

# HEALTH, HEALTH SYSTEMS and GLOBAL HEALTH

**Thematic Discussion Paper**

**2nd Global Consultation on Migrant Health:  
Resetting the agenda**

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DEVELOPING CAPACITIES IN MIGRATION MANAGEMENT

## Abstract

The health paper explores the complex and varied aspects of migration health through a global health lens using generalized observations and frameworks to describe the major elements of the issue. Current priorities are outlined in the context of the phases of the migration process, including origin, transit and destination components. The model also accommodates modern aspects of migration including circular migration, labour migration and the process of return.

Building on the phase-based approach to migration health, the paper explores the health and medical aspects of migration through two frames of reference; acute high volume movements and long term sustained migratory flows. Both of these situations are of topical current interest and have global implications. These situations are described in relation to ongoing and planned international global health activities and initiatives including, Universal Health Care, the Sustainable Development Goals and global public health security. Additionally, the current and future health needs of migrants are outlined in relation to the ongoing work towards the recently developed global compacts on responsibility sharing for refugees and safe, regular and orderly migration.

The paper reviews major sources of evidence and health indicators, outlines global needs in terms of additional data and information necessary to develop global policy and describes potential partnerships that could facilitate an integrated, global approach to health and migration.

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## Introduction

Midway through the second decade of the 22<sup>nd</sup> Century, migration and population mobility continue to attract and demand attention and focus at global level. Following a trajectory that parallels other aspects of modern globalization, the movement and flow of individuals, communities and populations exerts ever greater influence on the international stage. Migration influences many health determinants<sup>1</sup> and outcomes<sup>2</sup> across the globe. These influences extend across the entire global health spectrum<sup>1</sup>. They can be observed at both the individual and population health level and affect the health sector at all levels, from the provision of clinical services to public health planning and health policy development. In this regard, migration is increasingly being recognized and appreciated as a fundamental component of global health.

The relationships between health and migration have been topics of interest, discussion and study for some time. IOM and WHO organized an international conference on what was then called Migration Medicine in 1990<sup>2</sup>. Attention and focus on the health of migrants increased over the following two decades. By 2008 a World Health Assembly resolution focused on the health of migrants framed a global health response in the context of international migration<sup>3</sup>. The resolution noted the need for strategies to sustain and improve the health of migrants and those who host and interact with them. Two years later a Global Consultation produced a framework designed to assist in in that process that identified specific priority areas for action<sup>4</sup>.

Since that time, the world has experienced several significant events of direct relevance to health and migration. Conflict, geo-political and economic situations have created and supported the largest number of refugees, displaced populations and forced migrants since the end of the Second World War. Large numbers of those individuals have flowed towards areas of safe haven and/or better conditions often at great risk, producing a crisis situation in parts of the Middle East and Europe. Ongoing violence and poverty in parts of Central America, particularly from the Northern Triangle region (Honduras, Guatemala and El Salvador) continue to generate large flows of people north towards the USA. That journey, while absent of maritime risks, exposes many migrants to further violence and exploitation<sup>5</sup>. All of these movements are associated with risks of sexual and gender based violence.

The 2014 Public Health Emergency of International Concern (PHEIC) stemming from a major outbreak of Ebola Virus Disease occurred in parts of West Africa. In 2016 a PHEIC event occurred in response to clusters of microcephaly and Guillain-Barré syndrome in the Americas associated with the ongoing outbreak of ZIKA virus. Both of these events highlighted the critical importance of human mobility (large trans-border population flows and international travel) and in ensuring adequate public health responses.

Together these events have increased the profile of, and interest in migration and health particularly in terms of global health security (GHS). The current geo-political environment coupled with continued

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<sup>1</sup> In this document, a health determinant refers to personal, social, economic, and environmental factors that influence health status.

<sup>2</sup> In this document, a health outcome refers to a change in the health status of an individual or population that is attributable to an intervention or series of interventions.

global disease challenges provides an important opportunity to review and revisit global migration health in light of the 2008 WHA resolution and the 2010 Consultation.

The operational framework produced by 2010 Consultation was centered on four basic core elements of the 2008 WHA Resolution on Migrant Health. Those elements were:

1. *The monitoring of relevant migrant health indicators<sup>3</sup> and outcomes using program and policy relevant health information that is comparable across the migration spectrum,*
2. *Supporting the implementation and adoption of relevant policy, legislative and legal frameworks that support and sustain the health of M/MP based on international standards and recommendations,*
3. *The development of migrant-sensitive health systems that provide appropriate and sufficient service in an inclusive and coordinated manner, and*
4. *Supporting the establishment and nurturing of health-focused partnerships, networks and international frameworks that extend across all phases and locations of the migration process.*

The importance and impact of migration, including some of the health aspects have been recognized and addressed through several international activities.

At regional level, migrant health has received specific attention during the planning of future European health strategies and policy<sup>6</sup>. In the Americas, the health concerns generated by the northward flow of migrants from Central America encompass the consequences of violence including PTSD, other aspects of psychosocial health, the health of unaccompanied minors and some infections such as tuberculosis. The events prompted a presidential declaration of a humanitarian crisis<sup>7</sup> and governmental response including health support for unaccompanied minors<sup>8</sup>. Globally, the United Nations 2030 Agenda for Sustainable Development, adopted in 2015 recognized the contribution of migrants towards growth and development while noting the need for coherent and comprehensive global responses<sup>9</sup>.

Events in 2015 related to the Mediterranean migrant crisis reinforced the importance of common and coordinated strategies, responses and actions necessary to address refugee and migrant health needs. These were elucidated at a WHO European Region, High-level Meeting on Refugee and Migrant Health held in November of that year that produced a strategy and action plan<sup>10</sup>. More recently, for the first time, in September of 2016, the UN General Assembly arranged a high level summit on large movements of refugees and migrants. The summit committed to addressing current migration issues while planning for future pressures. In terms of the latter aspect, the summit defined concrete plans to build on current commitments through the formulation and adoption of a comprehensive framework for safe, orderly and regular migration including guidelines for the management of vulnerable migrants.<sup>11</sup>

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<sup>3</sup> In this document, a health indicator is a single measure that can be reported regularly, tracked over time and which provides relevant information about population health. WHO has produced a reference of 100 core health indicators (WHO. Global Reference List of 100 Core Health Indicators, 2015. Available from: [http://apps.who.int/iris/bitstream/10665/173589/1/WHO\\_HIS\\_HSI\\_2015.3\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/173589/1/WHO_HIS_HSI_2015.3_eng.pdf?ua=1) )

In parallel with regional and global activities, migration-associated initiatives and health oriented endeavours have continued and evolved since the 2010 Madrid consultation.

Strengthening health systems (HSS) has become an important developmental as well as a strategic goal at national and global levels<sup>12</sup>. Some elements of the internationally agreed six basic building blocks of HSS<sup>13</sup>, such as health services and the health workforce are directly influenced by migration. Additionally, in some locations or situations, migrants represent underserved or marginalized populations that are HSS targets. In this regard restrictions on access to health insurance programs or the ability to use needed health services because of poverty or fear places migrants at risk of further impoverishment or financial destitution<sup>14</sup>.

Colombo Process Member Countries represented by Ministers of Labour in 2016 resolved to address health issues relating to Labour migrants and promote the implementation of migrant-inclusive health policies to ensure equitable access to health care and services as well as occupational safety and health for migrant workers<sup>4</sup>. The 'Colombo Declaration 2016' also saw the inclusion of 'Migrant Health' as a new thematic priority, considering the importance of promoting the health of migrant workers throughout the migration cycle to reduce long term economic and social cost, although some aspects of it has already been dealt under the thematic area of 'Pre Departure Orientation (PDO)'. This initiative will have a bearing on the SDG target 3.8 on achieving universal health coverage including 'access to safe, effective, quality and affordable essential medicines, vaccines and healthcare', since without including migrants in such an endeavor, who are identified as a vulnerable group, it would not be possible to universalize the Goal on health.

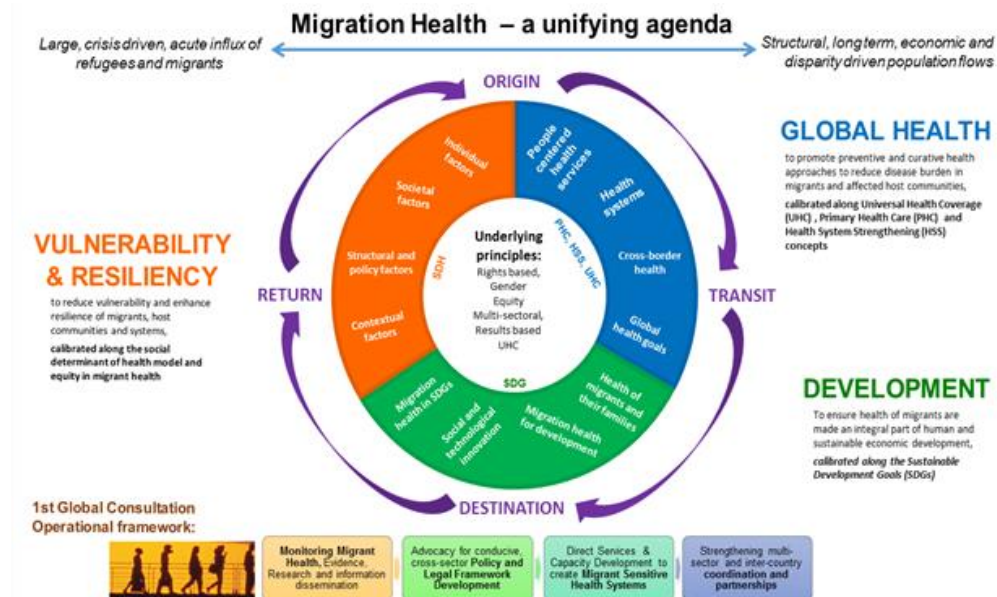
Universal Health Coverage (UHC) has been an integral component of international development and the global health agenda<sup>15</sup>. As work towards the goals of HSS and UHC continues, improving and ensuring access to health services for migrants and other mobile populations such as the internally displaced will need to become more integrated into regional and international actions. In spite of good intentions, some migrant populations may not always have access to needed services that they can afford. Since the Madrid consultation, frameworks and monitoring strategies that assess UHC have become more defined<sup>16</sup>. Migrant specific indicators may need to be developed and integrated into those activities. Globally, some monitoring initiatives such as MIPEX<sup>17</sup> are specifically oriented towards migrants and mobile populations, others more widely focused.

Elements and aspects of migrant health can be observed in each of the above noted initiatives and activities. Yet there remains a need to work towards a modern, integrated, dynamic and flexible approach to the health of migrants that can transcend and link all of the processes in a holistic manner. The 2008 WHA resolution and the 2010 Madrid consultation set the stage and direction towards a model of migration health involving the process-related phases of the migration experience. Considering the migratory process as a series of linked and related phases provides a continuous and holistic perspective on health and population movement that reflects modern migration. This approach can also facilitate a symmetrical relationship other global development and global health activities. It also allows for the recognition and organized relational association of health indicators and outcomes that extend

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<sup>4</sup> [www.colomboprocess.org](http://www.colomboprocess.org)

from the migrants' environment and place of origin, encompassing all aspects of the migratory journey (including transit or temporary residence) through to arrival and integration at the new destination.



As this is a dynamic and process-focused approach, as opposed to an administrative or legal status approach, it extends to and includes components such as return, circular and transient migration. Those elements may not always be components of traditional immigration/emigration models. Additionally, the phase-oriented perspective recognizes and includes aspects of migrant health that extend after the initial arrival and integration periods, appreciating the health-associated aspects of migration that can stretch into generational demographics.

This paper suggests that these two basic components; the core elements outlined in WHA Resolution, and the phase-based approach to migrant health reflecting the components of the migratory process, can support more integrated, global approaches to monitoring, improving and sustaining the health of migrants. This approach is broad enough to include elements of traditional migration and refugee flows as well as irregular migration, mixed migration and the generational aspects of health that can extend long after arrival and integration into a new place of residence.

