

JO VEAREY
CHARLES HUI
KOLITHA WICKRAMAGE



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MIGRATION AND HEALTH: CURRENT ISSUES, GOVERNANCE AND KNOWLEDGE GAPS¹

Introduction

There is a dynamic and complex relationship between migration and health. Migration can lead to greater exposure to health risks, such as those migrant workers working in conditions of precarious employment with limited access to affordable health care. Migration can also be linked to improved health – for instance, after moving from a context of persecution and fear of violence to a safe environment. In this chapter, we examine the four key aspects of migration and health: (a) the health of individual migrants (“migrant health”); (b) the ways in which migration can affect the health of populations (“public health”); (c) health-care systems responses; and (d) the global governance of migration and health.

The first aspect – migrant health – can be defined as the differences in health found between migrants and populations at both origin and destination, and across different migration settings, such as labour migration, international and internal displacement, or irregular migration. Whether individual migrants will experience improvements or declines in their health status will depend partly on their interactions with the multiple factors that determine their health before, during and after their migration journey. Such factors – known as the social determinants of health – include access to safe transit, quality housing and health care.

The second issue – public health – focuses on how migration can affect the health of populations, including the ways in which healthy migrants can promote social and economic development and progress towards the global target of universal health coverage (UHC), which aims to ensure access to affordable and quality health care for all.² However, if poorly managed, migration can negatively affect populations’ health. For example, a migrant mother struggling to access documentation may be unable to access timely health care for her child – including vaccinations – for fear of arrest, detention or deportation. This could contribute to the spread of communicable diseases, such as measles, across and within borders, with negative health effects for the entire population.

The third issue concerns systems responses to migration and health. The development of migrant-sensitive health-care responses and the monitoring of migrant health, through a Migration and Health in All Policies (MHiAP) approach, can address the health needs of migrants. Poorly managed, inadequate or discriminatory immigration and health system responses can have multiple negative consequences for the health of migrants and the communities with which they interact.

The fourth issue is the global governance of migration and health. This involves a focus on the ways in which migration and health can be mainstreamed into global governance processes, including identifying key strategic opportunities to do so.

1 Jo Vearey, African Centre for Migration and Society, University of the Witwatersrand and Centre of African Studies, University of Edinburgh; Charles Hui, Faculty of Medicine, University of Ottawa; and Kolitha Wickramage, Global Migration Health Research and Epidemiology Coordinator, IOM Manila.

2 UHC2030, 2017.

The chapter examines these four key issues. It starts with a brief overview of definitions and determinants. It then provides an overview of the factors that determine the health vulnerabilities and resilience factors of diverse migrant groups. Systems responses, and an overview of current approaches to the governance of migration and health, are then outlined. Key evidence gaps are highlighted, and the chapter concludes by emphasizing the importance of investing in effective migration and health governance, and how current approaches could ideally be strengthened.

Migration and health: Key facts

- **Good health encompasses mental, social and physical well-being.**^a The field of migration and health encompasses health concerns arising from human mobility, such as the transmission of infectious diseases, and should engage with all aspects of well-being in the context of migration and with all who are affected, including families of migrants and the public health of communities with whom migrants interact during all phases of the migration journey.^b
- **People who move are often healthier than those who stay behind and may display what is known as the “Healthy Migrant Effect”.** This means that those who move tend to be healthier and live longer than people living in both the communities they leave and those to which they arrive.^c Health vulnerabilities and resilience factors are dynamic and change over time, and this elevated health status – if migration is not managed properly – can be eroded due to the poor living and working conditions experienced post-migration.^d
- **Migrants are not automatically vulnerable to poor health outcomes.** It is the conditions associated with different phases of the migration journey (pre-migration, transit, arrival and return) that may negatively or positively affect health.^e
- **Many migrants struggle to access health care.** Despite human rights norms on the right to health, and promotion of UHC for all, States are only obligated to provide a minimum basic package of emergency medical care to irregular migrants.^f Even regular migrants sometimes face legal barriers, racism and corruption, which inhibits health-care access.^g Plus, migrants often underutilize health-care services and delay seeking health care.^h
- **Healthy migration can benefit the health of communities.** For example, ensuring the good health of migrant workers can – through remittances sent home – enhance the socioeconomic status of family members, therefore promoting access to health care and education.
- **Health-care providers face challenges in managing care for migrants,** including: language and cultural barriers, resource constraints within health systems to deliver services, and the contradiction between professional norms/ethics and domestic laws that limit migrants’ right to health care.
- **Strategic leadership and investment in building alliances between migration management systems and the health sector is needed.** Multisectoral action is needed to support alliance-building between immigration and health actors across multiple governance groups: the State, civil society – including migrant groups – the private sector and academia.ⁱ

- **Investment in the field of migration and health supports social and economic development.** Investment in monitoring and mitigating health risks is key to maintaining the health of migrants which, as a result, supports progress towards the Sustainable Development Goals and global health targets.
- **Migration and health research capacity needs to be built globally, particularly within low- and middle-income countries.** Existing research output focuses disproportionately on a few categories of migrants and health concerns, and on migration to and from high-income countries.^j

a WHO, 1946.

b Wickramage et al., 2018b.

c Aldridge et al., 2018.

d Ibid.

e IOM, 2004.

f Lougarre, 2016.

g Migrating out of Poverty, 2017.

h Suphanchaimat et al., 2015

i Khan et al., 2016; Vearey et al., 2019; Wickramage and Annunziata, 2018.

