Migrants’ Health

Responding to a changing landscape

Stephen A. Matlin, François Gemenne, Marie Munoz-Bertrand, Cécile Rousseau, Paul Spiegel, Anneliese Depoux, Michael Klag and Antoine Flahault

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Summary

Rising numbers of migrants and refugees globally and changing perceptions, attitudes and policies towards them in a number of countries that have been their traditional destinations formed the background to a Symposium on ‘Migrants’ health: health and health care delivery for specific groups’ held at the World Health Summit Regional Meeting in North America, Montreal, on 8 May 2017.

Major changes were highlighted, that have been taking place in many countries in recent years, in the ways that migrants and refugees are portrayed in the media and in political discourse, and in the perceptions of migrants and refugees and attitudes toward them by populations in transit and host countries. In some places, a very important shift in the perception of refugees has occurred, from a sympathetic view of refugees as victims to be assisted and of migrants as a welcome addition to the labour force that boosts economic activity, to one of fear that characterises the incomers as threats to economic and health security, to social cohesion and stability and to national and cultural identity – a shift from being perceived as ‘at risk’ to being considered ‘a risk’. Discussants emphasised ways in which this shift may have a negative impact on the health of migrants.

Discourses on the vulnerability of the host country often ignore the reality of the migrants themselves. Many migrants and refugees have a good educational level, show a vibrant entrepreneurial spirit and undertake formal and informal work to support themselves and their families and contribute to the economy.

Political and media portrayals of migrants and refugees are often volatile, emotive and short-lived, changing according to circumstances and either responding to or attempting to reinforce or direct public attitudes. The challenge now is to go beyond emotional images, with more rational representations.
Environmental factors are of growing importance and the poorest need assistance to facilitate their relocation to safer places. As climate change and extreme weather events increasingly threaten traditional landscapes and livelihoods of entire communities, there is a need to study the impact on human migration and population displacement and the ways that health factors play roles as a cause or consequence of displacements. Migration can be an adaptation strategy: it is not necessarily a failure to adapt, but a way to alleviate stress on resources and to improve access to health, etc. However, resources are necessary for migration to be a realistic adaptation response.

Three key arguments can be made for focusing on the health of migrants: (1) Migrants have a right to health; (2) Including migrants in health systems improves public health outcomes; (3) Healthy migrants contribute to positive development outcomes.

While much attention has focussed on the heightened potential for transfer of communicable diseases, physical health issues needing to be addressed may also include pregnancy and non-communicable diseases, as well as injuries sustained in transit. At least as important are psycho-social issues, which may be occasioned by traumas sustained before or during their migration or by experiences of rejection, fear of deportation, isolation, family separation, discrimination or exploitation after arrival. Moreover, patterns of health problems displayed by different groups shift over time. Children and youth are an especially vulnerable group of migrants and may experience multiple combinations of adverse conditions and events, with girls being particularly at risk, but the effect of migration on children has not been extensively researched, especially for migration to or between low- and middle-income countries.

When migrants lack health insurance, obtaining services can lead to excessive out-of-pocket costs. This discourages migrants from accessing health services in a timely manner, exacerbating conditions that could have been addressed earlier at a reduced cost.

In multijurisdictional states like Canada where health is a devolved responsibility, there can be significant differences between the provinces in their approaches to health provision for migrants and refugees. In cases where services for migrants and refugees are restricted and insufficient to meet their health needs, it is often left to humanitarian organizations to fill the gap. Discussants questioned whether this voluntary approach is the most appropriate way to meet the humanitarian obligations established in international law; and to the extent that it reflects current reality, how to ensure that voluntary humanitarian organizations responding are adequately funded through charitable donations. The need for clear, evidence-based advocacy aimed at both policy makers and the public was highlighted.

International regulations directed at disease mitigation and control have not kept pace with the growing challenges associated with the volume, speed, diversity, and disparity of modern patterns of human movement. The World Health Organization is currently preparing a draft framework of priorities and guiding principles to promote the health of refugees and migrants, to be considered for adoption by the World Health Assembly in 2019.

At the national level, shifts are occurring in governmental policies that affect the health of migrants and refugees, but as yet there is a dearth of coordinated policy approaches to address the health implications associated with modern migration. Policy-making on migration and health is often conducted within sector silos that frequently have different goals, while coordination by decision-makers across borders and policy sectors is required, addressing the multiple phases of the migratory process, including pre-departure, travel, destination, interception, and return, recognizing that health intervention opportunities exist at each stage and that a new framework for understanding the migratory process is required.
It was noted that both supply-side and demand-side factors must be addressed to improve migrants’ access to health services. Factors among new immigrants have been shown to include a lack of knowledge of the health system, which limits their capacity to seek available services, as well as sometimes a fear of being reported to immigration authorities if they attend a hospital. For health care workers, while they have a moral obligation to provide urgent health care, the definition of what is ‘urgent’ can itself be a problem. Representatives from partner agencies escorting the patient can help to ensure that they are not reported and that their rights are respected.

