in detention, transit and identification centres. Such camps are often overcrowded and lack basic amenities such as running water and soap. Minimum public health measures, including routine testing and surveillance, have been impossible or extremely difficult to maintain, and outbreaks within these camp settings have been observed since the start of the pandemic *(117,123)*.

Despite being exposed to high-risk environments, including during health emergencies, refugees and migrants have remain marginalized within national health and social welfare systems across much of the Region *(121)*. Restricted entitlements, including access to health insurance, sick leave schemes or relief assistance for example, place people at great risk as they cannot afford to seek care or stay home from work *(20,38,120)*. The impacts of the economic downturn and loss of income that comes with working in often temporary, informal and casual labour sectors has impacted poverty rates among some groups, and diminished remittances to households in many low- and middle-income countries of origin *(20)*.

Lack of accessible risk and resilience information targeted to refugee and migrant populations is another significant vulnerability for these groups during emergencies. People need to know what health risks they face, and what they can do to protect themselves, their families and their communities *(124)*. Effective risk communication is also essential to building trust between the public and authorities *(124)*. However, a review of government-produced public health communications aimed at migrants during the COVID-19 pandemic across the 47 Council of Europe Member States found that only 23 had translated written online materials into at least three of their most common migrant languages by June 2020 *(125)*. Information on testing or health-care entitlements in common migrant languages was only found in three countries *(125)*. Of the 43 countries that had a government COVID-19 phone helpline, only nine offered access to the helpline in one of the three most common migrant languages *(125)*. The review also found that no Council of Europe member government had, by June 2020, produced risk communications targeted at people in refugee camps or informal settlements *(125)*. It is important to note, however, that in many cases NGOs have worked to fill these gaps and the WHO Regional Office for Europe also produced COVID-19-related communications in 42 languages. There is an essential need to focus on appropriate preventive health messaging and risk communication that is tailored to refugee and migrant populations, especially given their potential vulnerability during emergencies, with clear easily available information to help them to protect themselves and their communities.

Mobility and access to protection is another enduring aspect of health emergencies, and the global suspension of cross-border mobility across the Region and globally during the COVID-19 pandemic has left many refugees and migrants in incredibly vulnerable situations. In 2020 at least 168 countries globally closed or restricted cross-border travel, and mobility within and between countries still remains lower than pre-pandemic levels *(20)*. As early as March 2020 resettlement travel for refugees was also suspended apart from emergency cases *(126)*. Humanitarian corridors have been closed, and referrals under the Dublin Regulation suspended *(126)*. There has also been an alarming rise in the number of asylum seekers sent back to countries where they are at risk of persecution, an apparent breach of international law *(126)*. Furthermore, search and rescue operations in the Central Mediterranean, where more than 10 000 refugees and migrants died between 2015 and 2019, also ceased due to logistical difficulties caused by the pandemic *(126)*. People on the move have been forced to stay in cramped and makeshift shelters or detention centres without means for physical distancing or

appropriate hygiene. There have been reports that many have been unable or unwilling to seek care, even if symptomatic for COVID-19, due to fear of repercussions *(31)*. Lockdowns more broadly have also impacted the capacity of refugee and migrant groups in accessing resources such as essential services and social support networks. It is also important to note that there is a critical gender dimension in that female care and domestic workers are often employed in isolated workplaces and may be at increased risk of gender-based violence during times of restricted movements and stay-at-home restrictions.

Notably, according to the United Nations Office on Drugs and Crime, COVID-19-related restrictions have had a different impact on the smuggling of migrants fleeing conflict and persecution compared with other types of migration *(127)*. In 2020, for example, there was an increase of smuggling on the central Mediterranean route from Libya to Italy *(127)*. The closure of land, sea and air borders may generally have increased the smuggling of migrants because of the increased complexity of crossing borders, often resulting in the use of more risky routes and conditions and higher prices for services *(127)*. Human trafficking is another concern related to health emergencies, periods of economic downturn and increasing rates of unemployment *(128)*. As noted by the IOM, levels of mobility and patterns of movement during health emergencies are likely to become more localized, potentially being intensified through the creation of mobility corridors and travel bubbles *(128)*. There is, therefore, a risk of increased irregularity and greater costs to both migrants and Member States from migration during the health emergency *(128)*.

It is evident that there is no clear blueprint for maintaining safe cross-border mobility in circumstances of international health emergencies, such as COVID-19 *(128)*. It is also evident that refugees and migrants are largely missing from emergency preparedness plans such as pandemic preparedness plans, despite the impacts of such emergencies disproportionately affecting these populations. As the Region learns from the experiences of COVID-19 and works towards advancing the EPW, it is essential that refugee and migrant health is fully accounted for in preparedness and response toolkits. As the pressure of the pandemic response recedes, there will be an opportunity to ensure that emergency planners think about borders, mobility and the health and safety of migrant populations and also that migration managers think about outbreak emergencies.

Many of the lessons of the COVID-19 pandemic can and should also be applied to help to prepare for future emergencies, including environmental and humanitarian disasters and other disruptors that may impact the flow of refugees and migrants into and out of the WHO European Region. Over past decades, the Region has been affected by significant numbers of events that fall into the IHR category of potential public health emergencies of international concern, as well as other natural and human-induced disasters *(129)*. The responsibility to ensure the safety and security of all people within a territory in the face of emergencies and disasters, regardless of nationality or migration status, lies with Member States *(119)*. However, even where this is recognized (formally or informally), non-discrimination in terms of the delivery of emergency assistance often translates into so-called diversity-blind approaches, without adequate understanding of the specific barriers that different people face in such situations *(119)*. Refugees and migrants need to be fully considered and engaged within disaster risk reduction policies and activities and civil protection efforts in host and transit countries *(119,130)*. This consideration should extend to risk assessments, public health capacity-building, emergency communications systems and stress-tested preparedness, and contingency planning that makes provisions for (cross-border) continuity of care *(119,130,131)*. Provision of essential services must be considered in this context, including minimum initial service packages for sexual and reproductive health for women, minimum

care packages for cross-border TB control and care and mental health and psychosocial support. It is also essential to ensure that health screening and border checks, where required, remain effective and ethical during periods of disruption in all emergency situations. Separating immigration enforcement activities from service provision, including access to basic services, is an important measure in this context and a key recommendation of the 2021 biennial report on the implementation of the GCM with respect to COVID-19 response and recovery *(132)*. Importantly, however, efforts should not be limited to the provision of acute emergency services; rather the needs and capacities of refugees and migrants must be accounted for in all longer-term activities related to disaster prevention and recovery *(119)*. Nationality and migration status generally play a larger role in terms of accessibility of long-term public assistance than for life-saving emergency services *(133)*.

