



HEALTH OF MIGRANTS: RESETTING THE AGENDA

Report of the 2nd Global Consultation
Colombo, Sri Lanka, 21–23 February 2017

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Acronyms and abbreviations

CRRF	Comprehensive Refugee Response Framework
EU	European Union
GCM	global compact for migration
GCMH	Global Consultation on Migrant Health
GCR	Global Compact for Refugees
IDP	internally displaced person
ILO	International Labour Organization
IOM	International Organization for Migration
MHADRI	Migration Health and Development Research Initiative
MIPEX	Migrant Integration Policy Index
NYD	New York Declaration for Refugees and Migrants
RCP	Regional Consultative Process
ReHoPE	Refugee and Host Population Empowerment Framework
SDGs	Sustainable Development Goals
SDH	social determinant(s) of health
TB	Tuberculosis
UHC	universal health coverage
UNHCR	Office of the United Nations High Commissioner for Refugees
WHO	World Health Organization
WHO EB	World Health Organization Executive Board
WHA	World Health Assembly
WHA.61.17	World Health Assembly Resolution on the health of migrants (2009)

Foreword

For centuries, migration has been a global, and largely positive, reality for individuals and societies alike. The urgency to explore viable and collective governance solutions to this megatrend of our time has only recently gained global momentum. Regrettably, this attention has been driven by the appalling toll in human lives paid by people desperately crossing seas, deserts, and dangerous borders in search of safe havens from war, poverty, and human-rights abuses. It is also influenced by divisive debates on migration management that are causing concern in many countries.

Migration has now reached the forefront of high-level international dialogues and processes such as the 71st UN General Assembly High-level Plenary Meeting on Large Movements of Refugees and Migrants in 2016, and the development of a Global Compact for safe, orderly and regular migration, and a comprehensive framework for refugee response by 2018. While health has long been considered an essential component of human and economic development, the health of migrants has remained in the shadows of key global health, migration, and development dialogues and processes, and many migrants still lack access to affordable health services.

The 2010 Global Consultation on Migrant Health in Madrid, coorganized by IOM, WHO and the Government of Spain, proposed an Operational Framework for the implementation of the World Health Assembly (WHA) Resolution on the Health of Migrants (WHA.61.17). Since then, new trends and developments have called for the validation and revision of those principles and strategies. This possibly entails the re-setting of the migrant health agenda as a global health agenda, in consideration of the size and scope of current migration that has increased by 41 per cent in the past 15 years and involves an estimated one billion people worldwide. Moreover, in considering its multiple implications in terms of health rights, human and health security, and the nexus between humanitarian relief and development. Additionally, past frameworks did not clearly identify specific sector contexts within which to systematically advance an agenda that is multisectoral in essence, and involves partnerships within Governments and between States requiring significant levels of diplomacy and international leadership, as it has been the case with other global health agendas, and a common platform for accountability and monitoring of its advancement that is today offered by 17 Goals and 169 targets of the 2030 Development Agenda, set on the prime scope of “leave no one behind”, not even migrants.

Acknowledging policy gaps and the urgency of advancing the unfinished agenda of migrant health, a High-level Panel on Migration, Human Mobility and Global Health was organized at the 106th IOM Council in November 2015 with the participation of WHO Director General M. Chan. Additionally, IOM Council document C/106/INF/15 on ‘Advancing the Unfinished Agenda of Migrant Health for the Benefit of All’ explored important challenges, programmatic accomplishments, lessons learned and good practices in the domain over several decades. It was at the 106th IOM Council that H.E. President Maithripala Sirisena of Sri Lanka offered to host the 2nd Global Consultation on Migrant Health. In response, IOM and WHO have strengthened their long-term partnership, consolidating technical resources and complementing each other to better meet the needs of Member States and migrants in advancing the migrant health agenda.

In January 2017, the Executive Board of the World Health Organization at its 140th session in January 2017, noted the WHO Secretariat report on ‘Promoting the health of migrants’ and adopted Decision EB140(9). This WHO Executive Board Decision requests WHO to, inter alia, “prepare, in full consultation and cooperation with Member States, and in cooperation with IOM and UNHCR and other relevant stakeholders, a draft framework of priorities and guiding principles to promote the health of refugees and migrants, to be considered by the 70th World Health Assembly (WHA) and the global action plan to be considered by the 72nd WHA”; and “to make every possible effort, in close collaboration with Member States, and based on the guiding principles, to ensure that health aspects are adequately addressed in the development of the global compact on refugees and the global compact for safe, orderly and regular migration, in close collaboration with relevant international organizations, to report thereon to the 71st World Health Assembly[...].”

This follows the initiative of various Regional Consultative Processes on Migration and Development having dedicated discussions on migration and health, in Costa Rica and Sri Lanka, for example. Additionally, WHO regional resolutions were adopted by Regional Committees of the Americas (CD55.R.13) and Europe (EUR/RC/66/R6) as well as a Strategy and Action Plan for refugee and migrant health in the European Region. Moreover, during the 69th World Health Assembly, a technical briefing session was dedicated to the topic of ‘Migration and Health’ and WHO Member States debated and took note of the Secretariat report on ‘Promoting the Health of Migrants’.

Convened in Sri Lanka in February 2017, the 2nd Global Consultation on Migrant Health brought together approximately 130 participants from all geographical regions representing various sectors within Governments, as well as civil society organizations, academics, experts, international organizations, regional institutions and professional and migrant associations. It provided a platform for in-depth discussion on migration health and explored ways to address the fact that millions of migrants are still denied access to health services and remain invisible in global health initiatives. Moreover, the event identified key opportunities, concerns, recommendations, and actions to advance the agenda. The participants' rich contributions to the Consultation allowed for debates on the development of a progress monitoring framework, actionable policy objectives and a research agenda on migration health.

We hope the Consultation has relaunched awareness to the crucial importance of including migrants in health systems and national health strategies, on the need to address social and migration management determinants that can cause harm to their health or increase their resilience, and of the continued political commitment of stakeholders at all levels to ensure that the health of migrants is adequately addressed in international dialogues and global processes within and outside the health sector. In particular and with a view towards the achievement of the 2030 Agenda on Sustainable Development, it is critical to bear in mind that in order to achieve true Universal Health Coverage (Target 3.8), migrants must be included, and that 'to facilitate orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies' (Target 10.7), health policies are relevant as well.

We are proud to present this Consultation report, which will carry forward these valuable messages to all stakeholders working to enhance the health of migrants, their families, and host communities. By taking a truly unified, whole-of-government, and whole-of-society approach we will be able to appropriately address the health needs of migrants for the benefit of all.



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Executive summary

The 2017 Global Consultation on Migrant Health was convened as a follow-up to the 1st Global Consultation on Migrant Health, held in 2010, in response to the renewed international attention to the health needs of migrants through agenda-setting on the 2030 Sustainable Development Goals, Universal Health Coverage, and other global health priorities. Informed by the Operational Framework from the 2010 Consultation, Member States, the International Organization for Migration (IOM) and the World Health Organization (WHO) have taken action on a variety of initiatives that have advanced programmes, policy and research related to migrant health.

IOM, WHO and the Government of the Democratic Socialist Republic of Sri Lanka jointly organized the 2nd Global Consultation on Migrant Health in February 2017 to offer Member States and partners a platform to:

- share lessons learned, good practices, and research on the health needs of migrants, and to identify gaps, opportunities and new challenges;
- reach consensus on key policy strategies and benchmarks to create a unified agenda on the health of migrants, for both acute large-scale displacement and long-term, economic and disparity-driven migration;
- engage multisectoral partners at a policy level for a sustained international dialogue and an enabling policy environment for change.

This consultation report summarizes the issues discussed at the consultation and offers recommendations related to the meeting's intended outcomes.

Parts 1, 2 and 3 offer the proceedings of the three-day consultation, starting with context-setting presentations by the organizers. Plenary sessions addressed the three thematic areas: Health, Health Systems and Global Health, Vulnerability and Resilience, and Development, and breakout groups discussed the issues raised by the presenters related to the three expected outcomes: actionable policy objectives, a progress monitoring framework, and a research agenda.

Part 4 summarizes the recommendations developed by the breakout groups for each of the three outcomes, led by a statement of principles derived from the cross-cutting themes. For each outcome, the recommendations address priority areas for action and highlight any special considerations or concerns.

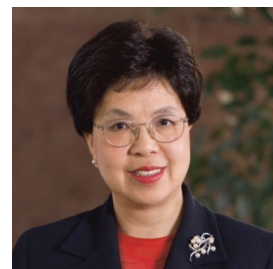
Part 5 places the work of the consultation in the context of upcoming global dialogues on migration and refugees. In the Way Forward session, representatives from IOM, UNHCR and WHO described how health can fit into the upcoming development of the Global Compacts for safe, orderly and regular migration and refugees, and offered a timeline for the implementation of the WHO 2017 EB decision, including the development of a WHO Framework of priorities and guiding principles to promote the health of refugees and migrants, and a global action plan. This section also includes a summary of the High-level Panel on the Colombo Statement, which expresses governments' support to promote the health of migrants at a multisectoral level, endorsed by 19 Member States.

Finally, the report contains excerpts of the three thematic papers on Health, Health Systems and Global Health, Vulnerability and Resilience, and Development; the text of key speeches; the Colombo Statement; and other relevant material.

KEYNOTE ADDRESSES

MARGARET CHAN

Director General, World Health Organization



Greeting from the World Health Organization in Geneva.

I thank the Government of Sri Lanka for hosting this second global consultation on migrant health, and the International Organization for Migration for coorganizing the event.

Ours is a world of unprecedented human mobility, with more people on the move than ever before. Some leave their homes seeking opportunities to work their way into better lives and livelihoods.

Others are displaced by intolerable, sometimes life-threatening situations. They escape to survive. They flee for fear of perishing if they stay.

All of these people have health needs. Refugees, in particular, deserve empathy and safe shelter, also for health needs that can be made acute by long and dangerous journeys.

The September 2016 New York Declaration is the first adopted specifically for refugees and migrants by the UN General Assembly.

The Declaration sends a strong signal that the world cares about refugees and migrants. It is also an expression of profound solidarity, both for those who have left their homes and those who give them shelter.

Significantly, the Declaration calls for a sharing of the burden and responsibility of providing shelter.

WHO and its Member States also care.

The January session of the Executive Board decided to ask the Secretariat to prepare a draft framework of priorities and guiding principles to promote the health of refugees and migrants.

We were asked to do this in close collaboration with Member States, and in cooperation with IOM and UNHCR.

The problems are complex. They are context specific, and they have a strong political dimension.

The need now is for concrete, practical, evidence-based guidance. WHO was further asked to conduct a situation analysis by identifying and collecting experiences and lessons learned on the health of refugees and migrants in each region.

These experiences and lessons will shape the draft framework.

Finally, WHO was asked to ensure that health issues are adequately addressed in the two global compacts called for in the New York Declaration: one on refugees and a second on safe, orderly, and regular migration.

Our work in all these areas will be reported to the World Health Assembly in May. The next step will be the development of a draft global action plan on the health of refugees and migrants for consideration in 2018.

We look forward to close collaboration with IOM and UNHCR as we undertake this important work.

Thank you.

WILLIAM LACY SWING

Director General, International Organization for Migration



Mr. Chairperson, Excellencies, Honourable Ministers, Heads of Delegations, Ladies and Gentlemen, I wish to thank our host, the Government of Sri Lanka, most especially President Maithripala Sirisena, for organizing this timely conference. Allow me to apologize for not being with you personally as another equally compelling matter requires my presence in Geneva.

Let me raise three points:

1. The need to understand the link between migration and health
2. The need to implement migrant-sensitive policies that are aligned with the person-centred Universal Health Coverage principles
3. The need or partnerships and coordination

1. The need to more deeply understand the link between migration and health and take action

We live in an era of unprecedented human mobility, a period in which more people are on the move than ever before. Today, there are nearly 250 million international migrants and 750 million internal migrants – one in seven of the global population. Migration is inevitable, necessary and if well managed, desirable. It is a reality to be managed and not a problem to be solved. The volume of current migration is an important indicator of the global importance of the health of those moving across and between borders, and of the importance to consider and address the health of migrants as a global health agenda for all. Despite migration being a fact of life, large groups of migrants remain at high risk of social exclusion, discrimination and exploitation; many still lack access to adequate health service or have to pay higher prices for it. Additionally, the realization of equitable standards of health for migrants, their families and communities hosting them remains an often neglected theme in both migration and health dialogues and goals. We need to work together to overcome this reality, and your leadership is essential.

Let me highlight that migrants and mobile populations do not generally pose a risk to health for hosting communities and they should not be stigmatized and associated with the risk of importing diseases. As we know, it is rather the conditions surrounding the migration process that can increase the vulnerability of migrant and mobile populations (MMP) and communities to ill health particularly for those forced to move and those who find themselves in so called ‘irregular’ situations. Which brings me to my second point:

2. The need to implement migrant-sensitive policies that are aligned with the person-centred Universal Health Coverage principles, that promote inclusion and integration, and address avoidable causes of vulnerability to ill health

Universal Health Coverage (UHC), or “leaving no one behind,” is high on the global health agenda. We can all agree that UHC only exists if health systems account for all of its community members, including migrants.

Successful integration of migrant and mobile populations into health systems is therefore critical to predict and prevent the spread of diseases, design evidence-based responses along mobility pathways, enhance national capacities to better promote the health of migrants, and enhance the contribution of migrants to sustainable development. All these will only be possible if we work together – which is the last point I wish to raise:

3. The need to improve partnerships and coordination

To properly address challenges relating to the health and well-being of migrants, we need to work together to better understand the health aspects of mobility. Migrant health issues cannot be solved by the health sector alone. Partnerships, health diplomacy, and leadership across all sectors and across all borders are required. Moreover, it is important we work towards a unified agenda across regions on the health of migrants, including those who are forcibly displaced. In IOM we much value our strong collaboration

with WHO and all our Member States, Civil Society and other actors towards this goal. Our task is to find commonalities and unifying principles in order to promote strengthened health systems and 'health for all'. We are at an opportune time as States begin work on the Global Compact for Migrants, which sets to lay down common principles pertaining to human mobility.

Health is a basic human right and an essential component of sustainable development. Being and staying healthy is a fundamental precondition for migrants to be productive contributors to the social and economic development of their communities of origin and destination. I trust that health ministries and representatives of government, civil society organizations, community members, the private sector and development partners, stand ready to promote the health of migrants and lead the mainstreaming of migrant health into all policies. Time is opportune for coming together and achieve results. I wish you a successful Consultation.

RAJITHA SENARATNE

Minister of Health, Nutrition and Indigenous medicine, Sri Lanka



Today, a world without human mobility is unthinkable. Migration has influenced most nations at some point of time. Our social development, cultural beliefs, education, even judicial systems, economic development are much influenced as a result of mobility and migrants of various types, Sri Lanka being no exception. Early civilizations to giant economies of today are heavily influenced by migration, one way or the other.

Global Health agendas which we all are too familiar with, such as 1978 Alma Ata declaration “The Health for All” and “Millennium Development goals” which followed, were meant to reach out to all, and in particular the vulnerable. These important drives for development of health had emphasis on different health related issues such as malnutrition, maternal and child health, communicable diseases such as Tuberculosis, HIV and Malaria, Water, sanitation and hygiene, etc. Mostly we focused on achieving national goals and targets and hence vulnerability may have been undermined, and this I believe, is a key factor to consider in the Sustainable Development Agenda which we have all embraced.

Universal Health Coverage is considered a key strategy for Sustainable Development and Universality means leaving no one behind. Identifying who is vulnerable is important in this context. It is time for us to examine vulnerable populations in our countries, and I believe, migrants are most likely to be included as vulnerable. In fact, in some countries, migrant populations contributing to economic development face significant health challenges without easy access to health care. Countries too face challenges in protecting their public health, when health systems are seen to be less inclusive. Diseases of public health significance such as malaria, Tuberculosis, HIV, are known to be better managed if doors are open for them to be identified.

Sri Lanka too faced many health challenges due to migration, and will continue to do so. The experience and understanding we have gained over the years was useful for us to develop an all inclusive migration health policy.

In 2008, when the Resolution on Health of migrants was adopted at the 61st World Health Assembly, we were one of the first countries to move towards understanding our migration health issues. (Hon. Nimal Siripala was the then Minister of Health) It was at that time the International Organization for Migration, which was then present in Sri Lanka to support internal migration related to Civil unrest at that time, extended their support to establish a Migration Health Secretariat in the Ministry of Health to address the issue in Sri Lanka. We soon realized that what we knew was in fact limited to few isolated researches at the time and some journalistic reports.

The approaches we took next were to identify a framework for a Rapid Situation Analysis. The RSA as we call it, paved the way to identify research and policy gaps. We also established a process for multisector involvement, through setting up of a National Steering Committee and a National Technical Task Force. The National technical task force identified research areas to be commissioned as research studies, which were approved by the National Steering Committee. The significance here is that many Government Sectors are needed to address Migrant health issues which extends beyond the Ministry of Health. It was important to build this understanding. A joint effort to identify and commission research studies created awareness on migration and health, and what can be done better together with other Government stakeholders.

The technical task force was comprised of technical experts from academia, different departments within the Health sector and experts from the other stakeholder Ministries such as foreign employment, labor, foreign affairs, National Planning, women and children’s affairs, Defense and Justice. We received support from the IOM to commission the National research studies and the evidence generated from the studies were discussed at a National consultation. This was the basis for the National Migration Health Policy. The Policy was launched in 2013 at the time His Excellency the President Maithripala Sirisena was the Minister of Health.

As we undertook these studies which I just mentioned, we were able to include into our migration health policy key components of health in inbound migration, outbound migration, families left-behind and internal migration. The Policy therefore is inclusive of all these aspects of migration.

The National Steering Committee headed by the Secretary, Ministry of Health, faced several challenges in addressing ongoing issues pertaining to health of migrants, even before the policy was developed. This can be seen as yet another success in an approach sensitizing other government stakeholders. I cite this example where after the end of the 30 year long civil unrest and normalcy returning in 2009, Sri Lankans who had been living for a long time in South India started returning home. Considering that there were epidemiological differences in the two locations, a health screen was being discussed. Some said off shore, some said upon entry. The technical task force carefully considered the situation and adopted the approach of welcoming them to Sri Lanka and directing them to access our primary health care and community health services. The primary care field staff were educated and instructed how to link the returnees to the required health services, by the provincial health authorities and a comprehensive package was offered after counselling them.

Another important approach we adopted was conveying the importance of being accountable. At two World Health Assemblies we reported our progress through a report card. We soon understood that as much as local advocacy is important, global advocacy too is important to implement migration Health policy. This is when we attempted to inform a group of labor sending and receiving countries, through the Colombo Process, the importance of Health of Migrants and the need to collectively address related issues. Our request to include such an approach in the agenda of the WHO Regional committee meeting was accepted, and interventions were made at the Regional Committee by almost all SEARO Members, all of them endorsing the relevance and the importance of such an approach to the region.