The question of cultures was recognized to be a multi-faceted factor of major importance, presenting challenges relating to the migrants and to the health workers and their service institutions. Migrants need more information, education, confidence building and advocacy on their behalf. Public institutions and some humanitarian organizations engaged in service delivery are sometimes reluctant to engage in public debate, worrying about potential loss of funding if they are seen to be advocating or lobbying. The responses of health workers and their institutions was frame in the context of ‘cultural competence’.

Achieving meaningful cultural competence in health care requires more than provision of in-service training of health workers and must involve systemic initiatives that can be developed around the idea of ‘cultural safety’, to address structural discrimination and avoid cultural blindness. Training challenges include addressing the risks of essentialization and stereotyping in training; the time burden of complex approaches in health care; the gap from information collection to clinical formulation; and the challenge of a culturally sensitive treatment plan. Training recommendations include promoting a fluid, systemic understanding of culture; integrating experiential and hands-on modalities in curricula; continuing education models to promote cultural consultation and case discussions; and creation of tools, including virtual tools such as e-learning modules and migrant-friendly hospital networks.

To prepare future physicians interested in humanitarian action emphasis was placed on the importance of introducing hands-on experience of different situations of ‘otherness’ in the medical curriculum; as well as the value of first trying to find humanitarian work to do at home, which would be transferable internationally.

The work of Doctors of the World/Médecins du Monde was used to exemplify an organization providing advocacy and humanitarian assistance to enable excluded and vulnerable populations to access health care at home and abroad. The organization argues that the case for caring about uninsured migrants rests on grounds of humanity, equity, coherence and common interest and there is a continuing need to act, including through provision of care, raising awareness, bearing witness and advocating for change.

The Symposium highlighted several critical areas for action, including:
- There is need to extend and update international and national policies concerning the treatment of migrants and refugees, including attention to their health needs.
- The discourse on migrants and refugees must move beyond emotional images to more rational representations of migrants and refugees.
- Migrants’ and refugees’ access to essential health services needs to be ensured, while removing their fear of being reported to immigration authorities.
- Approaches need to be developed that will embed not only ‘cultural competence’ but also ‘cultural safety’ in health services and the workers and institutions that provide them, including through systemic reforms to education and training.
Dialogue on the health of migrants and refugees

There are rising numbers of migrants globally due to diverse long-standing and emerging drivers. A complex matrix of factors impact on the health of those moving within and between countries, including climate change, new global health challenges and changing perceptions of and attitudes towards migrants. Against this background, the Symposium on Migrants’ Health was held during the first World Health Summit Regional Meeting in North America, organized by the M8 Alliance in Montreal, Canada on 8-9 May 2017. The Symposium on 8 May was co-organized and co-chaired by Antoine Flahault (Director at the Institute of Global Health, Switzerland; Director of the Centre Virchow-Villermé for Public Health Paris-Berlin; Professor in the Université Sorbonne Paris Cité) and Michael J. Klag (Dean of the Johns Hopkins School of Public Health, Baltimore).

Welcoming participants and introducing the Symposium, the co-chairs emphasized the importance of engaging with migrants and refugees in discussions and research and of focusing on human rights and how to achieve equity in access to health services. They noted that in the North American region, the influxes of migrants and refugees fleeing wars and disasters had, over many decades, contributed immensely to the host countries. The academic community, of which the M8 Alliance is a part, was contributing to providing health care in camps and other settings. There were currently more than 65 million refugees, which are people forcibly displaced by conflicts, violence and persecutions, many residing in camps for decades, and the need for inclusion of medicine and public health in the education available to them was highlighted.

The panel of speakers included Marie Munoz-Bertrand (Faculty of Medicine, Université de Montréal; Volunteer physician and member of the Medical Review Panel for Médecins du Monde/Doctors of the World, Canada; physician consultant, Direction régionale de santé publique de Montréal. Topic: Uninsured Migrants: How is Médecins du Monde Advocating for Access to Health Care?); François Gemenne (Executive Director of Politics of the Earth, Sciences Po, Université Sorbonne Paris Cité. Topic: Anthropocene and Its Victims: Migration, Agency and Vulnerability); Cécile Rousseau
The aim of the Symposium was to highlight the links between migration, the consequences for living conditions and the impact on health and health systems in the countries of origin and in hosting countries. Civil or military conflicts, as well as climate change (particularly when it causes extreme weather events), pose a real threat to populations and have consequences for the living conditions of people with potential for migration. Migrants who fled recently from Africa, Asia and the Middle East do not pose a threat to the health systems of the receiving countries, but rather they need continuing efforts to enable them to access medical and psycho-social treatment.

The Symposium explored country experiences in the context of global perspectives and pointed to the need for systemic approaches to the evolving global challenges. As the host country for the conference, examples from Canada were much in evidence and provided valuable insights from a long and complex history of interactions between indigenous peoples, settlers and successive new waves of migrants and refugees. Representatives of indigenous people welcomed the participants and highlighted the difficulties they had experienced in their engagement with settlers. Canada has a long-standing history and continuing experience of immigration and refugee settlement, with immigrants arriving from more than 190 source countries in 2015, comprising 271,660 new permanent residents (a 4.4 % increase compared to 260,265 in 2014 and with China, India and the Philippines having been the top three sources) and an unknown number crossing the border illegally. While the country continues to plan to receive new migrants and refugees through regular channels, it is believed that at present there are a few hundred thousand migrants in an irregular situation in Canada.