Including refugees and migrants in disaster risk reduction efforts more broadly is fully consistent with the whole-of-society approach of the Sendai Framework for Disaster Risk Reduction (Sendai Framework), adopted at the Third United Nations World Conference in 2015 and a major part of the post-2015 SDG agenda *(119,134)*. It is grounded in the notion that in order to build resilience and reduce the impacts of disasters disaster risk reduction efforts must address the vulnerabilities of all groups, especially the most marginalized. The Sendai Framework also explicitly recognizes that the knowledge, skills and capacities of migrants can be useful in the design and implementation of disaster risk reduction policies, plans and standards, and these groups make important contributions to the resilience of households, communities and societies at large *(134)*. For example, migrant and diaspora organizations are increasingly recognized as important actors during health and humanitarian crises, with rich social networks and useful experiences *(135)*. Diaspora organizations are multisectoral, work transnationally and often have access to information about affected populations; they also have the capacity to mobilize and circulate essential material and immaterial resources and the necessary linguistic and technological skills *(135,136)*. Connection and understanding of people's countries of origin and heritage are recognized as having important roles in humanitarian assistance *(136)*. The Sendai Framework calls for governments to engage with migrants in disaster management activities and structures as specific and resourceful stakeholder groups, together with indigenous people, women, children, young people, people with disabilities, older people and those of low socioeconomic status *(134)*. The Council of Europe also reiterated that refugees and migrants should be recruited and engaged as advisors, civil protection staff and volunteers in disaster preparedness and management mechanisms *(131)*. Disaster risk reduction policies and efforts can be an entry point in this way for improving the participation of refugees and migrants in decision-making, building relationships and fostering trust with host communities, and enhancing social inclusion *(119)*.

In September 2020 the WHO European Centre for Preparedness for Humanitarian and Health Emergencies was launched in Istanbul, Turkey. This geographically dispersed office[23] will serve as a regional centre of excellence for emergency preparedness and work specifically on risk management, the prevention of and response to emergencies and strengthening intergovernmental partnerships and community resilience. It will work with Member States to facilitate capacity-building and the institutionalization of evidence-informed best practices, as well as enhance operationalization of

[23] Geographically dispersed offices are fully integrated parts of the WHO Regional Office for Europe that are physically located outside of Copenhagen. There are currently six in the Region, each working on different thematic areas.

selected IHR core capacities *(137)*. Drawing on Turkey's strong culture of disaster management and the country's experience in hosting large numbers of refugees and migrants, the Centre will also work to provide technical assistance in contingency planning for humanitarian and health emergencies associated with mass population displacement and migration *(129,130)*. The Centre will do so through training, simulations and applied research, aligned with the priorities and principles of the Sendai Framework *(137)*.

5.1.2 Possible areas for collaboration

- Advocate for a multilateral and interagency dialogue for expanded legal pathways for regularization and for safe migration, including during emergency times. There will always be essential migration that occurs during health emergencies, and restricting legal pathways or entitlements to protection, health and social services risks the health and well-being of both refugees and migrants and host populations.
- Work to improve strategies and activities to strengthen operational response plans to protect refugees and migrants during humanitarian crises, including where national borders may be closed. Plans should underscore the obligations of States to provide asylum and protection, the right of all people to seek asylum and protection and the right to be in good health, even in transit.
- Advocate for more robust inclusion of refugees and migrants in national health emergency preparedness and response plans, in line with the Sendai Framework and the 1963 Vienna Convention on Consular Relations *(119,133)*.[24]
- Ensure emergency preparedness and contingency planning meaningfully accounts for the potential vulnerabilities and needs of refugee and migrant populations. This includes with respect to relevant directives to ensure their health, social well-being and livelihood security. Initiatives to promote trust-building with host communities and key authorities, as well as to improve refugees' and migrants' access to information and resources, should be key priorities.
- Engage in high-level tabletop exercises on refugee- and migrant-sensitive emergency preparedness, response and management. Possible topics could include both health emergencies and disease X outbreak scenarios (such as SARS-CoV-2) and other emergency situations such as those associated with rapid-onset climate and environmental disasters or sudden/mass population movement. It is essential that disaster risk reduction and emergency planning involve interagency collaboration to ensure a fully coordinated approach to refugee and migrant safety and security in such scenarios.
- Engage with and work to strengthen cooperation and coordination of crisis response activities between diaspora organizations and the more traditional humanitarian responders. Ensure that

[24] The Vienna Convention stipulates that the host country is responsible for ensuring the safety and welfare of all individuals in their territory in times of crisis irrespective of legal status and qualification *(119)*.

refugee and migrant groups are actively involved in the design and implementation of risk reduction and resilience-building activities, including related to post-disaster recovery *(133)*.

