

WHO REGIONAL COMMITTEE FOR EUROPE

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Ministerial lunch: “Migration and health in the WHO European Region”.

(Delegation of Italy)

WHO and Italy have been collaborating on the issue of migration and health for the past four years, after a major high level meeting held in Rome in 2011, anticipating today scenario. The first project on Public Health Aspects of Migration in Europe (PHAME1) was launched foreseeing the impact of the massive migrants’ wave that we had started to see.

That initial situation has now become extremely serious with criminal entities involved in human trafficking from the equatorial Africa, northern Africa, the Middle East and from wherever man made or natural disasters are making fragile environments unmanageable, resulting in scarce water, uncertain food, and broken social cohesion. Conflicts and social unrest are inevitably making existing poverty and misery more severe, resulting in the tragedy of migration. Today we see the victims of this situation trying to land in our ports, seeking asylum and a better life. We do not want to add additional determinants to their vulnerability, with unacceptable discrimination, denial, neglect.

We underline the need for a convergent support of all Member States, after two years spent in rescuing and providing help and assistance to over a quarter of million migrants almost alone. In Riga, at the informal EU ministerial meeting of April 2015, Italy, Greece, Malta and Cyprus requested the first discussion on migrants, after the tragedy that took over one thousand lives close to the island of Lampedusa, on the same day. It was not easy to persuade all MS that the migrants’ wave was going to soon hit their countries and their borders, scaling up the Mediterranean start.

The current situation of migration in Europe underlines the vulnerability of most migrants left alone in arranging their own hazardous migration. To date in 2015, about 450,000 refugees and migrants have reached European countries, adding to the almost 2 million who have taken shelter in Turkey and the additional 2 million in Lebanon and Jordan. 250,000 crossed the sea, more than doubling 2014 numbers. We start seeing strong differences between migrants coming from the Middle East and moving to central European countries and those who still come by the sea. The former are families and organized population groups, the latter are mainly individuals coming from a variety of countries, quite often infiltrated by criminal organizations.

We have observed that males proportion is decreasing in favour of females and unaccompanied children and teens, whose needs are evidently even more challenging. You may have seen what happened yesterday in the Aegean sea, where several children died. Overall, several thousands died: the official estimate is around 3,000 in 2015, compared to 3,500 in 2014. Our estimate is that the number may be close to 10,000 in the two years considered. This is almost the number of people who died from Ebola during the recent outbreak, for which we have very rightly mobilized billions of euros and thousands health workers.

Are we doing the same effort for migrants?

Much is still to be done also in such areas as combating the criminal organizations managing trafficking, with an evidence of barbaric practices such as massive killings and body organs transplanting on route from equatorial Africa to the Mediterranean transit camps.

New challenges are emerging, as wild poliovirus is currently circulating mainly but not exclusively in the Middle Eastern areas from where the second migrants' contingent is now moving. Obviously, individuals and families fleeing from conflicts in that region have been denied access to even basic health benefits, such as vaccinations, due to their national health systems collapse. They contribute substantially to our herd immunity dilution and may create dangerous epidemic foci, with a substantial number of 'young olds' in receiving countries (baby boomers, mainly) being exposed.

We are also managing a still occasional evidence of contamination of donors' blood and organs with West Nile virus. This is alarming and our surveillance network is at maximum alert nationwide. So far at least five regional authorities are screening massively, in particular in Northern Italy.

Resurgent TB is observed in the region and we are working extensively with WHO to establish reliable surveillance and diagnosis networks throughout the area. We are currently testing rapid surveillance mechanism on arrival that allow our first line health workers to identify potential TB patients among migrants and isolate them for quick diagnosis and possible treatment. May I add that we also screen sea crews rescuing migrants on arrival to our ports, and found a few open TB cases among crew members who had been cleared by Indian medical authorities from Goa. These examples underline the need to review and strengthen IHR also to re-establish mutual trust among collaborating countries.

I will not refer back to our Ebola outbreak management contribution, but we had a second Italian case, who was successfully treated and who challenged our quick epidemiologic and containment capacity with contacts with family members, friends and primary health staff. And a third high risk contact working for UNICEF was evacuated by our air force not longer than two weeks ago in close collaboration with WHO. We learned a lot, and even more from our NGOs and surveillance and laboratory teams working in the areas affected by the epidemics. In principle, without denying support to the Ebola centres, we chose to focus resources on the collapsing health systems. In fact, we had the impression that the massive, though slowly activated, contributions to Ebola were putting at risk other relevant aspects of the service delivery system that was in desperate need not to be neglected in front of a competing priority of such high visibility. Integrated Management of Childhood Illness (IMCI), maternal survival and protection, immunization were the key public health measures that we decided not to forget. This is in line with the WHO vision of health system strengthening even during the worst acute events that we have fully adopted and supported from any angle.