I should mention that, Sri Lanka also co-hosted a side event with Italy, IOM, UNHCR and WHO on “Health in the Context of Migration and Forced Displacement” at the UN General Assembly in New York last September. Sri Lanka also recommended Migration Health to be included in the agenda of the Executive Board of the WHA this year, highlighting the need for implementing a better monitoring system by WHO. We are pleased to note that many countries are interested in advancing the agenda of health of migrants through the mediation of the Executive Board of WHO.

The Government of Sri Lanka feels that the dialogue on Health of Migrants needs heightened emphasis globally and this led HE The President Maithripala Sirisena to invite for a second Global Consultation, we are witnessing today. The Colombo Statement should also be viewed as an effort to strengthen our understanding on the issues, so that we can work together on this subject.

I believe the technical discussions are structured to achieve appreciable discussion for future guidance on formulating of research agenda, monitoring frameworks and actionable policy interventions.

I have attempted to elaborate briefly the approaches taken thus far in policy development and moving the multi sector agenda forward.

In summary Sri Lanka followed a 6 step approach in its policy development which was all inclusive, evidence based, multi stakeholder, multi sector coordinated and had a responsive approach even during the development phase of policy. The process was also based on regional and international advocacy and accountability in reporting to the World Health Assembly.

I believe that during the technical consultation it may be useful for some comparisons to be drawn from what we have done and I have no doubt that there would be many other countries looking forward to contribute with their own experiences in this regard.

Excellencies, distinguished participants, I am deeply honored with your presence here today and I am confident that we will make the most of the Consultation to come up with ideas and solutions to take home and to improve the way in which we all work together in addressing.

Thank you.



Participants at the 2nd Global Consultation on Migrant Health (21-23 February, 2017)

INTRODUCTION

The acceleration and changing patterns of migration over the last few decades urgently call us to better understand and collaboratively govern human mobility on a global scale. This would facilitate the full realization of migration's development potential and curtail negative outcomes on individuals and societies. Concern for the health needs of migrants has emerged in many recent international dialogues, offering promising instruments, strategies, and principles through new multilateral commitments such as the UN 2030 Agenda for Sustainable Development, the debate on Advancing the Unfinished Agenda on Migrant Health at the 106th Council of the International Organization for Migration (IOM), the New York Declaration for Refugees and Migrants (NYD),¹ and the decision of the 140th World Health Organization Executive Board (WHO EB) on Promoting the Health of Migrants.

The number of people who migrated across international borders surged by 41 per cent in the last 15 years to reach 244 million in 2015,² with an unprecedented global estimate of more than 65 million displaced persons, 21.3 million of whom are refugees. Internal migration is estimated to account for another 740 million people³ worldwide, bringing the total number of 'people on the move' close to one billion people, or 1 in 7 of the world's population. This trend is projected to continue, due to demographic changes, conflicts, environmental degradation, and persistent economic and employment disparities across the globe.

Migration continues to evolve and become more complex through mixed migration flows, comprised of many categories of migrants⁴ and involving both traditional and new countries of origin, transit and destination. The vast majority of migrants cross international borders as migrant workers, and contribute to the productivity and growth of destination countries as well as their communities of origin. Remittances exceeded half-a-trillion USD in 2016.⁵ But protracted, unresolved conflicts have forced many displaced persons into urban communities rather than specific refugee settlements, with variable levels of security, social protection, access to services, or acceptance by local societies. Many seek better opportunities by crossing dangerous borders and seas, joining the desperate flows of irregular economic migrants trying to escape poverty in the fragile states of the Global South. This mixing of economic migrants with people who can legitimately claim international protection as asylum seekers calls for harmonized, sustainable, and people-centred responses that holistically meet both the short-term acute needs of the newly arrived and the long-term integration needs of diverse populations establishing new lives.

Specific health resilience and vulnerability factors are associated with each typology and phase of the migration process, whether acute and crises-driven, or long-term, structural and disparity-driven. Responses need to anticipate, prevent, or mitigate the determinants of ill health for migrants, while enabling access to needed services as a fundamental human right. This benefits both general public health and supports development through better health for both migrants and resident populations.

MIGRATION AND HEALTH

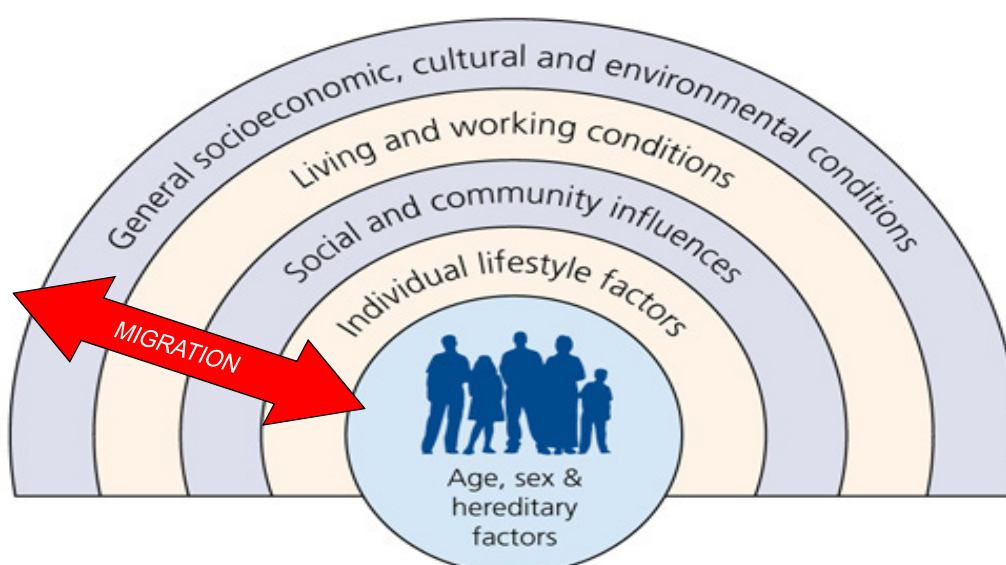
Migration can improve the health status of migrants and their families by providing an escape from persecution and violence, and by improving their socioeconomic status through better education, higher income, and the sending of remittances. There is extensive evidence showing that the vast majority of migrants are young, fit, and healthy when they embark on their migrant journeys. On the other hand, the migration process itself can expose some migrant groups to health risks through unsafe travel, exposure to diseases, limited access to health services, poor nutrition, psychosocial stressors, and harsh living and working conditions. Some migrants may be especially vulnerable, such as the very young and very old, unaccompanied minors, female heads of household, the low-skilled, those fleeing war or disaster, those in an irregular status or being trafficked, and all those who are ostracized and objects of xenophobia.

In their destination communities, migrants may not be granted adequate, equitable or affordable access to health services, and local health systems may not have sufficient capacity to manage acute or chronic health needs. Social exclusion, which is fuelled by discrimination, growing anti-migrant sentiments and inequity, has a further negative impact on health. Where health services are available, such services may not be culturally, linguistically or clinically sensitive to migrant populations, which can lead to undiagnosed conditions or ineffective treatment. Migrants may be unaware of available services, or unable to access them easily due to administrative hurdles, including the risk of incurring sanctions when in an 'irregular situation', or losing their employment and residency if affected by certain medical conditions.

MIGRATION IS A SOCIAL DETERMINANT OF HEALTH

Improving access to needed health services is not the only consideration in achieving positive health outcomes for migrants. The migration process itself is increasingly recognized as a social determinant of health for migrants, their families and communities (Figure 1). Policies and practices related to education, gender, labour, development, migration governance, and the humanitarian sphere affect migrants' resiliency and vulnerabilities, demanding a whole-of-government and whole-of-society approach that reduces the causes of negative health outcomes and promotes healthy lives for migrants and communities.

FIGURE 1. SOCIAL DETERMINANTS OF HEALTH⁶



MIGRATION HEALTH FOR DEVELOPMENT

Migration has begun to find a place in global health discussions, and health issues are being raised in high-level dialogues on development and migration, though not yet with a consistency that would enable meaningful policy changes and positive results. Migration health remains an under-researched area in global health and is scarcely addressed by health system planners. Given the ever-growing prominence of migration across the globe, governments are challenged to integrate the health needs of migrants into national plans, policies and strategies. Considering the diversity of determinants affecting migrants' health, and the development benefit that migration offers for individuals and societies, it is critical to involve a diverse set of actors and sectors to achieve the Sustainable Development Goals (SDGs) with respect to migrants and migrant-impacted communities. Investing in the health needs of migrants and mobile populations throughout the migration cycle protects global public health, facilitates social integration, and contributes to economic prosperity.

GLOBAL HEALTH SECURITY

In the era of increased human mobility and resurgent infectious diseases, the collective ability to prevent, detect, and respond to health threats across international borders depends on Universal Health Coverage (UHC)⁷ that leaves no one behind, including migrants. History has shown that protecting public health depends on accessing health services in a timely manner, regardless of migration status. Stopping an epidemic requires prompt diagnosis, treatment, and transmission prevention at the individual and collective level, not the closure of borders.

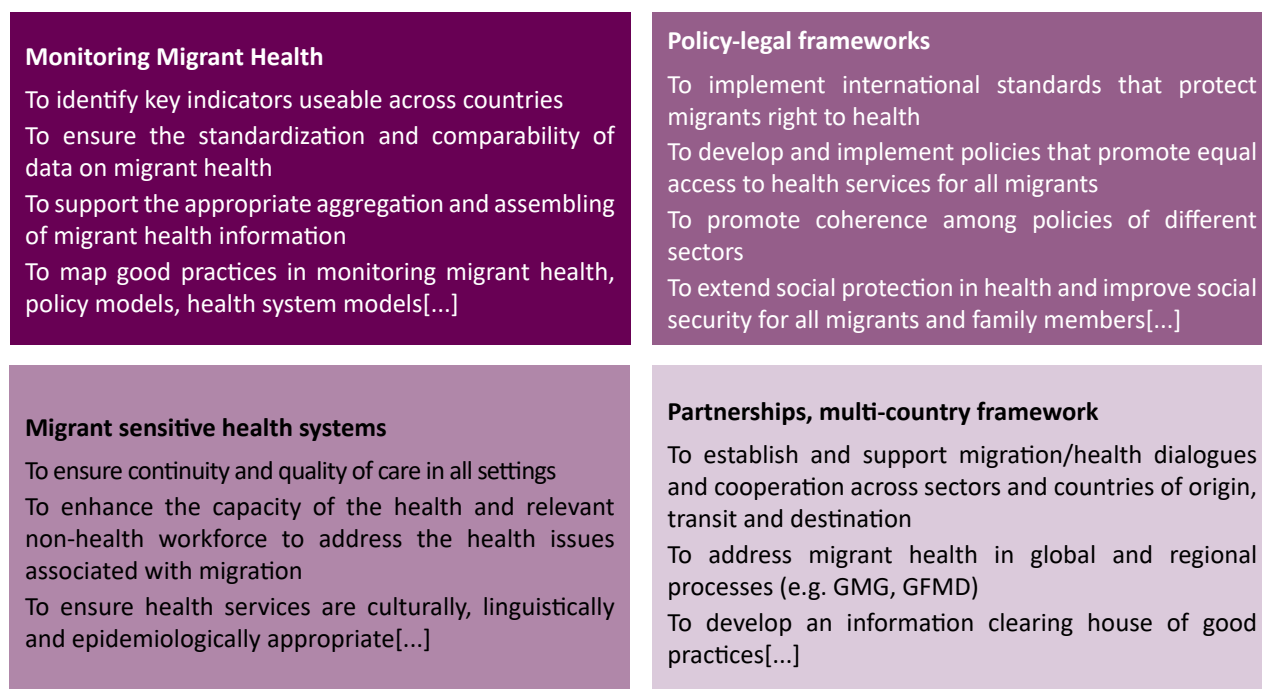
Addressing the health of migrants and mobile populations is therefore critical to global health security. Migrants are often forgotten in outbreak preparedness and response, such as those exposed to animals through working in forestry or livestock industries. Barriers to accessing public health systems can leave migrants untreated, undermining the comprehensive response required to keep all persons in a nation's territory healthy and safe. Providing easily accessible and quality health care to migrant workers and their families simultaneously protects the people of transit and receiving communities.

Migration health is thus a shared responsibility with public health impacts that extend beyond national boundaries. Regional and global stewardship requires policies and interventions that focus specifically on migrant and mobile populations. These include the harmonization of health-care strategies, the establishment of surveillance along mobility pathways, and the sharing of data and resources for efficient inter-government responses. Advancing a health security agenda linked to human mobility and migration requires global health diplomacy efforts and responsive foreign policy.

RESETTING THE AGENDA OF MIGRATION HEALTH

Acknowledging the essential relationship between good health and successful migration, WHO Member States adopted the 2008 World Health Assembly (WHA) Resolution on the health of migrants (WHA.61.17).⁸ The Resolution paved the way for the 1st Global Consultation on Migrant Health in Madrid in 2010, coorganized by IOM, WHO and the Government of Spain.⁹ The Consultation proposed an operational framework to guide implementation of the Resolution by Member States and stakeholders. It reaffirmed the need to adopt a rights-based, equity-driven, health system strengthening, and multisectoral approach. It identified four priority areas for action: i) developing systems and sharing good practices related to monitoring migrant health; ii) implementing supportive policy frameworks across sectors and across countries, including financial models; iii) creating migrant-sensitive, inclusive health systems supported by appropriate professional competencies; iv) organizing partnerships and mainstreaming migration health within relevant multidisciplinary frameworks (Figure 2).

FIGURE 2: MADRID OPERATIONAL FRAMEWORK: PRIORITIES¹⁰



The Operational Framework has since been used by several governments and health actors for health strategy and policy planning. Governments are increasingly faced with the challenge of integrating the health needs of migrants into national plans, policies and strategies across sectors, including responding to the call to ‘leave no one behind’ as stated in the 2030 Agenda for Sustainable Development.¹¹ Yet while awareness of the need to respond to the health of migrants is increasing, the necessary local and global technical and policy instruments are scarce. There are several factors that contribute to the uneven advancement of the migration health agenda, including:

- divergent views on migration and its governance related to definitions, recognized rights and entitlements linked to diverse typologies of migration;
- weak cooperation and priority-setting between health and other relevant sectors;
- a lack of consistent leadership and championing of the migration health agenda; compounded by the lack of a continuous venue for discussion and knowledge-sharing;
- an inadequate evidence base for policy and implementation;
- insufficient mobilization of resources for national and global responses, capacity development, and knowledge management.

At the 106th IOM Council in November 2015,¹² the urgency of advancing the unfinished agenda of migrant health was emphasized by IOM Member States through the organization of a High-level Panel on Migration, Human Mobility, and Global Health with the participation of WHO and supportive Member States. During the session, the President of the Democratic Socialist Republic of Sri Lanka, His Excellency Maithripala Sirisena, proposed a 2nd Global Consultation on Migrant Health, to be hosted by Sri Lanka. WHO has similarly revitalized its commitment to migrant health through actions at the regional level and the preparation of a new Framework and Action Plan as called for by the 140th WHO EB in January 2017.

OBJECTIVES OF THE 2ND GLOBAL CONSULTATION ON MIGRANT HEALTH

The 2nd Global Consultation on Migrant Health (GCMH) was held in Colombo, Sri Lanka on 21-23 February 2017, with the aim of resetting the agenda based on new trends and developments and relaunching a multisectoral partnership based on common understanding, unifying principles for coordinated actions, and renewed commitment amongst the 130 invited participants. These included representatives of Member States, partner agencies, civil society, private sector, and academia. The objective of the Consultation was to offer Member States and partners the opportunity to:

1. Share good practices, lessons learned, and research-based evidence on addressing the health needs of migrants, and to identify gaps, opportunities, and challenges;
2. Reach consensus on key policy strategies for action across regions on the health of migrants, reconciling acute large-scale displacement with long-term economic and disparity-driven structural migration, and to pave the way towards a possible roadmap of key future benchmarks;
3. Engage multisectoral partners at a policy level for a sustained international dialogue and future collaborative relationships.

Intended outcomes included:

1. A “Colombo Statement” that expresses governments’ intention to promote the health of migrants as a multisectoral global agenda, guided by a roadmap of future benchmarks.
2. Actionable policy objectives to guide the implementation of migration health in national, regional, and global health and migration agendas, including the Global Compact for Safe, Orderly and Regular Migration (GCM)¹³ and the Global Compact on Refugees (GCR),¹⁴ relevant WHO Action Plans, and other partner engagements.
3. Indicators and benchmarks to enhance the 2010 Madrid ‘Operational Framework’ with a progress monitoring framework.
4. A research agenda and network for the production and sharing of evidence to enhance migrant-inclusive policy development and practice.

Preparation for the meeting was supported by an international Scientific Committee; IOM and WHO staff at Headquarters, Regional, and Country (Sri Lanka) Offices; and several Planning Committees convened by the Government of Sri Lanka. Background papers were commissioned on the three key themes and action domains of the Consultation:

1. Health, Health Systems and Global Health: to promote preventive and curative health approaches that improve and mainstream the health of migrants and host communities through UHC, People-Centred and Integrated Health Services, Primary Health Care, Health System Strengthening, Public Health, and Health Security concepts.
2. Vulnerability and Resilience: to remove or mitigate determinants of vulnerability, and enhance the resilience of migrants, communities and systems, based on the Social Determinants of Health (SDH) model, as well as on principles of equity, social protection, and peace building.
3. Development: to ensure the inclusion of migration health within the scope of the 2030 Agenda for Sustainable Development, including the promotion of key indicators, migrant-disaggregated data, and benchmarks related to action on the SDGs at local, national and global levels, incorporating social protection, social and technological innovations and the engagement of civil society and the private sector.

CONSULTATION OVERVIEW

The three-day meeting opened with keynote addresses by the Consultation organizers. Plenary technical sessions addressed the three themes and action areas listed above, which were followed by breakout groups based on three cross-cutting outcomes for each theme: actionable policy objectives, a research agenda, and a progress monitoring framework. After exploring the themes, participants met again to consolidate the discussions into a proposal for each outcome. These proposals were presented to the group in plenary session.

A side event to discuss the formation of a research network was held on the margins of the Consultation. Throughout the Consultation there was also a ‘marketplace’ of posters and key research outcomes in the domain of migration health.

In the Way Forward session, IOM, WHO, and Office of the United Nations High Commissioner for Refugees (UNHCR) representatives addressed how the Consultation’s recommendations will contribute to upcoming processes such as the Global Compacts on Migration and Refugees, and activity by international health, migration and development organizations.

