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Briefing

Health, migration and the 2030 Agenda for Sustainable Development

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Key messages

- There are fundamental policy gaps in addressing the health needs of migrants. Global, regional and national institutional arrangements could be improved to facilitate dialogue and collaborative problem solving.
- Migration is a determinant of health: it does not have a systemic association with public health security threats to host communities but migrants do face distinctive vulnerabilities to poor health. These are exacerbated by 'migrant-unfriendly or migrant-indifferent' legal frameworks and health systems. Resolving these will require intersectoral approaches.
- There are no international standardised approaches for monitoring variables relating to the health of migrants. Development of data collection, monitoring and surveillance mechanisms is needed to understand migrant health needs.
- Migration can have a positive effect on the development of health systems if the International Code of Practice is adhered to and if there is strong coordination between home and diaspora systems and professionals.

Migration and the Sustainable Development Goals

People migrate to overcome poverty, escape conflict, or cope with economic and environmental shocks. In the words of the United Nations (UN) Secretary-General, migration is ‘an expression of the human aspiration for dignity, safety and a better future. It is part of the social fabric, part of our very make-up as a human family.’

Migration is one of the defining features of the 21st century and can contribute to achieving the Sustainable Development Goals (SDGs). For this to happen, we need a better understanding of the relationships between migration and key development issues – such as health, education, gender, labour and urbanisation. This series of briefs, commissioned by the Swiss Agency for Development and Cooperation (SDC), explore these relationships across the 2030 Agenda and the impact of migration on key development outcomes. The briefs are part of ODI’s work on ‘Leave no one behind: the first 1000 days of the SDGs’.

1 Introduction

This briefing presents an overview of health-related challenges faced by international migrants. Implicitly, the SDGs recognise the importance and interrelation between health and migration. SDG 3 aims to ‘Ensure healthy lives and promote well-being for all at all ages’, including that of migrants, while a number of other SDGs incorporate elements relating to health outcomes and migration. In this brief, we primarily focus on three distinct aspects of the interrelation. Firstly, migrants can be more vulnerable than other populations to exclusion from health services. Secondly, countries with high numbers of migrants with complex or hidden health needs may be hindering individual countries’ own efforts in reaching their SDG targets. These first two risks demand a critical reassessment of the capacities of both transit and destination health systems to manage the needs of migrants, as well as the policy frameworks that should be promoting the health of migrants. The third element is the impact of migration on health outcomes in sending countries, through remittances, technology transfer and behaviour change. The conclusion offers recommendations for better migration and health global governance, at both national and regional policy levels.

Migrants make a considerable net economic contribution in many countries. The good health of migrants has obvious intrinsic benefits, but is also essential if migrants are to fulfil the considerable potential economic and social benefits and contributions to their home and destination countries. Migrants should be able to live and work in safe and healthy conditions, enjoy access to health services and expect health outcomes similar to that of the rest of the population of their destination country. Yet when migration levels rise or health systems are stretched, decisions about who is responsible for the welfare of migrants becomes contentious in national and global policy debates. Migrants, by virtue of their mobility and status, are therefore at great risk of being invisible, deprioritised or even excluded from national health strategies. They are subjected to neglect, discrimination, ostracism and exploitation, the effects of which can curtail migrants’ life expectancies, increase mortality and directly affect social, physical and mental well-being. These effects

are further compounded by legal and socio-economic barriers that impede migrant access to health care.

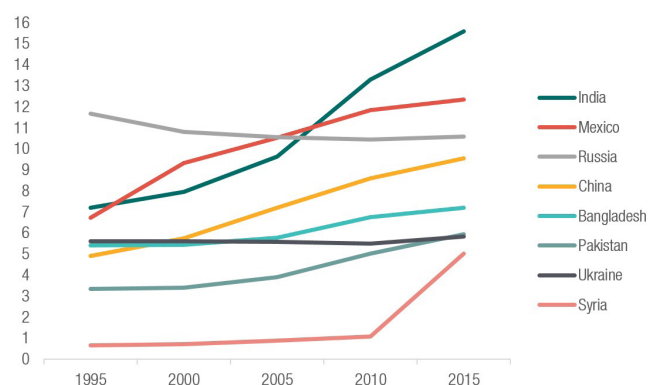
Two types of migrants are considered in this briefing: international economic migrants who move for the purposes of employment, and refugees who move because of fear of persecution, war or natural disaster. Internal migrants are not included in the analysis.

1.1 Migration trends

In 2015, the global number of international migrants reached 224 million, up from 173 million in 2000. However, as a proportion of the world’s population, the number of migrants has remained relatively stable over the past four decades at around 3% (UNDESA, 2016). Europe and Asia host the most international migrants (76 million and 75 million respectively), while southern Europe and Gulf states are the regions with the highest growth in labour migrants. Since 1995, the top sender countries have been consistent: India (15 million), Mexico (12 million) and Russia (11 million); with the most significant increase in Syria (0.6 to 5 million and continuing to rise).

Regarding forced migration, in 2014 the number of refugees worldwide rose to 19.5 million – the highest level since World War II. Refugees comprise approximately 8%

Figure 1: Origins of largest migrant populations worldwide between 1995-2015



Source: UNDESA (2015)

of the total number of international migrants (UNDESA, 2016). Using 2014 data, the United Nations High Commissioner for Refugees (UNHCR) found 30.4 million persons of concern, including both refugees and migrants. (See UNDESA, 2015; UNFPA, 2016; and UNHCR, 2016 for these statistics.)