This Symposium report synthesises the panellists’ presentations and comments made by participants in the subsequent question-and-answer session and frames them in the context of current conditions and trends.
The changing landscape of migrants’ and refugees’ health

The health of migrants has always reflected a complex nexus of factors related to their individual circumstances – including their conditions at the point of origin, their reasons for migration, the circumstances of their movement and their status and treatment on arrival at their destination. In general, most migration takes place within countries but a significant fraction involves movement to a new country. Some migrations take place in a planned, orderly and documented process, while others are hasty, unprepared and involve refugees fleeing for their safety, sometimes without documentation.

The rapid increase of population movement in recent years has important public health implications and therefore requires an adequate response, including from the health sector. While documented migrants arriving through regular channels to take up employment or join family members have generally had access to the same health services as citizens of their new host countries, undocumented migrants and those with status as refugees have often experienced restricted access in some host countries and in refugee camps where they may reside for many years. Displacements forced by circumstances, whether economic, environmental, political or social, pose particular threats to the health of the migrants, who may be subject to traumas, or lack the resources, capacities or opportunities to undertake safe passage or to access the health services they require en route or on arrival in their ultimate host countries.

A long-standing phenomenon on a growing scale
Migration has been a facet of human behaviour throughout history and flows of people continue to take place between different parts of the world (Box 1). According to the International Organization for Migration (IOM), more people are on the move now than ever before. There are estimated to be currently 1 billion migrants in the world (one in seven of the world’s population), of whom approximately 760 million are internal migrants (moving over relatively short distances and often not recorded effectively) and 250 million are international migrants. The United Nations (UN) reported that the number of international migrants worldwide has continued to grow rapidly in the 21st century, reaching 244 million...
in 2015, up from 222 million in 2010 and 173 million in 2000. According to estimates produced by the International
Organization for Migration (IOM) in 2010, approximately 10 to 15% of the world’s international migrants were
undocumented.\textsuperscript{8}

About 65 million of the world’s migrants are forcibly displaced—mostly internally and 86% of them are hosted in low- and
middle-income countries. The number includes c. 21.3 million refugees (due to many causes) of which c. 10 million are
stateless persons. 54% of refugees worldwide come from 3 countries: Somalia (1.1 million), Afghanistan (2.7 million) and
Syria (4.9 million), with the top hosting countries being Jordan (664,100, Ethiopia (736,100), Iran (979,400), Lebanon
(1.1 million), Pakistan (1.6 million) and Turkey (2.5 million).\textsuperscript{9,10}

\textbf{Box 1  Circular plot of migration flows between and within world regions during 2005 to 2010}
Only flows containing at least 170,000 migrants are shown

Graphic by Nikola Sander, Guy J. Abel & Ramon Bauer
Source: www.global-migration.info
The most vulnerable are often unable to migrate significant distances, as migration is expensive while the most affected are often the poor or people dispossessed as a result of the rising incidence of forced migration.

Funding for humanitarian assistance dipped from US$ 20.2 billion in 2011 to US$ 18.0 billion in 2012, but subsequently rose to US$ 28.0 billion in 2015, the highest on record. However, this corresponds to a shortfall of 45% for UN-coordinated appeals - the largest ever to date. In the face of this, a report from the Overseas Development Institute argues that it is time for the humanitarian sector to let go of some of the fundamental – but outdated – assumptions, structures and behaviours that prevent it from adapting to meet the needs of people in crises. Current trends include that there are prolonged crises, with more than 90% of countries with humanitarian crises having humanitarian appeals for over 3 years; UN agencies and largest international NGOs received 81% of the humanitarian assistance funding (2009-2013), while local and national NGOs directly received just 0.2% of total humanitarian assistance (2014); there is an increasing, new and complex mix of actors, with varying competence; while affected governments are increasingly taking the lead and controlling the response, local organizations are becoming more effective first responders; and there is increasing participation by Middle East governments and Islamic agencies and by the private sector.

Factors that contribute to migration are extremely diverse and often interact to produce the overall causation of movement. Historically, they have reflected political, social, economic and environmental conditions as well as the impact of natural disasters, disease outbreaks, wars and civil conflicts. Many of these factors have become more pressing in recent years, including extreme weather events, droughts, coastal erosion and flooding and other longer term environmental changes caused by climate change, as well as long-lasting civil conflicts.

Reports from WHO document that famine is a current significant factor in population displacement in places like South Sudan, Ethiopia, Kenya, Nigeria, Somalia, Uganda, and Yemen, with attendant risks of acute malnutrition and diseases resulting from a weakened immune system; refugees, asylum seekers and irregular migrants are at heightened risk for certain mental health disorders, including post-traumatic stress, depression and psychosis; and that there is a particular need to target TB screening to those at greatest risk, such as those who have been living or travelling in precarious situations. As shown by examples from many regions, including areas in Sub-Saharan Africa, women are often the most vulnerable and the most affected group.