5.3 Action pillar 3: develop inclusive environments that promote social inclusion, health and well-being

The third core priority of the GPW 13 and EPW is the promotion of health and well-being by creating social and physical environments that enable and promote safer and healthier lives and reduce health inequalities. This priority recognizes that health is inextricably linked to the environments and conditions in which people are born, grow, live, work and age. It is about using a biosocioecological and life-course approach, focusing on public health initiatives that address these social determinants of health from infancy and childhood and into adulthood and old age. This extends to the quality of physical and social environments, health promotion and preventive health (including childhood, adolescent and sexual and reproductive health and education), development of health literacy and health-seeking behaviours and a push for Health in All Policies. Such an approach is essential to maximizing the health and well-being of all populations, including refugees and migrants, and reducing health inequalities. A health-promoting environment is also important for reducing social and cultural barriers to integration, reducing acculturation stress and facilitating participation and positive social and economic development. Investing in the health and well-being of refugees and migrants is ultimately good public health practice that is for the benefit of all society. Legislating social rights and ensuring appropriate social and income protection policies are in place for all people are also important tools for realizing these health gains.

The development of inclusive environments, however, is not only the responsibility of the health sector and must be pursued though an intersectoral framework that also recognizes the impact of policies outside of the health sector on health and well-being. It will also require collaboration across all levels of government, including local government and municipalities. As the primary destinations for refugees and migrants, it is important to note the importance of cities and urban centres in not only addressing immediate needs as first responders but also in enabling long-term integration *(13)*. With urbanization and migration continuing into the future, cities will also continue to play a significant role in the provision of services and infrastructure, in workforce integration and, indeed, in developing social cohesion *(13)*.

A key aspect of promoting health and well-being is that of social inclusion and addressing discrimination. Refugees and migrants continue to experience discrimination, racism, xenophobia and stigmatization, both within the WHO European Region and around the world. This is not a recent development, and even prior to the COVID-19 pandemic both the public and the political discourse on migration and displacement has been increasingly polarized, with discussions regarding refugees and migrants being increasingly framed by fear and division *(42)*. There has been a tendency over recent years for governments to concentrate on security-focused and infectious disease control approaches, at times resulting in punitive measures, including border restrictions, arbitrary detention and denial of services and care that should be secured by international rights-based conventions *(32,138)*. Despite it being well documented that there is no direct link between migration and the importation of infectious diseases to the WHO European Region, 2019 article in *Lancet* stated: "the persistent trope of a migrant as an infectious outsider who threatens the wider community continues to gain public and political currency"

(33). Political and public discourse, including in the media, at times has also portrayed these groups as unlawful, violent and a burden on social systems, and has tended to link them to crime *(33,139)*.[25] An analysis of press coverage of the refugee and migrant crisis in five European countries during 2014 and early 2015 found that some countries employed particularly aggressive campaigns against refugees and migrants, who were often discussed as threats to national security, threats to cultural cohesion and/or threats to the health and welfare systems of those countries *(139)*.

The COVID-19 pandemic has resulted in even further hostility towards foreign-born people and later-generation migrants across the Region, and responses have driven inequalities. Fear of the virus has been reported to exacerbate already high levels of xenophobia and stigmatization and has even given rise to verbal and physical attacks against refugees and migrants *(31)*. This is a frequently cited phenomena during disease outbreaks, where migrants are often unfairly discriminated against and perceived as vectors of disease. In times of health emergencies where resources and pharmaceuticals are in demand, provision to non-citizens may also be contested or deprioritized based on decisions that lack an evidence base *(121)*. This is consistent with research in Europe that suggests, in the context of deservingness of health and social policies, that European citizens broadly perceive migrants as the least deserving of welfare target groups *(51,141)*. Such claims are often made in terms of refugees and migrants having not (yet) contributed to society, or that generous welfare services such as health-care provision will mean attracting more migrants *(51)*. These arguments are not only unsupported by robust evidence but are also in conflict with human rights declarations *(51)*.

Discrimination, racism and social exclusion are also key social determinants of health; the duration of exposure to social exclusion is linked to the range and severity of health disadvantages. Refugees and migrants living in Member States with less-favourable integration policies (for example, exclusionist and assimilationist policies) have reported poorer health outcomes *(17)*. Even where legal entitlements are in place and upheld, discrimination and exclusion at the structural level remain key issues for addressing refugee and migrant health. Social stigmatization and anxieties that are generated by restrictive immigration policies also minimize migrants' sense of entitlement to rights *(121)*. Further, evidence demonstrates that discrimination in health-care systems, including in Europe, "enacted through subtle, invisible practices that are normalised into everyday medical routines" leads to poorer health outcomes and increases the risk of morbidity and mortality for some refugee, migrant and ethnic minority populations *(142)*. More specifically, racial discrimination within health-care settings has been associated with unequal care, delayed care, reduced adherence to treatment uptake and refraining from seeking care, among other things *(142)*. This not only results in poor health outcomes for these groups but also risks the health of host populations and results in increased health-care costs for Member

[25] In June 2021, at the Forty-seventh session of the United Nations Human Rights Council, a report of the High Commissioner for Human Rights was adopted on the Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers *(140)*. In paragraph 15, the Report notes "the dehumanization of people of African descent – a practice rooted in false social constructions of race… has sustained and cultivated a tolerance for racial discrimination, inequality and violence. Narratives that falsely associate Africans and people of African descent, including migrants, with criminal activities or that play on economic or even national security anxieties continue to be used to justify laws and practices governing criminal justice systems, migration policy and border governance."

States. Lack of access to interpreters and cultural translators, as well as other persistent administrative and financial barriers, also increases on health-care inequalities.

Promoting social inclusion and working to reduce hostilities and prejudices experienced by refugees and migrants both at a structural/political level and at the interpersonal level must continue to be a high priority.