2 Health and migration in the 2030 Agenda

Health is central to the social, economic and environmental dimensions of sustainable development, both as a beneficiary and a contributor. In addition, health is considered an indicator of ‘people-centered, rights-based, inclusive, and equitable development’ (UN, 2015); a key aspiration of the 2030 Agenda is to ‘leave no one behind’, reflected in the Goals, nearly all of which state, ‘for all’. Achieving these Goals will require an inclusive approach that should include migrants by default. Although migrants are given special attention in some of the SDG targets, none relate specifically to their health status. Yet migration functions as a social determinant of health and will, crucially, affect the achievement of numerous targets across several Goals.

2.1 SDG 3: health and well-being

The health-related SDG 3 is underpinned by 13 targets that cover a wide spectrum of health and well-being for all populations. Migration flows intersect with this Goal through a number of different channels.

1. **Individual migrants.** One of the strongest features of the 2030 Agenda is universality. Leaving no one behind means including migrants in efforts to tackle poor access and inequity in health care. Migrants can be at higher risk of poor health from infectious diseases, non-communicable diseases and mental health problems due to a range of factors at different points before, during and after migration.
2. **National outcomes.** Migrants are less likely than other populations to access or fully benefit from their host country’s health care system, which can result in poorer health outcomes when measured at the national level. For countries with large migrant populations and limited capacity in the health system, this will impede their ability to reach the targets in SDG 3.
3. **Health systems.** Migrant remittances are a critical source of household incomes and foreign exchange in several countries, and this income feeds into household and government level health spending. Returning migrants and those in diaspora communities can influence policy and practice in domestic health systems, help with crisis response during epidemics and influence health seeking behaviour at the individual level, often with a positive effect on health outcomes.

The vulnerabilities faced by migrants, and how they intersect with selected SDG 3 targets relating to health and well-being are summarised in Table 1.

One of the channels through which migration can affect health and the achievement of SDG 3 is through the impact on the health systems of the source country. As with the impact on individuals, there are many ways that this can play out in practice. However, three factors are key: the impact on resource flows, the impact on human capital and response to disasters.

1. **Resources.** Where migrant remittances are a large percentage of GDP, they boost government revenues through higher taxes, and will increase the resources available for public spending (e.g. remittances are more than 15% of GDP in Haiti and Honduras, nearly 30% of GDP in Nepal, and over 20% of GDP in Liberia and the Gambia (World Bank, 2014). Increased household income from remittances increases the funds available for out of pocket spending on health services, and several studies have found that receiving households spend more on health services than non-receiving households (e.g. UNESCAP, n.d.).
2. **Human capital.** A great deal of attention has been paid to the question of the ‘brain drain’ and the extent to which migration can undermine health systems. Migration related shortages of human resources for health can hamper progress in health care delivery and improving population health (Mills et al., 2008). But, while every effort should be made to retain skilled people, the evidence that the ‘brain drain’ harms developmental outcomes is contested (Clemens, 2014). In addition, there are benefits to returning migrants who can bring skills acquired abroad to strengthen the domestic health system. A study in Ghana, for example, found that returning doctors, nurses and midwives brought with them skills in a range of medical techniques and systems management that were used either in the public health system or through setting up new private facilities, often with new investments from diaspora communities or other new sources (Adzei and Sakyi, 2014).
3. **Disaster relief.** Migrants and diaspora communities often respond strongly when a disaster strikes their home country. During the Ebola crisis in West Africa, for example, diaspora communities raised money for affected communities and donated equipment. However, the overall impact of these efforts was reduced by weak links to the public health system and to the donor-led relief effort (Chikezie, 2015).