**International recognition and safeguards**

The UN has five legal instruments related to international migration: (a) the 1951 Convention relating to the Status of Refugees, (b) the 1967 Protocol Relating to the Status of Refugees, (c) the 1990 International Convention on the Protection of the Rights of All Migrants and Members of Their Families, (d) the 2000 Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, and (e) the 2000 Protocol against the Smuggling of Migrants by Land, Sea and Air. Together with the instruments on the rights of migrant workers adopted by the International Labour Organization (ILO), these form the basis of the international normative and legal framework on international migration. The 1951 Refugee Convention and its 1967 Protocol have been ratified by 145 and 146 United Nations Member States, respectively, but as of October 2015, only 36 Member States had ratified all five of the instruments, while 14 Member States had ratified none.

The 1951 Refugee Convention defined the term ‘refugee’ as a person unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. It consolidated previous international instruments relating to refugees, and
provided the most comprehensive codification of the rights of refugees at the international level, outlining the rights of
the displaced, as well as the legal obligations of States to protect them. Among these obligations are the requirement that
Contracting States accord to refugees lawfully staying in their territory the same treatment as is accorded to nationals in
respect of social security provisions, including those relating to occupational diseases, maternity, sickness and disability.
The strategic objectives on migration health of the IOM are based on four pillars: monitoring migrant health; enabling
conducive policy and legal frameworks on migrant health; strengthening migrant-friendly health systems; and facilitating
partnerships, networks and multi-country frameworks on migrant health.19

The centrality of the concept of ‘protection’ has been emphasised in the work of IOM20 and UNHCR and its partners21 and
the importance of this concept, as applied to the health of refugees and migrants, was highlighted in the Symposium.
In this context, deep concerns were expressed by discussants in the Symposium about attacks on health workers and
hospitals, which had occurred in 23 countries in 2016, especially in the Yemen and Syria, despite the UN Resolution
declaring ‘no immunity’ for such human rights violations.

The Platform for International Cooperation on Undocumented Migrants (PICUM), founded in 2001, representing a
network of more than 140 organisations and 160 individual advocates working with undocumented migrants in more
than 38 countries, has built a comprehensive evidence base regarding the gap between international human rights
law and the policies and practices existing at national level. PICUM promotes recognition of their fundamental rights,
providing an essential link between local realities and the debates at policy level. It has highlighted that the lack of
migration statistics that give careful consideration to the specific issues facing undocumented migrant women leads to
further inequalities, discrimination and increased vulnerability. Women and children are disproportionately impacted by
limitations of basic rights and by restrictive migration policies; in particular, the lack of an independent residence status
is a very common challenge faced by women and children migrating to the European Union. PICUM has stressed that
there is no clear evidence showing that granting access to healthcare to undocumented migrants encourages irregular
migration22
Changing portrayals, perceptions and attitudes

The Symposium highlighted major changes, taking place in many countries in recent years, in the ways that migrants and refugees are portrayed in the media and in political discourse, and in the perceptions of migrants and refugees and attitudes toward them by populations in transit and host countries. Discussants emphasised ways in which these shifts may have a negative impact on the health of migrants.

Significant shifts in attitudes to migrants and refugees have taken place in recent years in some countries, including in Europe and the USA. Large displacements of populations have occurred due to factors such as wars and internal conflicts, persecution of minorities, population pressures and climate change and other environmental problems, adding to the desire of people in less affluent societies to migrate to improve the economic prospects for themselves and their families. Increasing levels of migrants and refugees have occurred in parallel with economic downturns, while there has been a rise of anti-globalization, nationalist and populist sentiments in a number of countries that has been marked by political and social resistance to migrants. As a result, responses in some countries have changed from a sympathetic view of refugees as victims to be assisted and of migrants as a welcome addition to the labour force that boosts economic activity, to one of fear that characterises the incomers as threats to economic and health security, to social cohesion and stability and to national and cultural identity.

These changes in attitude have been characterised as a shift of the established paradigm in some countries from one of ‘rights’ to one of ‘privileges’, with the ‘entitlement’ of different groups in society to a share in its benefits brought into question. Analysis of different parliamentary debates reveals an inversion in hierarchy from seeing migrants and refugees as ‘vulnerable populations in need of protection’ to presentation of the host country as ‘vulnerable’ and being deprived of resources. Studies have shown large increases in host countries’ perception of their own vulnerability. Waves of hate crime and violent incidents against those perceived as migrants were seen after the 2016 US election and after the 2016 UK Brexit referendum.
Discourses on the vulnerability of the host country often ignore the reality of the migrants themselves. Many migrants and refugees show a vibrant entrepreneurial spirit, undertaking formal and informal work to support themselves and their families and contributing to the economy, justifying the view that “immigrants do more good than harm” when given the opportunity to participate in economic and social activity. Examples include:

- Syrian refugees in Turkey accounted for 26% of new foreign businesses registered in 2014. The influx of Syrian refugees displaced Turkish workers from informal labour, but later moved into formal jobs with better wages. Poverty rates fell further in regions hosting Syrian refugees than elsewhere.26,27
- Large numbers of Rohingya refugees from Myanmar have moved undocumented to Malaysia, where they undertake extremely diverse employment at unskilled and skilled levels and create small businesses, while forming a strongly self-supporting community to help manage their precarious situation.28
- In Canada many of the immigrants, including recent arrivals from Muslim countries, have a high education level and are often qualified in the health field. However, professions and diplomas are often not well recognised in host countries, where the medical profession tends to be highly corporatized and protective, presenting a major barrier to using the skills of professionals qualified elsewhere.