## A Uniform Place to Start: Migration Health and the Phases of the Migration Process<sup>5</sup>

The flow and movement of individuals, communities and populations are activities as old as humanity itself. While moving from one location to another remains continues to be the basic nature of migration, the processes around the movement have evolved and changed over time. It has been common to consider migration through a uni-directional movements framed in the context of the *immigration / emigration* paradigm. People left their place of origin, either voluntarily, through force or economic incentive and settled permanently at a new destination. Over time, they and their descendants would begin to assume the social and cultural aspects of their new home, including health indicators and outcomes. Many programs, policies, studies and investigations into migrant health are founded on those principles, which retain considerable validity for regular organized migration.

The majority of those migration health endeavors include monitoring, investigating and recommending interventions on the basis of differences in health indicators between migrant and host population cohorts. This was and continues to be frequently undertaken on the basis of specific disease or diagnosis criteria. Differences in prevalence, incidence and outcome indicators are the basis or rationale for many programs or interventions directed at migrant cohorts. Historically, they often reflected health activities, programs or policies already in place within the host or destination country. Frequently they were focused on specific diseases, such as tuberculosis or other infectious disease. Programs and practices of this nature continue in many traditional immigrant receiving nations.

Modern migration however is subject to and influenced by factors different from historical patterns of immigration. More easily accessible international travel, globalization, de-colonialization, international development, population growth and geo-political changes have combined to affect the nature and demography of modern migration. The size and diversity of migrant populations has increased and new directional patterns of movement have evolved. For example, the numbers of refugees, asylum seekers, temporary and permanent migrant workers and internally displaced populations now dwarf the numbers of traditional, regular immigrants, the population that historical migration health programs were initially designed for.

Policies, programs and strategies designed to consider, monitor or support health in the context of historical migration patterns can be challenged by the dynamics and demography of current migration.

- National in nature, they often reflected the specific interests and the specific migration patterns of individual countries and consequentially differed between nations. On the global platform, these differing national interests and focus can make finding common parameters and health policy coordination cumbersome and difficult.
- They were frequently disease, not health, based and often reflected national, as opposed to global disease prevention/intervention strategies.

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<sup>5</sup> For the purpose of this document the term ‘migrant’ should be considered as general descriptor representing *all persons who move away from their place of habitual residence, within a State or across an international border, regardless of the person’s legal status, of the causes of the movement and of whether the movement is voluntary or not.*



- As a result migration health expertise and understanding was frequently “national” in scope and within those nations addressed through program and policy “siloes” (infectious diseases, mental health, occupational health etc.).
- Epidemiologically, they tended to be based on one of two sets of criteria: 1). the legal or administrative status of the migrant (i.e. regular immigrant, refugee, asylum seeker, migrant worker) at the time of arrival, and/or 2). Nationality, citizenship or place of birth. Again those criteria vary between individual nations, complicating comparison and analysis of information between countries and regions.
- Finally, because much of the effort devoted to migration health occurred at or after arrival, the majority of program activity took place in the host or destination nation. As a consequence much of the mitigation and intervention activity directed at migrants, dealt with the health consequences of migration, not in preventing or alleviating them.

In an attempt to more adequately address the health implications resulting from modern migration in a more global context, a more process oriented and integrated framework was proposed. As the 20<sup>th</sup> century ended the concept of considering migration health in uniform, integrated manner began to crystalize<sup>18</sup>. The intent was to approach global migrant health in a more lateralized, less disease/illness based manner that would be internationally and perhaps globally, applicable.

Through this lens, health aspects of migration are considered in terms of the migratory process itself. All migrants experience these phases of the process no matter what their legal or administrative status, physical location or personal characteristics represent. This framework supports a standardized manner of organizing and coordinating an approach to health and migration that mirrors the migrants’ experience.

It considers health in terms of:

- the place of origin,
- the physical journey,
- the arrival phase at the destination,
- the period of settlement and integration, and
- the process of return for those who do so<sup>6</sup>.

It must be noted that the phases of the migration process model does not suggest that all migrants and mobile populations experience the same events or outcomes. Different cohorts will face different forces, influences and situations that vary by time and location. Outcomes will differ between migrant cohorts as a result of those forces. However, model provides the ability to compare all of those outcomes in a systematic, manner that can be related to the phase of migration. This approach, unaffected by legal definition, size of the movement, location or status of the migrant, can assist in

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<sup>6</sup> This process component also includes the circular migration pattern of those who repetitively live and work outside their country of permanent residence temporarily and return home.

identifying particular indicators and needs which may otherwise have been masked or lost in a broader migration dynamic.

It can also assist in the development of globally applicable frameworks that can compare health risks on the basis of migration phase in order to prioritize migration health needs and determine where best to address them. This approach is broad enough to allow for aspects and considerations that may not easily fit into traditional uni-directional derived migration health activities. For example circular migration, dual or multiple citizenship, extended periods of transit, return and longitudinal health issues that may extend beyond the granting of residence or nationality can be related to the phase of the process. As recently noted by researchers in the field it allows for a “multistaged and cumulative nature of the health risks and intervention opportunities that can occur throughout the migration process, and points to the potential benefits of policy-making that spans the full range of migratory movement.”<sup>19</sup>

The phase-based framework approach provides a standardized basis of assessing and comparing indicators and outcomes that are not *a priori* a product of the complex legal, administrative and operational environment that surrounds modern migration. Against this basic framework, it is possible to consider those environmental factors (i.e. *currently a refugee in one context and health data capture system may be an economic migrant in another*), against a consistent comparative matrix.

Examining the health aspects of migration in this context may also provide a standardized and consistent approach that can be applied in situations of high volume acute flows as well as longer term movements sustained over time. It also supports a greater focus on health rather than individual or specific diseases. It is suggested that a symmetrical health-based approach of global scope can provide a framework broad enough to support policies and guidelines that will encompass individual diseases/illnesses as well as social determinants of health. It will also provide information and best practice sharing while supporting the development of global migration health expertise in origin, transit and destination locations.

Identifying such needs and determinants in the context of the phase of the migratory process can also assist in the better targeting of prevention, mitigation and health intervention programs for migrants. Benefits in that regard include improved awareness of who is in need, and where in the process, the most appropriate place for action resides.

## Current Global Priorities in Health and Migration<sup>7</sup>

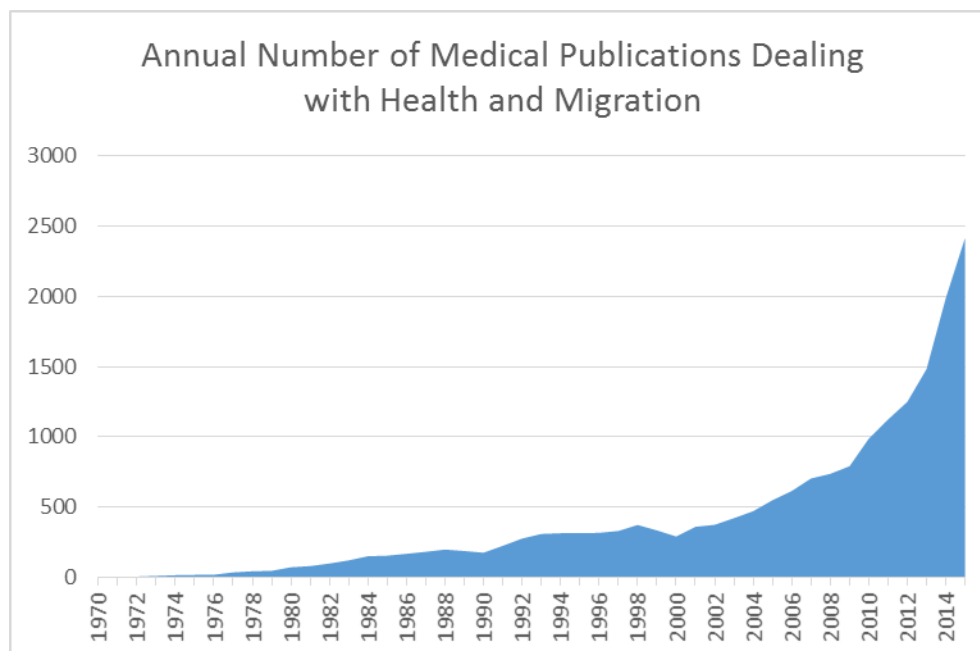
As modern migration has evolved, the focus on the health aspects associated with or resulting from the migratory process has expanded. In some locations absolute numbers of migrants have increased, generating volume-based impacts that exceed historical norms. Larger and more diverse migrant flows can be associated with new and different health challenges and situations.

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<sup>7</sup> A PubMed search using the terms Global Migration Health Policy revealed 301 articles, a second using the terms Global Migration Health Programs revealed 141. Articles deemed relevant were selected by the author for reference use consistent with the TOR. In addition, “grey” literature and organizational and agency literature sources were utilized.

Historical approaches to migrant health tended to be concerned with events at the migrants' destination. Current attention is broader and comprises the study of the health effects and impacts involving places of origin, transit and resettlement. As noted above, communicable diseases were often primary areas of interest in migration health. Recently, more attention is being directed towards non-communicable diseases and illnesses. Modern migration health studies also extend to the cultural, social and cultural contexts of migration and integration as exemplified by life course theory<sup>20</sup>. Additionally, current areas of interest are broader, commonly regional and global in scope, expanding the national focus of earlier migration health priorities.

The growth in study and attention directed at the relationships between health and migration are reflected in the volume of research on the topic. The figure below indicates the output of a Med Line search of the terms "health" and "migration" since 1970.



Through a global lens, migration is recognized as an integral component of the process of modern globalization. As such, it is appreciated that migration is: 1) an integral component of global and regional labor force mobility, 2) an element of the economic concepts related to human capital and 3) a significant force in population dynamics. The role played by migration in those aspects of globalization brings the issue of migration health into other global arenas through:

- The impact of migration on global development (SGDS),
- The access to and utilization of health services by migrants (HSS, UHC),
- The relationships and health aspects of climate change and environmental migration,
- The influences of migration on health and human security<sup>21</sup>,
- The migration health aspects related to gender.

Through these relationships, migration is recognized as being a relevant component in widespread, activities and initiatives in the global health, development, environmental and security sectors<sup>22</sup>. However, migration is not always a formal or organized element of those initiatives. As global work progresses these areas, it will be increasingly important to ensure that the roles, effects, impacts and consequences of migration and associated health issues become integrated components of the strategies, policies and programs involved.

## Specific Issues and Priorities

Whether voluntary or forced, migration has always been a component of the human experience. The flow of migrant populations between and within regions and nations influenced demographics and the social, political, economic and health sectors of society. Modern globalization, regional population dynamics (such as declining birth rates and ageing populations), the numbers of migrants themselves, the evolution of origin, transit and destination patterns and social and political responses have combined to make migration an important component of the 21<sup>st</sup> century international agenda<sup>23</sup>. The health of migrants and their needs for accessible, efficient health services are globally recognized as elements of that global agenda.

Global issues of this complexity present a plethora of needs and areas for action. Three topics of current global interest will be considered as a basis for contextual discussion around the broader issue of migration health. Those topics are; the health aspects of high volume migratory movements which are considered from the perspective of acute and short term flows and in terms of the health aspects of long term or sustain migration. The second topic deals with the migration health aspects of important global public health events. The third item briefly looks at the migration of health and medical personnel from less developed to more developed regions.

The final issue, commenting on the migration of health personnel while perhaps appearing slightly out of context, is included for two reasons. A considerable amount of international consultation and collaboration has been undertaken in regard to this aspect of migration health and that experience may provide valuable insight as health matters are introduced into the refugee and regular migration Global Compacts. Additionally, the global movement of health workers has implications for the future of UHC and sustainable development.