5.1.3 Possible areas for collaboration

- Though whole-of-government engagement, foster public health initiatives that address social determinants of health across the life course, including improving the quality of the social and physical environments in which refugees and migrants live and work. The role of cities and urban cities may be of particular importance in this context.
- In the spirit of moving towards UHC, advance a framework of laws and regulations that avoids harmful restrictions on health-care entitlements, and engage with health-care providers and other stakeholders to minimize discriminatory barriers to the access and uptake of health services. This extends to improving availability of and access to information and resources. Programmes to improve the intercultural competence of service providers and increase access to cultural mediators and interpreters should also be a priority.
- Engage stakeholders to work to improve opportunities for social inclusion for refugees and migrants, including through community-centred approaches that support migrant communities to have an active role in decision-making and programming.
- Actively work within and across government sectors and civil society including media organizations to oppose xenophobia and racism that fuels prejudice and exclusion of refugee and migrant populations.
- Advocate to counter disinformation to disrupt negative and misinformed public and political discourse surrounding issues of migration and displacement and promote evidence-informed information that highlights the social, economic and cultural benefits of diversity and migration.
- Engage behavioural insights experts to help to shift national policies to address racism.

5.4 Action pillar 4: strengthen migration health governance and evidence- and data-driven policy-making

Facilitating safe, responsible and dignified migration, as envisaged in the GCM, requires a strong commitment to good migration governance. Only through well-planned and coordinated migration policies and processes can the challenges and opportunities presented by migration be met in ways that are meaningful, mutually beneficial and respectful of international standards and human rights. Good governance in this respect is also a key factor in breaking down structural drivers of exclusion and countering negative political and public narratives about refugees and migrants, as well as improving health outcomes. At the same time, health can also serve as an entry point for strengthening mechanisms of migration governance. While many of the key features of migration and health governance relate to the issues of multisectoral engagement and alliance building discussed elsewhere in this document, a major area for focused action is tackling the scarcity of high-quality migration health data.

The collection of data on refugees and migrants and the integration of such data into national health information systems continue to be key priorities for improving and safeguarding the health of these groups. Without the availability of high-quality data and information, it is difficult to fully understand the scale and nature of human mobility into and within the Region, the social and economic conditions and risk factors that refugees and migrants encounter, or their health status and care needs. Properly disaggregated, data can also provide critical information about the specific health-care needs of particular risk groups, including women and girls; minors and adolescents, both unaccompanied and accompanied; people living with disability or chronic illnesses; older people; and survivors of trauma or violence *(143)*. Evidence of this kind is essential for evidence-informed policy-making and programming that is attuned to and advocates for good health outcomes, as well as for addressing public anxieties and concerns surrounding migration *(2)*.

Data-driven decision-making is an underlying foundation of the GPW 13, EPW and the SDGs and is dependent on strengthened data collection for monitoring. SDG 17.18 underscores the need for capacity-building to increase the availability of high-quality, timely and reliable data disaggregated by factors such as ethnicity, migration status, gender, age and disability status. Data collection was also one of the strategic areas of the Strategy and Action Plan, and the progress report on its implementation in 2020 noted that while there has been positive progress, this continues to be a key priority area. Strengthening the global evidence base for policy-making remains an explicit objective of the GCM.

At present, data pertaining to health and migration are limited and represent neither all migrant populations nor the breadth of health conditions or inequities that are of concern *(144)*. Many Member States lack routine systems to collect such data and, where they are collected, the data are rarely well integrated into national health information systems *(144)*. The data collected currently are also often fragmented and not comparable across countries and datasets, sometimes even within the same country *(144)*. This is due not only to varying definitions of migrant populations but also to differences in data collection methods, the variables and indicators used and the regulations on data collection *(144)*. For example, some data collection instruments may record nationality, while others record country of birth *(5)*. Regulatory frameworks in some Member States do not allow registration of ethnicity or other migration-related indicators *(5,145)*. For example, a paper in *Lancet* published at the beginning of the pandemic in April 2020 found that none of the 10 countries with the highest COVID-19 case notifications, including in the Region, reported COVID-19 data related to ethnicity *(146)*. This is despite evidence even at that time indicating what is now well documented: that Black, Asian and minority ethnic groups are disproportionately impacted in regard to SARS-CoV-2 infections, related hospitalizations and deaths *(146–148)*. Where there is interaction between ethnicity, migration or other factors (including health status or behaviours, for example), this should directly and urgently inform public health interventions, yet current data collection does not always capture this. Difficulty in accessing migrant subgroups, language barriers, lack of trust in authorities and institutions that collect such data and use of non-digital records are additional barriers to complete and quality data *(144)*. Assuming effective data governance frameworks are in place, effective digital tools, including in the context of e-health services, could be explored as innovative methods for health data access and management.

A further issue regarding health information is that of health and migration research in so far as research outputs are not consistent with global migration patterns *(149)*. Much of the research generated on international migration comes from high-income destination regions such as western

Europe, with very little representation from low- and middle-income countries, including across Asia, the Middle East, Africa and eastern Europe, where the largest mobility flows occur and in which many migrants to western Europe originate or transit *(149)*. Most health and migration research is also focused on refugees as a specific population group. Literature on migrant workers constitutes only approximately 6% of all literature despite the total number of migrants being seven times higher than that of refugees *(149)*. There is also a paucity of literature on the intersection of gender, migration and health, particularly in terms of the rights and vulnerabilities of female migrant workers *(149)*. Research on maternal and reproductive health is also disproportionately lacking *(149)*. There is a clear need and opportunity for collaboration to increase knowledge generation and leadership on health and migration in the low- and middle-income settings from which many refugees and migrants to Europe originate or transit through. A whole-of-route research agenda that captures more proportionately the patterns of human mobility and the intersections of gender and other social inequalities will help in understanding not only the factors that put refugees and migrants at risk but also those that facilitate thriving and resilience, which is critical to informing inclusive and effective responses *(149)*. Enhanced collaboration between education and research institutions around the world, including across neighbouring WHO regions, to develop resources and professional competencies is required to improve health and migration outcomes. WHO collaborating centres are an invaluable resource that can be further utilized to support the bridging of research and policy-making at the country level. Current programmes through these centres include improving participatory health research methods and building capacity for more meaningful engagement of refugees and migrants in research *(150)*.