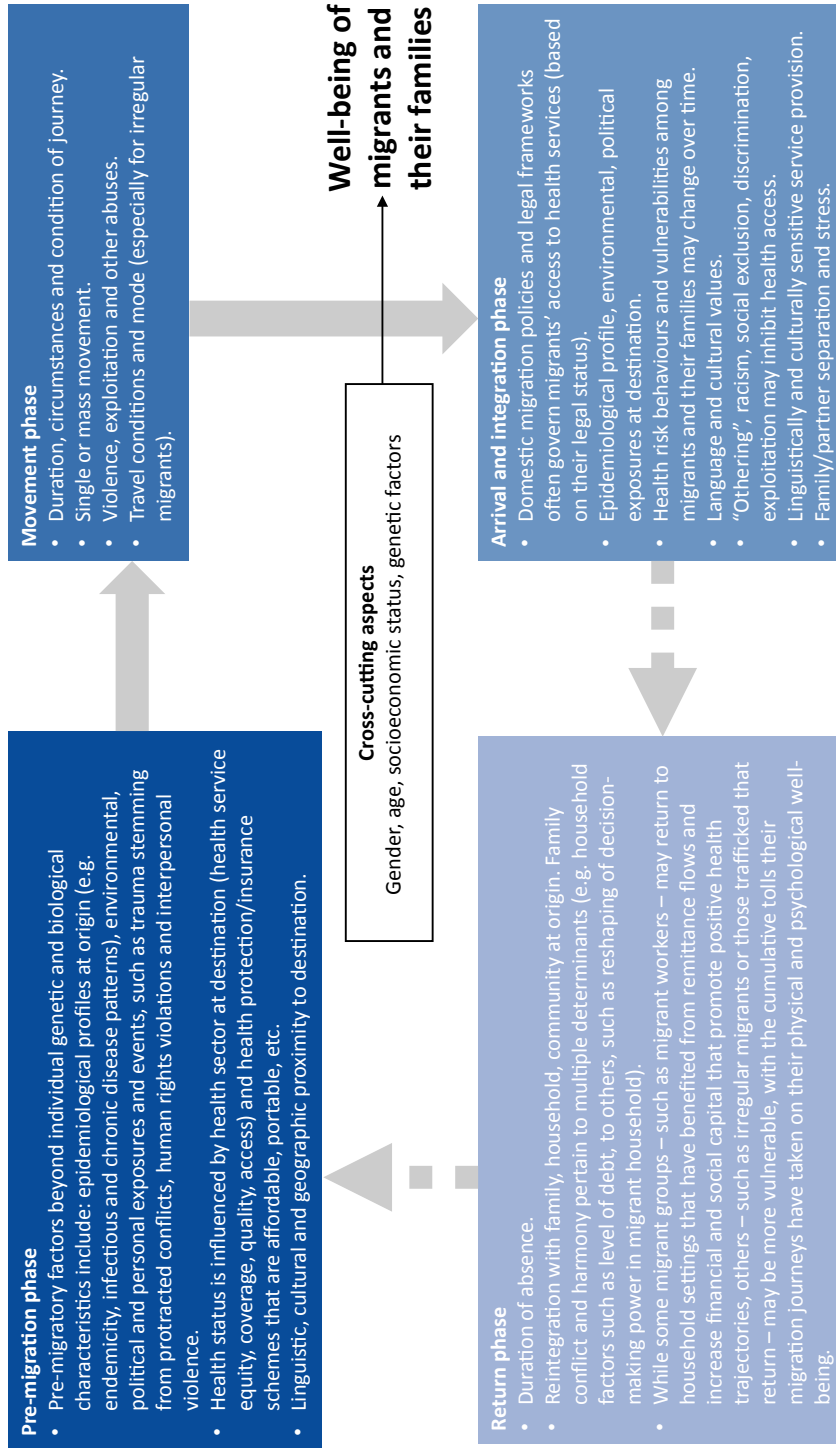
j Sweileh, 2018.

Definitions and determinants

The World Health Organization (WHO) defines good health as a “state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity”.³ This recognition of mental and social well-being, in addition to physical well-being, is critical, and emphasizes the importance of viewing health holistically. The state of a person’s health is shaped not only by one’s access to health services, but by a multitude of factors, which are termed the “determinants of health”. Figure 1 shows how the determinants of health can be applied to migrants across the migration cycle. Individual determinants are factors such as age, sex and genetic predisposition to disease, and the epidemiological profile of a given context and the disease exposures associated with it. Structural determinants are usually politically mediated – such as legal frameworks and societal attitudes towards migrants – and can result in a range of inequalities in socioeconomic status. For migrants, structural determinants of health include the conditions associated with the different phases of their migration journey – pre-migration, movement, arrival and integration, and (for some) return.

3 WHO, 1946.

Figure 1. The determinants of migrant health throughout the migration cycle



Source: Adapted from Gushulak, Weekers and MacPherson, 2009; IOM, 2008.

The various legal frameworks associated with different phases of the migration journey are important structural determinants of migrant health. This is because a migrant's legal status in a country can determine, for example, the extent to which they can access safe working conditions as well as the quality and affordability of health care. As illustrated in figure 1, there are multiple determinants of health – both individual and structural – that can have both positive and negative effects on health. An irregular migrant, for example, is unlikely to find work in the formal sector, and has to rely on the precarious informal sector, where work can be both unsafe and – often – illegal. As a result, irregular migrants may experience greater vulnerabilities to poor health, including increased exposure to infectious diseases, violence and injury. They are likely to face many challenges in accessing quality health-care services, and have very limited (if any) access to social protection services.

Migrant health

The field of migration and health explores the patterns in health found between migrants and the host population, and across different migrant groups, including in contexts where the host population may be struggling to meet its own mental, social and physical well-being needs.⁴ Exploring these patterns is important for several reasons. Firstly, the development of public health strategies over many decades recognizes the need for inclusiveness – the need to incorporate whole societies when addressing communicable disease control, such as through immunization programmes. The exclusion of subpopulations – such as migrant groups – must be avoided.⁵ There is a significant burden of tuberculosis (TB), HIV, hepatitis B, hepatitis C and vaccine-preventable diseases in migrant populations. Addressing this important group in surveillance, screening and linkage to care is crucial to meet the public health targets of countries and regions.⁶ Secondly, some health-related interventions developed for specific subpopulations, such as migrant groups, can provide or lead to health benefits for the whole population.⁷ Thirdly, ensuring the best possible health of migrants before, during and following their migration journeys enables them to maximize their inclusion and contributions to their host society, facilitate their support to families of origin, and minimize potential health-related costs borne by both the destination country and migrants themselves.⁸ Even in acute displacement situations, such as large-scale refugee flows, immediate health issues (along with food and shelter) are of primary concern, and dedicated resources are needed to meet these critical needs for the good of individuals, local communities and the broader society.⁹

Understanding health vulnerability and resilience is central to the field of migration and health. Migrants are not a homogenous group, nor are their needs, health vulnerabilities and resilience factors. Gender is a key dimension that particularly needs to be considered (see the text box below).

4 Lee, Sim and Mackie, 2018; Thomas, 2016.

5 Thomas, 2016.

6 European Centre for Disease Prevention and Control, 2018.

7 Chung and Griffiths, 2018; Thomas, 2016; Wild and Dawson, 2018.

8 Lu and Zhang, 2016; Wickramage et al., 2018b.

9 Abbas et al., 2018; Griswold et al., 2018.

Gender dimensions in mortality and abuse in “low-skilled” labour migrants

Globally, there is a higher proportion of male (58.4%) than female (41.6%)^a international migrant workers. Males dominate manufacturing and construction jobs, while female migrant workers work mainly in service sector jobs (nearly 74%), such as domestic services – often in conditions of precarious employment.^b Systematic reviews indicate a range of health vulnerabilities of female domestic workers, including poor access to sexual and reproductive health services.^c Poor work and living conditions, particularly restrictions on mobility and non-payment of wages, further exacerbate difficulties encountered by female domestic workers.

There is also limited empirical research on female migrant worker abuse, despite the phenomenon being widely reported in the media. Studies have shown that female migrant worker abuse manifests in multiple ways, including physical, sexual, emotional, psychological, spiritual and verbal abuse, and in terms of financial exploitation.^d

a ILO, 2018.

b ILO, 2015.

c Benach et al., 2011; Malhotra et al., 2013; Senarath, Wickramage and Peiris, 2014.

d Benach et al., 2011; Malhotra et al., 2013; Murty, 2009; Senarath, Wickramage and Peiris, 2014; IOM, 2017b.

Health vulnerability can be defined as the degree to which an individual is unable to anticipate, cope with, resist and recover from the impacts of diseases or epidemics.¹⁰ While most often associated with low socioeconomic status, health vulnerability can also arise when people are isolated, insecure and defenceless in the face of risk, shock or stress, including during and following migration journeys. Health resilience, on the other hand, results from individuals having access to the resources needed to cope with a threat to health or to resist the impact of a health hazard. Such resources can be physical or material, but they can also be found in the skills or attributes of individuals and their social networks.