## Health Impact and Consequences of High Volume Migrant Movements.

### Acute and Short Term

Globally, migrant populations are at unprecedented levels, estimated to be nearly 250 million people, a total that represents a 40 % from levels at the turn of the century 15 years ago<sup>24</sup>. The majority of these individuals are healthy but do require adequate access to health prevention and promotion services. As with any population, some of these individuals have illnesses, disease and underlying health conditions that require health and medical care, treatment and support. In addition, the forces and events that create and sustain involuntary population displacement and refugee situations are often associated with violence, trauma and situations that create vulnerability and adverse health outcomes.

It is not difficult to appreciate that receiving and hosting large numbers of refugees, displaced populations and migrants can have serious impact and consequences for low and middle income nations. However, the rapid arrival of substantial mobile populations can be challenging for wealthier and more developed nations as well. Systems designed for routine flows of new arrivals can be overwhelmed by volume. Additionally, security and border control programs and practices may be challenged by thousands or tens of thousands of people who arrive quickly.

High volume movements often include a 'mixed migration' demographic encompassing refugees, trafficked migrants, economic migrants and unaccompanied minors. As many of the migrants are transient, on their way to other destinations or perhaps eventual return to their place of origin, organizing and delivering health services takes place in a dynamic and somewhat fluid "mixed migration" environment that can involve refugees and asylum seekers, irregular migrants and the victims of trafficking/smuggling.

While the immediate post-arrival needs of all migrants may be the same, each of the subpopulations may be subject to administratively and legally different processes and policies. The results can be operational and logistical challenges in acute situations which are resource intensive and not particularly productive<sup>25</sup>. Globally, the implications of mixed migratory movements are being met through holistic approaches that address the needs and rights of all on the move while recognizing the specific legal and protection needs of refugees. Mobilizing human, logistical and medical resources to deal with the health needs of large volumes of new arrivals while at the same time, ensuring and maintaining security and protection is costly. Immediate attention must be directed to urgent health needs and care with additional attention directed to identifying longer standing health and psychosocial issues in the new arrivals.

The risk of injury and death has always been associated with irregular migration and the smuggling and trafficking of individuals<sup>26</sup>. Injuries and fatalities reflect the nature of the journey, the quality of the transportation used and the geography and climate of the area where travel is undertaken<sup>27</sup>. As the numbers of those seeking access via these irregular routes increase there is a corresponding toll of morbidity and mortality due to accident, misfortune and violence.

Overland routes such as those exemplified on routes in the Americas, Africa and continental Europe can result in death due to environmental exposure or transport in dangerous vehicles. Travel over water, when associated with overcrowded and unseaworthy vessels can be associated with very large numbers of casualties. Over water routes used by those seeking irregular methods of entry are most frequently observed in Oceania, the west coast of Africa and the Mediterranean. Since the 2010 Consultation there has been a dramatic increase in the number of deaths in those seeking access to Europe via Mediterranean routes. This has drawn increased attention on the risks involved and generated national, regional and international and focus on the issue<sup>28,29</sup>.

No matter where they occur, the rapid influx of large numbers of unexpected or unanticipated arrivals will impact local health and social services. Immediate medical and humanitarian assistance is required and depending on the numbers involved, local or front line services may need support or external assistance to deal with the demands. The ultimate impact on health services will depend on the volume

and duration of the movement and proportion of arrivals who are ultimately in transit to distant locations versus those who remain in the nation of first arrival.

Responses to recent and ongoing migrant flows have demonstrated the need for three major components to manage these events.

- Adequate anticipation and planning,
- Coordinated regional responses as opposed to individual national responses, and
- Burden sharing to equilibrate impacts between areas.

Examples of relevant activities in that regard include:

1. A wider mobilization of resources to monitor flows and offer assistance and support to those in distress<sup>30</sup>.
2. The Missing Migrants Project, an empirical system to document, track and report migrant deaths in order to evaluate and support policy initiatives designed to reduce these events<sup>31</sup>.
3. Regional European Health Strategy and Action Plans<sup>32</sup>.
4. Expert assessment to assist in addressing public health needs<sup>33</sup>.

As noted, the health systems in even highly developed nations may experience logistical, administrative and fiscal challenges in the face of unexpected high volume migrant arrivals. The impact on less developed or less robust health systems can be more severe and may compromise national economic and development goals. For example, a reduction in the health component of the Human Development Index for Jordan has been associated with the impact of refugees resulting from the Syrian conflict<sup>34</sup>.

## Medium and Long Term

Geography and geo-political factors affect the flows and accommodation of displaced populations. UNHCR estimates that more than 85% of refugees are currently hosted by low and middle income nations. Unfortunately, many refugee situations are not short term. Several refugee movements represent medium and long term events that in some cases extend generationally. In low and middle income nations where there are challenges of meeting the health and development needs of their own populations, the pressures and impact of hosting large migrant/refugee populations further overstretch resource demands. In situations that simply involve large numbers of migrants, the basic and regular health needs of these populations are significant in their own right. When those movements involve co-existing or ongoing humanitarian crises additional levels of demand can be present, generating higher levels of need.

The long-term impact of hosting refugees and displaced populations may cascade backward and can impede national development and the implementation of national health care goals and strategies. The pressures and demands of hosting large migrant populations in low and middle income nations can impede and delay the attainment of global goals and targets in terms of Primary Health Care, health system reform and economic development in general.

These issues and pressures on health systems are not limited to acute refugee movements and population displacements alone. As migration becomes a greater component of population and labour

force growth in many nations, the proportions of national populations of migrant or immigrant heritage are increasing. Depending their origin, history and method of arrival in the host country some of these migrants may have health determinants that differ from the host population. Additionally, the simple medical and health aspects of providing health prevention, promotion and treatment services may be complicated by a series of cultural, social and linguistic factors that are different to those in the host or mainstream population.

Access to services can further complicate health care provision for migrant populations. In some locations, even though the migrants may long term residents, they may not be considered eligible for some benefits or able to access or utilize some health or social services. When those differences between migrant and host population cohorts are either large or significant they can impact the effectiveness of national health policies and programs and negatively affect the health of migrants. Over time the cumulative effects of untreated or inadequately addressed health needs in migrant populations may result in situations that represent even greater cost or service demands.

In this context, it is important to note that not all differences in health determinants between migrant and host populations are negative or less than optimum. Depending on source location and migrant category, migrants may display health indicators that are better than or exceed those of the host population<sup>35</sup>. This 'health immigrant effect' differs between nations and between nations in the same region<sup>36</sup>. In cases where new arrivals do have better outcomes than host populations, efforts to supports and sustain these health migrant effects and indicators need to become integral components of migrant health initiatives.

Many of the health implications of migration were believed or anticipated to diminish over time. Second and third generations issuing from migrant progenitors were infrequently monitored or considered as individual cohorts. When they were studied it was often in the context of ethnicity or race as opposed to the generational aspect of migration<sup>37</sup>. Many standard international definitions of nationality, place of birth or immigration status, while providing an important and useful demographic indicator and reference for health status, have an important deficiency. Depending on location and national definition, individuals may be classified as residents in data systems when they obtain citizenship. This is very common for children born to migrant parents who may be classified and monitored as components of the host population and not migrants. Children born to migrants often have health, cultural and social influences that result from the migration history of their parents and may display health indicators that differ from those of non-migrant host population cohorts.

In addition, some important genetic and biological determinants of health that arrive with migrants can continue to influence health for generations. Finally, the descendants of some migrant populations continue to exhibit some social determinants of health that differ from the host or mainstream population. Salient examples are provided the challenges faced by individuals of migrant heritage in the context of seeking compatible donors for transplant<sup>38</sup> or targeted genetic therapy as well as specific travel health related risks involved in travel to visit friends and relatives (VFR travel)<sup>39</sup>. Understanding, recognizing, monitoring and appropriately dealing with the health of migrants, their families and in some cases their descendants is a growing area of interest in several nations.

In this regard, the experience of nations where immigration is a long standing policy for population growth or where migrant populations make up large components of the national population can be helpful.

Examples include:

- The development and use of evidence based guidelines for the health care of migrants for health providers<sup>40,41</sup>.
- Applying multigenerational approaches when addressing long standing migrant populations<sup>42</sup>.
- Longitudinal studies of migrant health indicators<sup>43</sup>.
- Integrating place of birth, migration status and duration of residence into national surveys, census data field and other statistical references<sup>44</sup>.

Extrapolating and sharing that knowledge and information with other nations where migration is a newer or less monitored process is a current area of activity in the global health sector. A goal in this context would be to have migration recognized as a determinant of health that is systematically and standardly included in national health and demographic information systems.

## Migration and public health events of national, regional or global public health importance<sup>8</sup>.

Disparities and differences in environment, social determinants of health, economic development and availability of resources support and sustain differences in the global prevalence and incidence of many infectious diseases. The flow of people across and between these gradients of prevalence can be associated with the subsequent epidemiological patterns in migrants that differ from other populations. In the vast majority of situations the infections are well understood, treatment and / or prevention available and impact on global public health is not significant.

However, in rare situations newly recognized or novel infections may have global public health importance. Migration and population mobility have been recognized as factors involved in the emergence or re-emergence of infections and microbial threats of public health importance for nearly 3 decades<sup>45</sup>. During the same time, health issues have become increasingly prominent components of the global security and foreign policy agenda<sup>46</sup>. In addition to the spread of serious infectious diseases, migration related events or impacts on the health sectors of some nations may have security and foreign policy implications<sup>47</sup>.

Since the 2010 Madrid Consultation the world has experienced the emergence and re-emergence of some important infections where migration and population mobility have been of concern. Middle East respiratory syndrome coronavirus (MERS-CoV) was recognized in the Middle East in 2012 and some cases have been exported with travellers<sup>48</sup>. An outbreak of Ebola Virus Disease (EVD) in West Africa in 2014 occurred in a region of high regional population flows, international travel and migration. The size and scope of the outbreak resulted in the event being declared a Public Health Emergency of

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<sup>8</sup> In this section global public health importance is used in the context of the international spread of disease that requires a coordinated international response.



International Concern (PHEIC) according to the current International Health Regulations<sup>49</sup>. More recently, the extension of Zika Virus infection to areas of South America and the recognition of neurological and pediatric complications associated with that infection also prompted the declaration of a PHEIC in early 2016<sup>50</sup>.

The implications of population mobility including migration were recognized early in all of these recent events and were considered in the development and implementation of mitigation, control and prevention programs and practices. The relationships between regional and international travel, the flow of migrant workforces, international immigration and the patterns of travel of resettled migrants<sup>51</sup> (VFR travel) are complex, requiring individual, situational assessment. In terms of infectious disease control, there is heightened awareness in regard to the importance of migration during complex public health emergencies<sup>52</sup>.

As a result, contingency and response planning for new and anticipated future events increasingly contains components devoted to or directed towards migrant populations. It is important to note however, that in spite of some public anxiety about migration, fear regarding the health implications *per se* remains limited<sup>53</sup>. Surveys in Europe have indicated that most negative concerns associated with recent refugee arrivals related to more to security and terrorism, economic impact and crime rather than health or infections<sup>54</sup>.

Currently, the implications of migration are recognized or acknowledged in practically all strategies developed to enhance global public health. Since the Madrid Consultation in 2010 several regional and global activities and endeavours have worked to support national and global capacities in this regard. Examples include:

- The revisions and modernization of the International Health Regulations, underway since the 1990s, have continually worked to improve national and global capacities in terms of the prevention, detection, surveillance and response to events and situations of global public health significance<sup>55</sup>.
- In 2013 the European Union adopted a decision to assist in managing serious cross border threats to health. This decision strengthens preparedness, supports improved risk assessment, facilitates joint medical counter measures and enhances coordination of response.
- In 2014 the Global Health Security Agenda, a partnership of nations, international and non-governmental organizations and other partners was created to facilitate collaborative, multi-sectoral activities to support national and global capacities to meet biological and infectious disease threats<sup>56</sup>.