Critically, further consideration must be given to data management and protection and research ethics. First, issues around the safety of refugee and migrant data must be adequately explored and addressed. The collection of biometric data, for example, which is widespread in development and humanitarian contexts including refugee contexts, presents significant implications for populations *(151)*. This is both in terms of the exclusionary aspects of collecting biometric sample, and the very real security risks to people where such data are lost or misused; the consequences of this have been seen in other parts of the world *(151,152)*. Issues around data safety and the potential repercussions of identifying oneself and one's migration status help to explain why refugees and migrants are often reluctant to share personal information and so often avoid presenting to services, thus further exacerbating vulnerabilities *(143)*. Even where personal information and data are shared, the limitations of informed consent, particularly in humanitarian settings, need to be considered *(152,1533)*. More broadly, confidentiality of personal information and appropriate firewalls between health and immigration authorities is essential.

Secondly, in terms of research ethics, it must also be ensured that the collection of data and conducting of research is not an end in itself but is considered together with strategies for effective knowledge translation into policy. There is often a disconnect between the production of knowledge by researchers and its use by policy-makers. Researchers may tend to engage with policy-makers after findings are generated rather than as collaborators in research, while policy-making often lacks meaningful engagement with key stakeholders *(39)*.

Lastly, it cannot be assumed that additional or improved data always lead to better policies or health outcomes for refugees and migrants *(103,143)*. While there is a need to continue to advocate for an evidence-driven agenda, care must be taken not to oversimplify the policy process or to see technical responses as key to improved outcomes *(143,154)*. Health policy, particularly as it relates to migration which is often politically contentious, is never apolitical, even where evidence is available and clear.

Even the most robust evidence can be disregarded or used selectively *(103)*. Future collaboration should focus on bringing policy-making and civil society together, including refugees and migrants themselves, to strengthen the research agenda for improved outcomes.

5.1.4 Possible areas for collaboration

- Work to strengthen mechanisms and processes that enable good migration health governance, including enhancing country-level stewardship and accountability for health and migration.
- Organize national multistakeholder working groups for migration health data collection, processing and sharing, with a view to developing and implementing a national strategy for integrating migration health data within national information systems *(144)*. Data collection must be viewed through a lens of ensuring continuity of care for refugees and migrants.
- Integrate core migration variables into already existing reporting frameworks, such as the WHO Joint Monitoring Framework, to reduce additional reporting burden and enhance cross-country comparability in close collaboration with WHO's global Health and Migration Programme *(144)*.
- Encourage collaborative research networks for knowledge generation and sharing, and increased opportunities for leadership on health and migration in low- and middle-income countries within the WHO European Region and neighbouring regions, with the support of the global Health and Migration Programme, particularly in source and transit countries. The WHO Global Research Programme is an example of such work. External to WHO, the MiSHA Network, an international and interregional collaborative network that aims to strengthen research capacities and advance a collaborative research agenda on different aspects of mobility and health in south Asia and the United Kingdom, is another example. Academic and research partnerships such as these can also help to develop professional competencies with respect to health and migration.
- Promote mechanisms for policy-makers, researchers and other stakeholders to collaborate on driving a research agenda within the Region, and define the analyses needed for effective national and regional interventions *(39)*.
- Explore digital health innovations, as a flagship initiative under the EPW as a potential means to improve practices related to the collection and use of refugee and migrant health data. High standards of data protection and safety must be in place, and full consideration given to health ethics.
- Promote engagement with refugee and migrant communities in planning and implementation of health research, and the application and dissemination of findings.

5.5 Action pillar 5: explore innovative ways of working and develop partnerships as a vital enabling tool

Solidarity, partnership and international cooperation underpin all of WHO's work, and this is no different in the context of refugee and migrant health. Guided by the lessons of a whole-of-society and whole-of-route approach, including the importance of interregional collaboration, there is a need to strengthen engagement and coordination among the complex constellation of actors with roles in refugee and migrant health within the Region and globally. The international community needs to continue to strengthen existing partnerships between Member States, the United Nations family, EU agencies and other partner organizations and institutions, and to seek out new allies and connectors where

partnerships on health and migration are yet to be fostered. This will be critical to strengthen existing agendas and open new channels of collaboration and dialogue on health and migration.

Intergovernmental forums and organizations offer important opportunities in this context. Engaging closely in multilateral forums, such as on climate change or disaster preparedness, may also be key entry points to advocate for health and migration. Health diplomacy is a critical tool for developing the alliances and connectors needed to achieve health outcomes in such political arenas. Migration management has become an increasingly politicized issue with regulatory, security, sovereignty and economic considerations at times taking precedence over health and social well-being *(155)*. Health diplomacy is needed to facilitate the multi- and intersectoral responses necessary to address challenges as multifaceted as the public health aspects of migration; it is also a critical mode of action and way of working in modern systems of governance where actions are negotiated, designed and implemented *(2)*. As evidenced through the negotiations for the global compacts, where WHO was able to assert health in the face of other interests and sectors, diplomatic skills can make an important difference when operating in these systems *(2)*. Where technical and political issues often intersect and the protection of security and sovereignty clash with the need for collective action to protect the right to health for all, adopting a sensitive political lens to a public health approach is necessary in mobilizing support *(2)*. It will be important for public health professionals and government and agency officials to engage with the tools and strategies of health diplomacy to ensure that health and migration has a place high on the political agenda for years to come *(2)*.

Securing the health and well-being of refugees and migrants cannot, however, be achieved by countries and international organizations alone. Given the highly politicized complex nature of migration, engagement of non-state actors is necessary, including with refugee, migrant and diaspora communities themselves. NGOs and civil society actors also remain indispensable for bringing nuance, evidence and humanity to the debate *(2)*.

Finally, an important aspect of solidarity and international cooperation is the need to commit resources to carry out the EPW, and implement actions moving forward in a sustained and durable way. In line with the global compacts, the mobilization of timely, predictable, adequate and sustainable public and private funding is necessary for successful and meaningful progress towards refugee and migrant health and well-being. This includes through commitment to better mechanisms for health financing and social protections, a fundamental aspect of UHC.