Political and media portrayals of migrants and refugees are often volatile, emotive and short-lived, changing according to circumstances and either responding to or attempting to reinforce or direct public attitudes. Representations of migrants (of all kinds) are extremely important as they influence perceptions and guide public policy. There is a contrast between policies on migrants and on public health, with the latter being based on evidence while the former is based on ideology and perceptions. Representations are sometimes very emotional: examples cited included (a) graphics suggesting massive migrations from Africa into Europe29 that can give rise to fear and anxiety; and (b) media photographs of a drowned young migrant child on a beach,30 which had generated a wave of public compassion. There are presentations of migrants and refugees in public discourses and the media (e.g. as ‘invading others’; one major UK newspaper used the term ‘cockroach’) that would not have been seen 20 years ago, projecting them as potentially dangerous or terrorists. When acts of terrorism do occur, they have resulted in an increase in perceived discrimination, hate incidents and crime against migrants.31 References to migrant influxes as a ‘refugee crisis’ are going hand in hand with polarization in society as to how ‘others’ are viewed. In some places, a very important shift in the perception of refugees has occurred, from them being ‘at risk’ to being ‘a risk’. The challenge now is to go beyond emotional images. Migration is now a structural element for societies in the 21st century and more rational representations are required.

Studies emphasise that attitudes are not homogeneous within a given country but vary widely between segments of the population. For example, in the UK, substantial differences in attitudes to immigration have been found among different demographic groups.32 Research on attitudes of healthcare workers to refugees regarding entitlements and rights to health care highlights differences in attitudes in different institutions – a key factor in staff attitudes. Contact with refugees had a positive effect in positive institutions, but increased negative attitudes when institutions’ attitudes were negative. i.e., as might be expected, prevailing stereotypes and prejudices were reinforced.33

Shameful images that are transmitted around the world of people in desperate crises stimulate immediate expressions of compassion and promises of help. However, a ‘hierarchy of compassion’ has emerged34 in which refugees from some places or resulting from some causes are given preference – but this is malleable, as seen when the vulnerability of minors was first emphasised in responding to recent refugee influxes in Europe, but then countered with questions about the accuracy of determination of age and first country of refuge. It is also reflected in the selectivity of humanitarian funding given to certain favoured causes. There is very serious underfunding of needs for refugee support in the Rohingya conflict in Myanmar and in South Sudan and Central African Republic, which are being mostly ignored.
Migrants and climate change

Growing numbers displaced
There is a positive relationship between environmental degradation and migration. Different factors intermingle, but environmental factors are of growing importance and the poorest need assistance to facilitate their relocation to safer places.

There are questions about the capacity of the world to limit climate change and it is necessary to anticipate seriously a 4°C rise, as a consequence of which some tipping points would be reached and some regions would become uninhabitable.

As climate change and extreme weather events increasingly threaten traditional landscapes and livelihoods of entire communities, the need to study the impact on human migration and population displacement has never been greater. The first illustrated publication mapping this complex phenomenon clarifies terminology and concepts, draws a typology of migration related to environment and climate change, describes the multiple factors at play, explains the challenges, and highlights the opportunities related to this phenomenon.

Like physical events such as earthquakes (e.g. Lisbon 1755), extreme weather events (e.g. Hurricane Katrina, USA 2005) and major droughts (e.g. Dust Bowl, USA 1934-37) can result in massive displacements of populations that may be short-lived and local or long-term and international. Such disaster-induced displacements are easy to recognise and attribute and, for example, there was an average of 26.4 million persons per year displaced by disasters in the period 2008-2014, with climate-related events being a much larger factor (86%) than geophysical events (Box 2).
However, the more gradual shifts in environmental conditions resulting from slow, long-term climatic changes that impact on the productivity and habitability of land and on sea level rises that inexorably eat away at coastlines may cause a more gradual and incremental pressure, combining with other cultural, economic, political or social factors to stimulate migrations that are difficult to apportion precisely to each specific cause. Hence, while ‘climate refugees’ are presented as the human faces of global warming, estimates of the present or potential future numbers vary extremely widely and they need to be seen as part of a multi-causal issue within the overall context of migrants and refugees. Scare tactics that demand action on climate change by stimulating fear of large refugee influxes (see, for example, the startling images created for the 2011 London Futures climate change exhibition at the Museum of London) may be counter-productive in reinforcing opposition to welcoming migrants.

