Forced Displacement and Humanitarian Health Symposium Proceedings

12 November 2018

CENTRE FOR HUMANITARIAN LEADERSHIP

Executive Summary

This Forced Displacement and Humanitarian Health Symposium provided an open forum for humanitarians, academics, policy makers, researchers and students to explore and discuss the impact of migration on health.

In 2017, over 68.5 million people were forcibly displaced due to conflict, violence or persecution across the globe. Internally Displaced Persons and refugees reached 42.2 million and 23.2 million people, respectively – the highest ever recorded.

Migration has rightly become a leading priority on the global health agenda with humanitarian agencies addressing ways to better meet the health care needs of people on the move

In this, the Inaugral symposium on Forced Displacement and Humanitarian Health delegates explore some of the drivers of forced displacement including conflict, climate change and socio-political issues and the potential impacts on humanitarian health policy and practice both now and in the future.

This one day event was held at Deakin Downtown, Melbourne Australia, and hosted by the Centre for Humanitarian Leadership

The event was attended by close to 100 delegates representing NGO, Academic, Primary Healthcare and private sector groups.

Throughout the day's presentations and open discussion sessions, common observations, themes and needs emerged.

- There is increasing evidence that humanitarian need and disease burden due to escalating and prolonged conflict is, and will continue to rise, into the future.
- Health must continue to be recognised a fundamental human right and a rights-based approach to providing healthcare for the forcibly displaced is required.

- Humanitarian and UN organisations need to be prepared to be a provider or health care services, but only as a last resort as provision of health care is the responsibility of whoever is in geographic control: whether this be government or rebel forces.

- Systemic change in global healthcare resourcing to meet the current and emergent humanitarian healthcare needs is required as funding needs continue to go largely unment.

- Securing access to affected populations in an increasingly securitised world will require novel solutions and individuals and organisations will need to protect against potential criminal charges. Increased engagement diaspora, local volunteers and expatriate health professionals accredited to practice in their countries of origin are avenues that warrant further attentiion.

- Concentrated humanitarian action in the five key migration source countries – Syria, Afghanistan, South Sudan, Myanmar and Somalia, in addition to managing effects in neighbouring countries is, and will continue to be, key in managing present need and maintaining regional and global health security. This is especially pertinent for control of communicable disease and vaccination programs.

- In supporting the humanitarian health needs of the forcibly displaced, health programmes must be sufficiently supported by WASH and protection schemes in both mobile and settlement populations.

- The electronic surveillance and use of electronic health records for refugee populations is a topic of continued concern, especially with respect to population surveillance: data security, data use and misuse, informed consent and what this means for continuance of health care.

Systematic change in global healthcare resourcing will be required to meet the healthcare needs of people on the move.

Forced Displacement and Humanitarian Health Symposium

The most recent figures on forced migration and displacement describe a sobering picture. In 2017, over 68.5 million people were forcibly displaced due to conflict, violence or persecution. Internally Displaced Persons and refugees reached 42.2 million and 23.2 million people, respectively – the highest ever recorded.

Migration has become a leading priority on the global health agenda with humanitarian agencies addressing ways to better meet the health care needs of people on the move.

In this symposium we explore some of the drivers of forced displacement including conflict, climate change and socio-political issues and the potential impacts on humanitarian health policy and practice both now and in the future.

The Forced Displacement and Emerging Humanitarian Health Issues in the Asia Pacific and Fragile States Symposium aims to:

- Explore policy options and approaches to improve the health of migrants
- Discuss the lessons learned from the European Migration crisis
- Identify and analyse the major challenges to health associated with migration, particularly across the Asia-Pacific
- Facilitate and promote the exchange of information through a technical network of humanitarian stakeholders to enhance migration health policy, practice and advocacy
- Promote the exchange of information on migrant health by leveraging modern information technology.

This event is proudly presented by the Centre for Humanitarian Leadership, a partnership between Deakin University and Save the Children, Australia. These proceedings provide a record of the day's presentations and discussions with abstracts of speakers' presentations provided and key points from discussions noted.

In holding this event we acknowledge the Boon Wurrung people of the Kulin nations, the traditional owners of the land on which we gathered. We pay our respects to the local people for allowing us to have our gathering on their land and to their Elders: past, present and future.