Migrant relevant components of these initiatives:

- Guidance for event management at points of departure, transit or entry
- Travel and transport risk assessment: guidance for public health authorities and the transport sectors
- Considerations regarding requirement/benefit of exit and entry screening at airports, ports and land crossings
- Ensuring migrant populations are included in national surveillance systems.
- Specific post arrival surveillance for migrants and travellers from affected areas.
- Coordinating surveillance and detection activities between origin, transit and destination locations.

- Ensuring the occupational health and safety of those working with or interacting with migrant populations in emergency situations.
- Ensuring that information and prevention activities are linguistic and culturally appropriate.

While there is similarity and some overlap between all of these undertakings, continued attention and coordination will be required to ensure policy, program and practice integrity. The importance of migration is acknowledged, but migrant-specific policy components are not always fully integrated into the agendas. In addition, many disease control programs have national components and trans-border continuity of care and international information sharing for diseases not related to the provisions of the International Health Regulations varies considerably. Ensuring a consistent approach to migration in the context of global public health preparation and response capacities remains a goal.

### The health system impacts of the migration of health workers from less developed or economically advanced nations/regions.

Not all of the health related consequences of migration and population mobility occur in the migrants themselves. The departure of large numbers of highly trained or skilled workers seeking international employment opportunities can affect service delivery and capacity at the place of the workers' origin. The departure of, or difficulty in recruiting or retaining health and medical personnel in low or middle income economies can hamper national and regional development and improvement in the health sector. The migration of medical personnel has been associated with difficulties in attaining appropriate levels of primary health care and more advanced development goals<sup>57</sup>.

Recent reporting on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel has noted "significant increase in awareness, commitment and dialogue with regard to implementation of the Code"<sup>58</sup>. The subject remains an area of collaborative study and evaluation.

It should be mentioned that discussion and economic analysis in this area is fluid and complicated. There is evidence to suggest that migration, even if it depletes source nation human resources can be associated with positive economic outcomes. The return of income generated abroad by diasporic migrants is an important component of international economics. These remittances are associated with poverty reduction in the source nations as well as creating further incentives for human capital development and training<sup>59</sup>. Additionally, the return of trained health personnel assists in improving the quality of and availability of care. As noted earlier, the education, retention and migration of health workers will influence and affect both UHC and sustainable development initiatives and represents a further example of the importance of migration in the evolution of global health.

## Evidence and Experience

Assessing current approaches to health and migration and examining the evidence generated in a relational context, is challenging. As noted earlier in this document, modern migration is dynamic, diverse and continually evolving. Demography, patterns and volume of movements can change markedly over relatively short periods of time. Programs, policies and investigations developed or implemented in even the recent past and the information collected as a result of those practices, may have limited relevance in terms of some current migration events. Globalizing the results of investigation and study is further complicated by the legal and administrative aspects of the immigration process that may categorize some migrant populations differently between nations.

In spite of the best international intent, determinations regarding citizenship, right of residence and access to national services frequently remain the responsibility of individual countries. Terminology, administrative and legal status of migrants varies between nations and sometimes between nations in the same region<sup>60</sup>. In some locations data is nominalized on the basis of nationality. Migrants can cease being identified as such when they obtain citizenship or right of residence and then become considered elements of the host or national population in statistics or reporting. In other locations country of birth or last permanent residence is used, while in some others ethnicity is considered. The definitions, applications and use ethnicity in monitoring and recording health information varies considerably between nations that use the term in national statistics.

Countries with nascent or small-volume regular immigration flows may devote the majority of their attention to irregular migrants, refugees and asylum seekers. In some jurisdictions children born into migrant families may be included as national citizens in health data capture systems. In other locations access to and utilization of health, medical and social services by individuals may be determined by residency or immigration status. These differences can impede the comparison of data and trends between nations and the analysis of global trends.

This generates challenges in monitoring the longitudinal health of migrants, may dilute the true impact of migrant cohorts within the larger host population denominator and may mask significant or important linkages between health indicators and outcomes with migration characteristics. These data limitations are not limited simply by the lack of standardized inclusion of foreign born or migrant residents in national health information or reporting systems<sup>61</sup>. Administrative or legal immigration status alone may not adequately reflect the heterogeneous nature of migrant communities nor delineate either accurate or relevant information regarding specific health conditions or needs. Advancing global migration health will need to be supported by standardized, normative migrant-status variables that can be applied internationally.

A further issue that influences a globally integrated approach to health and migration, is tendency to focus on the issue from a disease or condition based context. This is often the result of national border health or quarantine actions designed to mitigate and manage imported diseases of public health importance<sup>62</sup>. As a consequence, there are national differences in which diseases or conditions are monitored in migrant populations. Low incidence nations may direct considerable resources and attention towards specific diseases or conditions that may be more prevalent migrant populations. Other nations and institutions may focus on psychosocial, mental health, maternal child health issues. Each is important in its own context but there continues to be need for broader and more standardized

health-focused policies and practices that consider the wider aspects of migration. Examining the aspects of the health of migrants in a more globally integrated manner will require the greater attention to and use of health variables and standard indicators such as those used in other global health initiatives such as UHC<sup>63</sup>. Disease or specific condition based monitoring or reporting will continue to be collected and can support and accompany the broader health indicators but greater focus on migrant health needs as opposed to migrant disease rates should be developed.

## Evidence from Acute and Long Term Migration Flows

### Information Derived from Acute Migration Events

Large volume migratory movements always generate responses and those responses include health components. Providing immediate care and treatment to those displaced or fleeing has been a basic humanitarian principle. Those activities are directed at reducing mortality and providing treatment for those who are noted to be ill during the acute phases of movement. Commonly this is undertaken through an initial assessment to identify those in immediate need, followed by more detailed diagnosis and treatment of those with less critical problems<sup>64</sup>. As noted elsewhere in this document, rapidly evolving, large scale movements, such as those observed in Southern Europe over the past three years can sometimes overwhelm existing capacity and trigger a broader emergency response as the situation develops. Basic health information is collected and monitored while response and mitigation efforts are mobilized when situations or outbreaks occur<sup>65</sup>. Depending on the reporting requirements and practices of the location and agencies involved, data may be reported nationally, internationally or disseminated academically<sup>66</sup>. It is important to note that much of this information results from individual clinical encounters rather than systemic population based surveys.

This process continues when the migratory flows or population displacements are protracted as demonstrated by the provision of health care services refugee camp or resettlement situations. When displacement becomes chronic, health services can extend to the areas of prevention and promotion providing funding and resources are sufficient. Over time these health policies and health services provision have become standard components of modern humanitarian responses. Health information in these situations is routinely collected and shared between providers and international agencies<sup>67</sup>. Disease surveillance and monitoring practices are routinely included in programs that support refugee or displaced person movements. Outbreaks and occurrences of rare or unusual diseases are rapidly identified and dealt with. Endemic and chronic diseases are managed within the capacity of local resources.

While these programs are frequently stretched by demands that exceed resource capacity there are standardized guidelines and approaches to address the health needs of the acutely displaced<sup>68, 69</sup>. Advances in technology facilitate the collection and analysis of basic information, even in acute events and the increased use of these systems is expected to generate more evidence regarding the health status of those on the move.

Together these sources can provide useful and important information on the health and condition of migrants in acute large volume movements. Trends and needs can be identified and services and programs targeted to specific issues mobilized.

### Evidence from Sustained or Long Term Migratory Flows.

Long term migrant populations represent the source of the majority of available migration health data and information. Investigations, studies and analysis of disease incidence and prevalence in migrant cohorts and populations have been undertaken and reported for decades. More recently other health determinants in migrants are now subject to evaluation. Patterns of health service utilization, long term health outcomes and social determinants of health are routine areas of modern migration health study.

Nations with long standing migration patterns and formal immigration programs frequently integrate aspects of migration, citizenship or place of birth integrated into aspects of their national surveillance or reporting systems. As a sequelae of maritime quarantine or infectious disease control programs, new arrivals may be subject to medical examination as a requirement for immigration or long term residence. Some nations with national health insurance programs also assess prospective immigrants in terms of non-infectious diseases or other disorders such as substance abuse in an attempt to reduce downstream costs or service demands after admission.

Mandatory immigration health programs generate information that can provide historical perspective on the prevalence of some illnesses and health relevant conditions in those subject to the requirements. Reflecting the historical interest in managing imported infections a large amount of this information is related to infectious diseases, tuberculosis being one of the most common examples in this regard<sup>70,71</sup>. While most often used to assist domestic or national disease control activities in the country of destination, the information provides secondary surveillance and monitoring indicator for conditions in migrant source nations<sup>72</sup> or even down to municipal or civic level<sup>73</sup>. Longitudinal use of information from migrants can improve the understanding of modern epidemiological dynamics and support global strategies aimed at mitigating or controlling diseases of global importance, such as tuberculosis<sup>74</sup>.

In nations where migrant-relevant health data is available, increasing knowledge and information about non-communicable diseases is accumulating<sup>75</sup>. Examples can be observed for practically all aspects of health care from disease specific studies<sup>76</sup>, gender and reproductive health<sup>77</sup>, mental health<sup>78</sup>, the use of health services<sup>79</sup> and aging<sup>80</sup>. The growing acceptance of migration as determinant of health should result in better data and understanding of additional migrant health needs. The inclusion of migrant-relevant elements into national social and health statistics provides insight in the influences and consequences of migration across a broad range of health determinants including social determinants of health and access to services<sup>81</sup>. Extending these practices more widely could become important aspects of the global development strategy<sup>82</sup>.

### Challenges in the Assimilation of Migration Health Information.

Health care service providers in transit and resettlement situations are directly involved with the delivery of care and treatment of migrant populations. During their activities they can encounter needs

and conditions that differ from those of the host population. Depending upon the experience of the provider, some of the clinical situations and social conditions encountered may be unfamiliar. Differences in health conditions between migrants and the host population can be further complicated linguistic, cultural and social factors. Faced with the clinical needs of minority, sometimes marginalized and often vulnerable individuals these providers frequently develop or acquire experience and practices that improve and support the health of migrants. Modern information technology and connectivity easily allows the knowledge and experience gained by those who treat migrant and mobile populations to be distributed and more widely shared.

Challenges in systematically assimilating experience and information regarding migrant health are common. Lack of resources and personnel dedicated to the migration health sector is frequent. Migration health programs are often “add ons” to existing operational structures or policies originally designed for other purposes. The lack of sufficient prioritization of migration health activities against other demands can lead to consequential program weakness due to funding and capacity issues and resource diversion when crises arise in other sectors.

During the past decade coordinated and collaborative undertakings have created empirical and evidence based guidelines for dealing with several aspects of migration health<sup>83</sup>. Collaboration and networking of health care providers dealing with the health of migrants extends to and has supported the development of centers of excellence, teaching and research in the field. A specific example is provided by the Equi Health Project delivered by the EU and IOM for supporting health provision for migrants including the Roma and vulnerable populations<sup>84</sup>. Similar to other activities and endeavors noted in this document, some of these undertakings are national in scope<sup>85</sup> but there are other regional and international activities under way<sup>86</sup>. In Europe IOM and the EC for example have produced both a health assessment handbook for refugees and migrants<sup>87</sup> and personal health record for migrants<sup>88</sup>.

One universal observation common to the spectrum of experience and guidelines is the importance of engaging the migrant community itself at all levels of the process. The benefits of having inclusive approaches that utilize the linguistic and culturally appropriate input and services of migrants and their families have demonstrated positive impact on outcomes and program success.

Improving evidence and information collection globally can be enhanced through high level, coordinated and globally coordinated guidance and information structures. Optimally this would see more fully organized and coordinated migration health policies, practices, guidelines and expertise linked to other global activities such as HSS, UHC and global public health endeavours.