Three key aspects of climate change link with displacement of populations: (1) sea level rise: coastal regions will be the first and most affected areas, with impacts especially large where there are large coastal cities (a sea-level rise of 1cm puts 1 million people at risk of displacement); (2) droughts and land degradation: impacts on migration are difficult to forecast, e.g. migration flows tend to decrease at the peak of droughts, as households devote their resources to primary needs; (3) extreme meteorological events: especially large impacts have been seen in some Asian regions in the last decade.
Migration, climate change and health
The relationships between migration, health and climate change have usually been addressed two-at-a-time, but not often together, whereas the three issues are actually deeply connected. For example, climate change can impact on health, which may become a cause for displacements. This has been highlighted in previous dialogues organized by the Centre Virchow-Villermé.41

Migration as an adaptation strategy
Migration can be an adaptation strategy: it is not necessarily a failure to adapt, but a way to alleviate stress on resources and to improve access to health, etc.42,43 However, resources are necessary for migration to be a realistic adaptation response, as highlighted in the Cancun Adaptation Framework44 (Box 3) and in the Nansen Initiative45 of Norway and Switzerland which was successful in achieving the endorsement, by 109 governmental delegations, of an Agenda for the Protection of Cross-Border Displaced Persons in the Context of Disasters and Climate Change (Protection Agenda) at a global intergovernmental consultation on 12-13 October 2015 in Geneva.46

Box 3 The Cancun Adaptation Framework: Protection Agenda
Paragraph 14. Invites all Parties to enhance action on adaptation under the Cancun Adaptation Framework, taking into account their common but differentiated responsibilities and respective capabilities, and specific national and regional development priorities, objectives and circumstances, by undertaking, inter alia, the following:
(f) Measures to enhance understanding, coordination and cooperation with regard to climate change induced displacement, migration and planned relocation, where appropriate, at the national, regional and international levels;

UN Framework Convention on Climate Change: Cancun Adaptation Framework47
Changing needs and responses to the health of migrants and refugees

Three key arguments can be made for focusing on the health of migrants:48
1. Migrants have a right to health
2. Including migrants in health systems improves public health outcomes
3. Healthy migrants contribute to positive development outcomes.

Health issues
While attention has often tended to focus on the heightened potential for transfer of communicable diseases, in practice migrants and refugees display a very wide spectrum of health-related issues, depending on their conditions on departure and their circumstances during movement. Physical health issues needing to be addressed may also include pregnancy and non-communicable diseases, as well as injuries sustained in transit. At least as important are psycho-social issues, which may be occasioned by traumas sustained before or during their migration or by experiences of rejection, fear of deportation, isolation, family separation, discrimination or exploitation after arrival.

Moreover, patterns of health problems displayed by different groups shift over time. For example in the UK, elevated levels of schizophrenia that were seen among immigrants from the Caribbean are now associated particularly with migrants from Arab and Muslim countries. The increased risk of schizophrenia and related disorders among immigrants persists into the second generation, suggesting that for this condition post-migration factors play a more important role than pre-migration factors or migration per se. The risk is mediated by the social context49 and a study of differential patterns of risk across ethnic subgroups in Ontario suggested that psychosocial and cultural factors associated with
migration may contribute to the risk of psychotic disorders, with some groups being more at risk, whereas others were protected. Increased levels of violence in some migrant groups are also changing over time – for example, in the UK an upsurge has been observed in youth radicalization and violence among descendants of immigrants.

The experiences and impacts of youth migration are mixed and can be positive for both the migrants themselves and the countries in which they settle. However, children and youth are an especially vulnerable group of migrants and may experience multiple combinations of adverse conditions and events, with girls being particularly at risk.

The travel, living and working conditions for many young migrants can carry exceptional risks for their physical and mental well-being. These conditions include unequal access to healthcare and services, marginalisation and abuse. They are often linked to restrictive immigration and employment policies, economic and social factors, and anti-migrant sentiments in societies – conditions often referred to as ‘social determinants’ of migrants’ health. Social inequality has a major impact on youth health. The effect of migration on children has not been extensively researched, especially for migration to or between low- and middle-income countries.

Health insurance

When migrants lack health insurance, obtaining services can lead to excessive out-of-pocket costs. This discourages migrants from accessing health services in a timely manner, exacerbating conditions that could have been addressed earlier at a reduced cost. The provision of cost-effective primary health care – as opposed to heavy reliance on costly emergency care – improves well-being, avoids loss of productivity and is line with public health and human rights principles.

One of the five overarching principles of the Canadian health system is universality, with the Provinces being required to provide access for 100% of the residents in order to receive Federal funding. Nevertheless, in practice there are significant numbers of uninsured migrants, both due to irregular migration and to regular migration being affected by inadequate protection and long immigration processes during which the migrant is not insured. The impact on patients of the lack of medical insurance includes serious health problems not being taken care of, unnecessary physical and psychological suffering, missed opportunities for preventative care, and financial burden and indebtedness. Health professionals and health systems are also affected, including by disruption in health care provision and systems, ethical dilemmas, and increased societal costs.

In practice, the Canadian experience shows that there can be significant differences between the Provinces in their approaches to health provision for migrants and refugees. For example, in response to a question about whether there any public health policies to protect migrants and refugees from diseases such as HIV, it was noted that some provinces do have programmes to protect migrants especially in infectious diseases. However, there are none in Quebec, where protection may be offered only on a case-by-case basis, relying on the approach of the individual practitioner.