The final event was a High-Level Panel on the Colombo Statement, featuring an address from H.E. President Sirisena, and presentations by government representatives from various sectors and regions of the world. The Colombo Statement, which was endorsed by 19 ministers and government representatives, affirms commitments to

- “lead in mainstreaming the migration health agenda within key national, regional, and international fora, in domains such as migration and development, disease control, global health, health security, occupational safety, disaster risk-reduction, climate and environmental changes, and foreign policy, as guided by the 2030 Agenda for Sustainable Development” (point 3.3)

and

- “promote the principles and agreements reached at the 2nd Global Consultation on Migrant Health as inputs to future global initiatives, intergovernmental consultations, and Governing Bodies processes contributing to the formulation of a meaningful Global Compact for Safe, Orderly and Regular Migration and where responses share common elements to the Global Compact on Refugees in 2018 as appropriate” (point 3.4)

This report offers highlights of the presentations and discussions at the Consultation, and presents the proposals related to policy, monitoring and research. The annex has excerpts from the background papers (the full-text papers are available online at www.iom.int/migration-health/second-global-consultation), as well as the full text of the Colombo Statement.

NOTES

¹ UN General Assembly resolution 71/1, New York Declaration for Refugees and Migrants (13 September 2016), A/RES/71/1.

² International Organization for Migration, Global Migration Trends Factsheet 2015. Available from: http://publications.iom.int/system/files/global_migration_trends_2015_factsheet.pdf

³ United Nations Development Programme, *Human Development Report 2009 Overcoming barriers: Human mobility and development* (New York, Palgrave MacMillan, 2009). Available from: hdr.undp.org/en/content/human-development-report-2009.

⁴ Unless specified otherwise, for the purpose of this and other documents prepared in the context of the 2nd Global Consultation on Migrant Health, the term “migrant” is understood as an umbrella term covering all the persons who move away from their place of habitual residence, within the State or across an international border, regardless of the person’s legal status, of the causes of the movement and of whether the movement is voluntary or not.

⁵ Ratha, D. S. Plaza and E. Dervisevic, *Migrant and Remittances Factbook 2016*, 3rd Edition. (Geneva, Global Knowledge Partnership on Migration and Development - World Bank Group, 2016). Available from: <http://www.knomad.org/publication/migration-and-remittances-factbook-2016>. (Cited 7 Feb. 2017).

⁶ Based on the Dalhgren and Whitehead’s 2007 model.

⁷ www.who.int/universal_health_coverage/en/

⁸ World Health Organization. (2008) 61st World Health Assembly, Resolution WHA61.17, Health of Migrants. Available from: http://apps.who.int/iris/bitstream/10665/23533/1/A61_R17-en.pdf. This is also included in the Annex of this Report.

⁹ World Health Organization, *Health of migrants: the way forward - report of a global consultation*. (Geneva, World Health Organization, 2010). Available from: <http://publications.iom.int/books/health-migrants-way-forward-report-global-consultation>.

¹⁰ Ibid.

¹¹ UN General Assembly resolution 70/1, Transforming our world: the 2030 Agenda for Sustainable Development (18 September 2015), A/RES/70/1.

¹² International Organization for Migration. Advancing the Unfinished Agenda of Migrant Health for the Benefit of All, 106th Session of IOM Council. (Geneva, International Organization for Migration, 2015). Available from: <https://governingbodies.iom.int/system/files/en/council/106/C-106-INF-15-Rev1-Migration-Health.pdf>

¹³ United Nations General Assembly, A/RES/71/280 of 6 April 2017 (Modalities for the intergovernmental negotiations of the global compact for safe, orderly and regular migration). Available from: https://www.iom.int/sites/default/files/our_work/ODG/GCM/A-71_280-E.pdf

¹⁴ United Nations General Assembly, Resolution A/RES/71/1 of 13 September (New York Declaration for Refugees and Migrants Annex I and II). Available from: www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_71_1.pdf

PART I

OPENING THE CONSULTATION

Participants to the Consultation were welcomed by a traditional candle-lighting ceremony and keynote addresses by the heads of the three sponsoring entities: the Government of Sri Lanka, IOM, and WHO.

Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine for Sri Lanka, opened the Consultation by placing Sri Lanka's interest and leadership on migration health in the larger context of the beneficial influences of migration throughout history. When Resolution WHA.61.17 was adopted at the 61st WHA in 2008, Sri Lanka worked with IOM to establish a Migration Health Secretariat in the country's Ministry of Health. This led a migrant health policy development process that was inclusive, evidence-based, multistakeholder, and multisectoral. Among many outstanding accomplishments, Senaratne highlighted the importance of accountability both internally and in the larger global community, through report cards on the implementation of Resolution WHA.61.17 presented at two WHAs. "We soon understood that as much as local advocacy is important, global advocacy too is important to implement migration health policy," he said. He described Sri Lanka's leadership in promoting the inclusion of health in the Colombo Process¹ and regional WHO processes.

"Migration is inevitable, necessary and desirable", said William L. Swing, Director General, IOM. "It is a reality to be managed and not a problem to be solved." The volume of current migration underscores the importance of addressing the health of migrants as a part of the global health-for-all agenda. Despite this reality, large groups of migrants remain at high risk of social exclusion, discrimination and exploitation and many still lack access to adequate health services or must pay higher prices for them. He echoed the importance of implementing migrant-sensitive policies that are aligned with the person-centred UHC principles, and the need for action grounded in partnerships, health diplomacy, and leadership across all sectors and borders.

Margaret Chan, Director General, WHO, acknowledged the challenges faced in making progress on migration health and called on participants to make a meaningful contribution to this effort. “The problems are complex. They are context specific, and they have a strong political dimension. The need now is for concrete, practical, evidence-based guidance,” she said. The 2016 NYD sends a strong signal that the world cares about refugees and migrants and should share responsibility for their welfare. She noted the concern that WHO and its Member States have for the health needs of migrants, and described the WHO EB decision,² which calls for the establishment of a framework for action and guidance that will roll out over the next two years.

SETTING THE SCENE

Davide Mosca, Director of the IOM Migration Health Division, and Kanokporn Kaojaroen, WHO Migration and Health Officer, offered context for the Consultation’s deliberations with a comprehensive review of current migration trends, the interrelationship of health and migration in global agenda setting, and the opportunities for the Consultation to inform global actions. The ‘setting the scene session’ took stock of recent developments on both health and migration, and presented a new conceptual model used in the planning of the Consultation, in an attempt to ‘reset the migrant health agenda’ along common parameters and understandings, multisectoral approaches, and current global goals.

TABLE 1: GLOBAL ESTIMATES OF MIGRANT POPULATIONS (as of end of 2015)³

Category of migrant	Population estimates
International migrants	244 million
Internal migrants	740 million ^a
Internally displaced persons	40.8 million
Refugees	21.3 million
Asylum seekers	3.2 million
Trafficked persons	44,462 ^b
Displaced by natural disasters	19.2 million
Migrant workers (international)	150 million ^c

In the last two decades, health has gained visibility and status in global agenda setting due to at least three interrelated factors that require global cooperation and partnership for the achievement of results of mutual interest.⁴ These include security (in the context of global disease threats); economics (related to the economic impacts of health risks and the growing global marketplace for health goods); and social justice (which sees health as a human right, an essential component of development and social stability, affected by a variety of social determinants). Migrant health touches upon all three factors, yet despite the sizeable volume of people involved, the agenda has not gained momentum as a global health agenda nor found consistent traction in either migration or development debates. Historically, attention to migration health issues has focused on diseases and border control. A shift towards equity and inclusiveness for migrants has not found large and sustained support for a variety of political, economic, and societal reasons. One can argue that this represents a contradiction with the current discourse in health that emphasizes people-centred approaches, equity and universalism, with a declared aim of leaving no-one behind in the development agenda. Migrants, particularly the low skilled, or those in an irregular status, remain a forgotten, neglected, or purposely excluded population cluster. In many cases this is due to ‘political sensitivities’, or a perception of financial burden that neglects to consider the positive economic and societal contributions of migrants. This reality confirms that solutions cannot be found in the health sector alone, but require rational, evidence-based migration governance and inter-sectoral partnership.

^a According to 2009 UNDP estimates.

^b In 2014, according to the US State Department’s annual Trafficking in Persons report.

^c According to 2013 ILO estimates.

MILESTONES

Since the 2008 WHA Resolution on Health of Migrants and the 1st GCMH in 2010, WHO, IOM and some supportive countries have worked together to promote the health of migrants in a variety of health and development agendas. These include the WHO post-2015 TB Global Strategy;⁵ the WHO Global Technical Strategy and Budget for Malaria 2016-2030,⁶ where explicit reference to migrants and Resolution WHA.61.17 is made; and the post-Ebola revision and implementation of the International Health Regulations (2005), which recognizes that attention must be given to human mobility in cross-country border areas and along mobility pathways.

These actions, however, confirm a general tendency to maintain a ‘disease-control approach’ to migration health issues. Migration has largely been unrecognized in other important frameworks for health equity and inclusiveness, such as the SDH agenda (2008-2011), the framework on integrated people-centred health services (2015),⁷ and the agenda to promote UHC within the SDGs (2016), all of which address issues of equity on the basis of nationality and citizenship. These critical omissions reveal that migrants’ access to health services is often determined by their legal status and the regulations, norms and practices of sectors other than health. More convincing evidence and rationales are necessary to reverse this trend. Recognition was given for the contributions of several countries that have systematically engaged in promoting migration health in multisectoral, cross-regional and international debates on diplomacy and partnership, like the Colombo Process, the Puebla Process,⁸ the Foreign Policy and Global Health framework,⁹ and the Global Forum on Migration and Development,¹⁰ though with varying degrees of success to date. Efforts need to be intensified to achieve policy changes that will improve migrants’ health, and academia, policy institutions, and civil society have an important role to play.

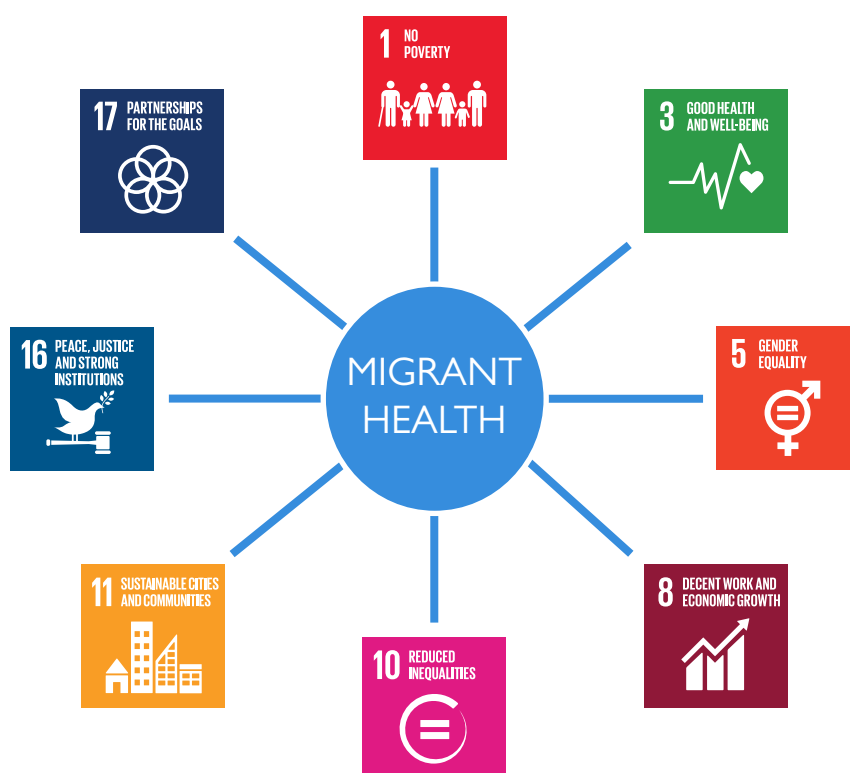
The recent refugee and migration crisis in the Mediterranean area, with large and desperate movements associated with untold suffering and the loss of thousands of lives, has focused attention on the theme of migration and revealed a deeply split political discourse. Despite the emergency context of this crisis, it has aggravated divisions related to differentiated legal status and the categorization of migrants along varied levels of protections. By focusing on the crisis and humanitarian context, governments ignore the long-term aspect of migration trends that require forward-thinking policies and actions. Long-term displacement means increased numbers of people hosted within local communities rather than formal refugees camps. Thus temporary, parallel systems of assistance are not sustainable or cost-effective, suggesting the need for mechanisms that focus on the nexus of humanitarian and development needs that strengthen local systems and promote the self-reliance of refugees and migrants.

While ‘large movements’ addressed by the NYD is understood to reflect ‘a social and geographical context, the capacity of a receiving State to respond, and the impact of a movement that is sudden or prolonged,’ the reality is that all migration involves mixed flows of people who move for different reasons using similar routes. The vast majority of migrants are regular workers, students, traders, and other mobile groups, with different levels of vulnerability, resiliency, and access to care.

Partially in response to these trends, the WHO EB addressed the health of migrants and refugees in January 2017. Regional resolutions have been adopted by WHO and Pan American Health Organization (PAHO) Regional Committees of the Americas¹¹ and Europe, and the European Region has developed a Strategy and Action Plan for refugee and migrant health.¹² A *High-level Panel on Migration, Human Mobility and Global Health* was organized at the 2015 106th IOM Council,¹³ and the Council document¹⁴ *Advancing the Unfinished Agenda of Migrant Health for the Benefit of All*, explores important challenges, programmatic accomplishments, lessons learned, and good practices in the domain over several decades. Moreover, during the 69th WHA in 2016, a technical briefing session was dedicated to the topic of ‘*Migration and Health*’ and WHO Member States debated and took note of the Secretariat report on ‘*Promoting the Health of Migrants*’.¹⁵

A key opportunity for integrating the health of migrants into a prominent multiactor global agenda is presented by the 2030 Development Agenda and its 17 SDGs. Based on the principle of “leave no one behind,” many SDG goals and targets offer opportunities to promote migrant health, both directly and indirectly, across sectoral lines and with the engagement of a larger constituency of actors and stakeholders. Starting with the critical goal of UHC, the health targets outlined in SDG 3 address a broad range of issues, from communicable diseases to mental health. Other SDG targets address resilience to economic, social and environmental disasters, orderly and safe migration, global multistakeholder partnerships, child and gender based violence, forced labour and trafficking, peace and society building, education, and social protection schemes that should be examined through the broader lens of social determinants that impact migrant health and well-being (Figure 3).

FIGURE 3: TRACING MIGRANT HEALTH IN THE SDGs¹⁶



The 2016 NYD, launching the Global Compacts on Migration and Refugees, is another milestone in the process of strengthening the global governance of migration. A side event on ‘*Health in the context of migration and forced displacement*’ was organized by IOM, WHO and UNHCR in the margins of the UN General Assembly Summit for Refugees and Migrants.¹⁷ At this high-level meeting, the NYD was signed, within which health was addressed only in a fragmented fashion in the final document. Presentations on how to raise the position of health in the development of the Global Compacts were given in the Way Forward session of this Consultation.

The following table gives an indicative picture of the migration and health milestones leading up to the 2nd GCMH, as well as upcoming global processes.

Despite these accomplishments, progress on the migration health agenda is challenged by the increasingly negative social and political discourse about migrants and refugees. There has been a rise of anti-migrant sentiment and restrictive policies, accompanied by decreasing public confidence in governments’ ability to manage migration. The progress made on initiatives like the SDGs and the NYD appears to be a response to the scale of the tragic events coming from refugee crises rather than the recognition of the positive contributions made by migrants for inclusive growth and sustainable development in countries of origin, transit, and destination. It is essential to see migrants as ‘part of the solution and not part of the problem’ and to support their health and well-being as a precondition to their powerful social and economic contributions.

TABLE 2: ROADMAP OF SELECTED MIGRATION AND HEALTH DIALOGUES AND PROCESSES

2008	61st WHA: <i>Adoption of the Resolution on the Health of Migrants (WHA.61.17)</i>
2010	1st Global Consultation on Migrant Health: <i>Operational Framework based on Resolution WHA.61.17</i>
2015	WHO High-level Meeting on Refugee and Migrant Health: <i>Stepping up action on refugee and migrant health, Towards a WHO European framework for collaborative action (November)</i>
	106th IOM Council: <i>2nd Global Consultation on Migrant Health is announced (November)</i>
2016	69th WHA: <i>Technical Briefing on Migration and Health and Agenda item on Promoting the health of migrants (May)</i>
	71st UN General Assembly Summit on Refugees and Migrants: <i>Side event on Health in the context of migration and forced displacement, organized by IOM/WHO/UNHCR organized and the Governments of Sri Lanka and Italy (September)</i>
	Recommendations on access to health services for migrants in an irregular situation: an expert consensus (October) ¹⁸
2017	140th WHO EB Decision on promoting the health of migrants and refugees (January)
	2nd Global Consultation on Migrant Health (February)
	70th WHA: <i>Framework of priorities and guiding principles, Resolution on Promoting the health of refugees and migrants and Agenda item on Promoting the health of refugees and migrants (May)</i>
2018	Global Compact for Safe, Orderly and Regular Migration and the Global Compact on Refugees to be adopted, 142 nd WHO EB, 71 st WHA and 109 th IOM Council
2019	WHO Draft global action plan on the health of refugees and migrants, to be considered for adoption by the 72nd WHA
2030	Working towards the SDGs, achieving UHC for all, including migrants, regardless of migratory status

CALL FOR A UNIFYING AGENDA

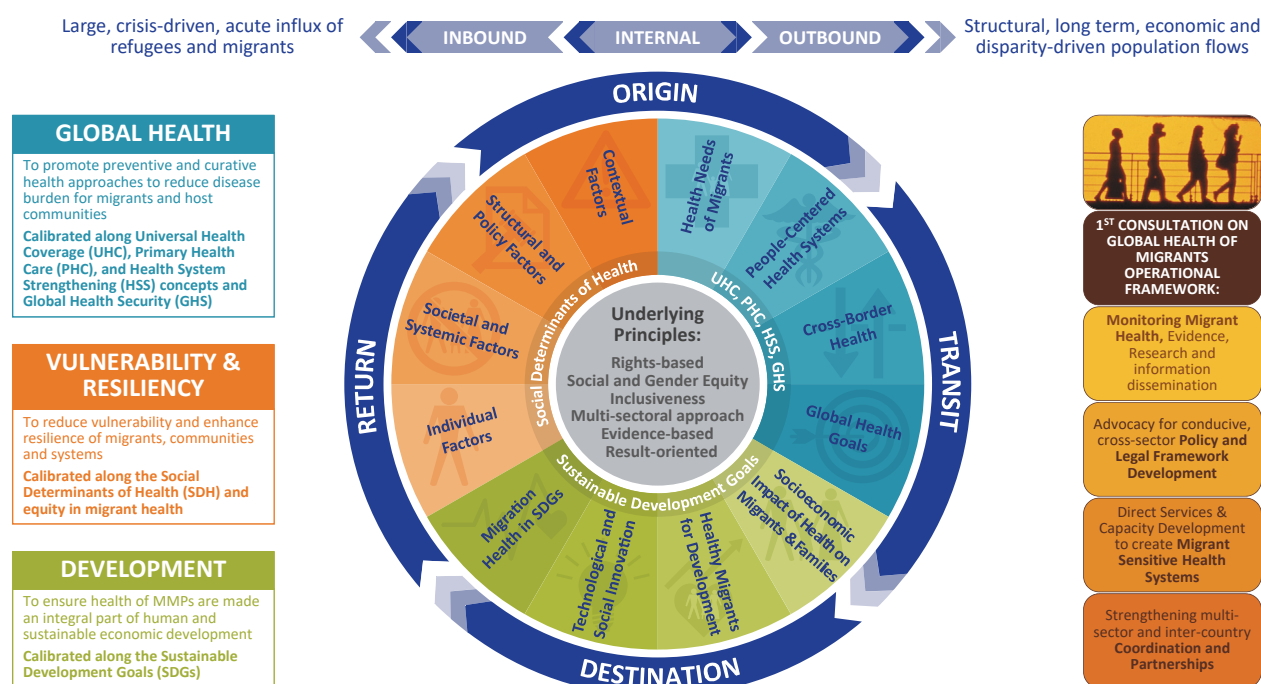
The organizers called for the Consultation to work towards a comprehensive, people-centred “unifying agenda” that reconciles acute, crisis-driven, large-scale displacement, with long-term, economic and disparity-driven structural migration, paving the way towards a common roadmap of key benchmarks and accountability. A unifying agenda that puts people with their health needs at the centre of attention, along the mobility pathways at origin, transit, destination and return, should involve multiple stakeholders. Engaging actors beyond the health sector can broaden the scope of actionable policy objectives, leading to improvements that reflect the multidimensional nature of migration as it affects migrants, their families and communities.

