Migration, displacement and health systems – podcast transcript

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Kim Ozano: Hello listeners, and welcome to Connecting Citizens to Science. I'm Dr Kim Ozano, and this is a podcast where we discuss current research and debates on global health. Today's episode is the fifth in a six-part miniseries brought to you by ReBUILD for Resilience. ReBUILD is a research consortium that examines health systems resilience in fragile settings that experience violence, conflict, pandemics, and other shocks.

Today's focus is migration, displacement, and health systems. A report by the United Nations High Commissioner for Refugees has found that displacement has tripled in one decade, from 40 million to 118 million, and this does not account for climate refugees.

So, what does this mean for health systems that have been shaped around issues of national and political borders? We find out from our guests and co-host, who talk us through the importance of integration for health and social outcomes, and the cultural changes that are needed to address discrimination and exclusion in healthcare.

We have with us today, Professor Fouad Fouad, who has conducted extensive research on migration and health, focusing on multidisciplinary approaches to forced displacement, health systems and humanitarian settings, and the political economy of health in protracted crisis. Professor Fouad is also the IDRC chair of the Forced Displacement Programme in the Middle East and the co-director for the Refugee Health Programme at the Global Health Institute.

His role as a member of several technical working groups, which include the WHO Global Consultation on the Health of Migrants and Refugees, and the Global Research Agenda on Health and Migration. Fouad serves as a Commissioner in The UCL Lancet Commission on Migration and Health and is a Commissioner in The Lancet Commission on Health Conflict and Forced Migration.

Also joining us today, we have Dr Santino Severoni, the Director of the Department of Health and Migration at WHO headquarters in Geneva. Dr Severoni has over 24 years' of experience. He has held senior roles at the WHO regional office for Europe and worked globally in health sector reforms, system strengthening, and complex emergency management. Since 2011, he has focused on public health aspects of migration, leading efforts to implement global migration and refugee compacts, and coordinating WHO's first world report on the health of refugees and migrants.

I also have the pleasure of being joined by co-host, Dr Joanna Raven. She is a reader and the Research Co-director of ReBUILD for Resilience. Dr Raven has worked in global health for more than 25 years and has focused on strengthening health

systems. She is also a health worker herself, so she focuses on supporting the health workforce to deliver person-centred care that is of good quality and leaves no one behind.

Hello Jo, and welcome back to the podcast. It's great to see you again. I was wondering if you could kick us off by setting the scene of migration and displacement globally and the scale of the problem and what this means for health systems.

Joanna Raven: So, first of all, I'm really delighted to be here with such global experts, Foaud and Santino, to discuss such an important topic. As you've said, Kim, you've highlighted that despite numerous migration initiatives and programmes, displacement continues to increase. In 2023, the number of forcibly displaced and stateless people rose to record highs, and this is really a symptom of a world in turmoil, marked by war, displacement, coups and natural disasters. More than 1 billion people are on the move globally, which is staggeringly about one in eight of the global population. Of this total 281 million people are international migrants, and 84 million are forcibly displaced by maybe conflict, by politics, by climate crisis, etc. And among those forcibly displaced, 35 million are children, and 1 million were born into refugee life. And the number of people on the move is expected to grow due to poverty, lack of access to basic services, lack of security, conflict, the climate crisis, environmental degradation and disasters.

But it's clear that refugees and migrants often face worse health outcomes in countries of transit or in, in fact, the ones they end up staying in. They face barriers to accessing health services, including language, cultural differences, discrimination, and restricted use of health services. Migration, displacement, and health systems is a really, really complex topic and we're really lucky to have Fouad and Santino to really unpick this, this complex area. I'd like to hear your thoughts, Fouad, on why migration and displacement are important to consider in health systems.

Fouad Fouad: Jo, thank you very much for inviting me. So, why migration is important in public health and in health systems, I think because people in general need health. Unfortunately, the entire current health system has been shaped around the issue of national health systems. So, people considered as resident or citizens, actually those people have clear access to health, but for people on the move, actually, it's another issue. And although there's a lot of efforts in the last decades to improve the access of migrants into health, there are a lot of barriers, and we can see now these barriers growing up more and more.