Such discrepancies in the range or standard of health care (as well as other public services) provision are not uncommon in multijurisdictional states with devolved responsibilities. In cases where services for migrants and refugees are restricted and insufficient to meet their health needs, it is often left to humanitarian organizations to fill the gap. Discussants questioned whether this voluntary approach is the most appropriate way to meet the humanitarian obligations established in international law; and to the extent that it reflects current reality, how to ensure that voluntary humanitarian organizations responding are adequately funded through charitable donations. The need for clear, evidence-based advocacy aimed at both policy makers and the public was highlighted.
Policies and practices
A review of the published literature concluded that international regulations directed at disease mitigation and control have not kept pace with the growing challenges associated with the volume, speed, diversity, and disparity of modern patterns of human movement. It supported the thesis that human population mobility is itself a major determinant of global public health.56

In January 2017, the 140th WHO Executive Board (EB) made a Decision57 on ‘Promoting the health of refugees and migrants’, reaffirming the New York Declaration for Refugees and Migrants58 and in particular its annexes on the global compact on refugees and on the global compact for safe, orderly and regular migration. The EB Decision requested the WHO Director-General, among other things, to prepare a draft framework of priorities and guiding principles to promote the health of refugees and migrants, collecting experiences and lessons learned on the health of refugees and migrants in each region, working towards a draft global action plan on the health of refugees and migrants, to be considered for adoption by the World Health Assembly in 2019.

Shifts are occurring in governmental policies that affect the health of migrants and refugees. As a result of the changing global contexts of demographics and urbanization, we are less and less ‘us and them’ and increasingly becoming a new kind of hybrid humanity. But there has not been commensurate development of coordinated policy approaches to address the health implications associated with modern migration. Policy-making on migration and health is conducted within sector silos that frequently have different goals, while coordination by decision-makers across borders and policy sectors is required, addressing the multiple phases of the migratory process, including pre-departure, travel, destination, interception, and return, recognizing that health intervention opportunities exist at each stage and that a new framework for understanding the migratory process and the five phases of migration is necessary.59,60

The Symposium also heard about the need for improved accountability of policy-makers; and for more efficient, effective and sustainable interventions. Experiences with cash-based interventions show that it is possible to change humanitarian responses. In the past, assistance has been in-kind, but now in Jordan, Lebanon and Turkey, UNHCR and the World Food Programme are providing ATM cards and coupons (e.g. in Jordan US$ 500 per month credits are given for supermarkets), which also leads to an improved local economy (recognizing the need to ensure that prices are not elevated).

Above all, the need for courageous leadership beyond the health sector was recognized in the comment: “the bottom line is that it is political will that counts. It’s not looking good for migrants. The problem is beyond public health”.

Health services
Participants addressed challenges concerning how to improve migrants’ access to health services from several perspectives, noting that both supply-side and demand-side factors were involved. For some new immigrants, in Canada for example, recent research showed that a big issue is their lack of knowledge of the health system, which limits their capacity to seek available services. In Germany, where the Charité in Berlin has been responsible for treating tens of thousands of refugees outside hospital, including pregnant women, it has proved very difficult to get those patients who need hospital treatment to come in.

Health care workers have a moral obligation to provide urgent health care – but the definition of ‘urgent’ can itself be a problem in relation to migrants and refugees in different settings. In access to the Emergency Room, it is very important to work with partners who escort and vindicate rights and monitor the treatment. Migrants may fear being reported to immigration authorities and the partners’ agencies and escorts can try to ensure that they are not reported and their
rights are respected. Experience shows that once one health worker receives migrants and advocates for them, it is easier for the whole team to rally round.

Another factor recognized to be of major importance is that of cultures. It was noted that this is a multi-faceted issue, with challenges relating to the migrants and to the health workers and their service institutions. Migrants need more information, education, confidence building and advocacy on their behalf. Public institutions and some humanitarian organizations engaged in service delivery are sometimes reluctant to engage in public debate, worrying about potential loss of funding if they are seen to be advocating or lobbying. More could be done to try to steer public debate and to conduct advocacy.

Discussion about the responses of health workers and their institutions was framed in the context of ‘cultural competence’, defined as a set of congruent behaviours, attitudes, and policies that come together in a system or agency or amongst professionals and enabling effective working in cross-cultural situations. In the context of health care, it involves understanding and appropriately responding to the unique combination of cultural variables – including ability, age, beliefs, ethnicity, experience, gender, gender identity, linguistic background, national origin, race, religion, sexual orientation, and socioeconomic status – that the professional and client/patient bring to interactions.

**Education, training, advocacy and awareness raising**

Participants reflected that achieving meaningful cultural competence in health care requires more than provision of in-service training of health workers. Not just micro approaches but systemic initiatives are very important and it was considered that a new paradigm is needed in medical schools and other training settings. This may be developed around the idea of ‘cultural safety’, for example drawing on the Maori experience in New Zealand, to address structural discrimination and avoid cultural blindness. Development of tools is important: to ensure migrant-friendly hospitals (as in the initiative on a migrant-friendly hospital networks in Europe) by transforming the institutional climate; to address the language barrier through different interpretation models; and to improve cultural formulation to address the complexity of culture in the clinical realm.

