Health on the move: the impact of migration on health

This discussion note has been prepared specifically for the SDC Global Meeting on Migration and 2030 Agenda (25.–27. May 2016, Charmey – Switzerland) and represents initial findings for a comprehensive Policy Brief on the topic which ODI will publish in July 2016 as part of an SDC funded mandate.

Key messages

- Migrants are often not reached by public health interventions and face barriers to accessing health care
- There is no international standardized approach for monitoring variables related to the health of migrants
- There are limited health outcomes data for refugees who do not live in camps. Outcomes for refugees in camps vary widely according to country of origin and host country.
- Migrants are at elevated risk of being left behind in countries’ efforts to reach the SDG health targets

1 Introduction

The briefing presents summary information about international migrants in relation to health services and the sustainable development goals (SDGs). It describes the health needs and health service delivery for different types of migrants, in different settings and in what ways they may be excluded in government policies to achieve the Agenda 2030 goals.

1.1 Definition of terms

Two types of migrants are considered: international economic migrants who move for the purposes of employment, and refugees who owing to fear of persecution, war or natural disaster are outside their country of origin and are unable to avail themselves of protection from that country.

1.2 Migration trends

15-year span of migration trends [to be described with graphics]. Summary data on overall migration:

- 244 million migrants in 2015, approximately 3% of global population, (up from 173m. in 2000). Europe and Asia host the most international migrants (76 million and 75 million respectively). Countries with highest growth in economic migrants are S. Europe, Thailand and Gulf States.
- 19.5 million refugees in 2014. 86% of refugees are in developing countries, and more than half come from three countries (Afghanistan, Syria and Somalia)

1.2.1 Migration and achievement of the health SDG (Goal 3).

SDG 3: Ensure healthy lives and promote well-being for all at all ages. Summary of 13 targets, [to be presented in a text box]. The SDGs do not explicitly include any targets relating to the health status of migrants, but migration functions as a social determinant of health and will affect the achievement of the goal and targets. There are two main risks:

- Migrants are at higher risk of disease due to various factors before, during and after migration
- Migrants are less likely than other populations to access and benefit from their host country’s health care system; poor health service delivery to migrants, in the context of their specific health needs, will have an impact on health outcomes: in countries where the proportion of international migrants in the total population is high it will affect the achievement of some targets under Goal 3.

1 Authors: Olivia Tulloch, Fortunate Machingura, Claire Melamed
2 Serving the health needs of migrants

- Migrants are generally considered at higher risk of disease from overcrowding, poor housing sanitation, and maternal mortality. Access to primary health care, and services for mental health, HIV, TB, sexual and reproductive health are major problems.

- Newly arrived migrants coming from communities affected by crisis have complex needs and heightened risk of health problems related to movement: physical and environmental threat, hunger, exposure to violence and trauma.

- Longer term economic migrants tend to have similar health needs to the wider population in host countries, but in addition are more likely to experience work related accidents (for example, where migrants are concentrated in the construction sector), violence and abuse.

- Host countries with high proportions/numbers of migrants may need to cope with high inflows of people in a short space of time, yet, within existing resource constraints and policy frameworks. There can be important legal, discriminatory, cultural and linguistic barriers to accessing services, exacerbated by lack of knowledge.

- Data on migrants’ health outcomes is not generalizable or easy to compare. Data on health outcomes for refugees appear to vary widely according to country, but refugees in urban environments reported significantly higher satisfaction with overall health, physical health and environmental wellbeing than refugees placed in camps.

2.1 Case studies

Syrian refugees and the response in Turkey

**Situation:** 5m Syrians have fled the country since 2011 (UN OCHA, 2016), of these 10% are in camps, 90% are dispersed in the populations of their host countries and half are children. Female refugees outside camps are among the most vulnerable, of whom 40% are thought to lack access to services, approximately 700,000 are of reproductive age and about 30,000 are pregnant (UNFPA, 2015). The major health problems experienced by Syrian women refugees are complications during pregnancy, high levels of gender-based violence (GBV), frequent UTIs, depression and anxiety, prostitution. Child refugees have high incidence intestinal parasites, anaemia, malnutrition, are poorly immunized and many experience chronic mental health problems including post-traumatic stress disorder and depression. Turkey hosts the largest number of refugees in the world and about half of Syrian refugees are in Turkey, most of these live outside of camps, are unaccounted for and live in very challenging circumstances. Despite housing the majority of Syrian refugees, accurate data relating to their health outcomes in Turkey are much more limited than neighbouring countries.

**Response:** Turkish citizens are covered by a universal health coverage (UHC) programme and registered refugees have the right to free primary health care. Following the influx of migrants the health system was overwhelmed by increased case load, over worked staff, shortages of supplies (3RP, 2016) and the WHO took over functions of health coordination, management and core services. 200 partners contribute to a Regional Refugee and Resilience Plan; and provision of health care identified as one of the most challenging aspects. The government encourages international solidarity given the magnitude of the problem, but coordination and financial support are persistent problems, with a significant proportion of pledged funds not arriving when planned.

**SDGs:** Turkey is guardian of the largest single refugee population in the world. 5 years into the conflict many are now ‘permanent refugees’ for whom a shift in the approach to providing for their health needs will be required. Those living outside camps are at greatest risk of being invisible to efforts to reach SDG targets, particularly UHC, maternal and child mortality. Their chances of achieving the SDG goal of ‘well-being’ is also severely impeded by poor mental health.