Table 1: Migration, health and SDG 3 targets - individual and national outcomes

SDG 3: Selected Targets	The intersections of migration specific vulnerabilities and health outcomes
3.1 Reduce the global maternal mortality ratio to <70 per 100,000 live births	<ul style="list-style-type: none"> Migrants, particularly those without legal residence permits, tend to experience higher maternal mortality and morbidity relative to the host populations. They tend to be more vulnerable to high blood pressure, poor nutrition, pre-eclampsia, premature or complicated delivery, fatigue and maternal suicide. Substandard or lack of services, patient delays, poor health worker-migrant communication, lack of knowledge about the transit or destination country health system can put expecting migrant mothers at risk. <p>(See Esscher, et al., 2014; van den Akker and van Roosmalen, 2015; Fellmeth et al., 2016.)</p>
3.2 End preventable deaths of new-borns and children under 5 years of age.	<ul style="list-style-type: none"> Migrants have greater difficulty accessing obstetric, antenatal and maternal health-care services. Poor health outcomes and higher mortality for migrant new-borns and children under 5 are related to overcrowding in low-quality housing, poor sanitation (both in communities and refugee camps), substandard health care, inadequate diets, the mother's educational attainment, and the migration process. Additional risk factors for poor migrant child health outcomes or life expectancy are poor mental health of migrant mothers, and residence in refugee camps <p>(Racape et al., 2010, Rechel et al., 2013).</p>
3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases (NTDs) and combat hepatitis, waterborne diseases and other communicable diseases	<ul style="list-style-type: none"> Migrants constitute nearly 40% of people living with HIV in the European Economic Area. The UNAIDS programme recognises migrants as one of the most vulnerable groups to HIV infection. They are also at increased risk of TB-related morbidity and mortality (IOM, 2012; Tomás, 2013). Although the global burden of malaria has substantially decreased, the cases among migrant populations within and between countries represent a high percentage of the total number of cases. E.g. In the Lao PDR, a surge in new cases between 2011-2015 was associated with economic migrant mobility. Limited access to health care services and preventative measures means migrants are less likely to receive treatment making fatalities from NTDs more likely. Although low in non-endemic countries, cases of NTDs are also common among migrants and often overlooked. Non-specific symptoms and inadequate knowledge among health care workers in non-endemic countries complicates diagnosis. <p>(See ECDC, 2010; IOM, 2013; UNAIDS, 2014; Cairns, 2015; SASPEN, 2015; WHO, 2015b.)</p>
3.4 Reduce by one third premature mortality from non-communicable diseases	<ul style="list-style-type: none"> Social and environmental factors interact with migration to form a complex pattern of determinants of non-communicable diseases (NCDs). Migrants in transit are at particular risk of not receiving continuous care for pre-existing chronic diseases. <p>(See WHO, 2016).</p>
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	<ul style="list-style-type: none"> Stressful conditions can heighten tobacco use, alcohol and substance abuse as a form of coping mechanism. This can be further exacerbated by long-term separation from families and stress over lack of legal status, causing many migrants to develop mental health problems, depression and anxiety disorders. Seeking treatment for these disorders comes with individual-level barriers, including limited local language proficiency, work demands, and internalised stigma around substance abuse. Migrants often do not have access to psychosocial services, resulting in increased mental health disorders <p>(See Negi, 2011; UNGA, 2013; Pagano, 2014).</p>
3.8 Achieve universal health coverage, including financial risk protection, and access to quality essential health-care services	<ul style="list-style-type: none"> Universal health coverage (UHC) is an important means of achieving cross-cutting health SDGs. Although countries adopt different mechanisms for UHC progress, a common trend emerges: migrants are often neglected and/or excluded. Migrants risk exclusion from coverage of insurance-based schemes and those in the informal sector are often invisible to UHC programmes. Where UHC policies favour service provision free of charge in public health facilities, undocumented migrants often fail to access these free services because of registration barriers. Where government spending on health fails to match the increased demand for health services, migrants can struggle to raise the household out-of-pocket payments to access health care.

Table 1 illustrates the multiple vulnerabilities migrants face and the SDG 3 targets which seek to alleviate them. It is important to recognise that the type and level of vulnerabilities change over time. Those who have settled long-term tend to have similar health needs to the wider population in host countries. Contrary to popular opinion in the west, there is a healthy migrant bias where first generation (non-refugee) migrants can have a lower crude mortality rate than the host population because the healthiest tend to migrate (Thomas and Thomas, 2004). However, refugees have a specific set of health needs which also evolve depending on the time elapsed since they took flight. These are described in Box 1.

Box 1: Refugees and forced displacement

Newly arrived refugees and displaced persons from communities affected by crisis have complex needs and a heightened risk of health problems related to their flight journeys. They are susceptible to a number of problems due to the likely exposure to physical and environmental threats, violence and trauma. As a result, they may face any and many of the following: loss of social networks and assets, poor language skills, knowledge and information in the new environment, decreased food security, and inadequate shelter, sanitation and access to safe water (FMO, 2016). Those who arrive in detention centres may also face abuse and ostracism (IFHR, 2008). As with other migrants, the varied experiences before, during and after displacement cause difficulties in creating mechanisms for gathering reliable health data, and particular difficulties in continuity of health care and record keeping. Many refugees lack access to any health records or continuity of service or provision for chronic conditions.

There is no evidence of systemic association with migration and public health security threats to host communities (WHO, 2016; European Parliament, 2016). However, the risks of infectious disease faced by refugees are exacerbated by poverty, poor sanitation and living conditions after arrival and there is potential for these risks to affect host populations in lower income countries if the public health and welfare systems are weak. The public health risks for refugees are difficult to address particularly when there are high inflows of people in a short space of time. Displaced people do tend to have a higher crude mortality rate (Thomas and Thomas, 2004). Child health is a major problem, as children tend to make up a large proportion of refugee numbers. Refugees' babies have lower birth weights and their children face increased risks of malnutrition, diarrheal conditions, infectious disease, anaemia, intestinal parasites, gastroenteritis, skin infections, wasting, stunting, delayed development and undiagnosed congenital anomalies (Tangcharoensathien, 2015).

A case study of refugees in Turkey, an upper middle-income country, provides a clear illustration of the difficulties in managing health care for refugees. Turkey is now guardian of the largest single refugee population in the world. Most of these refugees live outside camps, are unaccounted for and live in extremely challenging circumstances. Increasingly, they are considered 'permanent refugees'. Registered refugees have the right to free primary health care, but the protracted refugee situation means that many refugees are in a new state of flux as their long term status is unclear – they are far from receiving the benefits covered by a universal health care system.

Following the influx of migrants, the Turkish health system became overwhelmed by the increase in caseloads, resulting in overworked staff and a shortage of supplies. Consequently, the World Health Organization (WHO) took over functions of health coordination, management and core services, with 200 partners contributing to a Regional Refugee and Resilience Plan (3RP) that includes health care services. Coordination and financial support remain persistent problems, with a significant proportion of pledged funds not arriving when planned.

The vast majority of migrants in Turkey are at risk of being invisible to the public health system. Among those outside of camps, female refugees are the most vulnerable, 40% of whom are estimated to lack access to services (UNFPA, 2015).