5.1.5 Possible areas for collaboration

- Encourage greater multilateral and interregional engagement and cooperation on the public health aspects of migration and displacement to ensure both migrant-sending and migrant-receiving countries are able to enjoy the benefits of migration, while protecting the rights of refugees and migrants themselves. The global Health and Migration Programme can help to facilitate such engagement.
- Explore mechanisms for innovation and collaboration, including where partnerships on health and migration have yet to be developed. Subregional and interregional platforms or networks, for example, may be key opportunities to strengthen collaborative partnerships, enhance dialogue and enable sharing of information and good practices.
- Promote the tools of health diplomacy for facilitating international action on health and migration.

- Establish and/or strengthen capacity for the meaningful inclusion and participation of refugee, migrant and diaspora communities in policy-making and programming, alongside other nongovernmental stakeholders. These include the private sector, professional networks and academic and research institutions.

6. Moving forward

As this background document has highlighted, much has happened in the six years since the inception of the Strategy and Action Plan, from the sudden large number of refugees and migrants arriving into the Region during 2015–2016, through to the COVID-19 pandemic still unfolding and now the large displacement in Ukraine, affecting neighbouring countries and beyond. With the current Strategy and Action Plan soon expiring, now is the time to reflect on experiences, achievements and lessons to date, and to build consensus on a common vision for health and migration into the future.

Recognizing the heterogeneity within and across Regions in terms of specific circumstances and legislative environments, driving the pillars of action will require a strong commitment from WHO, its Member States and partners to mobilize public and political support and ensure that the health of refugees and migrants remains high on national and international agendas into the future. There is an opportunity to send a clear message that, despite the issues currently being grappled with, refugee and migrant health must remain a priority. The WHO Regional Office for Europe and its Member States must stand ready to work together in the spirit of solidarity and mutual assistance to ensure no one is left behind.

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Annex 1. Summary of action areas and indicators of the new strategy and action plan for refugee and migrant health in the WHO European Region

Strategic area 1: establishing a framework for collaborative action

Background

A coordinated and collaborative response is required to foster platforms of common action in origin, transit and destination countries. In particular, this must involve other United Nations agencies and bodies, the EU, the Eurasian Economic Union and international institutions and organizations, as well as a so-called One WHO approach, with the WHO European Region working closely with the WHO Eastern Mediterranean and African Regions. National and international collaboration with international partners should also be strengthened. Coordination between national and local levels is particularly important. Civil society and emigrant communities should be consulted and closely involved.

Objective

The objective is to strengthen collaboration with and among United Nations agencies and bodies, the EU and Eurasian Economic Union, the IOM and other national and international institutions and organizations with roles and mandates for migration and health issues, including NGOs. Collaboration should also be established with the private sector, professional networks and academia. Strengthening global human resources for health is a vital issue. There is a key role for WHO as coordinator and technical organizer of the health sector's response at the global and regional levels.

Strategic area 2: advocating for the right to health of refugees, asylum seekers and migrants

Background

Strong, positive political and societal will and commitment are required to promote migrant-sensitive health policies and programme interventions that can provide equitable, affordable and acceptable access to essential health promotion, disease prevention and good quality care for refugees and migrants. Such policies should be aligned with international and national laws and practices, and they should be applied with dignity and without discrimination, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status or ability to pay. This should go hand in hand with advocacy to recognize human rights and reduce discrimination and stigmatization.

This also entails government interventions, as appropriate, to ensure enforcement of supportive legislation that promotes transparency and accountability.

Objective

The objective is to provide the public with accurate and truthful information on refugee and migrant health issues, to reduce discrimination and stigmatization, and to eliminate barriers to health care and offer the requisite conditions for refugees, asylum seekers and migrants to enjoy a healthy life by informing refugees and migrants of their rights and the available pathways for addressing their health needs, as well as informing health and non-health workers.

Strategic area 3: addressing the social determinants of health

Background

In line with mainstream national population health strategies, the systematic analysis of and action on social and economic factors are important to improve the performance of long-term policies, strategies and interventions for health. While the case of migrants is no different from any other group, explicit consideration should be given to the main social, economic and environmental determinants of the different health risks and outcomes experienced by refugees, asylum seekers and migrants.

Addressing the determinants of refugee and migrant health requires joint and integrated action and coherent public policy responses involving the health, social, welfare and finance sectors, together with the education, interior and development sectors, as indicated in Health 2020.

Managing and addressing the complexity of migration is an issue not only for the health sector but also for the whole of government, across public policies and local, national and regional development agendas. The health sector has a key role in ensuring that the health aspects of migration are considered in the context of broader government policy and in engaging and partnering with other sectors to find joint solutions that benefit the health of refugees, asylum seekers and migrants.

Objective

The objective is to establish an effective policy dialogue on the health of refugees, asylum seekers and migrants across all relevant government and non-State actors, leading to effective whole-of-government and whole-of-society approaches, based on shared values, evidence and multisector policy dialogue.

Strategic area 4: achieving public health preparedness and ensuring an effective response

Background

Public health preparedness is not optimal in many countries, with improvements needed in multisectoral approaches and health system capacity to address the health needs of large influxes of refugees, asylum seekers and migrants, including in preparedness, surveillance and response, and public health participation in health system planning and development. Another important role of the health sector is to liaise with other sectors to ensure the provision of basic services, such as water and sanitation services.

Objective

The objective is to include the health needs of refugees, asylum seekers and migrants in the planning and development of public health capacities and services and in the elaboration and implementation of national health policies, strategies and plans based on Health 2020.

Strategic area 5: strengthening health systems and their resilience

Background

Member States should have in place core health system capacities to be able to address the immediate health challenges associated with migration and those for the medium to long term. They should also promote and coordinate intercountry cooperation and international community support to mitigate mortality and morbidity. At times of rapid large-scale international migration, this may require the establishment of additional health system capacities, and non-State actors may have an important immediate role. However, as a fundamental principle and to the extent possible, the health needs of refugees and migrants should be fully integrated into existing national health structures in accordance with national legislation and policies.