This agenda for conceptualizing action on migrant health presents the key themes of the Consultation -- Health, Health Systems and Global Health; Vulnerability and Resilience; and Development – as interlinked domains for action in the context of the migration cycle of origin, transit, destination and return. This is juxtaposed with the operational framework from the 1st GCMH that proposed action through policy development, migrant-sensitive health services, monitoring, and partnerships (Figure 4).

Each of the themes of the 2nd GCMH is further described in terms of specific areas for action from the demand to the supply side. For Health, Health Systems and Global Health, action can be taken to address the health needs of migrants within the changing contexts and priorities of disease control, access to services through UHC, developing people-centred health systems management of cross-border health, and advancing migrant health as a global health goal. Addressing Vulnerability and Resilience, which is based on the SDH model, requires responding to individual aspects of vulnerability, societal and system factors,

structural and policy forces, and contextual elements such as security, economics, and environmental concerns. In this discussion, vulnerability is defined as the health risks and pathologies migrants and refugees face resulting not from their own characteristics but from social, economic, environmental and experiential impacts, many of which must be resolved by legal, policy and practical measures. Migration health in a Development context involves looking at the socio-economic impact of health on migrants and families, the contributions of healthy migrants to development, the need for social protection, the role of technological and social innovation, and the place of migrant health in the SDGs at large. The visual models for these themes are shown in their respective sections in Part 2.

FIGURE 4: MIGRATION HEALTH: A UNIFYING AGENDA



Principles for moving forward include the right to health for all, regardless of status; universal health coverage and equitable access to quality; comprehensive, people-centred health care that recognizes the social determinants of health; and shared responsibility between all countries to develop policy and financing mechanisms that are harmonized and equitable. Achieving these goals will require an inclusive health policy and planning process, integrated into a larger whole-of-government and whole-of-society response; policy, regulatory, legal, and institutional arrangements supported by health monitoring and an evidence-based health information system; identification and dissemination of good practices and capacity-building; and a global coordination mechanism supported by partnerships and multicountry, multisectoral collaborations. All this would be impossible without the committed stewardship of leading agencies and parties and the international leadership and diplomacy of countries willing to champion a Global Migration Health initiative across multiple platforms of multilateral collaboration. Country leadership, the identification of multiple stakeholders, and benchmarks for monitoring advancement were the missing elements of Resolution WHA.61.17 and the operational framework of the 1st GCMH, and are intended to be addressed by this 2nd GCMH.

In the discussion, participants examined the idea of considering migrants and refugees together, given the unique protections afforded to refugees. Mosca responded that consistently with the 'health for all' imperative, the health sector should prioritize the individual beyond the definition of status to respond to the commonalities between the two groups, despite differentiated entitlements to protection. The group was admonished that frameworks and principles are instruments for common understanding and concerted actions but that the focus should be on developing actionable measures across sectors, phases of migration, and geographical areas to improve health of migrants. Participants deliberated how to transform the social and political climate towards better acceptance of migrants and their integration in society.

NOTES

- ¹ www.colomboproccess.org
- ² World Health Organization. 140th Executive Board, Decision EB140(9), Promoting the health of refugees and migrants (2017) Available from: [http://apps.who.int/gb/ebwha/pdf_files/EB140/B140\(9\)-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB140/B140(9)-en.pdf)
- ³ International Organization for Migration, Global Migration Trends Factsheet 2015. Available from: http://publications.iom.int/system/files/global_migration_trends_2015_factsheet.pdf
- ⁴ Kickbusch, I. Global Health Diplomacy, *Revista Eletrônica de Comunicação, Informação e Inovação em Saúde - RECIIS*, 4(1): 01-09 2010.
- ⁵ www.who.int/tb/post2015_strategy/en/
- ⁶ World Health Organization. Global Technical Strategy for Malaria, 2016-2030. 2015. Available from: http://apps.who.int/iris/bitstream/10665/176712/1/9789241564991_eng.pdf?ua=1&ua=1
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PART 2

THEMATIC SESSIONS

The main part of the Consultation features three thematic sessions that correspond to the three background papers on Health, Health Systems, and Global Health, Vulnerability and Resilience, and Development. Each session featured a presentation of the paper, responses from panellists, and breakout groups to consider the implications for the development of policy objectives, a monitoring framework, and a research agenda.

THEME 1: HEALTH, HEALTH SYSTEMS, AND GLOBAL HEALTH

The plenary session on Health, Health Systems, and Global Health featured the paper of Brian Gushulak, of Migration Health Consultants (Canada), which addresses the changing health needs of people on the move, how migration health fits into public health principles, current health strategies, and upcoming global activity on migration and refugee needs. It assesses major sources of evidence, identifies further data needs, and describes potential partnerships to advance progress. The paper raised the importance of cross-border continuity of care, harmonized protocols, cooperation, and sharing of data on the health needs of migrants; the impact of the economic downturn that has led to cuts in public services, including cultural mediation and interpretation; and the negative health impacts of more restrictive migration policies that lead to increased irregular migration. Michael Knipper, of the Institute of the History of Medicine of the University of Giessen (Germany), offered an introduction to the topic by addressing three issues: the health of migrants as a rights-based proposition, changing conceptualizations of migrant health, and the economics of migrant inclusion in health provision. He started by contrasting the 'coercive' (legal accountability) approach to human rights with the constructive approach that encourages addressing dignity, equity and anti-discrimination in health and other sectors. He noted the perceptions of migrants in health care have varied from carriers of disease, to vulnerable group, to populations in crisis that require a humanitarian approach. He proposed that we consider the value of creating integrative health systems for all residents of a

region or country: excluding migrants from regular health services and creating parallel health structures not only harms people but also creates considerable additional costs. Funding migrant inclusion in mainstream health systems should be viewed as an investment with long-term economic benefits for all.

The Global Health paper also contained a review by David Ingleby of policies that have laid the foundation for the Migrant Integration Policy Index (MIPEX)¹ Health Strand. Designed to supplement the existing seven strands of the MIPEX, which monitors policies affecting migrant integration in 38 countries, the Health Strand questionnaire measures the equitability of policies relating to four issues: migrants' entitlements to health services; the accessibility of health services for migrants; responsiveness to migrants' needs; and measures to achieve change.

Cost Analyses of Health Services for Migrants

The cost-benefit argument was further elaborated by Ursula Trummer, Center for Health and Migration (Austria), who gave the results of the "Cost analysis of health-care provision for migrants and ethnic minorities" study, conducted in collaboration with IOM and four European Union (EU) member states using hypothetical cases, primary data, register data, desk research and expert opinion.² Results from the study demonstrated that in the conditions and settings studied, timely treatment in a primary health-care setting is always cost-saving when compared to treatment in a hospital setting. This is true for the direct medical and non-medical costs, as well as the indirect costs.

Integrated Approach for Refugee Health Services

Herve Isambert of UNHCR stated that the agency is moving away from a stand-alone refugee health service model, funded by UNHCR and implemented by partners that work in parallel to Ministry of Health programmes, to develop a more integrated approach that builds on national service delivery systems. UNHCR calls on WHO to work with Member States to change laws and policies to create refugee and migrant sensitive health systems. They also recommend that donor countries and development banks respond early in humanitarian situations with flexible financing mechanisms to support both the humanitarian response and the needs of refugee hosting countries.

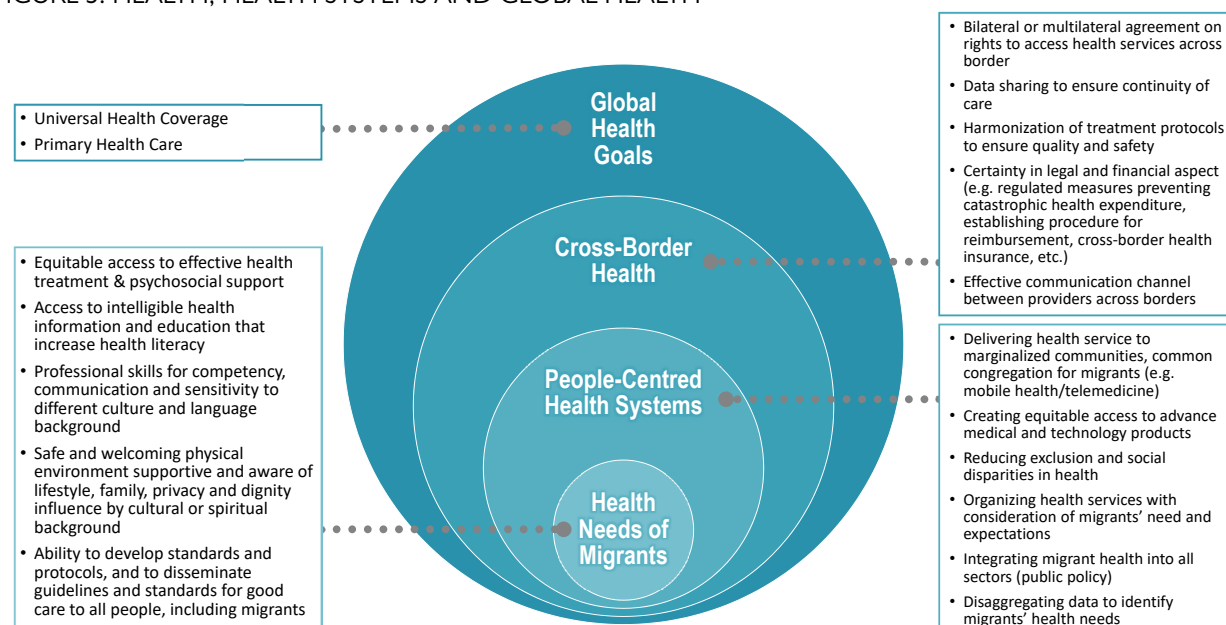
Universal Health Coverage Promoted, But Not Realized for Migrants

Taking up the theme of integrated rather than parallel systems of health care for migrants, Ibrahim Abubakar, of the Institute for Global Health and the Lancet Commission on Migration and Health (UK), acknowledged the necessity of adapting services for migrant-specific needs and responding to the unique needs of refugees. He expressed frustration with the contradictory stance of many countries that support universal health coverage in other countries but exclude migrants and refugees from equal access to services in their own territory. He stressed the need to emphasize the positive contribution that migrants make to local communities, and to challenge the incorrect perception that they compete for local resources.

Global Health Security

Lisa Rotz, of the Centers for Disease Control and Prevention (US) described how the Global Health Security Agenda (GHSa), led by countries, international organizations, and civil society, aims to promote global health security as an international priority and encourage full implementation of the International Health Regulations. GHSa integrates a migration component because mobility can have major impacts on public health and plays a role in spreading communicable diseases. The GHSa supports migrant health and migration by improving health systems and public health capacity to detect and respond to outbreaks.

FIGURE 5: HEALTH, HEALTH SYSTEMS AND GLOBAL HEALTH



BREAKOUT SESSIONS

A. Actionable Policy Objectives

This breakout group affirmed many of the themes expressed in the plenary panel, highlighting the need for migrant inclusion in UHC as a central tenet for the advancement of the migrant health agenda, with equal access to services and social protection floors for all migrants, as reflected in the International Labour Organization (ILO) and UN recommendations.

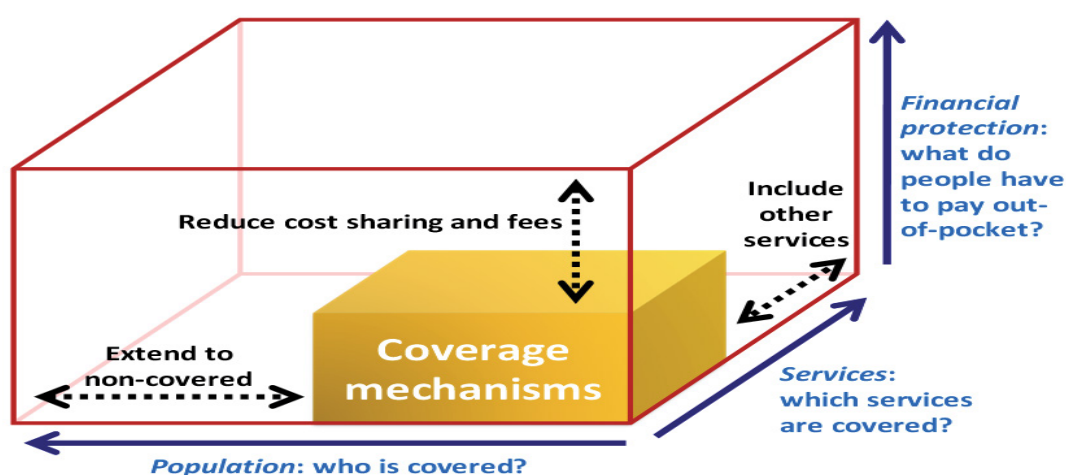
It was acknowledged that specific measures are needed to reach migrant and refugee populations that are socially or physically isolated including addressing language barriers and cultural differences and training providers in migrant-sensitive care practices. Participants called for mainstreaming migration and health in governance, by developing capacity within ministries, governments and supra-national institutions. Whole-of-government and whole-of-society approaches were deemed essential to address the multisectoral nature of migration and health. Concern was expressed that the determinants of health for migrants, refugees and internally displaced persons (IDPs) could be more substantially identified and addressed. This would involve developing indicators, measures, and a progress-monitoring framework. Several interventions insisted on the need to explicitly address xenophobia and toxic narratives around migration and the impact they have on health systems' responses.

Situations in Africa, Asia and inter-regionally demonstrated the need to ensure continuity of care across borders and throughout migration processes as well as address discrepancies in health coverage between origin and destination countries. Continuous dialogue and harmonization of protocols and monitoring systems should be enhanced within regional economic communities and other regional and interregional processes to strengthen cooperation and common intent. Other observations stressed that internal migrants (especially IDPs), returnees, and families left-behind, need to be included in migration and health approaches. Greater migrant representation and participation in these processes, was strongly highlighted, urging deliberate support for the engagement of migrant organizations and advocacy groups. Several comments underlined that financing is critical, insisting on the obligation of states and others to foster healthy conditions and health access. Concern was raised about finding ways to address inter-policy contradictions, such as national policy approaches that explicitly restrict and/or discourage access to health services by linking with immigration enforcement. Finally, it was acknowledged that actionable policy objectives and recommendations should be adapted to different contexts of migration. Addressing the needs of migrants from low income countries residing in middle income countries can be included in global health agendas and financing mechanisms such as those related to tuberculosis (TB), malaria, noncommunicable diseases, mother and child health, and others.

B. Progress Monitoring Framework

The monitoring group called for the harmonization of measures to monitor migrant health across countries and across the migration continuum. The UHC cube that reflects three dimensions of coverage – population coverage, service coverage, and financial coverage or financial protection – is a good instrument to monitor migrant coverage in health systems.

FIGURE 6: THE THREE DIMENSIONS (POLICY CHANGES) OF UNIVERSAL HEALTH COVERAGE³



The underlying principle should be monitoring for end results with respect to health status, health services access and utilization; health systems' responsiveness to migrant needs; and financial protection mechanisms. Gaps in relevant data and the quality of data collected must be addressed, ideally through 'globally useable indicators' and the inclusion of migrant variables in national statistics and relevant census surveys. The breakout group advocated for national and global databases based on the sharing of good practices by those already engaged in these activities. Civil society and migrant representatives should be involved in developing relevant and workable processes, and participation should be engaged at all levels and across sectors. The group cautioned that monitoring practices should not be used for discrimination, exclusion, or deportation. They highlighted the challenge of implementing appropriate monitoring policies when there is no legal framework, funding, or political will.

C. Research Agenda

The research breakout group addressed a wide range of questions on the preconditions for and benefits of research on migration health. They discussed how to document and quantify the costs of not responding to the health needs of migrants, from impacts on the individual to the broader social and economic costs. They outlined strategies to develop research-based information that educates and is persuasive to policymakers and the general public. These include adapting existing data collection and reporting mechanisms to incorporate migration and health elements; building upon IOM, WHO, MIPEX, and other migration profiling mechanisms; working at the local level, national and regional levels to analyse innovative interventions; and using research methods and dissemination strategies that empower affected populations and communities. Essential components of developing national research agendas include mapping migrant typologies and health patterns, legal frameworks, service provision and health protection, as well as identifying available data sources and current and potential research assets. At all levels, research agendas need to be supported by common definitions, migrant-specific ethical guidelines, research capacity development, and adequate, long-term funding commitments.