2.2 Links to health across the SDGs

Health is implicit in almost all of the other 16 Goals, not just in SDG 3. Progress on many of the Goals will affect health and the achievement of the Goal can be used to incentivise progress on migrant health, in some of the ways detailed below. Improving the health of migrants and all vulnerable people will be dependent on equity, as countries work towards achieving all SDGs, particularly those

relating to poverty, inequality, hunger and food insecurity, employment and peace (see Table 2).

The range of SDG targets should incentivise the development of intersectoral approaches that may help improve migrant health, alongside the health of other vulnerable groups. Different groups of migrants have specific vulnerabilities and needs according to the sector in which they work or live. The SDG targets can be

Table 2: Examples of major SDG targets that have an impact on health outcomes for migrants

Target	Goal and target (summary)
1.3	Poverty: Implement nationally appropriate social protection systems and measures for all. Key factor for migration: portability of social protection coverage across borders, or inclusion into national systems.
2.2	Hunger: End all forms of malnutrition, and address nutritional needs of key populations. Key factor for migration: ensuring migrants are reached by assistance programmes aimed at improving nutrition.
5.2, 5.3 & 5.6	Gender: Eliminate all forms of violence and harmful practices against women and girls, including trafficking and sexual exploitation, and ensuring universal access to sexual and reproductive health and reproductive rights. Key factor for migration: addressing the specific vulnerabilities of female migrants (see ODI brief on 'Gender and Migration', in this series).
6.1, 6.2	Water: Achieve universal and equitable access to safe and affordable drinking-water, sanitation and hygiene. Key factor for migration: ensure that large-scale movements of people do not increase stress on fragile water supply systems, and address water and sanitation provision in migrant communities and refugee camps.
8.8	Employment: Protect labour rights and promote safe and secure working environments for all, <i>including migrants</i> .
10.4 & 10.7	Inequality: Adopt fiscal, wage and social protection policies; facilitate safe, and responsible migration including through migration policies.
16.1 & 16.9	Peace: Significantly reduce all forms of violence and related death rates. Provide legal identity for all. Key factor for migration: conflict is a major driver of migration. Legal identity for migrants is an important factor in the effective planning of response and establishment of effective support systems.
17.18	Implementation: Increase availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, <i>migratory status</i> , disability, geographic location and other characteristics relevant in national contexts.

used to advocate for change in a number of these areas. Two targets in particular, relating to inequality (10.4) and employment (8.8), are relevant to tackling known problems for migrants. Migrant groups are more likely to experience work-related accidents (e.g. the construction sector) or violence (e.g. domestic workers); or to be abused at the hands of unscrupulous employers, or immigration services (NNIRR, 2008; Long and Crisp, 2011). A focus on inequality can also be used to address the legal, discriminatory, cultural and linguistic barriers that many migrants face when accessing services. If a serious commitment is made to 'leave no one behind', then progress on many of the other Goals and targets will have a positive impact on migrant health, as well as the overall achievement of SDG 3.

3 Responding to migrants' health needs and meeting the SDGs

It is clear from the discussion above that there are several channels through which migration will impact on health and the achievement of the SDGs. This section describes three major strategies essential to aid countries' efforts

to achieving the SDGs that have particular resonance for migrants.

3.1 Universal health coverage

Target 3.7 is 'Achieve universal health coverage, including financial risk protection, access to essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all'. Not only is this a target in itself, but it will be a contributory factor in the achievement of all the other targets in SDG 3. UHC is intrinsically inclusive of the entirety of a population, including migrants. It is expected to cover all the promotive, preventive, curative, rehabilitative and palliative health services people need, with affordable services being understood as not exposing the user to financial hardship. Providing UHC is a major financial undertaking, particularly in developing countries that may already struggle to provide basic health services for the wider host population. However, it is essential to tackling the question of migration and health outcomes, at both individual and national level.

Box 2: Migrants and universal health coverage

Thailand is a UHC pioneer for middle-income countries. There is a tradition of progressive health policies in Thailand and it was the first country in the world to integrate the needs of all migrants (including irregular and undocumented migrants) into its health system through a compulsory migrant health insurance scheme. UHC policy for Thais was introduced in 2002, and not long after, migrants too became entitled to the same health care rights. There is an immigrant population of nearly 4 million (constituting 6% of population) and migrants from three neighboring countries make up 5% of the Thai labor force. The government recognised the migrant contribution to the economy, considering health care a human right and concerned that without health services, migrants would exacerbate control efforts against communicable diseases.

This system *should* mean that Thailand is in a good position to achieve the SDG 3 targets for the whole population, including migrants. Yet uptake of the scheme remains quite low. The reasons appear to be language and cultural barriers, fear of discrimination, fear of losing employment due to absence and poor employer compliance with the scheme. Though the original UHC policy may provide a useful model, there is a need for greater understanding on how to improve its implementation with regard to migrants.

Countries considering UHC packages that integrate migrants would need to take action beyond simply extending the existing service coverage to migrants. This should involve consideration of advocacy with migrants and health promotion, feasibility of an annual fee, monitoring of implementation, transferability of health insurance between health facilities and quality of services for migrants (including non-discrimination). This also requires a good understanding of the social and cultural influences, language barriers on health outcomes and health seeking behaviour for the specific migrant groups.