One of the major issues is the issue of politics, not a social issue. Migration is substantially a political issue and therefore we cannot avoid considering that in the discussion. You see now in the news, every time talking about migration, anti-migration and all these issues. And this is specifically what affects people's access to their rights. Migration is a very historical issue. Since the dawn of history, people move. It's not new and people move for the same reasons - war, economy, looking for food - but now just in the last two centuries, we consider that is a problem and this problem increasing more and more.

Santino Severoni: You made a very powerful introduction. If I'm allowed to provocate and to oversimplify, I might translate all this complexity into two main reasons why this is important. The numbers that Jo you just mentioned, if we put together displaced internal migrants, international migrants, refugees, asylum seekers, we are talking about one in every eight people around the world to be on the move. So, one billion people today are moving. It was alluded at the speed of displacement because of the geopolitical instability we are sadly observing nowadays.

Second point, this means that if we are looking at the efficiency of the system, the efficacy of the health systems, a health system is able to do its job if it's able to address the health needs of all of the population who it serves. And if you're going to look at our society today, our society, because of these figures, is a diverse society. It will continue to evolve, so health systems need to follow the demographic changes. COVID proved to us that exclusion means public health failure, inclusion means cost effectiveness and public health success.

Joanna Raven: Thanks for those introductory remarks. I want to touch upon now the challenges that the health systems face in trying to manage these different and diverse groups. Fouad, you started talking about the national and political borders and I also think about these parallel structures that are often set up in different countries. Can we elaborate on those and discuss what these challenges are?

Fouad Fouad: Well, exactly. This is an issue. The current health system, it serves its population, and in a specific country, inside political borders. Let's imagine that people crossing these borders, there are some sort of thoughts and ideas about how to address that within the emergency phase or short-term phase. Well, we know now that people are moving in protracted times. The average, as per World Summit in 2017, that people move, the average length of migration is 17 years or 19 years now. So, what does it mean? It means that this is very protracted. Now, how to serve healthcare for those people in such sort of context?

Again, one of the issues is, as Santino mentioned, the issue of integration. I mean this is very basic, but integration is not just a technical issue. Integration has many implications. One of the top is the legality, the politics, the issue of economy, so how to address other systems, then we can try to respond to people's needs. So, unfortunately, addressing migration needs the creation of sort of parallel systems. Look to the Middle East, Lebanon, for example, Jordan, there's a national health system by the country, but also there's another part of the system for Palestinian refugees, like UNRWA, the UN Agency for Palestinian Refugees, and there's a sort of separate or third parallel health system. There is a sort of informal health sector run by refugee health workers, run by local organisations that work aside from the national health system. So, it creates that sort of, more complexity when thinking about integration.

Santino Severoni: Health systems are usually coming from different directions. Around the financial crisis in 2008, politics discover that the topic of migration could be very powerful in terms of being utilised in the political campaigns for certain political vision. The legal framework is utilised to integrate or to exclude people. To

define who are the people which are entitled to social services and which level of services. So the first issue is the mechanisms the countries are utilising to identify who are the people and how those people can access the service that the state made available.

The other element is related to availability of data, helping us to understand the situation. Research, because it's incredible to believe, but until a few years ago public health sectors were not paying attention to the issue of migration. We were paying attention to the issue of migration only in the case of emergency. So, when health was becoming a sort of side effect of the migratory process. But research is also important to show what is the cost of intervening and the cost of not acting in order to sit in front of decision makers, government, politicians, ministers, and providing them with the solid information to help make policy making and decision-making process effective.