DISCUSSION: COMMON THEMES

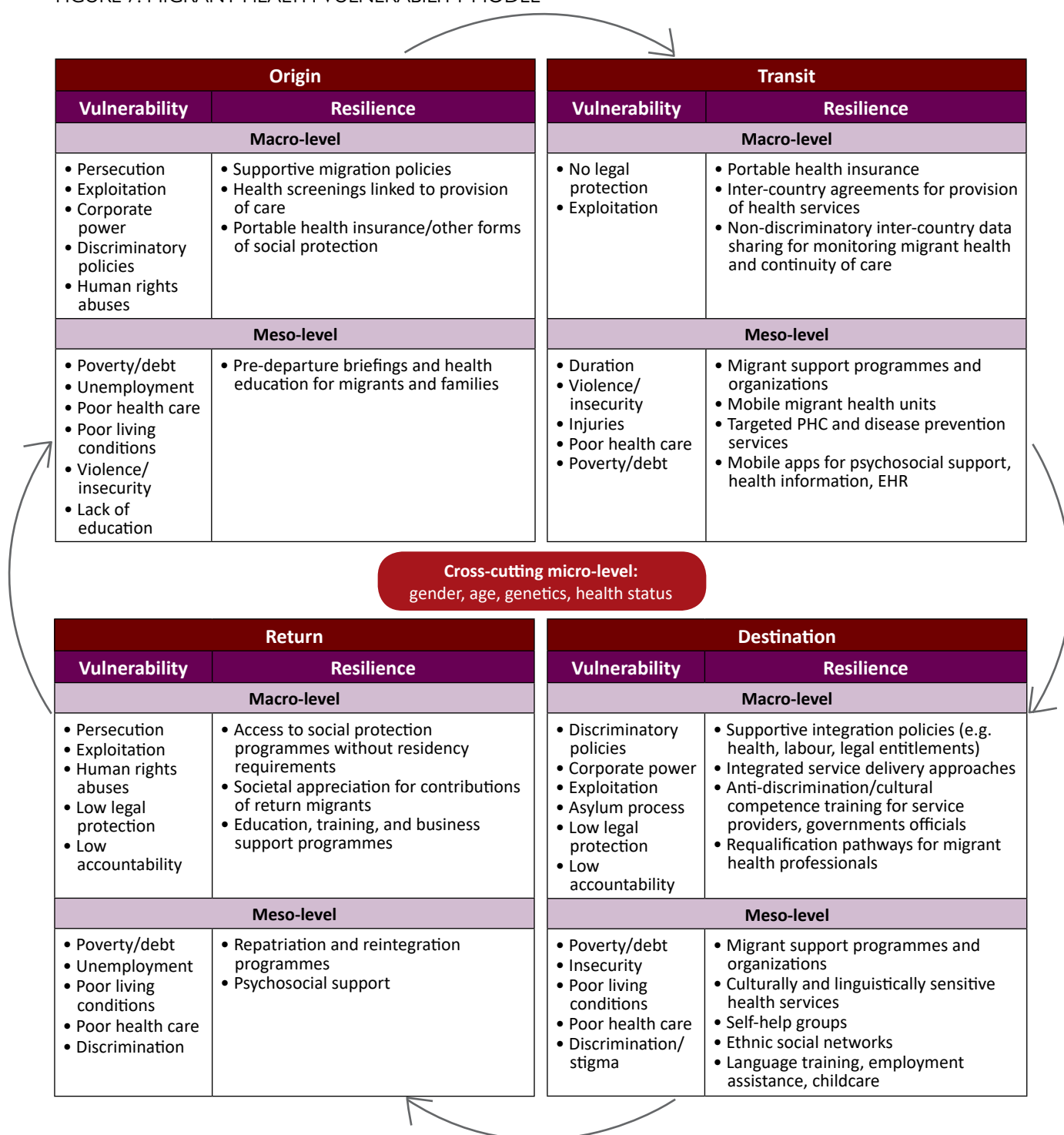
Daniel Lopez Acuña, of the Andalusian School of Public Health (Spain) summarized the key themes that emerged from the breakout discussion groups. In addition to the issues raised above, he noted the increasingly blurred lines between migrants and refugees in terms of their administrative status and where they live. He sharpened the points related to health security, addressing the human rights considerations and access to services through improved social protection. Reinforcing the need for cultural and linguistic adaptation of services to improve accessibility (and training for health staff to deliver this), he also called

for systems to assure continuity of care over time and throughout the system of health services. His report emphasized the need to end the stigmatization of migrants with respect to unjustified mandatory screenings.

THEME 2: VULNERABILITY AND RESILIENCE

Reducing vulnerability and enhancing the resilience of migrants, their communities, and the health systems that serve them, requires action on the social determinants of health from a multisectoral approach. It implies inclusive and participatory processes to shape programmes, policies and monitoring mechanisms. Chesmal Siriwardhana of the London School for Hygiene and Tropical Medicine presented the background paper on vulnerability and resilience. He discussed a conceptual framework – the Migrant Health Vulnerability Model (Figure 7) – that integrates SDH with the various stages of migration.

FIGURE 7: MIGRANT HEALTH VULNERABILITY MODEL



It offers an approach that transcends the traditional disease management strategies common to many migrant health programmes. Counteracting the impact of vulnerability are factors that increase resilience, defined as the ability of individuals and communities to recover from shocks and overcome adversity. Resilience is a dynamic phenomenon that includes individual capacities, social support, and positive environmental influences. It can be influenced by social, economic, political, health, and cultural factors at the individual, community and societal levels, and thus requires responses at all those levels and across sectors.

A separate analysis by Anne-Linde Joki (Migration Policy Group (MPG)) and Thomas Huddleston (MPG) of nine European studies suggests that migrants' health may be improved by fostering an integrative receiving context and providing the preconditions for social integration through equal access to health care, labour markets, education, political participation, and judicial systems. The empirical studies reviewed reinforce the previously established link between perceived discrimination and health outcomes, particularly for migrants. For example, the difference in levels of depression reported by migrants and non-migrants was significantly smaller in countries with more advanced anti-discrimination policies.

From Crisis Related Vulnerabilities to Long Term Health Determinants

The panellists addressed various aspects of vulnerability and resilience in their presentations and several overarching themes emerged. The vulnerability and resilience model highlights a necessary paradigm shift from crisis-related migration vulnerabilities to include those that emerge during the migration process and develop over time from exposure to social, environmental, and lifestyle conditions in countries of transit and destination. All panellists emphasized that facilitating inclusion and empowerment of migrants through information and culturally sensitive approaches can support individual and community resilience, and this extends to active engagement in the planning and execution of migrant health interventions and strategies.

Vulnerability of Undocumented Migrants

Chan Chee Khoo, of the University of Malaya, addressed the vulnerability of undocumented migrants, who lack the social protections given to migrant workers and are often difficult to track during disease outbreaks. Migrants are often perceived as freeloaders of public services, therefore a better understanding of their contributions to the country's economy is needed, with corresponding attention to how they can financially participate in health and social security systems.

Empowering Migrants/ Challenges of Labour Migration

Moises Uamusse from the Southern Africa Miners Association agreed that vulnerability often depends on how someone becomes a migrant. In the mining context, many of the regulations related to safe workplace conditions and cooperative health agreements are not implemented due to lack of political will on the part of management and government. As a result, he said, resilience does not take hold because people do not trust workplace or health programmes and give up their desire to seek services and protections. Information about aspects of everyday life and resources for integration is key to empowering migrants and assuring their place in the communities where they live.

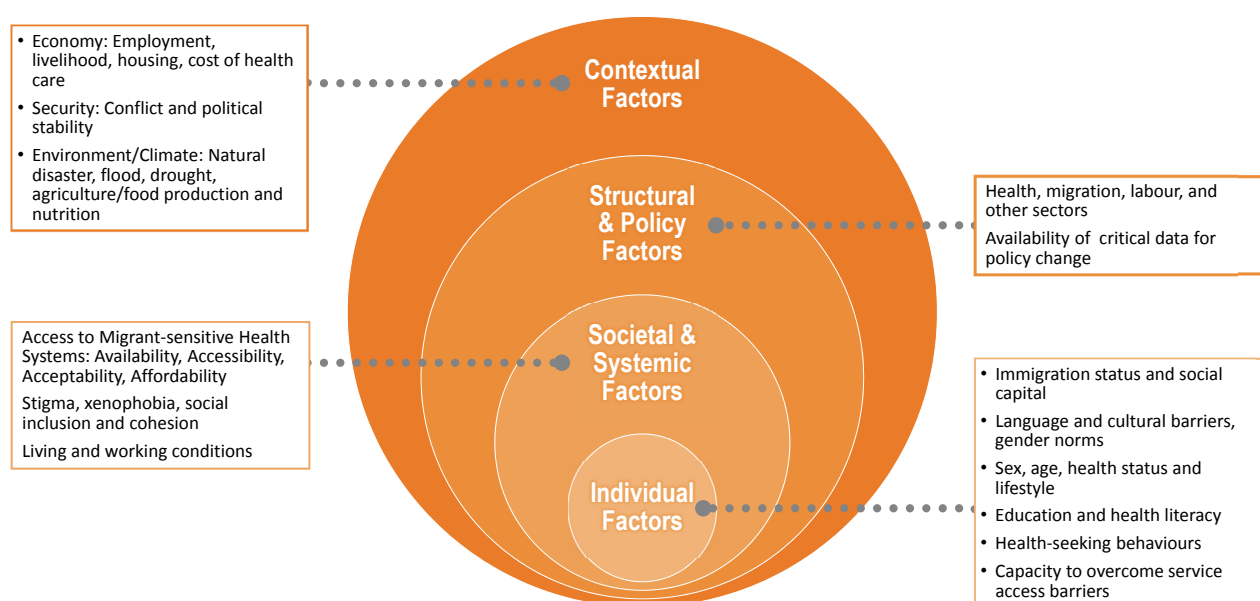
Multisectoral and Multicountry Model of Thailand

Thailand addresses the vulnerabilities of migrants by raising migrant issues at the national policy level; expanding health coverage for documented and undocumented migrants; strengthening primary care, prevention, and disease screening services; and involving migrants in planning and implementation. Phusit Prakongsai of the Thai Ministry of Health noted the importance of multisectoral and multicountry collaboration in Thailand's success and addressed the need to shift public perceptions about migrants.

Responses to Large Migration Flows in Europe

The recent wave of refugees and migrants into Europe has exposed many vulnerabilities in the social, structural and political systems that support health access and delivery. Santino Severoni of the WHO Regional Office for Europe identified the migrant's journey and the impact of injuries, respiratory infections, communicable diseases, and chronic conditions as contributing to migrant vulnerabilities. Countries can enhance their capacity to respond to large migration flows through early planning and preparedness scenario activities.

FIGURE 8: HEALTH VULNERABILITY AND RESILIENCE FACTORS FOR MIGRANTS



BREAKOUT SESSIONS

A. Actionable Policy Objectives

The breakout group on policy objectives developed recommendations for action on national, regional and global levels. Establishing a focal point in national governments to focus attention on, mainstream, and coordinate action on migrant health issues was identified as an essential approach to coordinating a multilevel response to vulnerabilities. The primary vulnerability of affordable access to health services can be addressed by creating innovative financing solutions for migrant participation in health insurance schemes. To strengthen migrants' resilience, countries of origin should collaborate with countries of destination to provide better information to migrants about the health related risks of transit and sources of care along the way and at the destination. Similarly, health-care providers at all points in the migration cycle should be educated about migrant health needs and non-discrimination. At the regional level, countries can collaborate through bilateral and multilateral agreements to monitor migrant health status and offer treatment. Overall, countries should aim to harmonize national policies and practices related to migrant health and to eliminate the administrative discontinuities and programme barriers that increase migrant vulnerability when they cannot access services. In addition to reducing vulnerabilities, all actors should support programmes and policies that enhance resilience, such as those that address migrant and refugee empowerment, education, humanitarian assistance, protection, access to justice, and fair employment and occupational laws and accountability mechanisms.

B. Progress Monitoring Framework

The monitoring group asked what measures of vulnerability and resilience would be used for, and how they might affect the policy development process. They addressed the need for standardized definitions of vulnerability and resilience with a common set of variables that could be measured. They raised the need to focus on resilience factors equally with vulnerability factors, and not use monitoring data as a mechanism to further stigmatize the most vulnerable migrants. This also raises the question of whether this kind of data would be collected and analysed for individual assessment and classification, or used as a measure of communal vulnerability and resilience, keeping in mind that structural variables are as important to consider as the health-related conditions or behaviours of migrants themselves.

Some of the variables suggested by the group include reasons for migration, risks inherent in travel and work situations, language acquisition, mental health status, and integration. The group identified a number of concerns about how to integrate variables related to migrant typologies, including the wide variety of migrant experiences. Furthermore, some categories of migrants are more vulnerable and avoid service delivery settings or data collection efforts because of a lack of information, restrictions on their freedom, or fear of deportation, for example.

C. Research Agenda

The research breakout group proposed using a social determinants of health framework to explore the factors, from individual to structural, that may influence vulnerability and resilience with respect to health across different migrant typologies and the lifespan and changing locations of the migrant experience. It is important to explore how and if migration experiences are associated with a range of health vulnerabilities, keeping in mind that individual level analysis is important to address as well. There is a need for multilevel and interdisciplinary approaches, partnerships with civil society for data generation and application, and methodological innovations that address how research is conducted and communicated, including the development of case studies across different contexts. The Sri Lankan experience of implementing a research agenda that informed policy development raised the need to better understand how this strategy worked and could be replicated.

DISCUSSION: COMMON THEMES

Session rapporteur Mariam Sianozova from Project Hope, summarized the inputs from the breakout groups by identifying three key themes: vulnerability in crisis vs. structured migration; strategies for empowering migrants and communities; and mechanisms to monitor and reduce migrant vulnerabilities. Resilience can be higher when migrants leave their countries in good health, but emergency situations can weaken this. Similarly, chronic diseases among migrants are associated with social determinants, vulnerability in transit and social exclusion in destination countries. Individual resilience can turn into community resilience with high quality and culturally appropriate information and support. Because social determinants contribute to the health challenges and pathologies that migrants face, the discussion of vulnerability and resilience should be more expansive to fully represent the migrant experience. Finally, proactively addressing resilience requires financed, multisectoral strategies across sectors, including supporting migrants in their communities, capitalizing on the development potential of migrants, enhancing educational opportunities, strengthening workplace protections, and improving overall migration governance.

The paradigm of vulnerability and resilience raised some concerns in the plenary session and breakout discussion groups. Some participants warned that these terms risk interpretations that migrants bear responsibility for being vulnerable (or insufficiently resilient) without considering the impact of external determinants or structural elements that work against migrants' well-being. The focus on vulnerability in the framework may also obscure evidence showing migration as a positive experience for many, offering new opportunities and highlighting the resilience and success of both individuals and communities. Overall, care should be taken in public discourse, policymaking and research to not use these concepts to stigmatize migrants, especially those at most risk for vulnerability. All groups also stated the principle of multistakeholder participation and accountability for developing evidence-based action plans, and reaffirmed the essential role of the migrant's voice in policy development, research, and monitoring. Responding to recommendations given by Consultation participants, the background paper for this theme was revised to strengthen the discussion on resilience.

THEME 3: DEVELOPMENT

The paper on Migration and Health in Development was presented by author Julia Puebla Fortier, of DiversityRx – Resources for Cross Cultural Health Care. Migration powers development, she stated, and without good health, migrants cannot work, be productive, or contribute to the social and economic development of their communities of origin and destination. However, examining the health of migrants in a development context presents many paradoxes, where benefits to migrants and their families must be weighed against personal and family risks and resource gaps in their home countries. She called for a balanced approach to discussing migration and health that “leads with the possible,” which is to say reframing the issue to highlight what has already worked and can be adapted, and emphasizing the potential to improve outcomes (individual, organizational, financial) while taking action to mitigate health risks, unmet needs, resource deficits, and negative politics. Migrants should be seen as energetic, resilient, and positive contributors to development and be engaged as actors in their own health destinies rather than victims. She reviewed the key themes of the paper related to the 2030 SDGs, linking the principle of “no one left behind” with the need for universal social protection for migrants. She described the role of labour and the private sector in addressing health, reviewed how new communication technologies can address gaps in connecting migrants and systems, and highlighted examples of multilevel and multisectoral national plans on migrant health from Sri Lanka and Thailand.

Strategy to Support Philippines' Labour Migrants' Health

Amuerfina Reyes, of the Philippines Department of Labour and Employment, described the opportunities and challenges faced by the more than 9 million Filipinos working in more than 200 destination countries. Their labour contributes to the development of these countries, and their remittances sustain the Philippine economy. Yet they often face abuse, exploitation, lack of access to health and social services, and risks to families left-behind. The government has taken an intersectoral policy and implementation strategy to support its citizens throughout the migration cycle. This includes pre-departure orientation, with modules on health; psychosocial support and other services for families left-behind; and several schemes for social and health insurance. She recognized the mixed opportunities and challenges posed by health worker migration, and noted the recommendations made by their former labour secretary to the UN High-level Commission on Health Employment and Economic Growth, including: recognizing and appropriately responding to health worker shortages at both ends of the pipeline; bilateral agreements that recognize qualifications and offer technical cooperation; adherence to ILOs decent work standards; and countering abuses, illegal recruitment and trafficking.

Community Engagement to Monitor Migrant Health

Amara Quesada-Bondad, from Action for Health Initiatives (Philippines) acknowledged the sacrifices and contributions of migrants who support the development of Philippine society. While offering social protection is traditionally seen as a country-of-origin responsibility, she challenged destination countries to recognize the contributions migrants make to their development agendas, and to ensure that their health, social protection and welfare systems include migrants. She noted the small number of migrant worker voices at the Consultation and re-emphasized the importance of including migrants in all processes where their needs are being discussed and planned for. She urged Consultation participants to not treat community engagement as an abstract concept, and called for community-led monitoring mechanisms related to the health and welfare of migrants.