Speakers and Panellists

Standing L- R:

Vicki Mau, National Manager of Migration Support Programs, Australian Red Cross

Sonia Brockington, Course Director Graduate Certificate in Humanitarian Health, Centre for Humanitarian Leadership

Majella Hurney, Head of Policy and Advocacy, Save the Children Australia

Stephen McDonald, Co-director, Centre for Humanitarian Leadership

Veronica Bell, Manager International Technical Services, Australian Red Cross

Dr Unni Krishnan, Director, Emergency Health Unit, Save the Children Australia

Patricia Schwerdtle, Faculty of Medicine, Nursing and Health Science, Monash University

Bernadette Murdoch, Chief adviser, brand, communications and communities, Rio Tint

Dr John Marsh, Executive Director Inclusiv Business, Save the Children Australia

Sitting L-R:

Sophie Perreard, Head of Teaching and Learning, Centre for Humanitarian Leadership

Dato' Dr. Ahmad Faizal Perdaus, Director Mercy Malaysia

Aurélie Ponthieu, Humanitarian Specialist in Forced Migration, Médecins Sans Frontières

Running Order

8.30 – 9.30 AM	Breakfast
9.30 – 9.45 AM	Welcome Address Sonia Brockington
9.45 – 10.30 AM	Keynote Presentation: Dr Faizal Perdaus From Preparedness to Response: Current and Emerging Challenges in Humanitarian Health Action for the Asia Pacific
9.45 – 10.30 AM	Guest Speaker: Dr Unni Krishnan Issues from the Frontline
11.00 – 11.30 AM	*Morning tea*
11.30 AM – 12.05 PM	Guest Speaker: Vicky Mau and Veronica Bell Australian Red Cross: Perspectives from the Asia Pacific Migration Network
12:05 – 12:40 PM	Guest Speaker: Aurélie Ponthieu Policy Responses to Migration: The experiences of MSF in Europe
12.40 – 1.00 PM	Protection and Health Q&A* Sophie Perreard
1.00 – 1.45 PM	L*unch*
1.45 – 2.20 PM	Invited Speaker: Majella Hurney Reaching the Unreached: Immunisation coverage for Forcibly Displaced Children
2.20 – 3.00 PM	Invited Speaker: Patricia Shwerdtle Climate Change, Migration and Health
3.20 – 3.40 PM	Discussion: Humanitarian Health Research Directions for Asia Pacific Facilitator: Phil Connrs
3.20 – 3.40 PM	*Afternoon Tea*
3:40 – 4:40 PM	Panel Discussion: The Role of the Private Sector in Migration and Health Facilitator: Stephen McDonald
4.30 – 5:00 PM	Summary and close Sonia Brockington

*Note: due to time contraints the Protection and Health Q&A was cancelled with opportunity for delegates to comment on this topic made available during the afternoon discussions.

Welcome Address

Sonia Brockington

I am very excited to welcome you all to the Humanitarian Health Symposium here at Deakin Downtown.

By way of brief introduction and background, the humanitarian health program was commenced in 2017 thanks to the generous support of GlaxoSmithKline which has enabled the establishment the Graduate Certificate in Humanitarian Health (GCHH), research funding including support to PhD candidates; and financial support for students from low and middle income countries to undertake the GCHH. The GCHH course has been established in conjunction with our Faculty of Health colleagues at Deakin and also with a number of our NGO sector colleagues who are in the room today.

This is our inaugural symposium focusing on health needs due to migration and forced displacement. Whilst examining the issue globally, our particular focus will be on the Asia-Pacific region. Migration and forced displacement are complex political, social, cultural and humanitarian issues, and I thank you for joining us to explore these though a health lens.

We have had an overwhelming response today's symposium with over 100 people registering from NGOs, academic, governments, private sector, consultancy, community-based organisations, health practitioners and many of our CHL team member. We will look forward to drawing on the views, questions and comments from everyone in the room whether in session, over lunch and coffee break.

In 2016 in the wake of the largest population movements since WW2, Ban Ki Moon, stated that this was not a crisis of numbers, but a crisis in solidarity.

Multiple high-level policy platforms to guide practice include the New York Declaration for Refugees and Migrants; World Health Assembly endorsements to promote the health of migrants and refugees; and the WHO Global Action Plan on Health of Refugees and Migrants. Despite these international platforms and the work of many individuals and agencies, displaced communities can still lack access to health prevention, health care, protection and the financial means to access these services.