Health systems should aim to offer culturally sensitive health care, overcoming barriers such as language, access to interpreters, administrative hurdles and lack of support for patient fees or for information about health entitlements. Systems should ensure support to refugees and migrants in navigating through the system, and should respond to the needs of all people, without discrimination and with dignity and respect. Harmful and discriminatory practices should be systematically eliminated. The health system should be recognized as a tool for identifying other issues and needs, such as abuse and violence.

Achieving these objectives may require modifying certain government regulations and legislation that limit access to essential health-care services that are acceptable, affordable and of good quality, as well as strengthening reporting and accountability structures and mechanisms. In line with equity-oriented health systems and public health approaches, efforts should be directed to all population groups. Financing mechanisms and tools should be considered in policy and planning and should include an analysis of the direct and indirect costs of not providing health-care services to migrants.

Health assessment is a tool to identify vulnerable groups and emphasis should be placed on improving the health of the most vulnerable, including children, pregnant women, adolescents, elderly people, people with disabilities and victims of violence or torture. The health needs of unaccompanied children require special attention. Issues relating to sexual and reproductive health, family planning, gender-based violence and rape management, forced marriage and adolescent pregnancy, and mental health and care should be prioritized. Education on, and legal aspects of, vulnerable groups should be addressed by health and non-health professionals.

There is a need for the prevention and management of physical and psychological trauma and injury among refugees originating from countries affected by conflict and violence, as they are often exposed

to the elements during their journeys. Some migrant women may wish to be cared for by female doctors, which could invoke issues of cultural sensitivity and gender-based equity.

Training on health equity and human rights-based approaches is a key element for health professionals and relevant non-health actors. Patient-sensitive health systems may benefit from fostering active and effective community participation and empowerment of refugees and migrants. The promotion of health literacy is a vital part of responding to migrants' health needs. Health systems should be sensitive to migrants' own languages, although in the longer term it is important that migrants learn the language of the country in which they are living. If permitted by national labour legislation, integrating migrants as health workers may be possible.

Objective

The objective is to reach agreement on the core health system capacities required to respond to the immediate and longer-term health needs of refugees and migrants, with special attention to those in vulnerable situations. Refugees and migrants should be provided with all necessary health support at the initial stages in the migration process; they should be assisted in overcoming the difficulties of arriving in a new environment and health service; and, subsequently, they should be offered all essential, necessary and appropriate health services, within the available resources.

Strategic area 6: preventing communicable diseases

Background

The movements of refugees, asylum seekers and migrants constitute a challenge to communicable disease surveillance and control, equivalent to that presented by the general population, and should be dealt with using the national and international framework and principles established by the IHR. This is an area of particular concern for transit and recipient countries.

Migrant populations may originate from countries with a high prevalence of certain communicable diseases. They may have become more vulnerable due to their migration journey. In addition, reception centres and overcrowded environments can become susceptible to the challenge of communicable diseases, particularly when large numbers of people share common shelter or hygiene standards are inadequate. Concerns need to be addressed on a risk-specific basis by means of well-functioning public health services, including surveillance and health protection, necessary and proportionate interventions, especially to limit immunization gaps, and sound public and community information.

Objective

The objective is to ensure the necessary capacities to address communicable diseases and all other health challenges as well as effective health protection in transit and destination countries.

Strategic area 7: preventing and reducing the risks posed by NCDs

Background

Evidence shows that migration may increase exposure to immediate hazards such as cold and heat while in transit and increase vulnerability to psychosocial disorders, reproductive health problems, neonatal mortality, drug abuse, nutrition disorders, harmful alcohol use and exposure to violence. Limited access to health promotion, disease prevention and care during the transit and early insertion phases of migration increases the burden of untreated and complicated NCDs and chronic conditions.

Objective

The objective is to ensure that the needs of refugees and migrants are considered as part of the national strategy for the prevention and control of NCDs. This is an essential component of the national health policy.

Strategic area 8: ensuring ethical and effective health screening and assessment

Background

In general, refugees, asylum seekers and migrants do not pose an additional health security threat to host communities. Initial screening can be an effective public health instrument but should be non-discriminatory and non-stigmatizing and carried out to the benefit of the individual and the public; it should also be linked to accessing treatment, care and support and not limited to infectious diseases. It is unlikely to be necessary if health systems are strong and capable.

All screening should respond to appropriate risk assessments and its effectiveness should be evaluated. It should ultimately serve the real needs of the refugees, asylum seekers and migrants. It should be provided on a voluntary basis, and with ethical attention to confidentiality. Access to screening programmes that are in place for the host population (for example, screening during pregnancy, for neonatal diseases and for school entry) should, however, be explicitly promoted for migrant populations. Confidentiality and medical ethics should be enforced and pre- and post-screening counselling should be provided.

Objective

The objective is to ensure that screening and mandatory examinations are risk specific and evidence-informed and serve the real interests of refugees, asylum seekers and migrants and the host population. All such examinations should be followed up by necessary health care.

Strategic area 9: improving health information and communication

Background

Priorities include improving the collection of and access to information on the health status of refugees, asylum seekers and migrants, their modifiable risk behaviours and access to health care. The provision of quality data should cover all groups and identify specific health needs and actions to address such needs, with identified costs where possible. Disaggregation and comparability of data are required. Cooperation should be established, if possible, with the countries of origin of migrants for the collection of health-related data.

Data, handled by those public health organizations customarily tasked with collecting surveillance and personally identifying data, should be stored securely and in accordance with data protection principles and should only be shared with third parties when there is an important health-care reason to do so and with prior consent of the individual concerned.