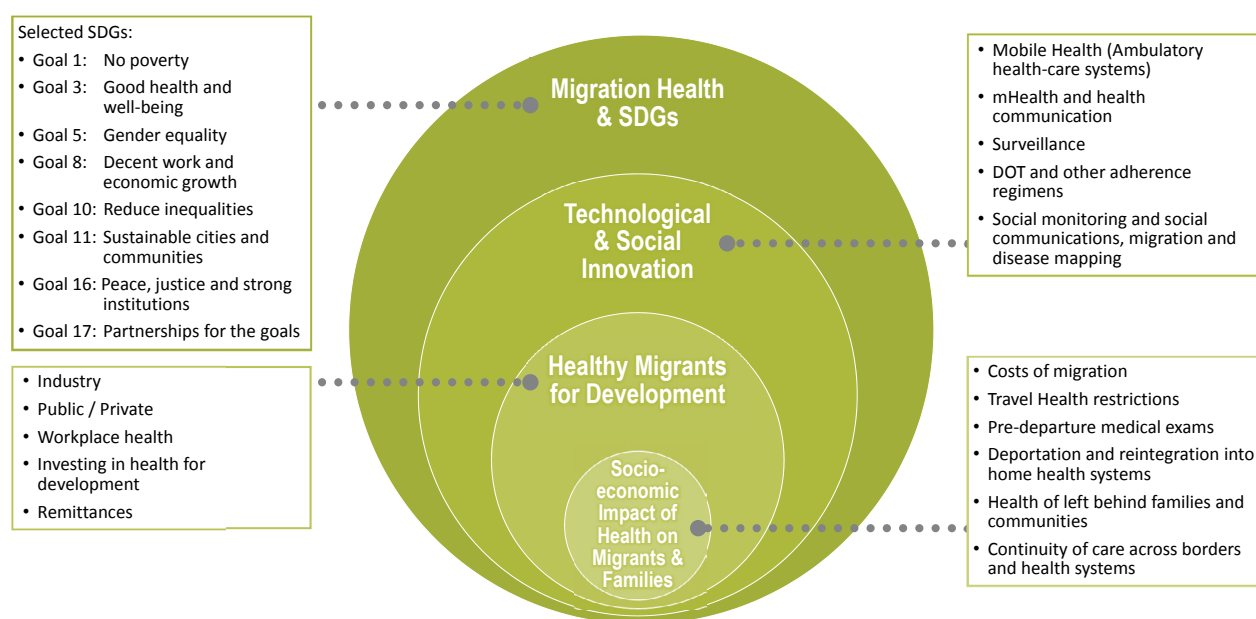
Supporting Mexican Migrants' Health Upon Destination and Return

Daniela Nuñez Pares, representative of the Ministry of Health of Mexico, echoed the observation of the two Philippine representatives, noting the substantial link between migration and development as a benefit to both Mexico and destination countries, which implies a shared responsibility for the health of those migrants. She described a number of programmes the Mexican government has established to support the health of Mexican nationals working abroad. In partnership with local organizations, the "Health Windows" programme provides health information, medical screenings, vaccines, and referrals to Mexicans working in the United States. The government also offers health-related services along its northern border for deported Mexicans, a 90-day insurance plan for returnees and their families who do not have social security, and a migrant-oriented smartphone app that links migrants to nearby health services.

Successful Partnership Model of the AIDS Response

Brianna Harrison, of UNAIDS, proposed the global AIDS response as a successful model of partnership, solidarity, innovation and social transformation that prioritizes the engagement of people living with and affected by HIV. She offered lessons learned from the global experience of tackling HIV/AIDS and suggested priority actions for policy, monitoring and research activities on the health of migrants, especially those affected by HIV. These include harmonizing efforts between health issues that are currently dealt with in silos; creating interlinked regional systems for data management and sharing, with particular focus on cross-border and transport corridors; and developing minimum standards for health and social protection for migrants. She highlighted the power of setting concrete, measurable, and ambitious global goals, citing the 15 by 15 HIV global treatment target as an example. Global agendas should have localized national target-setting processes with monitoring efforts supported by international benchmarks. She recognized local governments and cities as an entry point for ensuring that both internal and foreign migrants can access services, and called for additional research on the health impacts of urbanization on migrants.

FIGURE 9: DEVELOPMENT AND MIGRATION



BREAKOUT SESSIONS

A. Actionable Policy Objectives

The breakout group developed a substantial list of national, bilateral, regional, and global recommendations for action on migration health in the context of development. On the national level, expanding the scope of consideration to include returnees/deportees, detained migrants, and families left-behind was suggested. Recognizing the other social determinants of health, there were several cross-sector suggestions, including refugees' right to work, social protection for domestic workers, and supporting migrant-led organizations and unions. Country-to-country recommendations included more explicit negotiations between sending and receiving countries on health insurance options, and protection for those who need mental health support, maternal-child health services, or an equivalent level for on-going care. Bilateral and regional activity should prioritize more multicountry frameworks that include care and monitoring provisions, with high-level support to encourage action. At the global level, there were recommendations to create a strong link between the SDGs on safe, orderly migration and universal health coverage, and to include health in the Global Compacts, with strong promotion of the Colombo Statement in all global forums.

B. Progress Monitoring Framework

The breakout group on monitoring discussed a wide range of topics, from cross-sectoral efforts by governments to support migrants to the need for more documentation of good practices and meetings like the Consultation to discuss them (including bilateral technical information sharing). With respect to monitoring, the group highlighted the need to ensure that SDG monitoring includes relevant variables on migration. Governments should review existing monitoring mechanisms across the health and development sectors and incorporate migrant health-related variables. The research community can assist with the development of standardized terminology and variables.

C. Research Agenda

The breakout group addressed how a migration and health research agenda could be framed as an opportunity to enhance action on the SDGs, and whether the current SDG indicators can effectively capture migration and health variables. Some of the considerations include looking at how migration affects development outcomes, how to measure the impact of health on those goals, and what kinds of data sets need to be created or modified to yield disaggregated data on migrants that could lead to specific actions. They discussed the potential for linking MIPEx data with IOM's country Migration Profiles, allowing researchers to access internal data collected by IOM and UNHCR, and working with employers to analyse their data. The group identified a number of populations that need more attention from researchers,

including internal migrants, return migrants, female domestic workers, those in the international diaspora, and the communities affected by migration. There are also vulnerable migrant populations for which we need more information, such as undocumented workers and those in detention centres. This will require both innovative research methodologies and care that the process and outcomes of research do no harm. They called for more attention to psychosocial health, additional studies on the cost-effectiveness of giving migrants better access to health services, and articulating a values framework to guide research on migration and health in the context of development.

DISCUSSION: COMMON THEMES

Rapporteur Jocalyn Clark of The Lancet offered her perspective on the themes raised by the panellists and breakout groups. She observed that the inextricable link between health and development can seem obvious to some, but in discussions about migration, this interrelationship is often overshadowed by politicized concerns about security. She highlighted the importance of seeing the commonalities between different types of migrants, but not forgetting that each group has a different role in development and often presents distinct health needs. Acknowledging the value of leading with the positive, she said that research uncovers the stories that can reframe negative narratives. It is important to understand how different forms of media can reach different audiences, from the general public to policymakers. Pursuing breadth in the way we investigate health and migration, by developing collaborations with social science, policy and legal researchers, can lead to richer data. We must consider the most effective and ethical ways to weave the migrant voice into all these efforts.

NOTES

¹ www.mipex.eu

² http://c-hm.com/wp-content/uploads/2015/08/Infographic_explanatory-text.pdf
http://c-hm.com/wp-content/uploads/2015/08/Infographic_cost-savings.pdf

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PART 3

CONSULTATION OUTCOMES

After plenary discussion and analysis along the lines of the Consultation's three core thematic areas, i.e. *Health, Health Systems and Global Health; Vulnerabilities and Resiliency; and Development* together representing an integrated, multidisciplinary, participatory and development-oriented framework for action in migration health, the participants identified common principles, priority areas, special considerations or opportunities, to serve as general outcomes of the 2nd Global Consultation on Migrant Health.

The outcomes were intended to inform the drafting of the WHO Framework of priorities and guiding principles on the health of refugees and migrants following the decision taken by the 70th WHO Executive Board (January 2017) and in view of the WHO Action Plan expected for 2019; the on-going negotiations on the Global Compacts for Migrants and Refugees; and other relevant global health or migration and development agendas.

Parallel sessions and respective outcomes focused particularly on *actionable objectives, a progress monitoring framework and a research agenda*. Issues raised and recommendations made were further consolidated during a plenary discussion. The below outcome section reflects the discussion results.

CROSS CUTTING PRINCIPLES

Human rights framework - the migration health agenda is grounded in a rights-based approach that includes all mobile populations, regardless of their status, reason for migrating, context or phase of the migration or displacement cycle, with an aim at preserving lives, realizing equality, and the enjoyment of the highest attainable standards of health for all, to be reflected by policies and laws across sectors. All migrants should be protected from discrimination, harm and prejudices to their health, including those determined by policies, data management or research systems.

The 2030 Agenda for Sustainable Development promotes migrant health on the principle to “leave no one behind”. The achievement of the sustainable development goals and in particular the overarching health target 3.8 Universal Health Coverage, requires evidence-based inclusive policies that facilitate access to equitable and quality health services, balancing the costs and benefits of promoting ‘health for all’ from a public health and sustainable development perspective. Additionally, determinants of migrants’ and refugees’ health should be addressed using a Social Determinant of Health approach and through the implementation of multiple and relevant SDG goals and targets, including but not limited to target 10.7 facilitating orderly, safe and responsible migration and mobility of people by means of well-managed migration policies which are sensitive to health issues.

Mainstreaming the health of migrants - The health concerns of migrants and displaced should be mainstreamed in people-centred, health systems strengthening programmes, as well as other global health, humanitarian, and development-oriented initiatives, including migration and development dialogues, migration governance, and decent and protected work, addressing the specific needs and circumstances of the migration experience through evidence-based, epidemiologically informed policies, and linguistically and culturally appropriate services, with special emphasis on the needs of people in vulnerable conditions such as children, women, those with disabilities, and others marginalized and stigmatized for various reasons.

Shared responsibility - Countries of origin and destination share responsibility to ensure policy development, harmonization, and moreover, that migrants benefit from adequate health services, including cross-border care, and health financing and social protection floors. Likewise, partnerships among UN bodies, civil society organizations and other stakeholders are essential for a coordinated response to support countries and beneficiaries, and for promoting multisector action.

Social inclusion - Advocates and policy makers should raise awareness on the substantial contributions of migrants in society and should address the stigmatization of migrants that occurs in social discourse, services provider behaviour and policy structures. Migrants and refugees should be active stakeholders in programme planning and decision making.

Whole-of-government and whole-of-society approach - Successful migration outcomes require close cooperation and collaboration among countries as well as sectors. Only a whole-of-government and whole-of-society approach beyond the health sector, can ensure the needed mainstreaming of migration health within relevant policy domains, such as development, occupational health and safety, health security, foreign policy and global health.

OUTCOME 1: ELEMENTS FOR ACTIONABLE POLICY OBJECTIVES

Policy development and related decision-making need to be based on the best available data and the collection and dissemination of good practices.

National Level

- Establish a National Focal Point on Migration Health to lead a multisectoral, whole-of-government and whole-of-society rights-based strategy and coordination process that actively engages migrants, civil society and other stakeholders.
- Strengthen health systems and enhance people-centred and inclusive health services which foster integration and social stability; Enhance migrant-friendly services and related capacity-building, focusing equally on capacity to provide life-saving rapid interventions to migrants in need, as well as long term strategies to mainstream migrant health within health and other sector strategies.
- Strengthen core competencies and capacity development by means of training of policymakers, health and social service workforce, and mobilize resources, including those in the diaspora of health professionals in the country.
- Extend social protection in health and improve social security for all migrants and their families, work towards the pooling of financial risks (employers, government, private partners and migrants), and find innovative solutions for portability of benefits and continuity of care.
- Address and remove situations, conditions and elements of vulnerability to ill health experienced by migrants, including xenophobia, migration restrictions for migrants with health conditions and needs, policy gaps or inconsistencies; enhance migrant resilience, e.g. through adequate information, empowerment for self-help, and enforcement of labour and occupational health standards.
- Establish adequate indicators to monitor migrant health as well as measures to assess and monitor the impact of diverse policies on migrant health.

Regional Level

- Enhance cross-border cooperation and partnerships to harmonize policies and practices, and ensure continuity of care and health responses to emerging needs linked to human mobility, including in health and border management.
- Ensure the mainstreaming of migration health issues in bilateral, regional and multiregional dialogues on health, migration, development, labour, and foreign policy; enhance cooperation among countries of origin, transit and destination.
- Maintain commitments and advocate globally to ensure that regional perspectives are reflected in global dialogues and instruments.

Global Level

- Ensure a dedicated space for health and migration issues within the process of the Global Compacts, and within the Compacts themselves.
- Enhance the mainstreaming of migrants across sectors and within the scope of the implementation of the SDGs
- Ensure that outcomes of the 2nd GCMH are incorporated into the “WHO Framework of priorities and guiding principles” and future “action plan” and support their adoption and implementation.
- Enhance political leadership, partnership, and the mobilization of resources towards provision of evidence and monitoring, innovation, capacity development, participation and action to respond to health needs and challenges brought by global migration.
- Create and maintain multiagency regional and global platforms for collaborative learning, sharing of lessons learned, and on-going dialogue to support action, reflection, and solidarity.
- Galvanize high-level political leadership and identify health and development champions to raise the visibility of the issue towards the achievements of commitments and goals, for example a global initiative stemming from the Colombo Statement, a Special Envoy level advocate, a dedicated International Society.
- Ensure that health of migrants is mainstreamed explicitly in global health strategies, within humanitarian response frameworks, and all dialogues concerning migration and development with specific actionable goals and targets.

OUTCOME 2: RECOMMENDATIONS FOR A PROGRESS MONITORING FRAMEWORK

The 2010 GCMH (Madrid 2010) offered an ‘operational framework’ which included priorities and actions for policy priorities, migrant sensitive health systems, migrant health monitoring, and partnerships and multi country frameworks. A monitoring framework in migrant health is essential to reach accountability for tracking progress on achieving population health, health systems performance and implementation of policy objectives related to migrants.

FRAMEWORK OBJECTIVES:

1. Ensure that commitments, strategies and partnerships in migrants’ health progress towards expected results
2. Propose a common set of indicators and related data sets for local, national and global levels that are comparable and can be adapted to local and national circumstances, policies, and data sources
3. Establish standardized terminology and operational definitions related to migrant typologies and demographic characteristics
4. Promote harmonized monitoring mechanisms across countries and regions, and across the migration cycle and typologies
5. Promote inclusion of migrant health related indicators in the data collection systems of relevant sectors, such as labour, migration, housing, education
6. Advocate at the local, national and global levels for SDG indicators that are disaggregated and reflective of the migrant experience and migrant health needs
7. Advocate for a migrant health monitoring framework in the two Global Compacts, and in other international frameworks and platforms

PROCESS CONSIDERATIONS:

1. The monitoring framework should be based on and continuously supported by a platform for sharing good practices, lessons learned, and model systems
2. Monitoring frameworks and systems should be responsive and adaptable, recognizing that countries are at different stages of implementing migrant service, policies and monitoring frameworks. New technologies and databases should be utilized to improve the quality, use and dissemination of data
3. The monitoring process at each level should incorporate multisectoral engagement, an advocacy mechanism for programme and policy changes based on monitoring results, and community engagement to ensure that the actual health needs of migrants are considered and results are made available to them
4. Recognizing the fluid nature of migrant mobility, consideration should be given to developing portable health information to facilitate the trans-border flow of data between countries and stakeholders, especially during large, regional movements
5. Monitoring should capture data across all the stages of migration, and include families left-behind, displaced persons and returnees. Inclusion of hard-to-reach migrants such as refugees and undocumented migrants may require different approaches
6. Structural, process and outcome indicators could include those related to: migrant health status; determinants of health; administrative, policy, and legal structures that address migrant health needs; financing mechanisms; resource allocation to migrant related programmes; migrant access to services and social protection; service utilization by migrants; and, quality of services and care

SAMPLE INDICATORS:

Health, Health Systems and Global Health

- Evidence of systematic recording of a minimum set of migration indicators as part of local, national and global health data collection (e.g. place of birth, length of residence, immigration status)
- Protection mechanisms to preserve migrant privacy and confidentiality in place
- Verify the inclusion of migration status in relevant social indicators within relevant national statistical surveys and census (on such topics as income, education, housing, metropolitan/rural, incarceration)
- Verify countries provide access to health insurance/services and social protection in health programmes to migrants
- Statistics of access to health services access and/or utilization by migrant populations relative to host populations, by country of origin, including trends over time
- Migrants are accounted for in global, regional and national health strategies, plans and programmes, including the implementation of UHC, or disease-specific programmes
- Established focal points for the coordination of migrant health embedded within governments and regional networking
- Preparedness, core-competencies, standard operating procedures, and assets are available to respond to migrants' health needs in the context of large migration flows

Vulnerability and Resilience

- Determinants of vulnerability and resilience identified for various migrant populations and in different contexts and linked to specific SDGs for action and monitoring
- Evidence of structural policy action on migrant health vulnerability and resilience across health and non-health sectors, by country and region, e.g. implementation of relevant human rights frameworks; access to health services for all migrants without discrimination; systematic monitoring of implementation of policies, regulations and laws affecting health of migrants
- Evidence of practices to reduce vulnerability and address the social determinants of migrant health, e.g. health screenings of migrants linked to provision of care; decent work standards applied to migrant workers; support mechanisms for families left-behind; evidence of capacity-building for migrant friendly health services and developed standards for health services delivery
- Effective emergency and humanitarian responses in place and linked to long term planning for sustained responses to the health needs of migrants and displaced people
- Special considerations for vulnerable migrant groups, including women, children, displaced persons, in place throughout the migration process
- Policies' conduciveness and responsiveness in addressing needs is monitored using index methods (e.g. MIPEX)

Development

- Inclusion of migrant health issues in national, regional and international development agendas, across sectors and increase in bi- and multilateral agreements to enhance migrant health
- Health included as a subtheme in the GCM process or otherwise mainstreamed
- Progress monitoring of the health-related goals and targets of the Sustainable Development Agenda include migration indicators, e.g. migrants are accounted for in universal health coverage; inclusion of migrants in early warning and risk reduction systems; proof that migrants and dependent family members are eligible for social protection programmes
- Evidence of efforts to invest remittances more efficiently towards migrants' health and reductions in out-of-pocket health expenditures for migrants
- Evidence of inclusion of diaspora migrant health workers in the design, implementation and evaluation of migrant health services and educational programmes
- Non-government entities are engaged with technology and social innovation

OUTCOME 3: RESEARCH AGENDA

The research related discussion aimed at developing strategies to advance migration health research to formulate evidence-based policies and practices at national, regional and global levels. This outcome component benefitted from debates and recommendations of a dedicated side event during the consultation, ‘Migration Health Research Forum’. Working across the three Consultation thematic areas, the research discussion was guided by a number of questions: What are the opportunities and challenges, and the essential components associated with developing a research agenda on migration and health?; What values and approaches should guide the development of a national research agenda and data collection systems on migration health?

The increasing complexity of global, regional, and national migration trends; debates on “migrant” definitions and nomenclature; and polarizing political viewpoints on migration and its close tethering to nationalistic and populist movements present real challenges to researchers designing studies along epistemological, theoretical, and analytical lines. Particular challenges persist in collecting data on migrants in irregular situations and undocumented migrants ‘living in the shadows’ of society and working in countries with restrictive policies on access. These are underpinned by the research questions that emerged during the group discussions.