The health impacts of forced migration are profound and pervasive. Each stage of the forced migration journey is perilous, through fleeing conflicts, famine, persecution or climate related drivers.

Today, on behalf of the CHL and the team who have been working to bring today's event to fruition, I'd like to extend my thanks to our guest speakers who will be sharing their views, expertise and experience from many perspectives relating to research, policy and practice.

I look forward to robust, open and respectful dialogue throughout the course of today with a view to developing real and tangible outcomes for moving forward to bring about transformative action that improves the plight of the millions of people currently displaced.

Keynote presentation

From Preparedness to Response

Current and Emerging Challenges in Humanitarian Health Action for the Asia Pacific

Dr. Faizal Perdaus

The number of persons displaced globally is unprecedented and in many respects the future is upon us. We need to challenge current solution to meeting the health needs of migrants - with numbers of forcibly displaced totalling 68.5 million worldwide, and an estimated 44,000 people a day becoming displaced.

Regional factors driving displacement differ globally: migration in SE Asia is largely disaster driven, in Africa and Middle East, it is conflict. Displacement in Latin America is largely driven by narcotic wars. There are now more categories of people who are forcibly displaced, people are now displaced longer, natural disasters are more frequent and severe, and people displaced by climate related factors are increasing in number and diversity. Sea-level rise is affecting populations in the Indian and Pacific Oceans; and drought is driving competition for natural resources.

There are also new challenges facing humanitarian responses. People on the move are increasingly affected by psychological disorders precipitated by the refugee experience, by infectious parasitic diseases endemic to countries of origin and chronic disease endemic to host countries.

There are new actors on the scene, and there are new roles for old actors: this includes governments, government agencies, militaries, the private sector, financiers and philanthropists, insurance and re-insurance. All will have to do more to meet the needs of migrants and IDPs. We need to embrace and put more focus on technology. We need to invite technical subject matter experts to contribute in the manner of HUMTECH.

The Health Cluster is and should be a provider of last resort of humanitarian health care and needs to approach partnership building in was so all have something to gain. NGOs need to be flexible in their

"It is time to go about things differently."

Dr. Faizal Perdaus

approach: e.g. MERCY Malaysia's move from emergency health to reproductive health. WASH activities must occur in coordination with health.

A human rights-based approach to emergency response remains key: being the response in a non-discriminatory manner.

With respect to the financing of humanitarian health provision for displaced populations, it is crucial to ask: are the usual financial mechanisms working? How (or not)? By whom? For what? By who? This is an area needing innovation and increased engagement of global financing mechanisms such as investors groups (e.g. Global Financing Facility) and recognitions of the increasing importance of the World Bank. Humanitarian financing in general needs innovation and other ways of working (e.g. partnerships).

The World Health Organisation should also act as a provider of last resort, but roles and approaches may need to change especially with renewed assertion of state sovereignty.

Whilst conflicts remain pertinent, climate change will be the single biggest driver of forced displacement in the future. We must consider the climate change – water – migration nexus. By 2025, 2.4 billion people will be living in areas of intense water scarcity. This may displace as many by 700 million by 2030. Today in Jordan, displaced Syrian's have added one-third of the total population. This already in a country of existing water scarcity.

It is time to go about things differently. Giving money has its limits. Asking for money has its limits. Refugees need to be integrated into national health systems. The technical basis of the refugee population needs to be upgraded.

Presentations

Dr. Unni Krishnan: Issues from the frontline

Tonight, 815 million people will go hungry. Sexual violence against migrants, especially women and children is epidemic and underreported. To offer any assistance with success, we must apply a protection lens in addition to meeting the challenges to providing health care.

We need to meet the challenges of access, in negotiating 'humanitarian space', licencing for health professionals, funding, capacity gaps, brain drain (the movement of doctors and nurses from developing to developed countries), attacks on healthcare workers. We need to figure out how to quickly upskill local health workers.

In these challenges there is the potential for creative solutions. Local diaspora are a relatively untapped resource. For example, overseas born or trained health-care workers may retain licences or authorities to practice in affected states: these are people we can more actively engaged. Bangladeshi born or trained doctors now living in Australia (or elsewhere) may still hold or be eligible for a licence to practice and can therefore write prescriptions which would help meet and desperately unmet need in Cox's Bazaar.