Training challenges include addressing the risks of essentialization and stereotyping in training; the time burden of complex approaches in health care; the gap from information collection to clinical formulation; and beyond the improvement in alliance, the challenge of a culturally sensitive treatment plan. Training recommendations include promoting a fluid, systemic understanding of culture; beyond paying lip-service to cultural competence, integrating experiential and hands-on modalities in curricula; continuing education models to promote cultural consultation and case discussions; and creation of tools, including virtual tools such as e-learning modules as well as social tools such as the migrant-friendly networks in Europe.

The complexity of cultural sensitivity in clinical history and presentation must also be addressed. It is important to teach an approach that moves away from stereotypes (which increase negative attitudes to migrants). It takes time to think in a complex way, with a gap from collecting information to making sense of and interpreting it and further time needed for development of a culturally-sensitive treatment plan.

Responding to the question of how future physicians interested in humanitarian action can prepare themselves to contribute in a changing situation, discussants emphasised the importance of introducing hands-on experience of different situations of ‘otherness’ in the medical curriculum – not paying lip-service to ‘cultural competence’ but providing practical experience; and the value of first trying to find humanitarian work to do at home, which would be transferable internationally.
The question of whether there should have been a ‘migrant representative’ on the panel provoked an interesting reflection on the issue of who speaks for migrants. It was pointed out that it is very difficult to task an individual to ‘represent’ all of a very large and diverse array of migrants. Migrants are not a general group who know one another and each other’s problems. The important point was to have dedicated individuals and organizations with professional experience of the issues and the capacity to raise them effectively in different fora.

A detailed example of such an organization was provided by Médecins du Monde (MdM). An international medical organisation founded in France in 1980, MdM has been working in Canada since 1996 and is a network of 15 organisations operating in 79 countries, to empower excluded and vulnerable populations to access health care at home and abroad. It regards uninsured migrants in Canada as an invisible crisis. Field observations provide evidence for an access gap and for confusion within the health care system. However, there is a scarcity of data, lack of public services, limited public support and no funding. MdM’s programme for uninsured migrants in Montreal includes outreach that targets the most vulnerable populations; support for access to health care; attempts to understand the root causes of precarious situations and advocacy for social change. MdM has seen substantial increases in the number of uninsured migrants seeking and benefitting from their help since 2011, with pregnancy being the most prevalent among a very wide range of health issues presented.

MdM’s advocacy work in Canada centres on inducing and supporting changes in policies and practices, targeting Federal and Provincial authorities (Health, Immigration, Social and Family Affairs), health care professionals, health care institutions and academic institutions. In a survey of uninsured migrants being conducted by a research team lead by University of Montreal and funded by the Canadian Institute of Health and Research (CIHR), among 572 participants who had responded as of 27th April 2017, there was extreme mistrust and fear among a diverse and scattered population. The preliminary results were indicative of an association with negative social determinants of health and difficult access to health.

While progress was being made towards empowering uninsured migrants, with case-by-case advocacy being conducted and efforts made to raise awareness among clinical and academic partners and through meetings with all levels of government, there remained major challenges, with public support still being very limited and funding difficult to secure. There were currently limitations in the health provision strategy and it was clear that there would be no sustainable results without change in policies and practices. MdM argues that the case for caring about uninsured migrants rests on grounds of humanity, equity, coherence and common interest and there is a continuing need to act, including through provision of care, raising awareness, bearing witness and advocating for change.
Recommendations

The Symposium highlighted several critical areas for action, including:

• There is need to extend and update international and national policies concerning the treatment of migrants and refugees, including attention to their health needs.

• The discourse on migrants and refugees must move beyond emotional images to more rational representations of migrants and refugees.

• Migrants’ and refugees’ access to essential health services needs to be ensured, while removing their fear of being reported to immigration authorities.

• Approaches need to be developed that will embed not only ‘cultural competence’ but also ‘cultural safety’ in health services and the workers and institutions that provide them, including through systemic reforms to education and training.
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Ongoing work on migration and health

This report is part of a body of work on the relationship between migration and health, undertaken by the Centre Virchow-Villermé (CVV) together with partners. Reports of previous research and dialogues on the subject can be found on the CVV website (http://virchowvillerme.eu/climate-change) and include:


The next event on migration and health planned as part of the work of M8 Alliance partners is an Expert Group Meeting hosted by the Sapienza University of Rome, 23-24 June 2017. Information on the meeting was presented at the WHS Symposium in Montreal by Prof Luciano Saso (Vice-Rector for European University Networks, Sapienza University).

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Symposium report

With increasing numbers of migrants and refugees globally and changing perceptions, attitudes and policies towards them in a number of countries, it has become increasingly urgent to address the health needs of these people in line with international rights and accords and humanitarian principles.

The Symposium highlighted several critical areas for action, including the need to extend and update international and national policies; to move beyond emotional images to more rational representations of migrants and refugees; to improve migrants’ access to health services while removing the fear that they will be reported to immigration authorities; and to develop approaches to embedding not only ‘cultural competence’ but also ‘cultural safety’ in health services and the workers and institutions that provide them, including through systemic reforms to education and training.

Above all, the need for courageous leadership beyond the health sector was recognized in the comment: “the bottom line is that it is political will that counts. It’s not looking good for migrants. The problem is beyond public health”.