Examples of Research questions at nexus of migration, health and development to drive policy and practice:

- *National*: What are the experiences of migrants in navigating health systems? What are their beliefs, understandings, values and health literacy? How do these differ along migration trajectories/journeys, and by migrant typology, by legal status, by age of migrant, by country of origin? How (and in what direction) does health vulnerability and resiliency change during a person’s migration trajectory, and across the four phases of the migration cycle (pre-departure, during transit, at destination and upon return)?
- *National/Regional*: Does “low-skilled” labour migration (especially from low-income countries) cause negative health and social consequences to those left-behind children and elderly of migrant households? Or, do such migrants and their families thrive by using remittances to purchase better food, health care and education? Do such risks/rewards change over time? Which interventions are effective in reducing health vulnerabilities of such migrant families?
- *Global*: What role does human mobility play in the spread of diseases, and for the reintroduction of diseases such as Malaria in elimination or near elimination settings? To what extent have countries enshrined the right to health for migrant populations within preparedness and response plans for pandemics or other public health events?

Key elements of a composite framework for advancing research on migration health and to ensure policies are evidence-based are presented in the following figure.

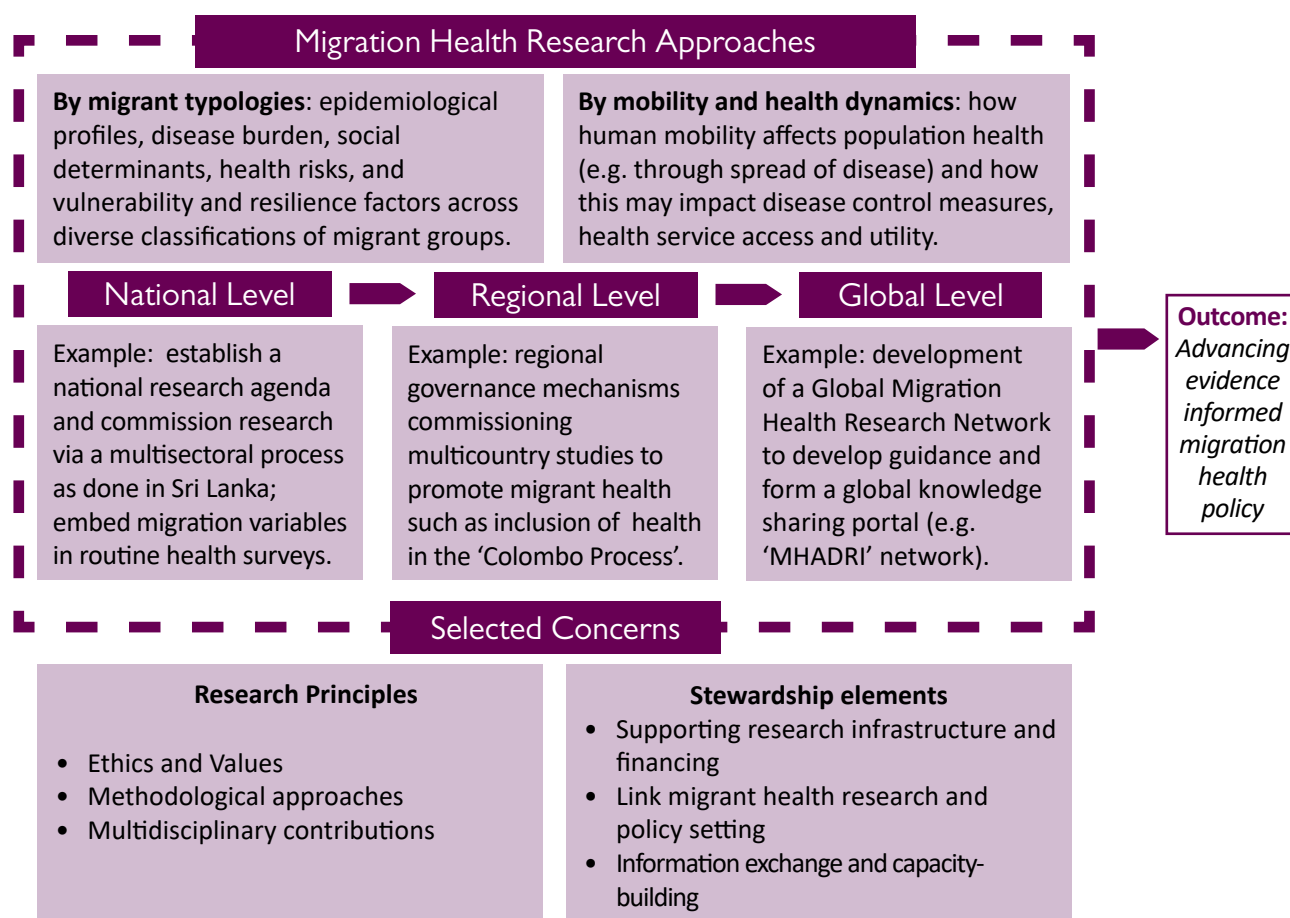
MIGRATION HEALTH RESEARCH APPROACHES

Two approaches on advancing migration health research were discussed.

Research on various migrant typologies: To understand epidemiological profiles, disease burden, social determinants, health risks, and vulnerability and resilience factors across diverse classifications of migrant groups. Descriptive migrant classifications may be based on:

- Migrant status (examples: refugees; irregular migrants; asylum seekers; internally displaced persons; migrant workers)
- Geography (examples: rural to urban migrants; inter-regional migration; internal migration; transnational migration; return migration)
- Temporality (examples: seasonal migration; labour related contractual migration; short-term/protracted migration)
- Socio-demographic status (examples: age, gender, economics, education, level of occupational skills)
- Motivations/Causal classifications (examples: family reunification; refugee resettlement; labour migration; student migration)

FIGURE 10: ADVANCING MIGRATION HEALTH RESEARCH AT NATIONAL, REGIONAL AND GLOBAL LEVELS



The diversity of migrant groups underlies the need to document 'migrant voices' and migration experiences along multiple trajectories when undertaking research examining health consequences of migration, for example, capturing the voices of children and elderly caregivers left-behind as a result of labour migration. Other research topics could include the issues, policies and programmes that influence health and health literacy among migrant populations or the role of communities, households, industries, schools, and transnational networks have in promoting health. Such research will be important in formulating policies and practices that are sensitive to diverse migrant groups without reinforcing stereotypes or operating from a deficit approach to respond to the health-care needs.

Research at the nexus of human mobility and health: To understand how human mobility affects population health through spread of disease outbreaks and how this may influence/impact disease control measures, health service access and utility. Migration processes can positively or negatively impact health outcomes just as health status can affect migration outcomes.

Human mobility is a critical factor in the spread of pandemics and outbreaks. The current understanding of the dynamics of disease transmission such as diseases as Ebola, SARS or H1N1 is that they cannot be stopped at borders. Research is needed to understand how human mobility affects population health and impacts health-care systems in terms of service access, use/behaviours. This could include looking at the dynamics of cross-border mobility of vulnerable migrant populations who work in the poultry sector to formulate preparedness and response strategies for avian influenza pandemics. This also requires the partnership with national, regional, and transnational actors.

Both approaches are necessary to understand how to respond to the complex interactions between migration, mobility and health to develop migrant-sensitive health systems and policies. Mobility and migration factors should be built into overall health systems design and service provision, rather than viewing migrants as a 'problematic' population group requiring specialist services.

NATIONAL, REGIONAL, AND GLOBAL-LEVEL ACTION TO ADVANCE MIGRATION HEALTH RESEARCH

This section presents examples of national, regional and global level action to advance migration health research.

National Level Action

- Identify a national focal point to establish a multisectoral national migration health policy and priority setting 'process' that is guided by principles of evidence and galvanizes high-level political leadership to raise visibility.
- Utilize existing national research structures and resources to develop a migrant health research agenda or undertake a dedicated research commission in migration health to drive policymaking and programme formation, guided by a national migration health research advisory working group.
- Mapping of all stakeholders involved in migration within a sovereign state and undertaking an analysis of existing service priorities/gaps to identify research priorities. What is the extent of health service coverage to migrants? What are service gaps and challenges in service delivery from perspectives of providers and migrants?
- Mapping of various migrant typologies and mobility patterns – Identify links between human mobility and health (e.g. importation of malaria from inbound routes).
- Domestic legal framework analysis – What is the extent of social and health protection? To what extent have various types of migrants been included within health sector plans, pandemic preparedness plans?
- Data mapping – To what extent do current demographic health surveys, population health surveys, applied research, and disease specific research capture migrant population groups? What are migration health related variables? How can health information systems capture such variables? What private sector data can be harnessed/accessed such as those from pre-departure health examinations? Do cross-border health information systems capture migration health data?
- Research mapping – Identify researchers across disciplines such as medicine, law, economics, social and political science, to drive a research agenda. Is migration health research a priority issue within the national health research agenda? What research capacities and funded programmes exist at the country level? Identify opportunities for research production and dissemination within existing structures and processes, including within university programmes, journals, funding agencies, and global thematic and research forums on other health issues.

Example of national level action, Sri Lanka

The Government of Sri Lanka, with the technical cooperation of IOM, commissioned a *National Migration Health Research Agenda in 2010* that ultimately contributed to the formulation of a *National Migration Health Policy* via an inter-ministerial action plan in 2013. Such national migration health research commissions may be a critical first step for member states to take stock and examine the migration health issues within their sovereign borders. Such efforts also build awareness and strengthen existing health, migration management and administrative systems in country to better harness, collect and assess migration health related data.¹

Regional Level Action

- Develop migration health specific disease surveillance, capacity-building, monitoring, applied research collaboration across national borders. For instance, the Mekong Basin Disease Surveillance (MBDS) consortium is a sub-regional cooperation spearheaded by health ministries from member countries Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam.
- Engage with private sector, industry groups and labour organizations involved in large scale cross-border infrastructure projects (such as mining, road, rail, port construction) to undertake assessments of the potential health impacts/consequences associated with human mobility during the construction phase and on population health following completion.
- Promote the assessment of migrant health-related concerns in the negotiation of free trade agreements that increase mobility coordinators between states, such as the *"Healthy, Caring and Sustainable ASEAN² Community"* initiative.
- Engage regional non-governmental networks, academic networks, and professional associations to participate in and promote migration health research agenda.
- Underline the role of regional and inter-regional governance mechanisms converging under domains of trade, labour, development and health, in undertaking applied research to advance better outcomes for migrants and communities in countries of origin and destination. For example, the Colombo Process³, a Regional Consultative Process on the management of overseas employment and contractual labour for countries of origin in Asia, integrated migration health within the Ministerial agenda for labour in 2016 and facilitated a multicountry study on immigration medical practices of labour migrants. Moreover, in November 2016, WHO launched the European Knowledge Hub on Health and Migration, a regional repository of scientific evidence on the subject. Within this Hub, a collaborative project, Migration and Health Knowledge Management, will aim to raise awareness, disseminate knowledge, and increase adoption of migrant-health good practices and evidence-based approaches across EU countries.

Global Level Action

- Collaborate with stakeholders involved in the implementation of the SDGs, the Global Compacts and other global initiatives to ensure that indicators and data collection strategies are sensitive to migrants and migration health related issues. Identification of datasets and data collection processes that can be adapted and mined for disaggregated health data related to migrants are also crucial in advancing the evidence base.
- Support for a global reference group that can be maintained to share research evidence, expertise, experience, and to develop methodological guidelines, undertake multicountry studies, provide training and build a global knowledge hub in migration health was highlighted. The 'Migration Health and Development Research Initiative' (MHADRI) supported by IOM is an example a global network of academics and partners convened to advance migration health research practice. The network aims to support research activities such as multicountry studies, and develop a 'migration health glossary' through an international Delphi consensus process and promote evidence-based programming and knowledge management from implementation.
- Promote migration health research to funders and development partners to stimulate research grant development and provide seed funding for a global agenda setting process and for research programmes is needed.
- Collaborate with scientific and professional associations, medical journals and other publishing houses to create better awareness on the need to better promote migration health research, promote global calls for research, disseminate knowledge, best practices and policy briefs on the inter-linkages between migration, health and development.
- Develop good practice guides on data collection systems, research methods and ethics, dissemination and policy integration strategies.
- Advocate to governments, donors and partners driving global health and 'vertical' disease control programmes and such as HIV and Malaria, to promote migration health research. For instance, the recent partnership between IOM, WHO and *International Union of Tuberculosis and Lung Disease* that outlined a framework for the prevention and reduction of the TB burden among migrants. A dedicated research publication within the Union's journal to promote migration and TB research was also undertaken.

SELECTED CONCERNS: RESEARCH PRINCIPLES AND STEWARDSHIP ELEMENTS

Selected concerns about *Research Principles* include the ethical and methodological challenges of conducting research with marginalized migrant groups, and the lack of major funding mechanisms for research at national, regional and global level. Researchers need to be sensitive when designing, applying and disseminating research findings as migrant health data may be misused, both at an individual and population level. Contributions from a range of disciplines, including anthropology, demography, policy analysis and epidemiology amongst others are required. The development of taxonomy of terms related to migration health and human mobility that captures the complexity of the issue without reinforcing the use of reductionist categories was also proposed.

Selected concerns about *Stewardship Elements* include the development of a research infrastructure on migrant health by securing support for research programmes and institutions and building needed capacity, especially for researchers in the global South. Furthermore, a migrant health research network, communities of practice, and international partnerships with those working on other global health priorities is key. The field of migration research also needs to address the experiences of service providers engaged with the various migrant populations, such as those within the health-care sectors, border management, law enforcement and labour migration. Effective communication strategies for disseminating and presenting research findings are critical to shape policy processes within global, regional and national levels, as well as public and political opinion.

In conclusion, there was consensus amongst the consultation participants on the need to enhance the quality and breadth of research evidence and related importance to create an 'enabling culture' for migration health research at country level to be linked to inter-sectoral policy and priority setting processes. Such processes need to be underpinned with ethical guidelines, academic freedom, adequate funding and capacity development.

NOTES

¹ Wickramage, K et al. Migration Health Research to advance evidence based policy and practice in Sri Lanka. Geneva, 2017, IOM Publications.

² Association of Southeast Asian Nations.

³ Colombo Process portal: <http://colomboprocess.org/>

PART 4

THE WAY FORWARD

The recommendations from the thematic and outcomes sessions are intended to provide guidance to countries, international agencies, and global dialogues on how to take concrete action to advance the health of migrants. To consolidate the objectives of the Consultation, the last plenary session featured representatives from IOM, WHO and UNHCR who spoke about how health fits into key upcoming global frameworks on migrants and refugees. Migration is the unfinished business of development, said Gervais Appave, of IOM. Global agendas have been agreed upon for the topics of education, trade, environment, and women. But agreement on migration has been stymied by the complexity of the issue, political timidity, and concerns about security and national sovereignty. There has been progress over the last 20 years, and there are efforts underway to consolidate and move forward. He described the process for the GCM, to be considered for adoption in 2018 after a series of global consultations, analyses and negotiations. Health is not currently one of the thematic priorities: health issues are mentioned in passing, such as the needs of refugees and children, and HIV and primary care. But there needs to be a push for much more, and he stressed the need for health and migration leaders to advocate with governments to take more concrete and comprehensive approach to health in the outcomes of the GCM.

Allen Gidraf Maina, of UNHCR, talked about the parallel GCR¹ that represents a commitment by governments to contribute to comprehensive refugee responses in a predictable and systematic way. The GCR will be informed by a Comprehensive Refugee Response Framework (CRRF),² applied in situations of large movements of refugees as well as emergency and protracted situations, which UNHCR will develop over the next two years. Maina gave an example of how the Government of Uganda, the UN Country Team and the World Bank is developing the Refugee and Host Population Empowerment Framework (ReHoPE),³ which aims to integrate refugees into national development plans. UNHCR intends to draw on experiences from ReHoPE and other existing mechanisms to contribute to the CRRF.

Kanokporn Kaojaroen of WHO provided an analysis of the health-related commitments currently listed in the two Global Compacts. Among the opportunities

for further development on health issues are combatting xenophobia, racism and discrimination in migrant and refugee access to health care, and ensuring nutrition, psychosocial support and health care, including sexual and reproductive health, for displaced persons. She highlighted the January WHO EB decision to consider a 'Framework of priorities and guiding principles' for consideration at the May 2017 WHA and to support the inclusion of health in the Global Compact discussions and outcomes. In consultation with Member States, IOM, and UNHCR, WHO will conduct a situation analysis during 2017 based on migrant health lessons learned. This will guide the development of a global action plan for consideration by WHO's Governing bodies in 2019.

HIGH-LEVEL PANEL ON THE COLOMBO STATEMENT

Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine of Sri Lanka opened the High-Level Panel on the Colombo Statement by recognizing the representatives from 39 countries who attended the Consultation, including senior government officials from 21 countries. He introduced the Colombo Statement as a truly significant step that calls for greater involvement of senior policymakers in the process of integrating and incorporating migrant health into the development agendas of countries. The text of the Statement was read to the audience, and H.E. Maithripala Sirisena, President of the Democratic Socialist Republic of Sri Lanka, praised the efforts of the Consultation participants and the countries guided the drafting the Statement. He recalled his early commitment to this issue as Minister of Health, culminating in a national migrant health strategy, and noted the need for international support to reach the goals articulated in the Statement.

There was a presentation of Sri Lanka's Migration Health Research Compendium, and additional statements were offered by representatives of IOM, WHO, and several of the countries that signed the Colombo Statement.

Maria Nette Motus, of IOM, recalled some of the key messages articulated at the meeting, including 'leave no one behind', 'healthy migrants in healthy communities', 'shared responsibility', 'lead with the possible', and last, but not least, 'nothing for us without us'. She observed that migrant health is the litmus test of the coherence of the SDGs, linking implementation of the UHC, health, and other goals that touch on migrant lives. She reminded the group that women are increasingly important actors in the economic transformations of their own livelihoods, leading to increased decision-making power and better well-being and development. Despite this, we must not forget that migrant women and girls are often disproportionately disadvantaged in the migration process.

Poonam Khetrpal Singh of the WHO addressed the legal and moral imperative of taking action on migration and health. She contrasted the recent unparalleled advocacy and awareness of human rights with the challenges presented by large-scale population movements, recalling German-Jewish philosopher Hannah Arendt's observation that the human rights of non-citizens are often vulnerable, however legitimate and just they may be. "In a world in which citizenship and sovereignty still matter, Arendt's haunting question, 'who has a right to have rights?' is as applicable now as it was 70 years ago." As global public health actors working alongside nation-states and non-governmental organizations, we have the opportunity to ensure the human right to health is secure for all, including migrants and refugees.

In the context of being the largest recipient of refugees in Latin America, the representative of Ecuador highlighted their new internationally acclaimed law on human mobility. Regardless of their migratory status, migrants, refugees and asylum seekers can access the National System of Public Health Care in a non-discriminatory and undifferentiated fashion. While the costs of such care are high for a middle-income country in the context of an economic downturn, he said, "the Ecuadorian state is proud to provide public health services to every person in the country, without discrimination and free of charges, thus respecting and recognizing the condition of health care as a human right."