We can broaden perspectives on funding: humanitarian health funding is chronically unmet (typically only one-third is met), whereas 1.7 trillion is spent globally on military spending.

We can invent the future by investing in better preparedness for before, during and after a crisis, by supporting stronger public health systems and work to stop, or at least compensate for the brain drain. We need to remember that health is a fundamental human right and it is the responsibility of whoever is in geographic control, be it the government or rebel forces.

Vicky Mau and Veronica Bell: Australian Red Cross and Perpsectives from the Asia-Pacific Migration Network

The Red Cross-Red Crescent society engages 1.7 million volunteers world-wide and through active country chapters is uniquely placed to work with migrants. The society therefore has a unique role in supporting the public health sector, especially with relation to epidemic and pandemic control.

More needs to be done to support first responders before disaster strikes. Asia-Pacific faces unique challenges, hosting one-third of global refugees and migrants, with trafficking and bonded labour high in the region. Microbial adaptation and evolution, and international travel and trade also factor in driving disease emergence.

The RCRC society is working toward streamlining response to health security threats, especially in host, origin and border countries by extending the formal public health systems.

Some innovative approaches are being trialled. The Norwegian Red Cross is partnering with Microsoft to enhance community surveillance to inform humanitarian responses and to use SMS technology to enhance early warning systems. Thirty-five national societies in Asia Pacific are part of the Asia Pacific Migration Network: established in 2012 the network takes a global migration focus and develops policy frameworks for the region and is abreast of developments in the domestic legal space.

Local societies are proving to be key in maintaining health security and early warning of migrant health issues. The Maldivian Red Crescent has outreach activities in TB monitoring of migrant communities, and also cross-border migration of HIV/AIDs.

We are observing in our work that mental health issues are of increasing importance and require effective outreach activities.

Aurélie Ponthieu: Policy Responses to Migration: The Experiences of MSF in Europe

The 2015 so-called crisis really started in 2013-14 with the arrival of Syrian refugees in Italy and across the Balkan's route. Medical and humanitarian needs of people transiting through Europe at the time were directly related to the lack of access to adequate healthcare, the lack of accommodation and shelter, inadequate WASH, food and registration procedures. International actors were reluctant to respond initially to due perceptions that rich European countries would provide aid and support. This of course did not occur and the state response focused primarily on security and border management rather than humanitarian assistance.

> "We can invent the future by investing in better preparedness for before, during and after a crisis."
>
> Dr Unni Krishnan

In addition to providing tradition forms of health support to migrants, MSF has observed an increasing requirement to adapt mental health care provision for people on the move. Other common health needs of the migrant populations included higher than normal percentages of reproductive age women (10%) requiring specialised healthcare, due largely to sexual violence enroute. Overall, the highest requirements are for obstetric and gynaecological care, trauma, respiratory, gastrointestinal and dermatological presentations. Chronic disease accounted for 4-16% of presentations, depending on the migration route. There was a low (communicable disease) risk to public health detected at borders.

Warnings signs of the crisis worsening from a political perspective included the border restrictions and fencing, the EU-Turkey deal, training of Libyan coast guards, criminalisation of assistance and blockage of Italian harbours, public addresses by border control agencies and addresses by governments denouncing NGO actions as being complicity with people smuggling operations. Preventing mortality at sea was used as a reason for increased controls to migration however this had other implications for mortality by other causes such

as environmental exposure (hypothermia during winter months). The closed borders resulted in immobility of immigrants and an increase in violence toward migrants, perpetrated by border guards.

The European migrant 'crisis' is a failure of policy, with health impacts on the migrant population due to conditions experienced during their migration journey, not because of it.

Majella Hurney: Reaching the Unreached: Immunisation coverage for Forcibly Displaced Children

Vaccinations are a crucial part of maintaining public health security globally. Vaccines have direct health benefits, direct cost savings and result in improved child development and overall productivity. Children living in conflict affected states and child refugees are however missing out.

Large scale disruption and displacement has significant implications for vaccination rates of children against communicable disease.

For example, prior to the outbreak of hostilities in Syria, the last confirmed case of polio was in 1999 and vaccination levels were at 90%. In 2013 there was a polio outbreak.