## Trends in Migrant Health

As noted earlier in this document, the size, diversity and scope of migration is steadily increasing. Migrants represent a significant and growing cohort of global, regional and many national populations. The scope and size of unplanned irregular movements driven and supported by conflict and instability have recently increased. Examining migration health through a global lens encompasses the health outcomes and determinants for a population that the UN estimates to be in the range of 250 million individuals<sup>89</sup>. If considered as a single nation this would represent the fifth largest country in the world.

Such a large and diverse population is comprised of an extensive aggregate of ages, genders, locations, social, economic and cultural determinants.

Physical and social determinants of health can be characterized according to many criteria, revealing areas of need across many metrics. Age alone, for example exerts influences on health determinants such as maternal child health, the health of children and adolescents extending to health outcomes for the elderly. Other examples include broad impact of chronic diseases and illnesses, mental and psychosocial health disorders, injuries accidents and disabilities and individual organic diseases. In that context, it is recognized that the health needs of migrants represent a spectrum that can be approached from the level individual and community requirements for services and programs and extend to broader population health perspectives. Addressing and meeting those needs varies in scale and scope as they do in any large nation, but a standardized, globally coordinated framework can provide the necessary integration to make the process equitable and consistent across the many migrant populations.

Noting or commenting on all of the migrant sub-populations, communities or groups at risk or affected by adverse or different health outcomes is beyond the scope of this document. It is implicitly recognized that the health and medical needs of different migrant cohorts and communities vary markedly. Forced migration, trafficking and smuggling and refugee generating situations will often be associated with a different set of health needs than those observed in other migrant populations. The same is true for migrant and temporary workers and regular migrants. Systematically identifying, prioritizing and dealing with all of the issues can be better undertaken through a holistic, integrated perspective which supports a globally coordinated policy framework. Inclusive, consistent principles and standards generally applicable to all migrants, across the origin, transit and destination spectrum, will support more granular programs and policies relevant and appropriate for specific populations and communities.

Taking a global perspective, modern migration flows occur against the backdrop of a world where significant disparities and inequity in levels of development, wealth and health indicators continue to exist. Perhaps the most fundamental principle in improving migrant health will be addressing those existing health inequities. That is already a common principle integrated into the majority of national and international health policies, such as UHC. Reducing disparity is also a cornerstone of development programs and activities. Improvements resulting from those endeavours that reduce inequity will consequentially improve and impact the health of migrants and it only requires a small change in the focus of those global health and development strategies to create and encompass a 'migration oriented' approach.

Relating the forces that are behind health outcomes in migrants to the components of the migratory journey supports the effective targeting of intervention and prevention activities and resources. Dealing with health issues before they develop or at the stage they are created may be more cost and outcome effective than simply managing the consequences after arrival or resettlement. Investment and efforts designed to reduce health inequities in source nations or regions will simultaneously affect potential future migrants who should, as a consequence, require fewer health services and who should have better social and medical determinants of health. This sort of coordination and collaboration can support better migration health through better overall global health.

Together those forces and activities provide the basis of the most important goals in migrant health.

1. The need to attend to, manage and mitigate the health needs of newly arriving vulnerable migrants in acute situations.
2. Ensuring adequate and appropriate provision and access to health care and services across the migration spectrum including origin, transit and destination locations and situations.
3. Providing culturally and linguistically competent health services for resettled migrants.
4. Identifying and monitoring migration-associated health indicators.
5. Ensuring that global strategies, initiatives and programs to improve health or reduce the global impact of disease include migration-related components.
6. Improving global development to reduce inequities in health indications and social determinants in health.

Achieving those goals will be facilitated by:

- Addressing the need for integrated, inter-sectoral migration health policies,
- Creating globally standardized variables to monitor migrant health (including disease surveillance but extending to other indicators),
- Supporting and guiding the use of those variables in national and international health data collection and monitoring systems, and
- Providing global stewardship in migration health during the development of the refugee and regular migration Global Compacts.

## Cross Cutting Issues

Not surprisingly, the cross cutting or lateral health issues associated with or resulting from migration are similar to other global health concerns. International treaties and protocols provide a legislative framework in terms of basic human rights and workers' rights. However levels of economic development differ. Nations with lower economic capacity face challenges in ensuring adequate levels of housing, education, employment, health care and other services for their own populations and large migrant inflows can create additional stress.

## Legal and Administrative Status

While not specifically a health issue, the administrative and legal definitional aspects of migration have important and significant implications for work towards better global migration health. Given the global focus and context of this document, a broad all-encompassing term and concept has been used to refer to those living away from their usual place of residence. This approach creates a current global population of migrants that approaches 250 million individuals<sup>90</sup>. In the context of this document, global refugees who number approximately 22 million are included in that total. It is important to note that refugees with well-founded fear of persecution that forces them to flee across international borders have rights and protection defined by the 1951 Convention and the 1967 Protocol and in international law that may not extend or apply to other migrant categories.

New global commitments recognize both the common aspects of the migratory process as well as the substance and nature of these differences between refugees and other migrants. Collective and



comprehensive global solutions based on equity and shared responsibility though three major action streams are integral parts of those commitments<sup>91</sup>. Those action streams include:

- Upholding the safety and dignity in large movements of both refugees and migrants,
- The adoption of a global compact on responsibility-sharing for refugees, and
- The development of a global compact for safe, regular and orderly migration.

Depending on location and circumstance migrant movements may be comprised of refugees and other mobile populations. Programs and policies dealing with the health of migrants will need to be both inclusive enough to ensure the respect, rights and dignity of all individuals while ensuring the specific legal aspects and protection associated with refugees.

## Disparity

In considering a global view of health and migration, it is important to observe that many of the health concerns associated with migration are not the result of migration *per se*. There are significant health risks and adverse outcomes associated with some migrant flows, in particular irregular, involuntary or refugee movements. These can result in process and travel-associated violence, injury, illness and death. However, many of the differences in health determinants (social determinants of health) and indicators (disease prevalence) between migrant and other populations are fundamentally the product of disparities and inequity between origin, transit and destination locations.

The impact of these pre-existing disparities is revealed through migration when the health outcomes for cohorts of migrants are compared to similar outcomes for other populations. Those differences can be observed in both non-infectious and infectious diseases, organic and psycho-social illnesses and occupational or situational maladies. They result not directly because of the migration process but as a consequence of the migrant bridging gaps in access to and use of preventive health services, clinical health care and treatment, medication and support. It is for this reason that the reduction of global and regional health disparities will significantly reduce the volume and scope of the health needs of migrants.

Reducing these disparities will require coordinated inter-sectoral action directed towards:

- Coordinated support and assistance for migrants in immediate need of life supporting care,
- Capacity building and strengthening of health systems across the migration spectrum (origin, transit and destination),
- Ensuring the universal health coverage and universal coverage to essential services for all migrants, and
- Linking short-term acute humanitarian assistance for migrants to longer term health system strengthening.

## Violence

Vulnerability and violence are major hazards in many migrant populations. For reasons that extend well beyond the migration process, women and girls, the young and the elderly are at increased risk. Some

phases of the process particularly the journey and transit aspects are associated with greater incidence of violence but the ongoing vulnerability of migrants can continue into the arrival and settlement components. Violence and vulnerability are also elements of migration-associated human trafficking and smuggling as well as forced or coerced labour.

National, regional and international violence prevention and intervention policies and programs in these areas should be developed in a manner sufficiently broad to include migrants and their families. Violence reduction in relation to migration should be seen as a public health priority.

## Gender Issues

While gender associated-health issues affect all populations, the migration process can pose additional gender-relevant health risks<sup>92</sup>. The appreciation of the role played by gender in migration health will involve better analysis of data in terms of gender as well as the consideration of the role played by gender relation across the migration cycle<sup>93</sup>.

Access to maternal and child health services may be interrupted or prevented during migration and lack of access to appropriate care may continue following arrival at the destination. This can lead to adverse reproductive health outcomes for some migrant populations<sup>94</sup>. Risk factors can be identified before conception and continue through pregnancy, childbirth and the postpartum period<sup>95</sup>. In addition to the risks of violence across the migration spectrum, migrants particularly children, girls and women can suffer sexual violence and victimization. Access to culturally appropriate care may be limited during the migratory process or after arrival and protection of women, children and girls may vary situationally.

Modern, integrated migration health policies and programs should be developed with appropriate attention cultural competency and gender sensitivity.

## Access to Services

As discussed earlier the underlying biological and demographic diversity of modern migrant and mobile populations is complicated by corresponding jurisdictional and capacity issues in meeting their health needs. Many migrants originate from, transit through or reside in nations with limited economic capacity and their presence can impact already stretched programs and services. At the same time it is important to observe that not of the challenges migrants experience in accessing health services occur in situations of low or middle economic capacity. In several highly developed and wealthy nations. Legislation regarding nationality or right of residence may exclude or deny some migrants, particularly the undocumented, stateless or transient from access to insured or national programs.

Monitoring and ensuring the availability of and access to basic health services for migrants is one key issue in the context of modern migration. Identifying and documenting specific areas of need will support the inclusion of migrant relevant components into other global health initiatives, specifically the health systems strengthening and universal access to health care and universal coverage. Ensuring coverage and access to care would alleviate many of the challenges faced by migrants and reduce adverse outcomes<sup>96</sup>.

From a global perspective the ability of migrants to access and utilize health services of sufficient quality can be seen as a required component or element of Universal Health Coverage (UHC). The basic principles of UHC are based on the premise that all people should be able to access and use the health services they need including health prevention and health promotion components; that the services available are of sufficient quality to be effective and that the use of the services is not associated with undue financial impact or hardship<sup>97</sup>.

Increased access and health coverage for migrants is important for many reasons. Better access to and greater utilization of health services improves population health<sup>98</sup> and reduces poverty, generating secondary gains across the health and economic sectors. Healthier migrants will support social progress and economic development across the migration spectrum. This can reduce downstream health and social services costs and consequentially facilitate integration for permanent migrants as well as return for those who wish to.

Ensuring that migrant populations and communities are integral elements of UHC strategies is an important principle of the global migration health dynamic. Nations and regions will need to ensure that their UHC strategies and policies include migrant populations. Stakeholders and partners not usually components of the health sector, such as labour, immigration, border services and migrant communities themselves will need to be components of UHC designs. Additionally, the mobility aspects of modern migration mean that viable, functional UHC strategies for migrants may need portable, trans-border components. Examples and analysis in this regard are underway in some regions<sup>99</sup>. Global tracking systems for UHC have recently been rolled out by WHO<sup>100</sup>. However, the integration, coordination and collaboration necessary to ensure that migrants are considered and represented in all UHC strategies will be extensive and complicated. Financing UHC for migrant populations in resource-limited nations may exceed national capacities.

Solutions and strategies to increase access to UHC for migrants will, in some locations and situations require, international or region burden sharing aspects and multilateral consultation and collaboration. This may require new approaches to health insurance for migrants or global or regional fund pools for managing acute events. In this regard partners and stakeholders include agencies, organizations and elements of civil society outside of the health sector. These issues related to UHC and migrants are likely to be a significant component of the health elements that will be involve in the development of both the refugee and orderly migration Global Compacts.

## Health and Migrant Workers

These issues are not limited to permanent migrants alone. For example, a patchwork of policies and programs exists to deal with the health of migrant workers. Employers may provide coverage or assistance to the workers themselves but there may be no consideration for the health of family members at the place of origin. Additionally, work-related coverage may cease with employment and the return of the migrant worker in spite of situations of occupational illness or injury acquire during employment. This raises a second key issue in the migration health discussion, the establishment, monitoring and support for internationally portable health benefits for migrant workers and their families.

The large number of global migrant workers who leave their homes to support their families do so under a mixture of health requirements and restrictions. Pre-employment, pre-travel and job site medical processes vary. Many reflect historical quarantine or immigration health style practices designed to prevent the arrival of certain diseases or illnesses. In many cases these practices are focused or centered on two criteria; fitness for employment and; some specific infectious diseases. Attention in the later regard is commonly directed at tuberculosis, sexually transmitted infections and vaccine preventable diseases.