3.2 Health systems, health workforce and migration

There is a global shortage and poor distribution of the health workforce. Lower-income countries, many of whom host significant numbers of migrants have a wide gap between the need for health workers and supply. As these countries attempt to fulfil the SDG target for UHC, this gap is likely to widen. Upper middle-income countries are likely to face a similar widening as demands for health care from aging populations increase. This demand stimulates international migration from low- to high-income countries (WHO, 2015a). This is exacerbated by ‘push factors’ in source countries, such as low pay, lack of career paths and poor working conditions. The WHO

Global Code of Practice on International Recruitment of Health Personnel ‘promotes a fair balance of the interests of the health workforce, so sending and receiving countries can help to address the challenges in the widening gaps in the health workforce’. But implementation of the code is suboptimal. Where the numbers are large enough, health worker migration can have an impact on the economy of the whole country, for example, in the Philippines, the remittances from migrants, of which health professionals make up a significant part, contribute more than 8% to the gross national income (Guinto, 2015). Win-win situations may be possible if countries attracting migrant health workers adhere to the code, and the countries from where migrants come from organise their health profession education systems and labour markets so that local populations’ access to health care does not suffer.

3.3 Barriers to effective implementation: coordination and data

One of the first difficulties in being responsive to migrants’ health needs as countries implement the SDGs is the lack of data available. Health characteristics differ according to a multitude of variables including type of migrant, sex, age, host and destination country, epidemiological conditions, employment status and poverty. Migrants are heterogeneous, their experiences and the reasons they leave or flee their home countries are multifaceted and there are inadequate data that give a digestible and accurate picture of their health needs (Thomas and Thomas, 2004; FMO, 2016). There is a great deal of anecdotal and case study evidence suggesting migrants have specific health needs that could limit achievement of the SDGs if they are not tackled. However, there is currently no international standardised approach for monitoring data variables and indicators related to the health of migrants, and many countries do not include migrant status variables in their health statistics, which makes tracking outcomes very difficult. This is not a problem confined to poorer countries. In the UK, a report from the Migration Observatory at the University of Oxford remarked, ‘it is currently difficult to gain a comprehensive account of the health of migrants because much existing evidence on health includes ethnic group but not migration variables’ (Jayaweera, 2014). Without targeted evidence, the policies, strategies and institutional arrangements to support migrant health are likely to remain inadequate at the national, regional and global levels.

A second challenge for implementation is the need for inter-agency and intersectoral coordination and cooperation, both within and between countries and regions. The action required to include a health lens in the number of areas influencing migrant health is complex. For example, in South Africa, achieving the SDG target relating to communicable diseases will be a major challenge. South Africa attracts the largest migrant population in Africa, mostly from countries in southern and eastern Africa

where the burden of communicable diseases is already high and HIV incidence is the highest in the world. Migration has been a key feature of the economy of the country and the region as a whole, with migrants making up about 6% of the population of South Africa. TB incidence and the HIV burden are particularly high in sectors in which migrants work (mining and agricultural labour), among migrants and non-migrants alike. Migration also had an impact on malaria incidence: the International Organization for Migration (2013) reports that in South Africa, almost half (48%) of all confirmed Malaria cases recorded between 2001-2009 in one border province were found in migrants from Mozambique. Tackling the communicable disease burden in South Africa will require a multifaceted approach that takes into account migrants. It can only be addressed through sustained, multi-sectoral collaboration across the region between ministries of labour, mining and health, and private industry (Mberu et al., 2016).

There are two SDG targets which may facilitate implementation of coherent policies and programmes to support better coordination and data. Target 17.18 focuses on data and monitoring, crucially including a call for disaggregation of data by migratory status. Reaching this target is essential in order to collect meaningful data to monitor outcomes informing health financing, human resources for health and health care coverage of migrants, and monitoring of the means of implementation. While target 16.6 works towards the development of effective, accountable and transparent institutions through which migrants could have recourse to hold governments, service providers and individuals to account on matters relating to their health and well-being.

4 Conclusions and policy recommendations

As people migrate, the socio-economic and political drivers of migration intersect. This intersect is increasingly complex, blurring the separation between voluntary and forced forms of migration. This briefing highlights that within this complex landscape, there is a clear and urgent need to reassess the capacities of both transit and destination health systems to manage the needs of migrants. Migrants frequently experience inadequate access to health care, and though there are pockets of progress, such as Thailand's Compulsory Migrant Health Insurance Scheme, many other countries are yet to consider migrants or refugees in their health care systems. In doing so, these countries are hindering their own efforts to achieve their SDGs, as well as preventing migrants from fulfilling their considerable potential in contributing to the net economy and the health systems of host and home countries. The 2030 Agenda for Sustainable Development identifies migrants, refugees and internally displaced people as vulnerable populations that 'must be empowered' (UNGA, 2015). For health, as for other sectors, migrants face

specific challenges that must be addressed if the world is to meet the aspiration to 'leave no one behind'.

The evidence reviewed suggests a number of issues which need to be tackled to ensure that migration contributes to, and does not undermine, the achievement of the SDGs. We make the following policy recommendations to achieve these aims.

Conclusion 1: There are fundamental policy gaps in addressing the health needs of migrants. Global, regional and national institutional arrangements could be improved to facilitate dialogue and collaborative problem solving

Recommendations: establish a formal, well-defined role within UN-based multilateral institutional arrangements that specifically monitors the implementation of migration and health policies

- Formal multilateralism must be pursued in areas where migration specifically intersects with identified health issues, including maternal and neonatal mortality, HIV/AIDS, UHC, vaccination and other targets under SDG 3.
- This will involve reaffirming the stewardship role of WHO on health and IOM on migration, but will also require new ways of collaborating to ensure that the two institutions, and others such as the International Labour Organization (ILO) and UNHCR, can effectively lead a joint global response to the health needs of migrants.