Some migrants are healthier than the communities they leave and the communities to which they arrive, displaying levels of resilience to the health challenges encountered.¹¹ However, these health benefits can rapidly wear away, and migrants may struggle to access positive determinants of health, resulting in a range of health vulnerabilities that are more pronounced than those of the local population. For example, prenatal and postnatal health complications are often worse in migrant women. Not only are experiences with pregnancy-related health care more likely to be negative, there is an increased risk of mental health disorders, maternal mortality and premature births.¹² A systematic review of perinatal health outcomes and care among asylum seekers and refugees reported that perinatal mental health disorders such as postnatal depression were more frequent in migrant women than in women from host countries. The study also reported a twofold relative risk of mortality of migrant women related to preeclampsia/eclampsia and thrombosis.

10 Grabovschi, Loignon and Fortin, 2013.

11 Spallek et al., 2016.

12 Heslehurst et al., 2018.

As outlined in table 1, those migrants with the greatest health vulnerabilities are those in situations that diminish their capacity to anticipate, cope with, resist and recover from the changes and challenges associated with the different phases of the migration process. Some migrants can be exposed to trauma, exploitation and abuse during perilous journeys. They may experience psychosocial stressors, nutritional deficiencies, dehydration, exposure to infectious diseases, a lack of health-care services or continuation of treatments, and face the unhealthy consequences of certain settings, such as immigration detention centres or informal and illegal work environments. The literature on these issues is predominantly from high-income destination countries, focusing on specific health issues, categories of migrants, and source countries.¹³ Some literature combines different migrant groups together into descriptive studies, and most do not have comparisons with the host populations. For these reasons, it can be difficult to generalize from the limited data, but many of these health issues are consistent across studies, as summarized in table 1.

Table 1. Summary of main health concerns of selected migrant groups in vulnerable situations

Irregular migrants	<ul style="list-style-type: none"> • Limited/no access to health-care services • More limited ability to pay for preventative and primary health care • Limited/no access to safe and legal work • Fear of deportation has multiple effects on emotional well-being and mental health, and impacts willingness to seek health-care services^a
Migrants in detention	<ul style="list-style-type: none"> • Conditions of detention are often punitive, jail-like conditions with limited access to medical care • Indefinite nature of detention contributes to the extreme distress, and cognitive, physical and emotional deterioration • Dramatically increased rates of depression and suicidal thoughts • Child migrants may be held in detention alongside their parents or separated from their families, and experience a lack of education or play opportunities^b
Child migrants and unaccompanied minors	<ul style="list-style-type: none"> • Preventative health interventions such as immunizations may be interrupted • Social isolation and separation from family members seriously limits ability to seek health care when needed • Persistence of mental health disorders even after settling • Age determination processes used as for immigration application resolution are controversial and fraught with imprecision and ethical challenges^c
Children “left behind”	<ul style="list-style-type: none"> • Potential benefit of remittances that can allow for money to purchase food and for educational benefit • Increased risk of anxiety, depression, suicidal ideas, substance abuse and growth disorders^d

13 Sweileh et al., 2018.

Adult caregivers “left behind”	<ul style="list-style-type: none"> • Elderly caregivers take on a disproportionate burden of care for the children left behind, with negative psychosocial and physical health consequences • Left-behind elderly caregivers experienced higher levels of depression, loneliness, cognitive impairment and anxiety, and had lower scores on psychological health compared with older parents with no migrant children^e
LGBTI migrants	<ul style="list-style-type: none"> • Migration can be undertaken to leave violence, discrimination or persecution • Trauma associated with need to continuously prove gender and sexual identity for asylum claims • High levels of depression, post-traumatic stress disorder, suicidality and substance abuse^f
Survivors of human trafficking	<ul style="list-style-type: none"> • High levels of physical and sexual violence, and workplace injury • High rates of depression, anxiety and post-traumatic stress disorder, attempted suicide • Chronic threats, excessive work hours, poor living conditions and severe curtailment of freedoms^g

Source: (a) Hacker et al., 2015; Martinez et al., 2015; Winters et al., 2018; (b) Filges et al., 2015; Robjant, Hassan and Katona, 2009; Sampson et al., 2015; (c) ISSOP, 2018; Jensen, Skårdalsmo and Fjermestad, 2014; (d) Fellmeth et al., 2018; (e) Graham, Jordan and Yeoh, 2015; Siriwardhana et al., 2015; Migration Policy Institute, 2015; Thapa et al., 2018; (f) White, Cooper and Lawrence, 2019; (g) Kiss et al., 2015.

Note: Migrant groups are not mutually exclusive (can be overlapping). What is meant by “irregular migrant” is discussed in chapter 2 of this report.

Public health

The second aspect related to migration and health is on how migration can affect the health of populations (public health). As outlined above, migrants can face challenges in addressing their mental, social and physical well-being needs. Migrants who have limited or no ability to access positive determinants of health (see figure 1) can experience poor health outcomes, with various consequences for public health. This situation could itself be the result of difficulties faced in accessing a secure income, perhaps associated with challenges involved in obtaining the necessary documentation to work legally. Should they be unable to access timely testing and treatment, chances for onward transmission of the disease to others within the community would increase, as would the likelihood of unnecessary costs being incurred by the host health-care system as a result. It is important to recognize that popular representations of migration and health tend to be exaggerated by the media, sometimes as part of anti-immigrant political agendas, in which migration is positioned as a threat to public health.

Regardless of the setting, if migrants access health care only when they are very sick, additional costs will burden the health-care system. In contrast, health-care services – both preventative and curative – that are easily accessible enable the health needs of migrants to be addressed before they become very sick, reducing overall costs to health-care systems. When considering infectious diseases, delays in seeking treatment or challenges encountered when attempting to continue treatment for chronic infectious diseases such as TB

and HIV can have negative effects for populations, as the potential for onward transmission of infection may increase. This is particularly true in the case of movement across international borders, where delays in seeking care are associated with multiple factors, including the fear of engaging with public services when one is without legal status, or the outright denial of access to care by health-care providers. The emergence of “sanctuary cities” in countries with restrictive immigration regimes has in part stemmed from a need to ensure that health-care services are available regardless of a person’s migration status. The “sanctuary cities” movement is based on human rights principles and health equity approaches that prioritize access to health care for undocumented migrants.¹⁴ For instance, no significant differences in reports of physician communication, or in measures of diabetes management between undocumented and documented immigrants, existed among Mexican immigrants receiving care in two immigration sanctuary areas in the United States where people seeking health services are not asked about immigration legal status, nor is immigration status reported to immigration officials. Undocumented immigrants achieved comparable clinical outcomes and reported similar experiences of health care as documented immigrants and United States-born Mexicans.¹⁵

Some groups of migrants – including refugees, asylum seekers and irregular migrants – may be particularly vulnerable to infectious diseases and experience worse health outcomes than the host population, or come from locations where certain infectious diseases are of high prevalence; these groups can benefit from targeted screening and interventions.¹⁶ Their journeys from one place to another – including forced movements from conflict zones with severely compromised health-care services – may result in interruptions in vaccination schedules, with potentially negative public health implications for both individual migrants and communities affected by migration.¹⁷