Screening, monitoring and enforcement of these practices and protocols are normally at the level of the nation where the workers originate and the health or labor sector in the nation where the workers are employed. Standardization and evaluation of the efficacy and efficiency of these health assessment and screening programs for foreign workers varies and there is a paucity of reporting or investigation on their effectiveness. Many tuberculosis screening programs are radiologically based and can lead to denial of employment simply due to the presence of radiological abnormalities that may be unassociated with any public health risk. Additionally, these employment related migrant worker health assessments may not be integrated into treatment or disease control programs that would ensure the adequate follow up and treatment of those identified with an illness or disease. Migrant workers may be simply denied work authorizations or returned to their nation of origin in the absence of integrated or coordinated follow up or treatment.

This situation presents both the need and opportunity for a coordinated, accountable set of indicators and health practices for migrant workers. Such a process could involve:

- The verification, validation and establishment of empirically based, internationally standardized health screening and assessment standards for migrant workers.
- The development of international guidelines dealing with diagnosis, referral and treatment of employment-relevant diseases and illness in migrant workers. These would include standardized methodologies and protocols for ensuring adequate care and treatment, either at the place of employment or migrant source nation coupled with standardized migrant health records to document care and manage concerns regarding public health risk.
- On-going international evaluation of such processes to better monitor migrant workers' health globally; assess trends and improve risk assessment in terms of the health of migrant workers. These processes would also complement other public health practices in terms of global disease surveillance and monitoring.

A specific cohort of migrant workers is represented by health workers themselves. The complex issues associated with the global migration of health workers and associated professionals are beyond the scope of this document. It should be noted however that migrant health workers represent valuable resources and can often provide linguistically and culturally appropriate service and support in acute movement situations where needs are greatest. Additionally, they provide similar benefits in delivering health care in long and medium term migration situations.

## Frameworks and Indicators

Many, if not all of the aspects regarding migrant health indicators and the operational framework resulting from the 2010 Madrid Consultation, remain valid. Additionally, the importance of effective global monitoring frameworks based on harmonized and agreed indicators has been outlined as a component necessary to monitor Sustainable Development Goals<sup>101</sup>. Many international organizations, agencies, national and academic institutions are already deeply involved in aspects of health and migration. Each brings its own expertise and perspective to the issue but the approach frequently remains siloed and monitoring is complicated by the absence of standardized terminology and indicators. It has been recognized that adding migration-relevant fields and indicators to existing health data collection systems would improve organizational and programmatic efforts in monitoring migrant health<sup>102</sup>.

Migration specific indicators, which would represent a thematic monitoring element in that context, would support both the SDG and migrant health-relevant monitoring. This will require coordinated, collaborative international and inter-sectoral foci or repositories for migration health knowledge, lessons and best practices. In order to generate a coordinated global approach encompassing all aspects of the topic, consensus and guidance are required. The recent entrance of IOM as UN Related Agency provides an increased capacity in global migration including health elements. The commitments of the UN New York Declaration of September 2016 offer appropriate opportunities to create and define, standards and policies of sufficient perspective and cross jurisdictional application in terms of migrant health. A goal in this regard, could be a globally focused and directed analytical and policy development group with sufficient academic and scientific capacity to compare and judge evidence while balancing competing demands across the migration spectrum.

Many of these aspects have been recently summarized and prioritized by WHO<sup>103</sup>.

In that context there are needs for:

### I. The identification of priority indicators and outcome measurements

Some international studies of migrant resettlement and integration do include basic health indicators. Self-reported health assessments provide relational context with host population cohorts and shed insight on basic aspects of health in relation to the settlement and integration of migrants in the broad context<sup>104</sup>. These studies note the continued needs for better specific monitoring while identifying differences between national surveys that make data comparison challenging. Some studies looking at the use of indicators in migrant populations group the indicators into three component types; Structural, Process and Outcome indicators<sup>105</sup> which may be a model for future global migration health indicator types.

There continue to be a plethora of studies and investigations comparing differences in the epidemiology of individual diseases or outcomes between migrants and other populations. These are frequently undertaken on national or even municipal level and the populations studied can differ in terms of migrant origin, movement or transit history and post arrival residence. The broad public health importance and potential impact of the diseases and conditions studied varies. Individual studies

examining the differences between migrant and host population cohorts in terms of individual conditions or infections at national levels may not reflect the greatest global health needs. For example, the arrival of some imported infections in wealthy nations with comprehensive public health systems may be less problematic than a similar situation in a less developed or under-resourced location. A prioritized approach to migrant health indicators taking local capacities into account would help define the most important health needs in a global context. National and institutional interests can continue to generate basic information and serve national health and public health needs but a coordinated globalized effort should focus on health issues of the greatest collective importance.

International collaboration and consensus prioritizing areas where global interests are paramount may help direct attention to achieve the generation of information and knowledge of wider application and use.

## 2. Better coordinated, integrated monitoring of relevant migration health information, behavior, programs policies and health outcomes.

This will require the establishment and greater use of national and international data in a standardized and relational context. Where possible the phases of the migratory process should be included in the analysis. Given the role of cyclical or recurrent migration, where individuals may cross the same or different borders multiple times, systems involving portable or easily accessed health information for migrants require development and implementation. In that regard, guidelines do exist for some individual diseases such as tuberculosis<sup>106</sup>, but the processes and practices should be expanded to include a broader range of health information. The importance of the smooth trans-border flow of health information between countries and stakeholders is very important during large, regional movements<sup>107</sup>.

Global guidelines and standards for the collection and use of migration relevant data should be prepared, discussed, agreed and disseminated. Optimally this work would be undertaken by a collective or collaboration with global focus that would work towards a standardized format and output. These activities will entail:

- Systematic reviews and collation of national policies and survey structures
- Integrated cooperation between origin, transit and destination nations
- Bilateral, regional and international coordination
- International standardization of terms and data fields
- Community (migrant) inclusion in program and policy design and development

## 3. Collaboratively prepared global strategies and guidelines focused on migrant health.

The explosive growth in the importance, interest and study in health and migration is generating large amounts of information, some data and a variety of conclusions. Some of the studies are the results of specific national requirements or interests others may reflect specific events or movements. The

relevance of this information may be limited in terms of cohort effects, time or the specific location in which it was collected. In the absence of a systematic approach to global migrant health, the volume alone of this information can be challenging to interpret and consider in the global context. There are examples of how guidelines and indicators for similarly complex issues, such as global development goals can be prepared<sup>108</sup> which may be useful in designing global migration health approaches.

Global and regional strategies and programs working to reduce the prevalence and burden of diseases and improving health such as the Global Fund have components that recognize or include migrants as key or important populations<sup>109</sup>. Similarly, many programs focused on specific diseases of global importance such as malaria<sup>110</sup>, tuberculosis<sup>111</sup>, hepatitis<sup>112</sup> and HIV<sup>113</sup> contain migration-relevant or migrant-targeted components. Bringing the experience and knowledge of all of these endeavors together and exploring commonalities and identifying opportunities for program symmetry will be an important building block of a uniform global migration health strategy.

These global strategies and goals must be integrated with the principles of achieving universal health coverage and universal access to quality essential health services for all. Concise guidelines and statements of the type and nature of those used by other international agencies would go a great way in improving the understanding and appreciation of global migration health.

#### 4. The collation, mapping and dissemination of practices and policies demonstrated to facilitate and improve migrant health.

It has become clear that it is necessary for health systems to improve both the access to and migrant-friendly aspects of services available to mobile populations. At the same time it is apparent that nations have to begin to improve the social and economic determinants of health affecting migrants across both the health and social services sectors<sup>114</sup>. Experience and practical knowledge varies between nations. Global migration health would improve through the organized review, assessment and evaluation of the programs, practices and policies involved in migration health at the national and institutional level<sup>115</sup>. The goal in this regard would be enhanced program and policy coordination with the avoidance of both redundancy and gaps in approach<sup>116</sup>.

Some collaborative activities of this type are underway. For example, the Migrant Integration Policy Index (MIPEX), provides a systematic comparison of policies associated with migrant integration in nearly 40 nations<sup>117</sup>. Several of the MIPEX indicators are health related and the index allows for systematic comparison between the national approaches and outcomes for the selected indicators. Additionally, recently the European Region of Who prepared a regional roadmap for the implementation of the 2030 Agenda for Sustainable Development that had an associated strategy and action plan for refugee and migrant health in that region<sup>118</sup>.

#### 5. Consideration of New and Novel Migration Health Partnerships

The dynamics, scope and volume of modern migration frequently exceed both the program and policy capacities of traditional migration health approaches. As the world moves to more coordinated globalized mechanisms of dealing with migration such as the compacts for responsibility sharing for

refugees and safe, orderly migration, new partnerships and alliances in terms of migrant health are being considered and proposed.

As migration is global rather than a national process and because migration health issues are much broader than specific diseases themselves, coordinated, comprehensive solutions will be required. Building on the lessons and observations of other global health initiatives such as the Global Fund and GAVI, wide coalitions and partnerships will likely be key to addressing migration health challenges. Those partnerships will need to include the involvement of civil society, the private sector including financial institutions, academic and research centers and most importantly migrant communities themselves. At the national level, domestic health and immigration services and agencies will need to be encouraged to develop integrated and symmetrical policies and programs that support and enhance international activities. Migrant-sensitive health legislation, policies and practices should be supported.

These relationships will need to extend across all components of the migration process from origin through to transit and settlement locations. Guidance and direction can be provided to partners and networks as the development of the Global Compacts progress.



# Annex: Monitoring progress towards ‘migrant-friendly’ health systems, with particular emphasis on Europe

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## Introduction

Like everyone else, migrants live out their lives within legal and policy frameworks that both create and limit possibilities for them. For migrants, however, there exist additional laws and policies that set them apart from non-migrants. These can have a major impact on their health, since they determine both their living conditions and the health services available to them. Every sector of policy-making is capable of influencing health, but despite efforts to promote ‘public health’ approaches and the principle of ‘health in all policies’, the health sector still has little influence over policies in other sectors: health policies are chiefly concerned with health services. When we speak of ‘migrant health policies’ we therefore refer mainly to the policies determining migrants’ access to services and the responsiveness of services to their needs.

Any attempt to improve migrant health policies must start from a firm evidence base. Accurate and detailed information is needed, not only on policies in one’s own country, but also on those in others; an international evidence base can show what policy options exist and how national policies differ from each other. However, to collect any information at all about migrant health policies it is necessary first to decide on the issues to be studied. What are the essential ingredients of a ‘migrant-friendly’ health system? Luckily, a fair amount of consensus has emerged over the last few decades over this question. This consensus has come about mainly through the activities of international, rather than national organisations. It is important to appreciate why international bodies play such an important role in migrant health. In democracies, policy priorities are determined by a political process in which many different interest groups are represented. The interests of migrants, however, are hardly ever taken into account in national policy-making: most of them do not have a vote in national elections, and even where they do, their numbers are too small to have much influence. Migrants and other groups that are under-represented in domestic politics have to rely on NGOs, CSOs and above all international organizations to look after their interests. A number of international bodies are concerned with the welfare of migrants, and it is mainly these which have taken up the challenge of formulating goals for health policy development. At the global level, these include the United Nations, WHO and IOM; at regional level, the EU, Council of Europe, NGOs, CSOs and comparable bodies in other parts of the world.

In this section we will trace out a ‘road map’ showing how ideas about desirable policies on migrant health have developed, focusing particularly on Europe. The milestones on this map take the form of legal instruments (treaties, conventions and regional laws), ‘soft’ instruments (declarations, recommendations and guidelines), and practical actions such as conferences, research programmes and the setting up of networks.