Support networks and organisations working on migration globally and regionally

- Support and promote non-binding and flexible regional consultative processes within and between regions. Policy-makers, representatives from planning ministries, health ministries and other relevant sectors need a forum to discuss common challenges relating to migrants, and share important context-relevant best practice and inevitable trade-offs.
- Recognising that many countries still ignore migrant health, encourage training, peer exchange programmes and sensitisation of government and non-governmental organisations involved in the delivery of health care and migration-friendly policies.
- Establish networks that can respond quickly in the event of sudden population movements such as a new influx of migrants caused by conflict or environmental disaster.

- Other institutions involved in advocacy and delivery of health intervention (such as the Global Fund or Gavi, the Vaccine Alliance) should be encouraged to ensure that migrants' needs are recognised in their global and regional planning processes.

Relevant SDG targets

- 3.1 Reduce maternal mortality.
- 3.2 End preventable deaths of newborns and children under 5 years of age.
- 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- 3.4 Reduce premature mortality from non-communicable diseases and promote mental health and well-being.
- 3.7 Universal access to sexual and reproductive health-care services.
- 3.8 Universal health coverage, access to safe, effective, quality and affordable essential medicines and vaccines for all.
- 10.7 Orderly, safe, regular and responsible migration and mobility.

Conclusion 2: Migration is a determinant of health: it does not have a systemic association with public health security threats to host communities but migrants do face distinctive vulnerabilities to poor health. These are exacerbated by 'migrant-unfriendly or migrant-indifferent' legal frameworks and health systems. Resolving these will require intersectoral approaches

Recommendations: domesticating international migration law standard and practices into national health strategies and other development and poverty reduction plans

- Integrate migration relevant aspects when designing national health strategies and plans.
- Promote 'Health in All' policies, an approach to cross-sector public policies that takes into account the health implications of policy decisions, forges synergies and avoids harmful health impacts to improve population health and health equity, and addresses the wider social determinants of health.
- Ensure that health policies are consistent with country obligations under international laws relating to migration.

Harmonise social protection legislation for better inclusion of migrants in state-provided health services

Through regional (economic) communities (e.g. East African Community or ASEAN) or coordination by bilateral and multilateral agencies (e.g. WHO, IOM, ILO, or World Bank), countries should agree to harmonise legislation and policies related to social protection or UHC. This may result in better inclusion of migrants into state-provided health services. To achieve this, we recommend a three-tiered process:

- Conduct a mapping exercise to identify national legislation on access to state-provided health services and social protection
- Review practical challenges for implementation, and barriers to access by migrants in different contexts
- Make recommendations for harmonisation between countries, and improvements for local implementation to increase inclusion of migrants into national systems.

Ensure that countries with large migrant populations following conflict or environmental disaster get adequate support from the international community to address the health needs of migrants without compromising services to the local population

Relevant SDG targets

- 1.5 Build the resilience of the poor and those in vulnerable situations .
- 3.1 Reduce maternal mortality.
- 3.2 End preventable deaths of newborns and children under 5 years of age.
- 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- 3.4 Reduce premature mortality from non-communicable diseases and promote mental health and well-being.
- 3.7 Universal access to sexual and reproductive health-care services.
- 3.8 Universal health coverage, access to safe, effective, quality and affordable essential medicines and vaccines for all.
- 10.7 Orderly, safe, regular and responsible migration and mobility.

Conclusion 3: There are no international standardised approaches for monitoring variables relating to the health of migrants. Development of data collection, monitoring and surveillance mechanisms is needed to understand migrant health needs.

Recommendations: collect, track and review disaggregated data of all migrants to evaluate and support their health needs

- National health information management systems, and monitoring and surveillance systems must collect disaggregated data by age, gender and location of all migrants. Only then can we begin understanding migrant health needs in detail to inform migrant-friendly policies and action.
- Such disaggregated data needs to be protected by adequate data protection, privacy and confidentiality measures.

Integrate and dedicate resources for infectious diseases surveillance and monitoring migrants within national and regional programmes

- Transit and destination countries to support the integration of infectious diseases surveillance and monitoring (e.g. for HIV/TB, malaria).
- With committed resources, transit and destination countries to support access to diagnostics, treatment and care for migrants within national disease control programmes.
- Migrants must have access to TB and HIV treatment, as well as support and care regardless of legal migration status. This will involve improvements in the portability of health information to facilitate the continuation of treatment, and clinical testing efficiency.

Support local accountability mechanisms and build grassroots capacity to track and monitor the protection of migrant health rights and safety

- Local faith-based, charity and volunteer groups, NGOs, and other local-level entities in sending countries should take the responsibility of educating and equipping migrants with relevant health information.
- In transit and destination countries, similar groups including the diaspora community must also document abuses and campaign with and on behalf of migrants for their health rights.
- Local groups can equip leading government ministries, employers and health service providers with knowledge, and support the means for increased intervention.