Migration, both within a country and across national borders, is a key consideration in the control of infectious diseases. One such example is the case of the Ebola outbreak in West Africa in 2014 (see text box below). Another example relates to interventions to address malaria. These require careful consideration of migration, which has been shown to affect diagnosis and negatively impact access to treatment and continuity of care. This may contribute to the spread of antimalarial drug resistance.¹⁸ Additionally, the reintroduction of malaria in countries reaching elimination through inbound migration presents further challenges to cross-border malaria control.¹⁹ Recognizing its importance in the control of infectious diseases, migration has been enshrined within the International Health Regulations and key disease control programmes in global health.²⁰ For example, the WHO framework for the global post-2015 “End tuberculosis (TB) Strategy” has identified migration and cross-border issues as a priority action area for countries with a low incidence of TB.²¹

14 Aboji, 2016.

15 Iten et al., 2014.

16 European Centre for Disease Prevention and Control, 2018.

17 Hui et al., 2018.

18 Lynch and Roper, 2011.

19 Cotter et al., 2013; Jitthai, 2013; Pindolia et al., 2012.

20 Lönnroth et al., 2015; Wickramage et al., 2013; WHO, 2015.

21 Lönnroth et al., 2015.

Migration and disease control – The case of Ebola

Internal migration and cross-border mobility for purposes of formal/informal trade, cultural events, employment, education and health remain an essential part of life for many communities in West Africa, where the free movement of people, goods and services is considered key for regional integration, prosperity and development.^a The Kissi Triangle cross-border region at the intersection between Sierra Leone, Liberia and Guinea, critical for trade and commerce, became the epicentre for the spread of the Ebola virus in 2014. The Forécariah–Kambia axis between Guinea and Sierra Leone was another corridor of human mobility that sustained transmission of the virus. During the month of July 2015 alone, four of the seven transmission chains of positive Ebola virus disease (EVD) cases identified in Kambia (Sierra Leone) were linked with positive EVD cases in Forécariah (Guinea). Communities residing on both sides of the border share strong familial ties. Cross-border movement is a part of these communities' daily lives and takes place mostly through unregulated border crossing points. Restrictions to human mobility were enforced by authorities in some settings to inhibit cross-border movements with the rationale of containment of the spread of EVD. The impact on trade and on the economy in the West African region was estimated at USD 1.6 billion (12% of the combined GDPs the three most affected countries).^b Health systems weakened through decades of conflict, and deficits of human resources for health and disease surveillance along mobility pathways, undermined effective disease control measures. The need to adopt evidence-informed methods to determine corridors of population movements and for understanding the primary drivers of human mobility is vital for targeted disease prevention, detection and response efforts, especially at border areas, while safeguarding countries' trade and economic interests.

IOM, with the support of government authorities and local communities, started mapping cross-border and in-country population flows between Guinea and Mali as early as December 2014. This information was then mapped against epidemiological data, enabling further analysis of vulnerabilities of travellers along their mobility continuums. Similar initiatives were subsequently set up at the Forécariah–Kambia border between Guinea and Sierra Leone, as well as at the Liberia–Sierra Leone border. Mobility mapping has since been expanded to include several sea landing points along the shores of Freetown and Port Loko, as well as internal movement between Kambia and Port Loko Districts in Sierra Leone. In all these locations, health screening and installation of infection prevention control measures were established, boosting the surveillance and response capacity of these three worst-affected countries and their neighbours.

a IOM, 2016.

b World Bank Group, 2015.

Health systems responses

The third aspect of migration and health is how health-care systems respond to migration and health. The health-care system is itself a determinant of health and, depending on the policies and legal frameworks of individual States, migrants may not be granted adequate, equitable and affordable access to health services, and/or local health systems may not have sufficient capacity to manage migrant health needs. For example, in countries of protracted crisis, migrant children fleeing conflict settings and seeking asylum with their families are more likely to have not met their vaccination targets due to disruptions in health-care delivery in countries of origin. Where health services are available, certain migrant groups may find it difficult to express symptomology and understand treatment instructions due to language barriers. Different cultural constructs of illness causation, such as those concerning mental health, challenge effective clinical management.²² They may also have difficulty with navigating unfamiliar health and welfare systems – especially when coming from countries with severely disrupted health systems.

A systematic literature review of reported challenges in health-care delivery to migrants and refugees in high-income countries identified three main topics of challenges in health-care delivery: communication, continuity of care and confidence.²³ Communication is critical for obvious diagnostic and treatment trajectories. The availability of trained interpreters from migrant communities was described as a key aspect in providing migrant-sensitive care. Training of such interpreters to ensure an ethical and professional approach to medical consultations was also highlighted. Continuity of care related to factors such as migrant understanding of the health-care system, integration and case management across different parts of the health-care system. Confidence was the third most common topic mentioned and related to trust in the health-care provider, ensuring cultural sensitivity in care provision and the ability to have agency. Studies indicated that, in cases where no trustful relationship was established, patients resorted to using traditional medicine and trusted “their own resources” from their community for treatment. Conversely, a systematic review that investigated the perceptions, attitudes and practices of health providers in the provision of health-care services for migrants found they were challenged not only by language and cultural barriers, but also by resource constraints within their workplaces, and incoherence between professional ethics and domestic laws that limited migrants’ right to health care.²⁴ Health-care providers used innovative means to ensure care provision in managing such clinical cases with civil society groups.

A key component of improved systems responses is the development of “migrant-sensitive health systems and programmes which aim to incorporate the needs of migrants into all aspects of health services, financing, policy, planning, implementation, and evaluation”.²⁵ As outlined in appendix A, this includes measures to: ensure culturally sensitive and linguistically diverse health service provision; enable access to primary health care; include non-citizen groups within national disaster preparedness and response plans; and establish reporting mechanisms within routine health information systems to ethically harness data to plan for migrant needs.²⁶ Often, migrants/“non-citizens” are excluded within preparedness and response strategies at national levels.²⁷

22 Fortier, 2010.

23 Brandenberger et al., 2019.

24 Suphanchaimat et al., 2015.

25 Siriwardhana, Roberts and McKee, 2017.

26 Mladovsky, 2013; Pottie et al., 2017; WHO, 2010b.

27 Guinto et al., 2015; Wickramage et al., 2018a.

Migration and health indicators and metrics

Accurate data on the health status, outcomes, and social determinants of migration health are an essential precondition for ensuring better monitoring and improving health and providing appropriate and accessible health service. The World Health Assembly (WHA) resolutions on migration health (61.17, 2008; 70.15, 2017) and the Global Compact for Safe, Orderly and Regular Migration²⁸ call on governments to better harness migration health data in order to formulate evidence-informed policy and practice interventions. However, the 2nd Global Consultation on Migration Health (2017)²⁹ and subsequent academic commissions³⁰ have indicated migration health data availability, quality and linkage to be highly variable, especially in low-to-middle-income countries. Little progress has also been made by member States and international organizations on advancing initiatives to improve migration health data collection and analysis at national, regional and global levels.