## International law

The most important milestones are the legal instruments that form the basis of the United Nations framework: the International Bill of Human Rights<sup>9</sup> and the conventions and treaties that have extended and build on it, such as the 1951/1967 Refugee Convention. Like its predecessor the League of Nations (1920), the UN was set up by the victorious allies in the wake of a major world war, in order to promote a world order in which such an event would never happen again. The UN Charter (1945) enshrined the basic values of “peace, freedom, social progress, equal rights and human dignity”. It was above all the stress on equal rights that gave the UN the task of defending minorities and vulnerable groups (which may include migrants) not adequately protected by their own governments.

After ratifying UN treaties, ‘States Parties’ are required to transpose them into their own legislation. For each treaty there exists a committee or court that determines how it should be interpreted. Treaties, like other laws, often rely for their ‘teeth’ on the accumulated corpus of interpretations and previous rulings (jurisprudence, ‘case law’). The right to health, for example, is specified only in very general terms in the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966); it is above all the Committee on Economic, Social and Cultural Rights (CESCR) that has determined, sometimes quite recently, how exactly it should be implemented.

In UN treaties, the right to health is universal, fundamental and unalienable; it cannot be made dependent on issues such as nationality or country of birth. National laws that limit a migrant’s right to health care – which in fact are found in most countries – are therefore *prima facie* violations of this right. Only in its interpretations published in 1990 and 2000, however, did the CESCR specify that the right to health care must specifically include primary care,<sup>10</sup> that care should be “available, accessible, acceptable and of adequate quality” (AAAQ),<sup>11</sup> and that it extends to preventive, curative and palliative health services and must include asylum-seekers and “illegal immigrants” [sic].<sup>12</sup>

Concerning these rights – and indeed many others – there is a yawning gap between UN treaties and the situation in most countries. Yet, as Knipper (2016: 993) puts it: The reluctance of states to seriously apply human rights “at home” is actually not a surprise: human rights oblige governments to attend to the particular needs of the marginalized, the weak, and the powerless. It was precisely the historical awareness of the vulnerability of minorities that motivated the authors of the Universal Declaration of Human Rights (UDHR) in the late 1940s.

Other UN treaties that touch on migrants’ right to health include the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, 1965), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979), the Convention on the Rights of the Child (1990), and the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990). (The latter has been ratified by only 49 states, almost all of them primarily countries of origin of migrants, not by any high-income countries that receive migrants.) Pace (2009) reviews international legal instruments relating to migrant health.

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<sup>9</sup> The three pillars of the International Bill of Human Rights are the 1948 Universal Declaration of Human Rights (UDHR, adopted in 1948); the International Covenant of Economic, Social and Cultural Rights (ICESCR, 1966); and the International Covenant on Civil and Political Rights (ICCPR, 1966)

<sup>10</sup> General Comment 3 (CESCR 1990), para. 10

<sup>11</sup> General Comment 14 (CESCR 2000), para. 12

<sup>12</sup> *Ibid.*, para. 34

## Regional legal instruments

Regional bodies such as the Council of Europe (CoE) and European Union (EU) have also enacted human-rights legislation which is binding on their Member States and has relevance to migrant health, such as the CoE's European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR, 1950) and European Social Charter (ESC, 1961, revised 1996), or the EU's Treaty on European Union – Maastricht Treaty (TEU, 1993) and Charter of Fundamental Rights (CFR, 2000). The EU has also issued a number of legally binding Directives that impinge on migrant health.<sup>13</sup> However, the principle of 'subsidiarity' in the EU strictly limits its ability to legislate on matters concerning health systems. Pace (2007) reviews European legal instruments relating to migrant health.

## 'Soft' instruments and practical actions

Despite the impressive number of international and regional legal instruments, in practice they are very sparingly used to effect changes in national legislation affecting migrant health. To start with, someone has to be prepared to invest the considerable resources required to bring a case; procedures are slow and cumbersome and case law is often underdeveloped. Non-binding or 'soft' instruments such as declarations and recommendations are increasingly preferred as a way of influencing national policies: these appeal to widely accepted principles and incorporate technical advice. (Indeed, legal instruments themselves are also intended to work in this non-coercive way, by providing inspiration and guidance.) 'Soft' instruments are often supplemented by practical actions (e.g. training packages, research programmes), which make available tools to facilitate certain developments for any governments interested in using them. Because of the limitations imposed by the subsidiarity principle, most of the initiatives taken by the EU fall into the 'soft' category.

Below are listed some of the main instruments and actions which have contributed to the development of migrant health policy, with particular emphasis on Europe.

## "Road map" of initiatives to promote the development of migrant health policy (especially in Europe)

In addition, numerous reports, research projects, networks, and teaching courses have been set up by the bodies listed above and their various agencies, as well as by universities, research institutes and NGOs such as PICUM, Médecins du Monde, Médecins sans Frontières, Jesuit Refugee Service, etc.

1948	UN	Series of treaties on human rights and combating discrimination
1950	CoE	European Convention on Human Rights
1961	CoE	European Social Charter (revised 1996)

<sup>13</sup> For example: Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin (the 'race directive'); Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers; Council Directive 2008/115/EC of 16 December 2008 on common standards and procedures in Member States for returning illegally staying third-country nationals (the 'returns directive').

1983	WHO	First European Conference on Migrant Health, The Hague
2000	EU	Charter of Fundamental Human Rights; Directive combating discrimination
2001	USA	Publication of National standards on culturally and linguistically appropriate services (CLAS) by Office of Minority Health
2001	CoE	Recommendation of the Parliamentary Assembly regarding Health conditions of migrants and refugees in Europe
2003	IOM/UNOHCHR/WHO	Publication of report International Migration, Health and Human Rights
2006	CoE	Recommendation of the Committee of Ministers to member states on health services in a multicultural society
2007	CoE	Bratislava Declaration on Health, Human Rights and Migration
2007	EU	Portuguese EU Presidency conference, Health and Migration in the European Union, Lisbon
2007	EU	Council of the European Union Note on Health and Migration in the EU
2008	WHO	World Health Assembly, Resolution 61.17 concerning the Health of Migrants
2009	EU	European Commission Communication on Solidarity in Health: Reducing Health Inequalities in the EU
2009	IOM	EU-Level Consultation on Migration Health, Lisbon: Better Health for All
2010	EU	Employment, Social Policy, Health and Consumer Affairs Council Conclusions on Equity and health in all policies: Solidarity in health
2010	EU	Spanish EU Presidency Conference, Moving Forward Equity in Health, Madrid
2010	IOM/WHO	First Global Consultation on Migrant Health, Madrid
2011	CoE	Recommendation 13 of the Committee of Ministers to member states on mobility, migration and access to health care
2011	EU	Resolution of European Parliament on reducing health inequalities in the EU
2015	WHO	High-level meeting on refugee and migrant health, Rome
2015	UN	Adoption of Sustainable Development Agenda
2016	UN	Summit for Refugees and Migrants, New York
2017	IOM/WHO	Second Global Consultation on Migrant Health, Colombo
<p>In addition, numerous reports, research projects, networks, and teaching courses have been set up by the bodies listed above and their various agencies, as well as by universities, research institutes and NGOs such as PICUM, Médecins du Monde, Médecins sans Frontières, Jesuit Refugee Service, etc.</p>		

## Creating an evidence base on migrant health policies

As can be seen above, a great deal of effort has gone into defining the directions in which policies should be developed in order to guarantee equitable health services for migrants. Several points can be made about this 'road map'.

- These ideas have had both a normative and an empirical basis: they are partly based on international law and ethical arguments, but also on empirical research on migrants' health and their interactions with health services. Both types of ingredient are essential underpinnings for any kind of public policy.
- Recent initiatives are mainly found in the period 2006-2011. During this period, however, there were no relevant developments in international law, although some significant decisions were made in European case law (Inverardi, 2016:54-61). The main initiatives took the form of what we have called 'soft' instruments.
- The recent reduction in the level of activity is probably due to the aftermath of the economic crisis of 2008, which (together with the 'austerity' measures subsequently imposed) had a devastating effect on many European countries. 'Migrant-friendly' became a term politicians preferred to avoid: at the national level, there were negative as well as positive developments in migrant health policy (Stuckler et al, 2009; Dubois & Molinuevo, 2013).
- The 2015 'refugee crisis' in Europe, which saw the arrival of over a million asylum seekers and irregular migrants, further strengthened the backlash against migrants and the rise of populist politicians. From 2015 onwards, most policy initiatives in Europe have been focused on this event, rather than on the structural health needs of migrants. For example, considerable resources were allocated to projects on infectious disease control, despite a lack of empirical evidence that contagious diseases were in fact a major problem among the new arrivals.<sup>14</sup> The topic was, however, a major theme among anti-immigrant politicians.<sup>15</sup>

So far, the evidence base for discussions about migrant health policy has consisted of a large number of scattered and uncoordinated studies of existing national policies. IOM (2016:3) lists 10 important scientific publications reviewing these policies, while Ingleby and Petrova-Benedict (2016:14) mention 14 other reports, mostly by NGOs, on policies relating to undocumented migrants. However, a major drawback of all these studies is the difficulty of integrating them into a coherent body of knowledge. Different kinds of migrants are studied, while different criteria and methods are used to identify them. The selection of countries varies greatly: some countries are studied repeatedly, others not at all. Some studies are recent, others quite outdated. Worse still, different conceptions of migrant health policy

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<sup>14</sup> See for example ECDC (2014). NGOs also reported that infectious diseases were not among the most common health problems encountered among arriving migrants; the cases that were identified had more to do with unhygienic living conditions than with 'import diseases'.

<sup>15</sup> The influential Polish politician Jarosław Kaczyński announced in October 2015 that migrants "have already brought diseases like cholera and dysentery to Europe, as well as all sorts of parasites and protozoa, which ... while not dangerous in the organisms of these people, could be dangerous here."  
<http://www.politico.eu/article/migrants-asylum-poland-kaczynski-election/>

underlie the research: each study asks a different set of questions and uses different methods to find the answers.

There is thus a great need for a study in as many countries as possible, examining policies simultaneously and using a standardised set of questions. Thanks to a fortunate series of coincidences, an opportunity to carry out such a study presented itself in 2011, when two major EU-subsidised projects (the IOM's EQUI-HEALTH<sup>16</sup> and COST Action IS1103, 'Adapting European health services to diversity')<sup>17</sup> decided to combine forces with a third, the Migrant Integration Policy Index or MIPEX<sup>18</sup>, to introduce a new MIPEX strand on Health. This longitudinal study has been measuring policies on migrant integration in a growing number of countries at four-yearly intervals since 2003<sup>19</sup>. The challenge was to develop a questionnaire on migrant health policies, using as far as possible the same methodology as the rest of MIPEX and basing it on the most relevant possible list of questions.

But on what should this list be based? Also in 2011, the Council of Europe published its recommendations on 'Mobility, migration and access to health services',<sup>20</sup> which combined most of the previous initiatives in the 'Road Map' described above into a state-of-the art summary of ingredients regarded as most crucial for an equitable migrant health policy. This provided an ideal framework within which to develop the MIPEX Health strand questionnaire. Seeleman et al. (2015), in a comparative study of six widely known approaches to 'responsiveness to diversity' in Europe, the United States and Australia (including the CoE recommendations), found a high degree of consensus between the approaches studied.

The migrant groups referred to by the MIPEX Health strand are the same as those in the rest of MIPEX: 'legal migrants' (primarily migrant workers, in order to keep the results simple); asylum seekers; and undocumented or irregular migrants. In EU/EFTA countries only policies for third-country migrants are studied, because the policies for citizens of other EU/EFTA countries are especially favourable and to a large extent harmonised with each other. Although health policies are viewed in this study as an aspect of integration policy (a perspective developed in Ingleby et al., 2005), that does not mean that they only concern 'one-way' migration, i.e. resettlement for life. The policies studied apply as soon as a person is classified as a migrant, which is generally after three months. They therefore also apply to short-term or 'circular' migrants.