Relevant SDG targets

- 3.1 Reduce maternal mortality.
- 3.2 End preventable deaths of newborns and children under 5 years of age.
- 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- 3.4 Reduce premature mortality from non-communicable diseases and promote mental health and well-being.
- 3.7 Universal access to sexual and reproductive health-care services.
- 3.8 Universal health coverage, access to safe, effective, quality and affordable essential medicines and vaccines for all.
- 10.7 Orderly, safe, regular and responsible migration and mobility.
- 17.18 Increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race ethnicity, migratory status, disability, geographic location and other characteristics.

Conclusion 4: Migration can have a positive effect on the development of health systems if coordination is improved between home and diaspora systems and professionals

Recommendations: support and enforce policies that help to retain, incentivise and remunerate the health workforce

- Addressing poor wages and improving career opportunities can help to alleviate the ‘push factors’ of migration in the health workforce.
- Implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel can help to address the challenges of the widening gap in the health workforce.

Support engagement between health professionals in diaspora communities and local health systems

- During epidemics, encourage systematic collaborations between diaspora communities and government, NGOs and donors to ensure that resources and expertise can be mobilised and used effectively in a way that is aligned with national strategies.
- Encourage twinning and other arrangements to increase collaboration and knowledge sharing between diaspora and home medical professionals.

Relevant SDG targets

- 3.1 Reduce maternal mortality.
- 3.2 End preventable deaths of newborns and children under 5 years of age.
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- 3.4 Reduce premature mortality from non-communicable diseases and promote mental health and well-being.
- 3.7 Universal access to sexual and reproductive health-care services.
- 3.8 Universal health coverage, access to safe, effective, quality and affordable essential medicines and vaccines for all.
- 3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries.

References

- Adzei, F. and Sakyi, E. (2014) 'Drivers of return migration of Ghanaian health professionals: perspectives from doctors and nurses in urban Ghana', *International Journal of Migration, Health and Social Care*, Vol 19, No. 2, pp.102-120 (http://www.academia.edu/9190243/Drivers_of_return_migration_of_Ghanaian_health_professionals_perspectives_from_doctors_and_nurses_in_urban_Ghana).
- Cairns, G. (2015) 'Four in ten people diagnosed with HIV in Europe are migrants', AIDSmap (24 June), available <http://www.aidsmap.com/Four-in-ten-people-diagnosed-with-HIV-in-Europe-are-migrants/page/2978799/> [accessed 4 June 2016].
- Chikezie, C-E. (2015) 'The Ebola Crisis and the Sierra Leone Diaspora', *Humanitarian Exchange*, Humanitarian Policy Group, ODI, London, No.64, June 2015 (http://odihpn.org/wp-content/uploads/2015/06/he_64.pdf).
- Clemens, M. (2014) 'A case against taxes and quotas on high-skill emigration', Working Paper 363, Centre for Global Development, Washington DC, May (<http://www.cgdev.org/publication/case-against-taxes-and-quotas-high-skill-emigration-working-paper-363>).
- Darshan, S. and Brown, M. (2015) 'Human African trypanosomiasis in non-endemic countries', *Clinical Medicine*, 15(1): 70-73.
- ECDC (European Centre for Disease Prevention and Control) (2010) *Migrant health: Epidemiology of HIV and AIDS in migrant communities and ethnic minorities in EU/EEA countries: Revised edition*, [online] available http://ecdc.europa.eu/en/publications/publications/0907_ter_migrant_health_hiv_epidemiology_review.pdf [accessed 6 June 2016].
- Esscher, A., Binder-Finnema, P., Bødker, B., Högberg, U., Mulic-Lutvica, A., and Essén, B. (2014) 'Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the 'migration three delays' model' *BMC pregnancy and childbirth*, 14(1), 1.
- European Parliament (2016) 'The public health dimension of the European migrant crisis', European Parliament Briefing [online] available [http://www.europarl.europa.eu/RegData/etudes/BRIE/2016/573908/EPRS_BRI\(2016\)573908_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/BRIE/2016/573908/EPRS_BRI(2016)573908_EN.pdf).
- Fellmeth, G., Paw, M. K., Wiladphaingern, J., Charunwatthana, P., Nosten, F. H., and McGready, R. (2016) 'Maternal suicide risk among refugees and migrants', *International Journal of Gynecology & Obstetrics*.
- FIDH (International Federation for Human Rights) (2008) 'Undocumented migrants in Malaysia: Raids, Detention and Discrimination', No. 489/2, March.
- FMO (Forced Migration Online) (2016) 'Impact of forced migration upon health', [online] available <http://www.forcedmigration.org/research-resources/expert-guides/forced-migration-and-public-health/impact-of-forced-migration-upon-health> [accessed 9 July 2016].
- Guinto R, Curran U, Supanchaimat R, Pocock N., (2015) Universal health coverage in 'One ASEAN': are migrants included? *Global Health Action* 2015. 8: 25749
- HRW (Human Rights Watch) (2005) *Ukraine: On the Margins: Rights Violations against Migrants and Asylum Seekers at the New Eastern Border of the European Union*, [online] available <https://www.hrw.org/report/2005/11/29/ukraine-margins/rights-violations-against-migrants-and-asylum-seekers-new-eastern>.
- IOM (International Organization for Migration) (2012) 'Migration and Tuberculosis: A Pressing Issue', International Organisation for Migration, [online] available <https://www.iom.int/files/live/sites/iom/files/What-We-Do/docs/Migration-Tuberculosis-A-Pressing-Issue.pdf> [accessed 9 May 2016].
- IOM (International Organization of Migration) (2013) *Global report on population mobility and Malaria, moving towards elimination with migration in mind*, IOM: Geneva.
- Jayaweera, H. (2014) *Health of Migrants in the: What Do We Know: Briefing*, Migration Observatory, University of Oxford: Oxford.