Sources of health data at country level are derived from multiple sources. First are health data derived from institutional registries or census-based data sources. These include, for example, birth and death registries capturing vital statistics and disease-specific registries, such as those for cancer, tuberculosis and malaria. A second source is through health survey data that may be collected periodically – for instance, demographic and health surveys. Research data are another major source providing specific information about specific communities or disease gradients. The final category includes a diversity of sources, such as those data from migration health assessments, health information systems at refugee camp settings, and big data projects such as the Global Burden of Disease project.³¹

A narrative review of migration health data collection practices in Europe revealed that most European Union countries do not collect data on migrant health in health-care utilization or disease registers, and those that do use different categorizations and definitions, so that data are not always comparable across countries.³² Health information systems, surveillance systems and disease registries do not systematically capture migration variables.³³ Migration modules have been tethered in only a few countries undertaking demographic and health surveys, such as Colombia and Ecuador, which capture data by place of birth. An exceptional case is that of Sweden, which in its annual survey of living conditions includes disaggregated data based on migration or residence status. People are classified either as first- or second-generation migrant, or non-migrant.³⁴

28 Objective 1 of the Global Compact for Safe, Orderly and Regular Migration underlines the need to collect and utilize accurate and disaggregated data as a basis for evidence-based policies; in addition, Objective 3 underscores the need to provide accurate and timely information at all stages of migration. The Compact explains that investing in improved methods for migration data collection “fosters research” and “guides coherent and evidence-based policy-making and well-informed public discourse” – allowing for effective monitoring and evaluation of the implementation of commitments over time.

29 IOM, 2017c.

30 Abubakar et al., 2018.

31 Available at www.healthdata.org/gbd (accessed 24 July 2019).

32 Rechel, Mladovsky and Devillé, 2012.

33 Giorgi Rossi et al., 2017; Riccardo et al., 2015.

34 Mladovsky, 2013.

Principals of data protection and ethical considerations are paramount for the collection, analysis, dissemination and linkage of migration health data – not only due to historical framing on race, ethnicity and health³⁵ and potential for stigmatization, exclusion or, in the case of undocumented migrants, deportation.³⁶ Efforts to capture the extent of migrant integration within health systems, and therefore capture measures of health equity, are exemplified by the Migrant Integration Policy Index (MIPEX) Health Strand project (see text box below). MIPEX Health Strand offers a survey instrument designed to investigate the degree to which policies affect migrant health and promote equity, allowing for comparison between different country contexts.³⁷

Migrant Integration Policy Index Health Strand

The Migrant Integration Policy Index (MIPEX) Health Strand is a survey instrument designed to investigate the degree to which policies affect migrant health and promote equity.^a It captures four dimensions considered critical for ensuring health equity: (a) entitlements to health-care coverage based on domestic legal and policy frameworks; (b) accessibility to health services; (c) responsiveness, such as on issues of language and cultural sensitivity; and (d) measures to achieve change, such as data collection and research to better inform services. Intersectoral application of the “Health in All Policies” (HiAP) principle, as well as mainstreaming of migrant health policies, are also included. A scoping review of available evidence on the association between health outcomes and integration policies conducted in 2017^b showed a majority of studies included MIPEX as a measure of national migrant integration policies. Data showed that health disparities between migrants and citizens, and between migrant groups, were generally reduced in countries with a strong integration policy.^c

a IOM, 2017a.

b Siriwardhana, Roberts and McKee, 2017.

c Ingleby et al., 2018.

In the context of health systems, a MHiAP response – modelled on the WHO Health in All Policies (HiAP) approach³⁸ and drawing on the MIPEX Health Strand³⁹ – aims to engage all the crucial governance actors and sectors involved in the field of migration and health. An example of this in action is the development of the National Migration Health Policy and action framework in Sri Lanka (see text box below).

35 Bhopal, 1997.

36 Hiam, Steele and McKee, 2018.

37 IOM, 2017a.

38 Juárez et al., 2019; WHO, 2014.

39 IOM, 2017a.

Lessons from advancing a National Migration Health Policy and action framework in Sri Lanka

Migration continues to be a catalyst to Sri Lanka's development within the South Asian region. Sri Lanka is both a labour-sending country (with over 2 million of its citizens working abroad), and a labour-receiving one – with a growing number of migrant workers from countries such as India and China arriving to work on large-scale infrastructure projects, such as new highways, seaports and airports. Such development is projected to further increase population mobility into and within the island. The end of a protracted civil war led to a return of Sri Lankan refugees from India and other countries, with many more internally displaced persons returning to their places of origin.

Addressing the health challenges of a dynamic range of population flows therefore becomes important. In recognizing the intersectoral nature of addressing migration and health, a participatory “whole-of-government” approach – which included civil society, the United Nations, academia and migrant advocates – was adopted by the Government of Sri Lanka to advance a National Migration Health Policy and Action Plan, which was launched in 2013. Sri Lanka is one of the few countries to have a dedicated migration health policy framework inclusive of all migrant typologies.^a The process was led by the Ministry of Health under auspices of an interministerial mechanism with technical partnership from IOM. A hallmark of Sri Lanka's policy development was an emphasis on an evidence-informed approach to guiding interventions/policy formulary. A national Migration Health Research Commission was undertaken over a three-year period, engaging local and international researchers to identify gaps in knowledge, conduct empirical research and gather data on migration health across inbound, internal and outbound flows. A pragmatic, action-oriented approach was adopted. For example, a National Border Health Strategy was developed to enhance point-of-entry capacities to enable better preparedness and response for health security risks, and capacities to address enhanced psychosocial support for returning female migrant workers.

Key lessons for advancing the National Migration Health Policy include:

- (a) Invest in an evidence-informed approach;
- (b) Ensure intersectoral coordination;
- (c) Engage diverse stakeholders from civil society, academia, industry and migrants themselves via participatory approaches;
- (d) Harness the network to be responsive to emergent issues (focus not only on policy formulary);
- (e) Embed an accountability framework;
- (f) Ensure global health diplomacy and engagement in regional and global processors.

An expanded case study is in appendix B.

a Wickramage, De Silva and Peiris, 2017.

The migration of health professionals

Health worker migration in response to the global shortage of health professionals demands dedicated and effective management, including building the capacity of health systems in origin countries, promotion of good practices and prevention of negative effects of health worker migration. There is a global imbalance between the availability of health workers and the burden of disease. For instance, sub-Saharan Africa has the lowest density of doctors and nurses, and the highest disease burden.⁴⁰ Well-managed migration of health workers can play a key role in development overall, as well as in building capacity of health systems, not only in receiving countries, but also in countries of origin.⁴¹ Global health tools such as the WHO Global Code of Practice on the International Recruitment of Health Personnel provide an evidence-based framework to promote good practices and prevent negative effects of health worker migration. As outlined in the WHO Global Code of Practice, there are strategies for both sending and destination countries to decrease reliance on foreign-trained health workers and mitigate the negative effects of health personnel migration on the health systems of developing countries. These may include, for instance: aligning government educational spending with employment opportunities; not hiring directly from countries with the lowest health-care worker-to-population ratios; and adopting innovative financing mechanisms, allowing local and private entities to provide complementary funding to government subsidies to health worker training.