Refugee camps in Kenya

**Situation:** There are 1.08 million immigrants in Kenya making up 2% of the population (UN, 2015). Most come from other East African states (IOM, 2015). Two camps host 530,000 refugees, predominantly from Somalia, S.Sudan and Ethiopia, of which Dadaab camp is the largest refugee camp in the world. Health posts in camps are overcrowded, understaffed and under-equipped and clinicians are overworked. The minimum emergency standard is 1 health care unit for 10,000 people, but in Hagadera camp, 2 health posts served the needs of 78,000 people. The major health problems observed relate to malnutrition, poor sanitation and gender-based violence. Death rates, particularly among children and maternal mortality are reported as unacceptably high.

**Response:** The UNHCR coordinates the partnerships to protect asylum-seekers and refugees; main health partners are UNICEF and Kenyan Red Cross. Capacity to provide health services has diminished due to increasing insecurity (attacks on health facilities) and a decrease in funding received by many aid organisations. Funding shortfalls are a persistent problem.

**SDGs:** Refugee camp populations are at risk of being left behind by all SDGs. Ensuring safety in camps and donors fulfilling their financial pledges will be an important part of managing to address this.
Health inequities in South Africa

**Situation:** In South Africa, 3.2 million migrants account for 6% of the population. It attracts the largest migrant population in Africa, mostly from Southern and Eastern Africa. The large refugee population is dominated by those from Zimbabwe, DRC, and more recently from Somalia. Between 2008-13, it was the top destination for asylum seekers anywhere in the world. There are well-documented health risks: violence which is particularly high against women and SAfrica has the highest rape rate in the world, and attacks on foreigners are common. TB incidence and HIV burden are the highest in the world, particularly in sectors in which migrants work (mining and agricultural labour). Data suggest that while TB and HIV prevalence is high for migrants (HIV as high as 40-50% for mining and laboring populations), it is not always higher than among non-migrants. Maternal mortality is also high (140/100,000) and anecdotal evidence suggests migrant women are at greater risk.

**Response:** The constitution gives the right to basic health care to living in the country regardless of legal status. This includes access to antiretroviral therapy. Health service delivery is however characterized by chronic inequity, and this is reflected in migrants’ access to health services. There are four main supply-side barriers: discrimination and being refused services; inadequate or inaccurate information about health rights; imposition of user-fees in contravention of policy; and, exclusion from emergency rape services.

**SDGs:** Achieving the SDG targets relating to communicable diseases (HIV/TB) and maternal mortality will be a major challenge in S.Africa. UHC through national insurance is planned, but for this to have real impact on migrants will require a substantial effort to overcome the existing barriers to health services and an explicit inclusion of migrants.

Migrant health insurance scheme in Thailand

**Situation:** There is an immigrant population of nearly 4 million (6% of population); migrants from 3 neighbouring countries make up 5% of the Thai labour force. The government recognized their contribution to the economy, considered access to health care a human right and was concerned that without health services, migrants would exacerbate control efforts against communicable diseases (TB/HIV/leprosy poliomyelitis). Health outcome data are dependent on small studies. A study of 80,000 migrants suggested a TB rate of 10% and syphilis infection in 5%. Studies of construction workers showed 69-88% of workers reported a work related accident and 79% of respondents had a skin disease (due to unsanitary conditions) within the last 6 months. There are generalized AIDS epidemics in Myanmar and Cambodia, and “source communities” for migrants that come to Thailand are known to have relatively high HIV prevalence rates, there are no reliable data on prevalence in Thailand. Many migrant workers are adolescents, among whom unplanned pregnancy is high, and at one border clinic, teenage pregnancy among Burmese rose from 18% to 26% in one year, another study found 60% of Cambodian women reported not using any form of contraception.

**Response:** There is a tradition of progressive health policies in Thailand and it is the only country in the world that has integrated the needs of all migrants (including illegals) in its health system through its compulsory migrant health insurance scheme. UHC policy for Thais was introduced in 2002, and not long after migrants became entitled the same health care rights as Thais.

**SDGS:** This system *should* mean that Thailand is in good position to achieve the SDG targets for whole population, including migrants. But, uptake of the scheme remains quite low. Reasons for this appear to be language and cultural barriers, fear of discrimination, fear of losing employment due to absence and poor employer compliance with the scheme. The policy may provide a useful model, however implementation needs improvement: e.g. advocacy with migrants and health promotion, reduction or flexibility in the annual fee, monitoring of implementation, transferability of health insurance between health facilities, improved quality of services for migrants and better understanding of the social and cultural influences on health outcomes and health seeking behaviour.

### 3 Recommendations

- Data availability is a major constraint on both policy making and tracking outcomes. Domestic health information systems, and data collected by donors for tracking project outcomes could help to overcome this constraint by collecting more information about migrant status and ensuring that migrant populations are included in sampling frames for surveys.
- The financing, organisation and delivery of health services need to be responsive to migrant needs, to ensure genuinely universal health coverage, and sector specific programmes such as National AIDS and TB programmes should integrate and dedicate resources for surveillance, diagnostics, treatment and care for economic migrants and refugees.