It is important to note that the top five refugee/IDP source countries – Syria, Afghanistan, South Sudan, Somalia and Myanmar – also have the lowest vaccination coverages. Approximately two-thirds of all unimmunised children live in conflict affected areas. Unfortunately, mass vaccination programs e.g. in Cox's Bazaar as supported by the Bangladeshi government are the exception not the rule.

The major challenges to receiving vaccinations for IDPs and refugees include a lack of legal status, political barriers, social barriers (e.g. language), host government failures and low demand (e.g. lack of awareness).

Gavi, the Vaccine Alliance is a public-private global health partnership committed to increasing access to immunisation, and vaccine prices are tiered according to a country's development status. Host governments may want to extend coverage to refugees and asylum seeks however the cost may be prohibitive. Advice to NGOs when advocating for vaccination coverage, is to appeal to the self-interest of the host or donor governments from a health security perspective.

With the expiry of current arrangements for global vaccinations expiring in 2020 and the formulation of the global compacts on refugees and migration, now is the critical period for action. Global instruments need to have provisions for conflict affected states.

Change priorities include: legal provisions for host governments to extend national vaccination programmes to migrants, advocacy for policy provisions for migrants in Gavi, innovative programming and development of technology for tracking immunisations.

Patricia Schwerdtle: Climate Change, Migration and Health

What is a climate refugee and are these people recognised as refugees and migrants? Drivers of migration can be social, political, economic, environmental and demographic. There are complex factors determining the decision to migrate and therefore it can be difficult to identify and protect climate refugees.

Climate migration is mostly internal, and people generally don't go far due to capacity and livelihood.

The Asia Pacific region is the most vulnerable to climate related disasters, the frequency and severity of which are only expected to increase due as we approach and pass global tipping points – where negative (environmental) feedback loops become exhausted. The latest research indicates that there is a 93% chance that greenhouse gas emissions will rise to levels that cause a >3-degree climate change by the end of the century. The future demand for humanitarian assistance globally will depend on temperature rise, however the individual human experience of climate change is a function of vulnerability, climate change impacts and exposure.

Dengue, malaria, cholera and gastroenteritis have all been indirectly connected to, and are considered climate related health issues. Direct health issues include heat and cold exhaustion.

Responses can be community led, for example the so far successful relocation of communities from the Carteret Islands to PNG due to sea level rise. To address climate related migration in sub-Saharan Africa, South Asia and Latin America there needs to be a move toward systems thinking and away from siloed responses.

South Sudan is a new failing state at the edge of climate extremes: it will become uninhabitable in at 1.5-2-degree world. In Cambodia there is mass rural to urban migration in areas vulnerable to sea level rise, migrant plight is further influenced by farmers trying to repay loans to cope. Immobility is also a feature of climate change migrations e.g. trapped populations in Myanmar.

The humanitarian sector's actions in reducing the effects of climate change on vulnerable populations currently relates to forecast based advice and financing, via the ICRC climate centre. Through providing reproductive choice to vulnerable populations, the Marie Stopes foundation is increasing individual and community resilience and ability to adapt to change. MSF is working to mitigate and adapt programmes to climate change, particularly in strengthening disaster response, expanding roles to include WASH and specialised programmes such as slum health.

> "The humanitarian community can take action and must not be complicit in business as usual."
>
> Patricia Schwerdtle

The humanitarian community can take action and must not be complicit in business as usual. Importantly the community must together advocate for change.

Discussions

Humanitarian Health Research Directions for Asia Pacific. Facilitator: Phil Connors.

Associate Professor Phil Connors opened the discussion to the floor.

Could the use of technology to survey refugee movements be used to further stigmatise refugees and who should own refugee data?

Dr Krishnan: A valid point as the data could be used by governments to deliberately discriminate.

Veronica Bell: There is no good answer, but it is better to be part of the change than not.

Aurélie Ponthieu: We are already surveilled, and it is true that governments are using technology to surveil refugees. It is an issue of informed consent and something that has been explored by MSF with the use of patient data for advocacy.

How can the humanitarian system adapt programmes to be better prepared for populations on the move?

Aurélie Ponthieu: First, through pre-positioning and secondly by understanding drivers.

Patricia Schwerdtle: We need to be able and prepared to reach out to people rather than them having to come to us.

Are any Australian humanitarian organisations using, or planning to use data from MyHealthRecord (an Australian government initiative)?