The global governance of migration and health

Governance is central to the development and implementation of any response to migration and health.⁴² Migration governance rests primarily upon the fulcrum of national sovereignty,⁴³ and ensuring that positive health outcomes require well-managed migration. However, there is often limited engagement from health authorities in high-level migration governance decisions beyond issues concerning global health security – including quarantine and border-health management – and migration is frequently forgotten in the development of health programmes.⁴⁴ Many countries have explicitly stated before international human rights bodies that they cannot, or do not wish to, ensure health protection, including the provision of essential health services, to migrants, and especially to irregular migrants.⁴⁵

A range of governance agendas on the domains of migration and health have developed in recent years, providing important opportunities for garnering political support for intervention (see figure 2). These agendas bridge the fields of migration governance, development and global health governance, and include: the Global Compact for Safe, Orderly and Regular Migration; the Global Compact on Refugees; the Sustainable Development Goals (SDGs); UHC; World Health Assembly processes; disease prevention and control programmes (including for malaria, HIV and TB); and the Global Health Security Agenda.⁴⁶ Effective governance requires strategic leadership and investment to build alliances between migration management systems and the health sector.

40 Crisp and Chen, 2014.

41 IOM, 2018.

42 By “governance”, we mean the ways in which an entity functions to develop and implement policy and practice, incorporating the State, civil society, the private sector and other key actors, such as international organizations.

43 Wickramage et al., 2018a.

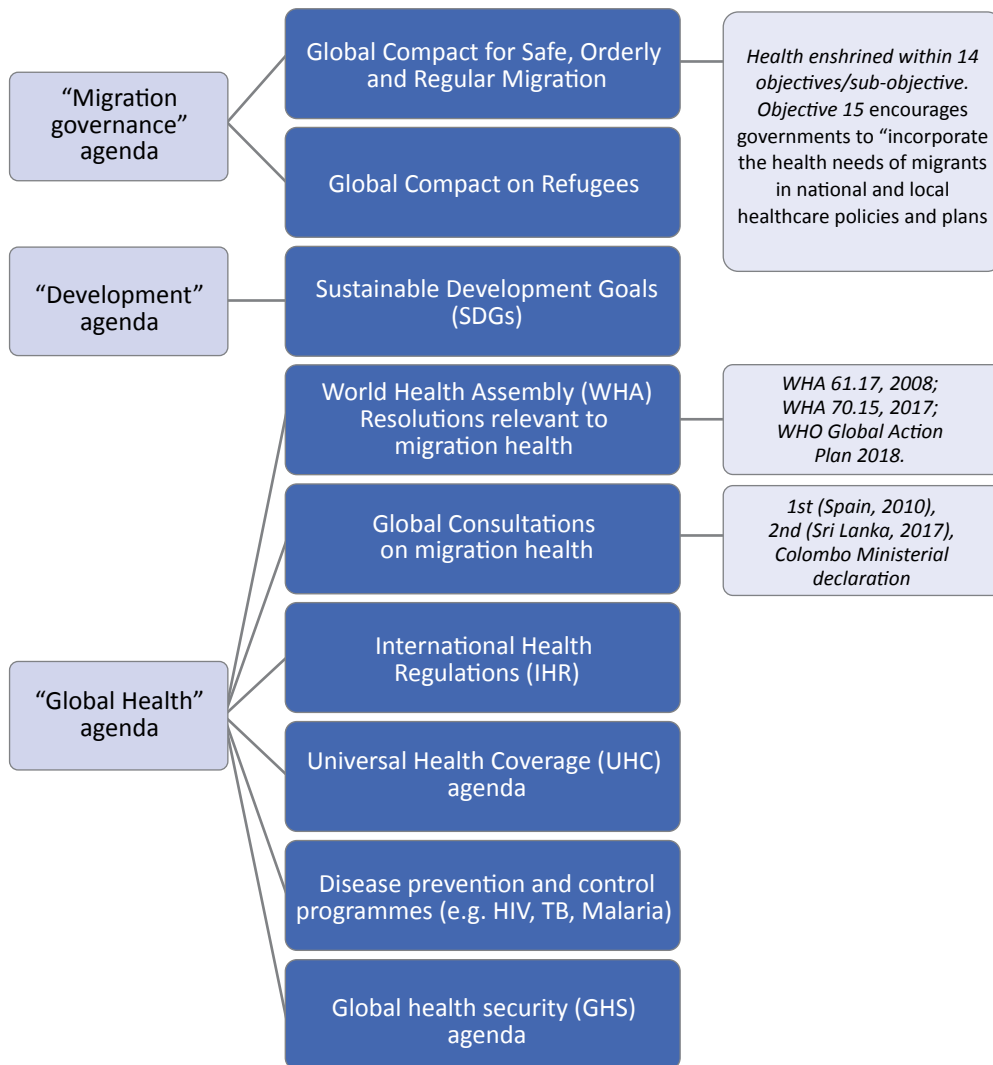
44 Wickramage and Annunziata, 2018.

45 IOM, 2013.

46 IOM, 2017c; UHC2030, 2017; United Nations, 2015; WHO, 2007, 2010a; World Health Assembly, 2008, 2017.

The SDGs suggest multiple demands to bring the migration, development and health sectors together to develop and implement unified and coordinated responses.⁴⁷ Target 3.8 of the SDGs calls for universal health coverage (UHC) – a key SDG target providing a strategic opportunity to improve responses to migration and health which will, by ensuring the good health of migrant workers and the associated flow of remittances, indirectly benefit social and economic development.⁴⁸ Migrants unaccounted for in UHC programmes are often missed in discussions about UHC goals at the country level.⁴⁹

Figure 2. Global agendas for advancing migration and health goals



47 United Nations, 2015.

48 UHC2030, 2017.

49 Guinto et al., 2015.

The Global Compact for Safe, Orderly and Regular Migration – discussed in chapter 11 of this report – features health as a cross-cutting priority with references to health and health-care access in several objectives. Key health-related objectives within the Global Compact for Migration with commitments and actions relevant to health are presented in appendix C. A number of experts have commented on weaknesses in the Global Compact in its realization of the right to health of migrants, including its absence on reproductive health and access to safe maternity care, which directly impacts newborn and child health.⁵⁰ Despite these limitations, the Global Compact for Migration does provide the health community the opportunity to use it as a tool to advance migrant-sensitive health policies and services within discussions on migration governance, where health often remains left behind.⁵¹

Gaps in migration and health research

Globally, various research initiatives are underway to assist in developing improved understanding of – and responses to – migration and health, with a focus on the implementation of evidence-informed interventions to improve the health and well-being of both migrants and communities affected by migration.⁵² While this field of research is growing, efforts to improve understanding of migration and health, and examples of migration and health programming, remain limited.⁵³ As outlined in the text box below, the existing literature on international migration and health is limited in scope. It focuses on (a) high-income receiving contexts of Europe and North America; (b) specific health conditions such as mental health, HIV and TB; and (c) specific migrant groups, including migrant workers, child migrants, unaccompanied minors and “left-behind” children, women, refugees and (female) survivors of human trafficking.⁵⁴ This highlights the need to improve research capacity in low- and middle-income country contexts, where the majority of migration takes place globally, and to increase the scope of research beyond the current focus on mental health and psychosocial well-being. Contextually relevant research agendas need to be set at the national and regional levels, through consultation with migrant communities, policymakers, practitioners, civil society and researchers.