Italy has coherently worked on several other tables, such as the GHSA (for which we will start assisting such countries as Egypt, Ethiopia, Sierra Leone, the Palestinian Authority and Sudan in building their own national capacity for the full IHR adoption) and the G7, with commitments agreed in Elmau, including the migrants' health aspects throughout the discussion and the agenda items.

The policy framework is now ready to be established and needs technical and scientific contributions.

PHAME2 aims at providing the required evidence and an impartial view on this complex issue based on the recognized WHO's added values, such as its capacity to generate technical and scientific knowledge, its objectivity, the possibility to advocate for migrants' needs and expectations overcoming the reluctance of a consistent number of MS and political leaders to accept the simple fact that migration is one of the leading forces shaping our century, will not disappear and cannot be ignored.

In fact, as the Lancet editorial of this week underlines, (and I quote) 'strangely, health has so far been largely ignored, and the voice of health institutions has been disappointingly weak or non-existent. At the time of writing, the National Academies of Science, the World Medical Association, the Royal College of Paediatrics and Child Health, the Royal Society,

and the Academy of Medical Sciences have been silent on refugee health, yet there is a moral obligation for health professionals to speak on this issue. We should see this crisis through the lens of health, focusing more strongly on the health and wellbeing of refugees'. We strongly believe WHO is now the main agent of change capable to influence our decision makers and support a collective social rethinking of how Europe should avoid neglecting and ignoring a massive challenge and a potentially devastating priority.

Conditions are now different, and a massive population wave is not only crossing the sea, but started walking and running. We will never be able to stop a population in the move.

We may also argue that we do not want to stop them, but rather want to make sure they are hosted, rescued and assisted.

There have been several international discussions over the past weeks on what to do and how to do it.

PHAME2 will be the main tool by which the public health implications of migrants' move will be assessed and the impact on hosting systems will be measured. It is from PHAME2 that we will generate recommendations that are going to change the current scenario forever, responding to the uncertainty of MS, policy makers and public opinion.

WHO is the authoritative source of neutral and objective information that will be able to provide guidance and reliable answers, based on facts.

So far, contingency plans have been designed for Sicily, for instance, which is a paradigmatic frontline area, where a standing working group (made of WHO, the regional government, my Ministry) is now reassessing needs and services provided, as well as the entire chain of command through which migrants are rescued and assisted, with the elaboration and adoption of standard operating procedures for a number of conditions and for health services provided on board of our vessels and in camps.

PHAME2 aims at providing Member States with knowledge and first hand experience in generating migrant-sensitive policies, in delivering appropriate and quality health services to migrants, in ensuring cross-border access to health services for the acute and chronic conditions affecting the migrants, and to address the resident population's potential health risks, also by reviewing the IHR.

In fact, there is a clear need to build a common European response capacity throughout the region, and no one is better placed than WHO to do this. Italy is proud to collaborate and to make its own (sometimes painful) experience available. We believe that WHO should now call for a European action plan on public health and migration, as an immediate output of PHAME2. This plan may be strengthened by making existing technical working groups migrants-sensitive in their deliberations, and by investing further in the Venice Centre, which is capable to provide (and I quote) 'an evidence-based, systematic and accountable approach to the full integration of the social and economic determinants of health into development strategies'.

No other determinant is more visible and urgent than migrants and the implications of their movements.

I can only reconfirm the full support of my Government and the Regional government of Veneto, hosting the centre, to pursuing these objectives. Venezia will be re-funded by the end of this fiscal year by a Parliament decision which has already been taken and should be published soonest. I know that the regional government is also organizing a major event very soon that will be mirrored by a high level conference of health ministers that my Minister Beatrice Lorenzin is proposing to organize in Italy during the first quarter of 2016.

Last but not least, in the year of Milano EXPO on 'feeding the planet', I underline the need to promote systematically the one health approach and to focus on food safety and food security as primary global goods obviously extended to the migrants whose right to equal access should not be denied. Italy, in collaboration with FAO and WHO, has been promoting a comprehensive international debate, including the migrants' dimension that will lead to

the 27th/28th October Ministerial meeting when the Milano chart will be signed and presented to Mr. Ban Ki Moon, UN Secretary General.

Finally, we sincerely hope that the Executive Board can consider our request to include this item in the Provisional Agenda of its 138th Session, reviewing and updating the World Health Assembly resolution on the Health of migrants 61.17 of 2008.

Thank you dr. Jakab, thank you colleagues and friends.