Communication efforts should offer health promotion and health communication to migrants to provide them with key messages and advice on health-seeking behaviours. These efforts should also provide information to refugees, asylum seekers and migrants on the health system in the host country and the avenues by which they can seek advice and support. Such communication should dissipate fears and false perceptions among refugees, asylum seekers and migrants, in an appropriate language, taking into account sociocultural and religious determinants; and should be adapted for the host population as well.

Objective

The objective is to ensure the adequacy, standardization and comparability of records on the health of refugees, asylum seekers and migrants, which should be made available to these population groups to facilitate access to health information and essential care.

Core indicators relevant to one or more of the nine strategic areas of the new strategy and action plan for refugee and migrant health in the WHO European Region

Core indicators	Rationale and objective	Indicator	Means of verification
Indicator 1: evaluating national health policies, strategies and plans	To identify the health needs of refugees, asylum seekers and migrants, and include these needs in the planning and development of public health capacities and services, and in the elaboration and implementation of national health policies, strategies and plans based on Health 2020	Inclusion of at least one explicit component on migration and health in the national health policy, strategy and/or plan	Biennial WHO data collection questionnaire
Indicator 2: evaluating the	To promote the understanding of core health system capacities required to	Realization of at least one	Biennial WHO data collection

assessments of the health needs of refugees, asylum seekers and migrants	respond to the immediate and longer-term health needs of refugees, asylum seekers and migrants, with special attention to those in vulnerable circumstances	assessment on the coverage of the health needs of refugees, asylum seekers and migrants by the national health system	questionnaire
Indicator 3: evaluating contingency planning and preparedness	To enhance the preparedness and capacity of health systems, and improve their response to the public health implications of potential sudden and large arrivals of refugees and migrants	Development of a regional or national contingency plan for large arrivals of refugees and migrants	Biennial WHO data collection questionnaire
Indicator 4: evaluating health information and communication to prevent communicable diseases and reduce the risks posed by NCDs	To ensure the adequacy, standardization and comparability of records on the health of refugees, asylum seekers and migrants, which should be made available to these population groups to facilitate access to health care, including the necessary capacities to address communicable diseases and all other threats and effective health protection in transit and destination countries; to include these population groups in the strategy for the prevention and control of NCDs	Inclusion of a migration status variable in existing datasets	Biennial WHO data collection questionnaire
Indicator 5: evaluating social determinants for health	To establish an effective dialogue on the health of refugees, asylum seekers and migrants across all relevant government and non-State actors, leading to effective whole-of-government and whole-of-society approaches, based on shared values, evidence and multisector policy dialogue; to promote active participation of non-health sectors and stakeholders during the national assessments of coverage of the health needs of refugees, asylum seekers and migrants	Use of intersectoral approaches when conducting national assessments of the health needs of refugees, asylum seekers and migrants	Biennial WHO data collection questionnaire

Annex 2. Promoting the health of refugees and migrants: draft framework of priorities and guiding principles to promote the health of refugees and migrants

Guiding principles

1. *The right to the enjoyment of the highest attainable standard of physical and mental health.* Refugees and migrants have the fundamental right, as do all human beings, to the enjoyment of the highest attainable standard of health, without distinction of race, religion, and political belief, economic or social condition. Furthermore, States Parties to the 1951 Convention relating to the Status of Refugees shall accord to refugees lawfully staying in their territory the same treatment as accorded to their host country nationals, with respect to public relief and social security, which may include access to health services

2. *Equality and non-discrimination.* The right to the enjoyment of the highest attainable standard of health should be exercised through non-discriminatory, comprehensive laws and policies and practices including social protection

3. *Equitable access to health services.* Equitable access to health promotion, disease prevention and care should be provided for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race; and in accordance with the international law for refugees. The health of refugees and migrants should not be considered separately from the health of the overall population. Where appropriate, it should be considered to include refugees and migrants into existing national health systems, plans and policies, with the aim of reducing health inequities and to achieve the SDGs.

4. *People-centred and refugee-, migrant- and gender-sensitive health systems.* Health systems should be refugee and migrant sensitive, gender sensitive and people centred, with the aim of delivering culturally, linguistically and gender- and age-responsive services. While the legal status of refugees and migrants is different, their health needs may be similar to or vary greatly from those of the host population. They may have been exposed to distress, torture and sexual and gender-based violence associated with conflict or their movements and may have had limited access to preventive and curative services before arrival in the host country. All of these factors may result in additional health-care needs that require specific health responses.

5. *Non-restrictive health practices based on health conditions.* The health conditions experienced by refugees and migrants should not be used as an excuse for imposing arbitrary restrictions on the freedom of movement, stigmatization, deportation and other forms of discriminatory practices. Safeguards should be in place for health screening to ensure non-stigmatization, privacy and dignity, and the screening procedure should be carried out based on informed consent and to the benefit of both the individual and the public. It should also be linked to accessing risk assessment, treatment, care and support.

6. *Whole-of-government and whole-of-society approaches.* Addressing the complexity of migration and displacement should be based on values of solidarity, humanity and sustainable development. The health sector has a key role to play in ensuring that the health aspects of migration and displacement

are considered in the context of broader government policy and in engaging and coordinating with other sectors, including civil society, the private sector, refugees' and migrants' associations and the affected populations themselves, to find joint solutions that benefit the health of refugees and migrants.

7. *Participation and social inclusion of refugees and migrants.* Health policies, strategies and plans and interventions across the migration and displacement cycle and in countries of origin, transit and destination should be participatory, so that refugees and migrants are involved and engaged in relevant decision-making processes.

8. *Partnership and cooperation.* Managing large movements of refugees and migrants in a humane, sensitive, compassionate and people-centred manner is a shared responsibility. Greater partnership and international cooperation among countries, the United Nations system, including the IOM, UNHCR and WHO and other stakeholders, are essential to assist countries in addressing the health needs of refugees and migrants, and to ensure harmonized and coordinated responses. WHO, in collaboration with other relevant international organizations, has a lead role to coordinate and promote refugees' and migrants' health on the international agenda.