50 Bozorgmehr and Biddle, 2018; Devakumar et al., 2018.

51 Wickramage and Annunziata, 2018.

52 Abubakar et al., 2018; Griswold et al., 2018; IOM, 2017c; Pottie et al., 2017; Wickramage et al., 2018b.

53 Ho et al., 2019; Sweileh et al., 2018.

54 Sweileh et al., 2018.

Global distribution of international migration and health research in peer-reviewed publications

By international migrant category:

- Refugees and asylum seekers (25.4%)
- Migrant workers (6.2%)
- Human trafficking and smuggling (3.2%)
- International students (2.1%)
- Patient mobility across international borders (0.1%)

By country income classification (based on World Bank Classification)

- Low-income countries (0.8%)
- Middle-income countries (9.6%)
- High-income countries (89.6%)

By thematic research areas:

- Mental health and psychosocial well-being literature (47.0%)
- Communicable diseases (13.7%)
- Non-communicable diseases (8.9%)

Source: Sweileh et al., 2018.

Note: A total of 21,547 documents were retrieved and reviewed. The variables are not necessarily exclusive, so percentages may not total 100 per cent.

Conclusion: Investing in migration and health to support social and economic development

Investment – by way of both financial and human resources, and political will – by States in the development of evidence-informed migration and health interventions will not only address the health needs of individual migrants, it will also improve public health and support efforts towards achieving UHC. This investment is particularly important for low- and middle-income country settings, where significant levels of migration take place.

Good health is a prerequisite for optimizing the benefits of migration (e.g. in the form of remittances); investment in migration and health therefore contributes to social and economic development in both migrant sending and receiving areas.⁵⁵ Policymakers, civil society, the private sector and researchers all have

55 Abubakar et al., 2018; IOM, 2017c; Onarheim et al., 2018; Trummer et al., 2016; Tulloch, Machingura and Melamed, 2016; Vearey et al., 2019; Wickramage et al., 2018b.

important roles to play – globally, regionally and nationally – in understanding and responding to migration and health, and migrants themselves must be involved in the development and implementation of policies and programmes.⁵⁶

To achieve this, investment in research capacity is first needed to improve understanding of the four key aspects associated with the field of migration and health that were outlined in this chapter – migrant health, public health, health systems responses and global governance opportunities. Research is needed to generate evidence-informed and context-specific interventions to address migration and health, which will, in turn, support UHC. Through partnerships with international organizations and academics, a new generation of migration and health scholars can be supported to develop new research approaches and monitoring systems to improve migration and health responses globally.⁵⁷ Additional research beyond the current focus on refugees and asylum seekers, and on mental health and psychosocial well-being, is needed to better inform improvements in health systems and services.

At the global level, improvements in understanding of the implications of human mobility in order to support and improve public health preparedness planning – including developing responses to infectious disease outbreaks or other health emergencies – are needed, requiring investment in building research capacity, particularly in low- and middle-income country contexts.⁵⁸ Working within the framework of a national migration and health policy process, the private sector can also support the development of programmes to improve the health of, for instance, migrant workers. The role of the private sector has been overlooked in the governance of migration and health and, among many other innovative roles, this can include sponsorship for building research capacity and interventions designed to address the health needs of migrant workers. Such programming will benefit the health of both individual migrant workers and their families, both in the origin and destination countries.

Frameworks that can provide guidance and indicate strategic opportunities to support migration and health interventions include: the 2008 World Health Assembly (WHA) resolution “Health of migrants”; the 2017 WHA resolution “Promoting the health of refugees and migrants”; the declarations made at two Global Consultations on Migration and Health; the WHO (draft) Global Action Plan on the Health of Migrants; and the Global Compact for Safe, Orderly and Regular Migration, which features health as a cross-cutting priority.⁵⁹ These can be used by academia, United Nations bodies, civil society and government actors to mobilize action, including within the private sector. Policymakers – with the support of researchers – need to identify how both the migration and health sectors can strengthen their engagement with migration and health through a MHiAP approach. As the integration and inclusion of migrants and migration are a vital component of global disease control programmes – such as those for TB and malaria – and global health security agendas, health should form a key pillar in the development of migration governance.

At regional levels, consultative processes to support the development of coordinated approaches to migration and health are needed. This could be achieved through integrating health into existing regional consultative processes on migration and development, and should include collaborations for disease surveillance and

56 IOM, 2017c; Wolffers, Verghis and Marin, 2003.

57 The Migration Health and Development Research Initiative (MHADRI) Available at <https://mhadri.org/> (accessed 25 July 2019) is a recently established global research network that seeks to address these issues and promote shared research activities and approaches in migration health.

58 IOM, 2017c; Wickramage et al., 2018b.

59 IOM, 2017c; WHO, 2010b, 2017, 2019; World Health Assembly, 2008, 2017.

interventions to support continuity of care across national borders. To operationalize these suggestions, States should consider identifying a national focal point that can drive the development of a national migration and health policy, and lead engagements at regional and global levels. This would require an evidence-informed, intersectoral, participatory approach, the development and adoption of an accountability framework, and centring of global health diplomacy. By investing in evidence-informed interventions, States will be better equipped to develop responses to migration and health at the local, regional and global levels. This will have positive impacts on the health of individual migrants, support efforts to achieve UHC by 2030, and – ultimately – ensure that individuals, communities and States can access the social and economic development benefits associated with healthy migration.

Appendix A. Key priorities and actions for monitoring migrant health and developing migrant-sensitive health systems

Monitoring migrant health

<p>Priorities to address</p>	<ul style="list-style-type: none"> • Ensure the standardization and comparability of data on migrant health. • Increase the better understanding of trends and outcomes through the appropriate disaggregation and analysis of migrant health information in ways that account for the diversity of migrant populations. • Improve the monitoring of migrants' health-seeking behaviours, access to and utilization of health services, and increase the collection of data related to health status and outcomes for migrants. • Identify and map: (a) good practices in monitoring migrant health; (b) policy models that facilitate equitable access to health for migrants; and (c) migrant-inclusive health systems models and practices. • Develop useful data that can be linked to decision-making and the monitoring of the impact of policies and programmes.
<p>Key actions</p>	<ul style="list-style-type: none"> • Identify key indicators that are acceptable and usable across countries. • Promote the inclusion of migration variables in existing censuses, national statistics, targeted health surveys and routine health information systems, as well as in statistics from sectors such as housing, education, labour and migration. • Use innovative approaches to collect data on migrants beyond traditional instruments, such as vital statistics and routine health information systems. • Clearly explain to migrants why health-related data are being collected and how this can benefit them, and have safeguards in place to prevent use of data in a discriminatory or harmful fashion. • Raise awareness about data collection methods, uses and data-sharing related to migrant health among governments, civil society and international organizations. • Produce a global report on the status of migrants' health, including country-by-country progress reports.