In many studies of access to health care no distinction is made between different kinds of factors that may come between a migrant and the health services. Like the CoE recommendations, however, MIPEX clearly separates 'entitlement' (the legal right to coverage of health care costs) from 'accessibility' (other barriers to access such as lack of information). Entitlements are usually laid down by national laws, whereas accessibility can vary between service providers. Entitlement concerns not only laws, but also the way they are implemented: some laws may grant coverage, but other administrative measures may

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<sup>16</sup> <http://equi-health.eea.iom.int>

<sup>17</sup> [http://www.cost.eu/COST\\_Actions/isch/IS1103](http://www.cost.eu/COST_Actions/isch/IS1103)

<sup>18</sup> <http://www.mipex.eu>

<sup>19</sup> The existing seven policy strands concerned Labour market mobility, Family Reunion, Education, Political participation, Permanent residence, Access to nationality and Anti-discrimination. Thirty-eight countries are studied, mostly EU/EFTA countries but also including the United States, Canada, Australia, New Zealand, Turkey, South Korea and Japan.

<sup>20</sup> [https://search.coe.int/cm/Pages/result\\_details.aspx?ObjectID=09000016805cbd6d](https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805cbd6d)

take it away – for example by requiring the migrant to present documents (or a medical card) they may not possess, or by granting it only on a discretionary basis.

The Health strand questionnaire, like all the strands of MIPEX, contains four dimensions or sub-scales: the first two are labelled Entitlement and Accessibility and concern the difficulties migrants may have in getting into the health system. (Only on the Entitlement scale are scores for the three different migrant categories disaggregated.) The next dimension, Responsiveness, concerns policies to solve problems that may arise once they are inside it (for example, linguistic or cultural barriers). The fourth dimension concerns ‘measures to achieve change’ – flanking measures needed to promote the improvement of national migrant health policies, such as data collection, research, coordination and leadership. This fourth scale contains an item on the application of the ‘health in all policies’ principle to migrant health in the country, but the migrant-friendliness of policies in other sectors than health is not studied further. The reason is that the other seven strands of MIPEX are already devoted to this issue.

The current MIPEX Health strand measures policies in force at 1st January 2015 in 38 countries<sup>21</sup>; full details can be found in the Summary Report (IOM, 2016). An overview of the 23 items is given in the Appendix. It is intended to repeat the survey along with the rest of MIPEX in 2019, which will show whether policies have been improving or deteriorating. The instrument does not simply provide qualitative data on each of the questionnaire items; it also provides scores on the four dimensions and a total score obtained by summing these. To convert the qualitative data into quantitative scores, the method developed by MIPEX was used. Since we do not know how much weight should be given to each item, a large number of items are used, measured on a 3-point Likert scale, and added together. The underlying assumption is that errors in the weighting of items will cancel out. (See IOM, 2016:18-21 for a discussion of the methodology.) The added value of quantitative scores is that they make it possible to compare the ‘migrant-friendliness’ of policies in different countries and to use statistical methods to detect patterns in the results. Some of the findings are described here:

- Regarding entitlements, legal migrants enjoy the best coverage, asylum seekers somewhat less good, and undocumented migrants much worse than both. In all but a handful of countries, coverage for the latter group is below the standard required by human rights law (see also Ingleby and Petrova-Benedict, 2016). Even for legal migrants, coverage tends to be less than for nationals, in particular for migrants with shorter stays and lacking an employer who pays premiums.
- Concerning accessibility, countries differ greatly in the efforts that are made to inform migrants about their rights to health care and how to exercise them, as well as other measures to help them find their way into care. Often, health workers appeared to be as badly informed about entitlements as migrants themselves.
- The responsiveness of health services to migrants’ needs varied even more widely. Eight countries scored zero, i.e. nothing whatsoever was done to adapt services, while six scored 70 or more out of a possible score of 100.

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<sup>21</sup> Thirty-eight countries are studied, mostly EU/EFTA countries but also including Turkey, Bosnia-Herzegovina, the Former Yugoslav Republic of Macedonia, the United States, Canada, Australia and New Zealand.

- Measures to achieve change were, somewhat surprisingly, only related to accessibility and responsiveness – not to entitlements. On this scale too there were very wide differences.

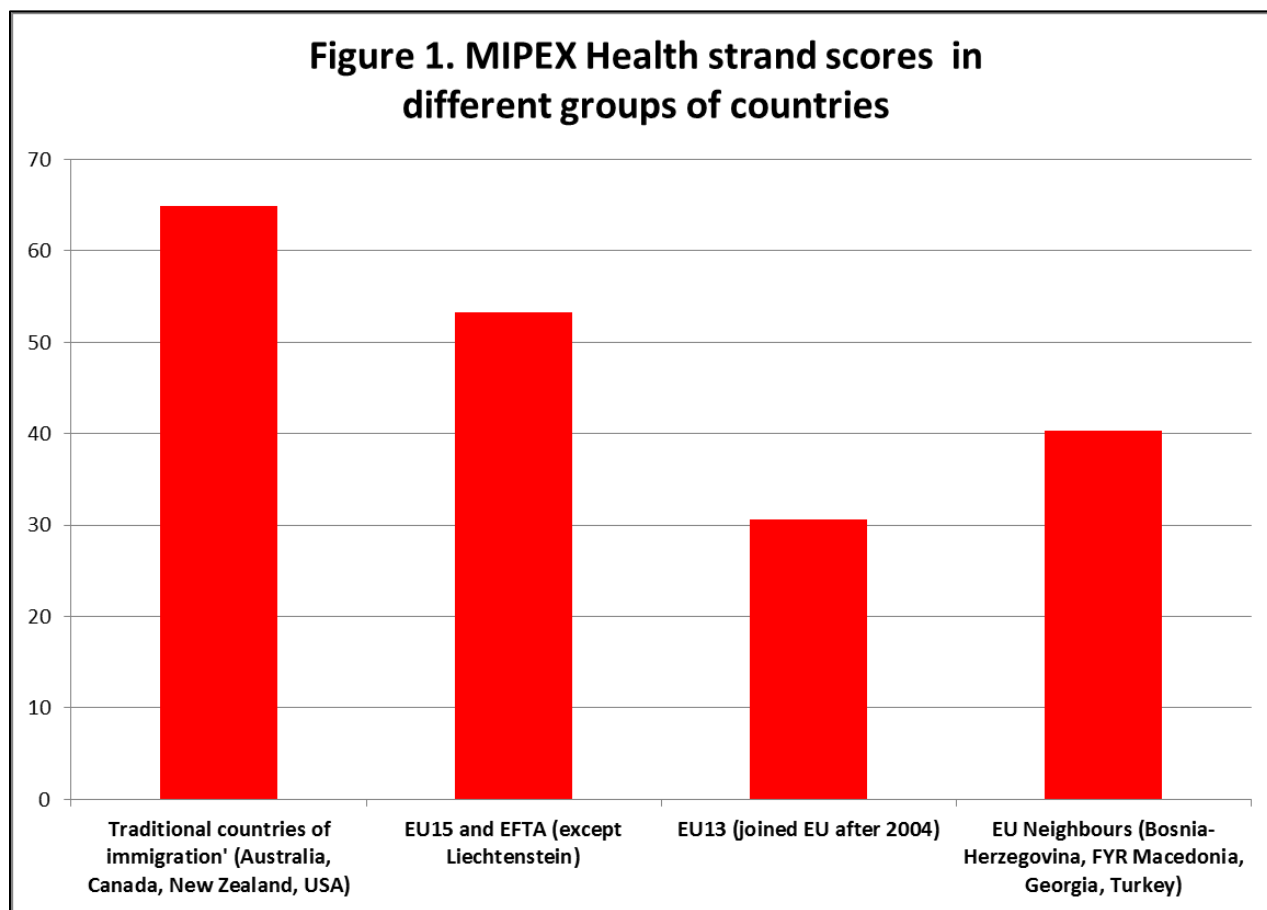
Efforts to analyse the patterns found in the scores and their relationship to background variables are still under way. Preliminary findings include the following:

- Some countries (e.g. France and Ireland) place a higher priority on good entitlements than on the adaptation of services, while in others (e.g. the UK) these priorities are reversed.
- Examining the relationship of Health strand scores to background variables immediately runs into the problem that the latter tend to be correlated with each other. A country's per capita Gross Domestic Product (GDP), the number of migrants it attracts, the amount of money it spends on health, its average scores on the other strands of MIPEX, and public opinion concerning migrants, all tend to be positively correlated. This makes it difficult to find out which of them is exerting the most direct influence on policies: though MIPEX scores are fairly robust, they do not have the metric properties required by most multivariate analysis methods.
- One finding to which this problem does not apply is that measures to achieve change are more often found in tax-based health systems than insurance-based ones. This may have to do with the fact that top-down planning is more characteristic of the former.
- As can be seen from Figure 1, total scores for the so-called 'traditional countries of immigration' (Australia, Canada, New Zealand, the USA) are slightly higher than those for the EU15 and EFTA countries; the difference is mainly due to the emphasis placed on the responsiveness of services, not to access – which is in fact slightly better in Europe. Countries which joined the EU since 2004 score markedly lower than EU15/EFTA countries. Indeed, they score even lower than neighbouring non-EU countries such as Bosnia-Herzegovina, FYR Macedonia, Georgia<sup>22</sup> and Turkey, despite the fact that the average per capita GDP of the latter countries is only two-thirds that of the EU13.

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<sup>22</sup> Georgia was not included in the original study (IOM 2016) but data on the country for this analysis have been kindly provided by Dr. Iveta Lazarashvili. Data on South Korea and Japan have also been collected, but they have not been used here or in the original study because it was difficult to ascertain whether the coding system was entirely appropriate.





To sum up, the MIPEX Health strand has already generated a wealth of findings that offer new insights into variations in migrant health policies and the factors which may underlie them. Detailed Country Reports describing the context of the policies and explaining the scores in detail are being added to the EQUI-HEALTH website<sup>23</sup>. The quantitative results provide an indication to countries of the issues on which improvement is most strongly needed, as well as a benchmark against which future policies can be compared. So far, the Health strand has been deployed in 39 countries, but there is scope for using it in many more in other regions of the world. The survey can in principle be extended to any country, but to achieve local validity, consideration may have to be given to operationalising certain questions in different ways.

<sup>23</sup> <http://equi-health.eea.iom.int/>

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## Appendix: Mipex Health strand questionnaire

There are 23 questions comprising 38 indicators. Numbers in brackets refer to the number of indicators used in each question. The full questionnaire is available at <http://bit.ly/1Yciud7>.

### A. ENTITLEMENT TO HEALTH SERVICES

Inclusion in health system, services covered, special exemptions:

1. Legal migrants (3)
2. Asylum seekers (3)
3. Undocumented migrants (3)

Administrative barriers to obtaining entitlement:

4. Legal migrants
5. Asylum seekers
6. Undocumented migrants

### B. POLICIES TO FACILITATE ACCESS

7. Information for service providers about migrants' entitlements
8. Information for migrants concerning entitlements and use of health services (3)
9. Health education and health promotion for migrants (3)
10. (Concerned geographical accessibility, omitted because of low reliability)
11. 'Cultural mediators' or 'patient navigators' to facilitate access for migrants (2)
12. Reporting of undocumented migrants / Sanctions against helping (2)

### C. RESPONSIVE HEALTH SERVICES

13. Interpretation services (3)
14. Availability of 'culturally competent' or 'diversity-sensitive' services
15. Training and education of health service staff
16. Involvement of migrants
17. Encouraging diversity in the health service workforce
18. Development of capacity and methods

### D. MEASURES TO ACHIEVE CHANGE

19. Data collection
20. Support for research
21. "Health in all policies" approach
22. Whole organisation approach
23. Leadership by government
24. Involvement of stakeholders / Contribution of migrant organisations to policy

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