- Long, K., and Crisp, J. (2011) *New Issues in Refugee Research: In harm's way: the irregular movement of migrants to Southern Africa from the Horn and Great Lakes regions*, United Nations High Commissioner for Refugees, Switzerland.
- Mills, E., Schabas, W., Volmink, J., Walker, R., Ford, N. et al. (2008) 'Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime', *The Lancet*, 371(9613)685–688.
- Negi N.J. (2011) 'Identifying psychosocial stressors of well-being and factors related to substance use among Latino day laborers', *Journal of Immigrant and Minority Health*. 2011;13(4), 748–75.
- NNIRR (National Network for Immigrant and Refugee Rights) (2008) 'Over-Raided, Under Siege: U.S. Immigration Laws and Enforcement Destroy the Rights of Immigrants, National Network for Immigrant and Refugee Rights' [online] available http://www.datacenter.org/reports/UnderSiege_web.pdf [accessed 9 May 2016].
- Pagano, A. (2014) 'Barriers to Drug Abuse Treatment for Latino Migrants: Treatment Providers' Perspectives', *Journal of Ethnicity in Substance Abuse*, 13(3), 273-287.
- Racape J, De Spiegelaere M, Alexander S, Dramaix M, Buekens P and Haelterman E. (2010) 'High perinatal mortality rate among immigrants in Brussels', *Europe Journal of Public Health*. 20(5):5 36-42.
- Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J. P., and McKee, M. (2013) 'Migration and health in an increasingly diverse Europe', *The Lancet* 381(9873): 1235-1245.
- SASPEN (Southern African Social Protection Experts Network) (2015) 'Migration and health care: The case of HIV and AIDS in Botswana, SASPEN brief 6/2015' [online] available http://www.saspens.org/brief/SASPEN-brief_2015-6_Refilwe-Sinkamba_Migration-and-Healthcare-HIV-Botswana.pdf [accessed 10 June 2016].
- Tangcharoensathien, V., Mills A and Palu, T. (2015) 'Accelerating health equity: the key role of universal health coverage in the Sustainable Development Goals', *Biomed Central Medicine*, 13:101.
- Thomas, S. L. and Thomas, S.D. (2004) 'Displacement and health', *British Medical Bulletin* 69 (1), 115-127.
- Tomás, B. A., Pell, C., Cavanillas, A, B., et al. (2013) 'Tuberculosis in Migrant Populations. A Systematic Review of the Qualitative Literature,' *PLOS* [online] available <http://dx.doi.org/10.1371/journal.pone.0082440>.
- UNAIDS (The Joint United Nations Programme on HIV/AIDS) (2014) 'The Gap Report 2014' [online] available http://www.unaids.org/sites/default/files/media_asset/04_Migrants.pdf [accessed 6 June 2016].
- UNDP (United Nations Development Programme) (2015) 'Technical Support Team issues brief: Health and Sustainable Development', [online] available <https://sustainabledevelopment.un.org/content/documents/18300406tissueshealth.pdf> [accessed 11 July 2016].
- UNDESA (United Nations, Department of Economic and Social Affairs) (2015) 'Trends in International Migrant Stock: The 2015 revision', United Nations Database [online]: POP/DB/MIG/Stock/Rev.2015.
- UNDESA (United Nations, Department of Economic and Social Affairs) (2016) *International Migration Report 2015: Highlights*, United Nations: New York [online] available www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2015_Highlights.pdf.
- UNESCAP, (n.d.) 'The Development Impact of Remittances', [online] available <http://sitereport.unescapsdd.org/remittances/development-impact-remittances>.
- UNFPA (United Nations Population Fund) (2016) 'Migration', [online] available <http://www.unfpa.org/migration> [accessed 9 June 2016].
- UNGA (United Nations General Assembly) (2013) 'Human Rights Council Twenty-third session, Agenda item 3, Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development', United Nations General Assembly, Switzerland.
- UNGA (United Nations General Assembly) (2015) 'Transforming our world: the 2030 Agenda for Sustainable Development', United Nations General Assembly, Switzerland.
- UNHCR (United Nations High Commissioner for Refugees) (2016) 'Population Statistics Database', [online] available http://popstats.unhcr.org/en/time_series [accessed 9 June 2016].
- van den Akker, T. and van Roosmalen, J. (2015) 'Maternal mortality and severe morbidity in a migration perspective', *Best Practice and Research Clinical Obstetrics and Gynaecology*.
- Webber, G., Spitzer, D., Somrongthong, R., et al. (2012) 'Facilitators and barriers to accessing reproductive health care for migrant beer promoters in Cambodia, Laos, Thailand and Vietnam: A mixed methods study', *Globalization and Health* 8(21) doi: 10.1186/1744-8603-8-21.
- WHO (World Health Organization) (2015a) 'Health in 2015: from MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals', WHO: Geneva.
- WHO (World Health Organization) (2015b) 'World Malaria report', WHO: Geneva.
- WHO (World Health Organization) (2016) 'Migration and Health: Key Issues', [online] available <http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues>.
- World Bank (2014) *Migration and Development Brief 26*, World Bank: Washington DC, April 2016, [online] available <http://pubdocs.worldbank.org/en/661301460400427908/MigrationandDevelopmentBrief26.pdf>.



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