Migrant-sensitive health systems

<p>Priorities to address</p>	<ul style="list-style-type: none"> • Ensure that health services are delivered to migrants in a culturally and linguistically appropriate way, and enforce laws and regulations that prohibit discrimination. • Adopt measures to improve the ability of health systems to deliver migrant-inclusive services and programmes in a comprehensive, coordinated and financially sustainable way. • Enhance the continuity and quality of care received by migrants in all settings, including that received from NGO health services and alternative providers. • Develop the capacity of the health and relevant non-health workforce to understand and address the health and social issues associated with migration.
<p>Key actions</p>	<ul style="list-style-type: none"> • Establish focal points within governments for migrant health issues. • Develop standards for health service delivery, organizational management and governance that address cultural and linguistic competence; epidemiological factors; and legal, administrative, and financial challenges. • Develop frameworks for the implementation and monitoring of health systems' performance in delivering migrant-sensitive health services. • Develop methods to analyse the costs of addressing or not addressing migrant health issues. • Include diaspora migrant health workers in the design, implementation and evaluation of migrant-sensitive health services and educational programmes. • Include migrant health in the graduate, postgraduate and continuous professional education training of all health personnel, including support and managerial staff.

Appendix B. Lessons learned in advancing a National Migration Health Policy and action framework in Sri Lanka

Sustained economic growth and peace dividends since the cessation of protracted civil conflict in 2009 has re-established Sri Lanka as a booming economy in the South Asian region. International migration continues to be a catalyst to Sri Lanka’s development. Sri Lanka is both a labour-sending country (with over 2 million of its citizens working abroad as labour migrants), and a labour-receiving one – with a growing number of migrant workers from countries such as India and China arriving to work on large-scale infrastructure projects such as new highways, seaports and airports. These developments will further increase population mobility into and within the island. The end of war also led to a return of Sri Lankan refugees from India, with many more internally displaced persons from other parts of the country, to their places of origin. Addressing health challenges of a dynamic range of population flows therefore becomes important.

Figure 1. Advancing a National Migration and Health Policy process in Sri Lanka



In recognizing the intersectoral nature of addressing migration and health, an evidence-informed, “whole-of-government” approach was adopted by the Government of Sri Lanka to advance the National Migration Health Policy process. The process was led by the Ministry of Health with technical partnership from IOM. Sri Lanka remains one of the few countries to have a dedicated National Migration Health Policy and Action Plan, which was launched in 2013.

Six key lessons in advancing the National Migration Health Policy

1. Adopt an intersectoral, participatory approach

An interministerial mechanism was established, led by the Minister of Health, to galvanize the migration and health agenda. The multisectoral coordination framework is comprised of three elements: (a) a dedicated secretariat within the Directorate of Policy and Planning to drive daily coordination; (b) a National Migration Health Taskforce (MHTF) to drive technical cooperation; and (c) a National Steering Committee to drive legal and executive level action. The MHTF enabled participation from civil society, the nongovernmental sector, academia and intergovernmental organizations, and migrants themselves.

2. Adopt an inclusive approach

After extensive deliberation, the MHTF targeted migrant categories across all three migration flows: inbound, outbound and internal. Inbound migrants include foreign migrant workers and returning refugees; outbound migration encompasses categories such as labour migrants, international students and military; and internal migrants include categories such as free trade zone workers, seasonal workers and internally displaced persons. Considering the large numbers of migrant workers, the left-behind children and families of international migrant workers were included as a dedicated fourth section for the policy.

3. Adopt a strong “evidence-informed approach”

A hallmark of Sri Lanka’s policy development was emphasis on an evidence-based approach to developing policy formulary and guiding interventions. A country migration profile was developed during the formative phase and a National Migration Health Research Commission was undertaken over a three-year period. Efforts were made to undertake multidisciplinary research studies that were not only rigorous but adopted high ethical standards. The findings were shared through a series of National Symposiums on Migration Health Research, with the participation of government agencies, migrant community representatives, civil society, development partners, United Nations agencies, the private sector and academia.

4. Adopt a pragmatic and responsive approach

An important feature of the policy development process was the imperative placed on responding to any nationally important migration and health challenges the country would encounter, rather than remain a static process, only for purposes of policy formulation. The utility of an interministerial taskforce in taking practical action was recognized. For example, a National Border Health Strategy was developed to enhance point-of-entry capacities to better prepare, respond to and mitigate global health security risks, and improve disease surveillance and coordination at points of entry.

5. Embed an accountability framework

Tracking progress and sharing regular progress reports at the national, subnational and global levels is a key aspect of policy implementation. Sri Lanka formally reported progress made against the four intervention domains detailed in World Health Assembly resolution 61.17: Health of migrants, in 2010 and 2011. A national report card on migration and health was also developed by the MHTF, and can be read in full at www.migrationhealth.lk. A recurrent challenge has been to sustain the coordination efforts both within the Ministry of Health and between ministries and partners.

6. Ensure global health diplomacy and engagement

In a globalized world, individual member States cannot “do it alone” in effectively advancing their national migration health agendas. Multilateral diplomatic efforts need to be made with both sending and receiving countries, recognizing that health vulnerabilities diffuse across all phases of migration and across borders.

Appendix C. Health in the implementation of the Global Compact for Safe, Orderly and Regular Migration

Objective 1: Collect and utilize accurate and disaggregated data as a basis for evidence-based policies

The action on developing country-specific migration profiles with disaggregated data in a national context should include health data to develop evidence-informed migration policies. This can begin with practical platforms for connecting research experts, scholars and policymakers globally to strengthen information systems to analyse trends in migrants' health, disaggregate health information and facilitate the exchange of lessons learned.

Objective 7: Address and reduce vulnerabilities in migration

The actions on addressing vulnerabilities in migration include provision of health care, and psychological and other counselling services, in particular for migrant women, adolescents, and for unaccompanied and separated children across the stages of migration. This would also require addressing migrant experiences, including xenophobia, migration restrictions for migrants with health needs, and other policy gaps and inconsistencies, as well as efforts to enhance migrant resilience, through adequate information, education and empowerment for self-help.

Objective 10: Prevent, combat and eradicate trafficking in persons in the context of international migration

Protection and assistance for trafficked persons will require integration of measures for physical and psychological health, including service delivery and capacity development. This will require cross-border cooperation and partnerships to harmonize intersectoral policies and practices, and ensure continuity of care and health responses to particular health needs of women, men, girls and boys.

Objective 15: Provide access to basic services for migrants

This objective encourages governments to "incorporate the health needs of migrants in national and local health care policies and plans, [...] including by taking into consideration relevant recommendations from the WHO Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants", which were developed in collaboration with member States, IOM and other United Nations partners. These commitments are linked with governments' plans for health-related SDG results (SDG 3 and others), including strengthening migrant-inclusive health-care systems.

Objective 22: Establish mechanisms for the portability of social security entitlements and earned benefits

Inclusion of health-related actions in this objective will require assessment and enhancement of financial risk protection in health services, to reduce the burden of catastrophic health expenditures on migrants. Social protection in health should be an integral component of reciprocal social security agreements on the portability of earned benefits for migrant workers at all skill levels, for both long-term and temporary migration.

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