Fouad Fouad: Actually, I want to ask Santino giving his very extensive experience, but before that, I would do some disclosure, that I didn't at the beginning and this might point at the question. So, I am myself a forced displaced person. I moved out of my homeland because of war and I sought refuge, but actually I'm not officially a refugee. I didn't register at UNHCR. I just could consider myself forced displaced and a migrant worker. I myself, also a doctor, tried, in many cases to have access to health in the country where I was, but I found it really very difficult to navigate the system. So, my question to Santino, when we have different national systems, where many refugees move out to these countries with different national health systems, how WHO could play a role in coordinating a change on the national health system or national health systems in these neighbouring countries?

Santino Severoni: If I'm looking to the current work we are having as a WHO on the topic of health and migration, I think what we are doing today is a strategy to move governments to identify entry points, then to build up areas of collaboration and really engage countries to move on. The tremendous challenge we do have that when we started his work, unfortunately, this was not long ago. So all of this is a new topic for WHO, this means a new topic also for member states. But there are a lot of progresses, and to answer your question, I will say, yes, it's possible to change things, but this need to be done, even if the challenge posed by the health and migration issues are universal, but then there is a necessity to address local answers because everybody is looking at their own reality. So you need to tailor the debate, the technical assistance intervention to the specific country needs. It's really a strategic approach, it means sharing resources. Maybe those close to the border, sharing human resources for health, sharing facilities, creating revolving economic financial mechanisms to allow people to enjoy services across the two borders when needed. In this I'm a bit sad because even if I'm visiting many countries, it's really very limited initiative, very, very embryonic initiative, because what is prevailing is still very much the idea of protecting, managing borders, so having a fence around the country. So, those are, in my view, cultural changes which require time and from our side requires persistence. You're speaking from the high authority of also having a life experience. What does it mean? The process you went through and now you are teaching. I think we need to start with the young generation and we need to be

persistent in order to generate a critical mass of people better understanding this topic because still we are navigating into a situation where this information, kind of inconsistent narrative are poisoning the reality. We believe it is so important to really support countries to undertake changes or helping the system at a local level to move on. We have a health system review tool, which is a complex process we are building together with a country authority, and we make clear that we want to stay in the backstage. We want to have the Ministry of Health taking the lead. Why is this? Because in a multi-sectoral issue like health and migration, this is already an empowerment process because we are encouraging the Ministry of Health to face the other line ministers and to have a leadership role, and to defend the importance of factoring the health dimension into national actions. But also, it's an opportunity, in many cases, we see health and other sectors learning from each other because they're living there in the same country, same government, but they don't know that different things are taking place in the country. We need to engage with the health diplomacy and patients and negotiation to make them understand the benefit of applying this tool. Once this tool is applied, we see countries getting super excited because it's helping them to understand what are the strengths and weaknesses in their systems and then to act not emotionally.

So this is a tool that we are applying to high income countries, middle low income countries. there is a financial element that is beyond the health sector. The big challenge is that there are a number of countries which today are hosting displaced populations, a large population of refugees, and they're renting a global civil service to all countries around the world because they're assisting these people, but they don't have enough international, particularly financial support in order to fuel their own national mechanism. So, those are a little bit of the complexity of what at least we observe around the world.

Joanna Raven: It will be great to have some examples of good practice from different countries.

Fouad Fouad: In Lebanon, in one of the ReBUILD research components, we developed what we called the learning sites, and the learning site is improving localisation to build the capacity where people can put this strategy for their health. And we tried actually, to consider that as very collective work. So, in one example that we did in Lebanon, where not only the host community, the Lebanese, engaged in the learning site experience, but also many refugees. Like we have a Syrian refugee doctor who is the vice president of the municipality health committee and has a voice similar to the Lebanese hosting population. We try to go beyond one example, ReBUILD research in four countries, and so we try to see if this model could be replicated in other contexts.