Dr Krishnan: There are clear guidelines from the WHO on use and retention of data.

Veronica: The Norwegian Red Cross has been working through the legal and ethical aspects of this issue with Microsoft.

Dr Perdaus: Government use of this data is a reality.

Did the ARC reach out to faith-based organisations for provision of mental health and psychosocial support?

Veronica Bell: ARC principles would have meant that we should have reached out.

MSF has a role to play in advocacy, what activities are being undertaken?

Aurélie Ponthieu: Governments don't need MSF to inform them about the degree of the crisis; it's political based on a perception that the 'European people' don't want migrants. MSF is trying to correct misinformation.

Will people return from mega-cities (i.e. will the rural-urban migration trend reverse?).

Patricia Schwerdtle: Many megacities are vulnerable [to climate change] however, recent migrants will have nothing to go back to so they won't leave.

If or when will South Sudan reach tipping point?

Patricia Schwerdtle: It won't take much to push it over. But perhaps more importantly, will anyone notice?

Private Sector Action in Migration and Health. Facilitator: Stephen McDonald

Stephen McDonald introduced panel members John Marsh from Save the Children Australia, Digicell and Incentive Futures, and Bernadette Murdoch from Rio Tinto and formerly, GlaxoSmithKline. In introducing the session, Stephen encouraged delegates to join in the exploration how the humanitarian sector can improve engagement with private business to better meet current and emerging humanitarian healthcare needs in our region.

John raised the question as to what the humanitarian sector would do if overseas development assistance was cut off as currently ODA is flat-lining and non-ODA and personal remittances are increasing. John raised the perspective that to engage the private sector, there needs to be a business reason to be involved. If there is no return for business, then engagement is not sustainable. Relationships can cover a spectrum, from transactional (core business) to the level of corporate philanthropy (which may not relate to core business activities). John then illustrated how technology and the private sector can be a powerful tool for assisting humanitarian effort using the example of internal migration following natural disasters in PNG where cell phone data from the time of event and days after provided detailed information migration patterns – away from, and then returning to the location of disaster.

Steve posed the question to Bernadette as to what relationships might look like as there is a desire to move away from corporate social responsibility to corporate citizenship. Bernadette confirmed that yes, there is desire for the private sector to move away from being an "ATM" to a more involved place where interests align. Businesses will approach these from a risk management perspective and want to be part of the solution from the earlier stages.

Steve then asked John to expand on his experiences with small to medium enterprises as an example of how to move beyond philanthropy. John commented that markets are an effective distribution mechanism and SME's always manage to pop up. SMEs are most effective where they form part of the greater market system.

The session was then open to questions from the floor.

If NGO's left the scene, would the private sector step up?

Bernadette's opinion was that in some ways they would, and in some they could not. Like the humanitarian sector, the private sector is only part of the solution.

How do NGO's better measure of outcomes, for example attracting private sector investment to sexual and gender-based violence programmes as outcomes are hard to measure.

Bernadette's thoughts on this were that companies want to contribute what they are good at, so you need to look for aligned interests.

How can NGOs better understand and communicate the monetisation of social investment as humanitarians are learning how to 'speak to business' on the go? Being able to monetise social investment would help to ensure long term benefit.

Bernadette agreed that this would be beneficial then each small activity would have to be profitable in the traditional sense.

Was permission from the PNG government required or sought to share the Digicell data? (directed to John Marsh)

John confirmed, that yes, a degree of government permission is required.

Is it the responsibility of the private sector to have an understanding of what humanitarian issues are?

Bernadette spoke to the social impact assessment side of business, how companies will undertake and assessment of benefits and risks of projects which does in some way relate to humanitarian issues. John's thoughts were that conditionalities could be applied to any relationships.

Note of thanks

This inagural Symposium on Humanitarian Health for the Forcibly Displaced was proudly presented by the Centre for Humanitarian Leadership with generous funding by Glaxo Smith Kline

The CHL is an innovative joint venture between Save the Children Australia and Deakin Univeristy and the ongoing work of the Centre would not be possible without the continued support from these and other partners including the IKEA Foundation.

Further notes of thanks from the Humanitarian Health team are extended to all in the CHL who assited in the coordination and organisation and support of this event, and to our guest speakers who contributed their expertise and time.

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