Santino Severoni: In terms of country practice, we have a platform in our website where you can track those country practices, also to learn what countries are doing. And we see about almost one third of the world's countries today are actively engaging in implementing in the health sector element of public health aspect of population movement. So we see a lot of practice, a lot of initiative. Among all of them, what I like very much is what's going on at the moment in Columbia, where the

provision of the national health insurance to 1.5 million migrants from Venezuela and all the health financing mechanisms to tailor or to activate the extended coverage, has been uncovering some policy setting dysfunctionalities or health system dysfunctionalities. So, at the moment in the country, they are proposing a health sector reform based on what they're learning when providing health insurance coverage to migrants from Venezuela. So very, very interesting. The entire population benefiting from a more equitable and more fair health system. Or, what Philippines has been doing. Philippines is a big supplier of migrants in all sectors, also healthcare workers. So what they did is pretty unique because they developed a very comprehensive programme of training, informing for migrants moving abroad in different sectors. And this has a huge impact in terms of alerting migrants, informing them what are the public health risks, and how they need to behave, but also building up a connection with the country in case of help. So, they are not stranded in case they are in need of help.

Last, it's Turkey, Germany, what happened a few years ago with Syrian refugees. Utilising people, displaced refugees, forced migrants working in the systems of the country's hosting them. So, the primary care expansion in the Turkish health system have been employing Syrian healthcare workers, cultural mediators, translators, bringing a new dimension of innovation and the efficacy of the national system. The same happened in Germany in trying to identify a fast track to recognise healthcare workforce skills and to include them into the national system. So, those are encouraging, initiative which are aiming more in uncovering the value of inclusion rather than building on separation and exclusion.

And I like very much what you are doing, Foaud, if I'm thinking to the academic world, the idea to bring this topic into public health teaching at the undergraduate and postgraduate level, I think it's a must. Because it's totally anachronistic to have future health care workers, generations, which they don't have basic understanding of the complexity of this topic. Either you want to be a clinician, either you want to be a nurse, or you want to be a policymaker or a public health care. You have to confront with a diverse world tomorrow. So, those are instruments which need to be taught undergraduate and postgraduate.

Kim Ozano: Thank you, so much. I've really enjoyed listening to the conversation. I've learned so much. I really like, Santino this, this call to consider cultural changes and how this requires time. So, we'd like to end the podcast with advice that you would give to people who really want to start working in the field of migration and displacement, whether it be for research or at a practical level.

Joanna Raven: I think integration of refugees and displaced people into the local health system is vital, not to have parallel systems running. And to do that, we need to support the lower levels of the health system to provide services in an integrated way, as we've heard from Lebanon and the ReBUILD examples, but very importantly, use evidence from research studies to do this in the best way.

Kim Ozano: Reinforce that integration and use of evidence. That's great. Fouad, please...

Fouad Fouad: One is to focus on the protracted long-term needs. The mentality of a humanitarian is to address the emergency phase. And we know that's not the reality. So, it's important now to develop programmes to address the chronic diseases. A second quick one is also about integration, but not just the services. It's about the education itself. There is a huge need, as Santino mentioned, to have migration and health in undergrad curriculums, even in high school.

Kim Ozano: Thank you very much. Look towards that long term need and move beyond the humanitarian emergency response. Santino, take us home with one final piece of advice.

Santino Severoni: Building on what Fouad mentioned, I think it's time to innovate the medical faculty curricula. I'm a clinician myself, I would love to have a little bit more teaching, when I was a younger student at the medical school or at the specialisation. So, I think it's important, especially with a change in society. The other element is a bit of a kind of a dream. Allow me to use a famous phrase, 'I have a dream', to see disappearing the political manipulation from this topic and really to discuss and work and address public health aspects of migration by addressing technical discussions, public discussions, not political sentiments or manipulation of this information. That will be very useful for everybody.

Kim Ozano: Thank you very much. Innovation and medical teaching and really to start engaging in public health discussion and move away from the political focus. So, that's some wonderful advice. I hope our listeners have enjoyed our wonderful guests, Dr Santino Severoni, Professor Fouad Fouad and Dr Joanna Raven. Don't forget, listeners, that this is the fifth of the six part miniseries, so do check out the other four episodes and stay tuned for the next one. So until next time, bye bye.