The Foreign Policy and Global Health Initiative, comprised of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, reinforced the importance of taking a multistakeholder approach on migration and health, including the involvement of national and local authorities, international organizations, international financial institutions, civil society partners, the private sector, the media and migrants themselves. Political commitment and action are essential to accomplishing the aims of the Consultation.

“There is no public health without migrants’ health,” said the representative from Switzerland. The challenge to achieving this goal requires effective cross-sectoral collaboration within national governments, international cooperation, and the exchange of good practices, as experienced during this week. He described Switzerland’s National Programme on Migration in Health, which promotes the health literacy of migrants and equal access to health care. It features a telephone interpreting service in more than 50 languages, web-based translated health information, and an online platform for intercultural training of health providers. Noting the country’s support for WHO’s European migrant strategy, the Colombo Statement and the New York Declaration, he stated Switzerland’s commitment to ensuring that the health needs of migrants are adequately addressed in the upcoming negotiations of the GCM.

Describing the health challenges faced by their labour migrants, the representative from Nepal observed that they can benefit from pre-departure health check-ups, orientations and a special package of health coverage to address their major health issues when working abroad. Nepal is working to waive health check-up charges and provide health insurance. He cautioned that the absence of guaranteed funding could undermine the WHO’s effectiveness in implementing the provisions in the resolution. He strongly urged the Secretariat to explore and propose innovative financing modalities and schemes for each adopted resolution.

The representative of Maldives noted the challenges of health screening and caring for migrants, and ensuring that employer-sponsored health coverage is adequate and accessible to all. He recognized the need for new financing mechanisms, adapting the health system (including data collection) to be more responsive to migrants’ needs, and addressing the vulnerability of migrants by responding to the social determinants of health.

As a source, recipient and transit country for migrants, Indonesia’s delegation noted their national policy on migrant health, health financing for migrants, and bilateral agreements that include migration and health. They characterized migration health as a responsibility of the global community and called for increased multisectoral, bilateral, and multilateral cooperation.

The representative from Egypt noted the large number of refugees and asylum seekers hosted by the country, and described the country’s health policies and systems as prepared and equipped to deal with their diverse health needs. A Ministerial Decree allows refugees in Egypt to be treated as Egyptian citizens, benefiting from the subsidies given to provide free health services, among other subsidies provided by the government to Egyptians.

Underscoring its national commitment to the realization of UHC, the representative of Myanmar observed that this goal necessarily includes reaching all populations, regardless of their migration status, legal status, or mobility. Nearly 20 per cent of Myanmar’s population are lifetime migrants, a proportion that is projected to increase. Myanmar highlighted many of its efforts to improve migrant health at the Consultation.

The Consultation saw a participatory, engaged and passionate discussion amongst officials, scholars, experts, and health practitioners. It was reinvigorated by the personal commitment, encouraging support, and extraordinary hospitality of H.E. President Sirisena and members of his Government, and by the participation of high-level foreign dignitaries. It provided a wide review of the complex and emerging issues associated with the health agenda of migrants and displaced people in an era of unprecedented and global human mobility. We hope that the Statement and commitment of participating countries will ensure traction for this agenda when it is most needed, and that the recommendations expressed by this expert group will contribute to a continuous roadmap towards achieving positive health outcomes for migrants. We are grateful to all who participated and to those who will further elaborate and put into action the concepts and ideas expressed at this gathering.

NOTES

¹ Global Compact on Refugees. Available from: [www.unhcr.org/events/conferences/58d135517/global-compact-on-refugees-roadmap.html?query=global compact](http://www.unhcr.org/events/conferences/58d135517/global-compact-on-refugees-roadmap.html?query=global%20compact)

² Comprehensive Refugee Response Framework. Available from: www.unhcr.org/events/conferences/584687b57/comprehensive-refugee-response-framework-new-york-declaration-global-compact.html

³ The Refugee and Host Population Empowerment Framework. Available from: https://d10k7k7mywg42z.cloudfront.net/assets/5667425fd4c96170fe082173/REHOPE_2_Page_Brief_141015.pdf



PART 5

DISCUSSION

BACKGROUND

PAPERS (excerpted)

HEALTH, HEALTH SYSTEMS AND GLOBAL HEALTH

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Current Global Priorities in Health and Migration¹

Historical approaches to migrant health have often been concerned with events or outcomes at the migrants' destination. Current attention is broader and comprises the study of the health effects and impacts involving places of origin, transit and resettlement. They also include attention to the more modern aspects of migration flows such as return and repetitive or cyclical migration. Communicable diseases were often primary areas of interest in migration health. Recently more attention is being directed towards non-communicable diseases and illnesses. Modern approaches to migration health studies more frequently address the cultural and social contexts of migration and integration as exemplified by life course theory.² Additionally, current areas of interest have expanded beyond the traditional national focus of earlier migration priorities to regional and global considerations.

Today, migration has not only demographic implications but is appreciated to be a key component of labour force mobility and related to the economics of global human capital. The role played by migration in those aspects of globalization intersects with

- The impact of migration on global development (SDGs);
- The access to and utilization of health services by migrants (UHC, HSS);
- The relationships and health aspects of climate change and environmental migration;
- The influences of migration on health and human security;³
- The migration health aspects related to gender.

As global work progresses these areas, it will be increasingly important to ensure that the roles, effects, impacts and consequences of migration and associated health issues become integrated components of the strategies, policies and programmes involved.

HEALTH IMPACT AND CONSEQUENCES OF HIGH VOLUME MIGRANT MOVEMENTS

Acute and Short Term

Health systems in even highly developed nations may experience logistical, administrative and fiscal challenges in the face of unexpected high volume migrant arrivals. The impact on less developed or robust health systems can be more severe and may compromise national economic and development goals. For example, a reduction in the health component of the Human Development Index for Jordan has been associated with the impact of refugees resulting from the Syrian conflict.⁴

High volume movements often include a 'mixed migration' demographic encompassing refugees, trafficked migrants, economic migrants and unaccompanied minors. While immediate post-arrival needs of all migrants may be similar, each of the subpopulations may be subject to administratively and legally different processes and policies. This can create operational and logistical challenges in acute situations that can be resource intensive and not particularly productive.

Administrative, security, border control and health systems may be challenged by thousands or tens of thousands of people who arrive quickly. Mobilizing human, logistical and medical resources to deal with the health needs of the new arrivals while ensuring and maintaining security and protection is costly in both human resource and economic terms. Immediate attention must be directed to urgent health needs with additional attention directed to identifying longer standing health and psychosocial issues in the new arrivals.

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

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

Examples of relevant activities in that regard include:

1. A wider mobilization of resources to monitor flows and offer assistance and support to those in distress.⁵ This may involve coordinated regional or international sharing of personnel and humanitarian assistance.
2. The Missing Migrants Project, an empirical system to document, track and report migrant deaths in order to evaluate and support policy initiatives designed to reduce these events⁶
3. Regional European Health Strategy and Action Plans.⁷
4. Expert assessment to assist in addressing public health needs⁸ involving coordinated monitoring, surveillance and if needed, intervention activities.

Medium and Long Term

Not all displaced population scenarios are short term. Many of these situations represent medium and long term events that may extend generationally. In low and middle income nations challenged to meet the health and development needs of their own populations, the impact of hosting large migrant/refugee populations further overstretch resources. Similar to the effect of acute crises, the long term impacts of hosting refugees and displaced populations can impede and delay the attainment of Primary Health Care, health system reform and economic development goals.

The simple medical and health aspects of providing health prevention, promotion and treatment services may be complicated by cultural, social and linguistic factors that are different from those in the host population. Even though the migrants may be long term residents, they may not be eligible for some benefits or able to utilize some health or social services. Over time, the cumulative effects of untreated or inadequately addressed health needs in migrant populations may result in even greater cost or service demands. Children born to migrants often experience health and social effects that result from the migration history of their parents and may display health indicators that differ from those of host population cohorts, but these are often unrecognized as many data collection systems do not identify second and third generation immigrants as such.

Models addressing generational health concerns include:

- The development and use by health providers of evidence based guidelines for the health care of migrants;^{9,10}
- Applying multigenerational approaches when addressing long standing migrant populations;¹¹
- Longitudinal studies of migrant health indicators;¹²
- Integrating place of birth, migration status and duration of residence into national surveys, census data field and other statistical references.¹³

MIGRATION AND PUBLIC HEALTH EVENTS OF NATIONAL, REGIONAL OR GLOBAL PUBLIC HEALTH IMPORTANCE¹⁴

Migration and population mobility have been recognized as factors involved in the emergence or re-emergence of infections and microbial threats of public health importance for nearly three decades.¹⁵ During this time health issues have become increasingly prominent components of global security and foreign policy agendas.¹⁶ In addition to the spread of serious infectious diseases, migration related events or impacts on the health sectors of some nations may have security and foreign policy implications.¹⁷

Since the 2010 Madrid Consultation the world has experienced the emergence and re-emergence of some important infections where migration and population mobility have been of concern. Middle East respiratory syndrome coronavirus (MERS-CoV) was recognized in the Middle East in 2012 and some cases have been exported with travellers.¹⁸ An outbreak of Ebola Virus Disease (EVD) in West Africa in 2014 occurred in a region of high regional population flows, international travel and migration. The size and scope of the outbreak resulted in the event being declared a Public Health Emergency of International Concern (PHEIC) according to the current International Health Regulations.¹⁹ More recently, the extension of Zika Virus infection to areas of South America and the recognition of related neurological and pediatric complications also prompted the declaration of a PHEIC in early 2016.²⁰

The importance of population mobility including migration was recognized early in all of these recent events and was considered in the mitigation, control and prevention programmes and practices. The relationships between regional and international travel, the flow of migrant workforces, international immigration and the patterns of travel of resettled migrants²¹ are complex, requiring individual, situational assessment. In terms of infectious disease control, there is heightened importance of migration during complex public health emergencies.²²

Currently, the implications of migration are recognized or acknowledged in many public health strategies:

- The revisions and modernization of the International Health Regulations, underway since the 1990s, focus on improving national and global capacities for prevention, detection, surveillance and response to events and situations of global public health significance.²³
- In 2013 the European Union adopted a decision to assist in managing serious cross border threats to health. This decision strengthens preparedness, supports improved risk assessment, facilitates joint medical counter measures and enhances coordination of response.
- In 2014 the Global Health Security Agenda, a partnership of nations, international and non-governmental organizations and other partners, was created to facilitate collaborative, multisectoral activities to support national and global capacities to meet biological and infectious disease threats.²⁴

Migrant relevant components of these initiatives:

- o Guidance for event management at points of departure, transit or entry;
- o Travel and transport risk assessment: guidance for public health authorities and the transport sectors;
- o Considerations regarding requirements/benefits of exit and entry screening at airports, ports and land crossings;
- o Ensuring migrant populations are included in national surveillance systems;
- o Specific post arrival surveillance for migrants and travellers from affected areas;
- o Coordinating surveillance and detection activities between origin, transit and destination locations;
- o Ensuring the occupational health and safety of those working with or interacting with migrant populations in emergency situations;
- o Ensuring that information and prevention activities are linguistic and culturally appropriate.

The importance of migration is acknowledged but migrant-specific policy components are not always fully integrated into the agendas. In addition many disease control programmes have national components and trans-border continuity of care and information sharing for diseases beyond the provisions of the International Health Regulations varies considerably. Ensuring a consistent approach to migration in global public health preparation and response capacities remains a goal.

Data collection and evidence on migrant health

It is challenging to assess the evidence on current and past approaches to health and migration. Information collected on programmes, policies and investigations developed or implemented in even the recent past may have limited relevance or applicability in terms of current migration events. Some of those difficulties are related to varying use and application of definitions and terms.

Terminology and legal designations for migrants vary between nations.²⁵ These differences can impede the comparison of data between nations and the analysis of global trends. This may generate challenges in monitoring the longitudinal health of migrants, dilute the true impact of migrant cohorts within the larger host population denominator and mask significant linkages between health indicators and outcomes with migration characteristics. Advancing global migration health will need to be supported by standardized, normative migrant status variables that can be applied internationally.

Examining the health of migrants in a more globally integrated manner will require greater use of health variables and standard indicators such as those used in other global health initiatives such as UHC.²⁶ Disease or specific condition based monitoring will continue and can support broader health indicators but a greater focus on migrant health needs should be developed.

Information Derived from Acute Migration Events

In large volume migratory movements, basic health information is collected and responses are mobilized when health events occur.²⁷ Much of this information results from individual clinical encounters rather than systemic population based surveys, and data may be reported nationally, internationally or disseminated academically.²⁸

When displacement becomes chronic, health services can extend to prevention and promotion providing funding and resources are sufficient. Health information in these situations is routinely collected and shared between providers and international agencies.²⁹ Over time activities have become standard components of modern humanitarian responses.

While these programmes are frequently stretched by demands that exceed resource capacity there are standardized guidelines and approaches to address the health needs of the acutely displaced.^{30,31} Advances in technology facilitate the collection and analysis of basic information, even in acute events, and the increased use of these systems is expected to generate more evidence regarding the health status of those on the move.

Evidence from Sustained or Long Term Migratory Flows

Long term migrant populations represent the source of most migration health data and analysis related to disease incidence and prevalence in migrant cohorts and communities. Patterns of health service utilization, long term health outcomes and social determinants of health are routine areas of migration health study. Immigration health programmes also generate information that can provide historical perspective on the prevalence of some illnesses and health relevant conditions in those subject to the requirements. With respect to non-communicable diseases,³² examples can be observed for disease specific studies,³³ gender and reproductive health,³⁴ mental health,³⁵ the use of health services³⁶ and ageing.³⁷ Wider acceptance of migration as determinant of health should result in better data and improved understanding of migrant health needs.

CHALLENGES IN THE ASSIMILATION OF MIGRATION HEALTH INFORMATION

Health providers caring for migrants in transit and resettlement situations often encounter needs and situations that differ from those of the host population. Lack of resources and personnel dedicated to the migration health sector is common. Migration health programmes are often “add ons” to existing operational structures or policies originally designed for other purposes. Insufficient prioritization of migration health activities in relation to other demands can result in programme deficiencies due to funding and capacity issues and resource diversion when crises arise in other sectors. Nevertheless, many providers have developed experience and practices to improve and support the health of migrants. Modern information technology and connectivity can facilitate the dissemination of knowledge and experience gained by those who treat migrant and mobile populations.

During the past decade many collaborative efforts have led to evidence-based guidelines for dealing with aspects of migration health.³⁸ Cooperation between health-care providers dealing with the health of migrants has supported the development of centers of excellence, teaching and research in the field.³⁹ Some of these undertakings are national in scope⁴⁰ but there are regional and international activities under way.⁴¹ In Europe, IOM and the EC for example have produced both a health assessment handbook for refugees and migrants⁴² and a personal health record for migrants.⁴³

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

Improving evidence and information collection globally would be enhanced though high-level, globally coordinated guidance and information structures. Optimally this would lead to migration health policies, practices, guidelines and expertise linked to other global activities such as HSS, UHC and global public health endeavours.

Health inequities in the context of migration

Modern migration flows occur in the global context of significant disparities and inequity in levels of development, wealth and health indicators. Addressing those inequities will improve migrant health if the needs of migrants are explicitly incorporated into national and international health agendas, such as UHC and development programmes.

Relating the forces that are behind health outcomes in migrants to the components of the migratory journey can support the effective targeting of intervention and prevention activities and resources. Dealing with health issues before they develop or at the stage they are created may be more cost and outcome effective than simply managing the consequence after arrival or resettlement. Reducing health inequities in source nations will improve the social and medical determinants of health for future migrants, reducing costs for them throughout the migrant trajectory.

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

Achieving those goals will be facilitated by:

- Addressing the need for integrated, inter-sectoral migration health policies;
- Creating globally standardized variables to monitor migrant health (not limited to disease surveillance);
- Supporting the use of those variables in national and international health data collection and monitoring systems;
- Providing global stewardship for migration health during the development of the refugee and regular migration Global Compacts.

Cross-cutting Issues

The crosscutting or lateral health issues associated with migration are similar to those in other global health agendas. These range from concerns about the legal status of migrants and refugees to disparities in health status, the role of health assessments, and the impact of gender. Other cross-cutting issues will be raised in the sections on development and the Sustainable Development Goals.

LEGAL AND ADMINISTRATIVE STATUS

New global commitments recognize both the common aspects of the migratory process as well as the substance and nature of these differences between refugees and other migrants. Collective and comprehensive global solutions based on equity and shared responsibility through three major action streams are integral parts of those commitments.⁴⁴ Those action streams include:

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

However, it is important to remember that refugees with well-founded fear of persecution that forces them to flee across international borders have rights and protection defined by the 1951 Convention and the 1967 Protocol and in international law that may not extend or apply to other migrant categories. Programmes

and policies dealing with the health of migrants will need to be both inclusive enough to ensure the respect, rights and dignity of all individuals while ensuring the specific legal aspects and protection associated with refugees.

DISPARITY

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

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

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

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

GENDER ISSUES

Access to maternal and child health services may be interrupted or prevented during migration and lack of access to appropriate care may continue following arrival at the destination. This can lead to adverse reproductive health outcomes for some migrant populations.⁴⁵ Risk factors can be observed before conception and continue through pregnancy, childbirth and the postpartum period.⁴⁶ In addition to the risks of violence across the migration spectrum, migrant children, girls and women can suffer sexual violence and victimization. Access to gender-sensitive, culturally appropriate care may be limited during the migratory process or after arrival and protection of women, children and girls may vary. Modern, integrated migration health policies and programmes should be developed with appropriate attention cultural competency and gender sensitivity.

MIGRANT WORKER HEALTH ASSESSMENTS

Many global migrant workers who leave home face pre-employment, pre-travel and job site health requirements and restrictions that vary by circumstance. Many reflect historical quarantine or immigration health style practices designed to prevent the arrival of certain diseases or illnesses. In many cases these practices are focused or centred on two criteria: fitness for employment and infection specific diseases such as tuberculosis, sexually transmitted infections and vaccine preventable diseases.

Standardization and evaluation of the efficacy and efficiency of these health assessment and screening programmes for foreign workers varies. The assessments may not be integrated into treatment or disease control programmes that would ensure the adequate follow up and treatment of those identified with an illness or disease. Migrant workers may be simply denied work authorizations or returned to their nation of origin in the absence of integrated or coordinated follow up or treatment.

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

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

Frameworks and Indicators

Many aspects of the operational framework and monitoring indicators from the 2010 Madrid Consultation remain valid. Effective global monitoring frameworks based on harmonized indicators are also seen as a necessary component of measuring progress on the Sustainable Development Goals.⁴⁷ Adding migration-relevant fields and indicators to existing health data collection systems would improve organizational and programmatic efforts in monitoring migrant health.⁴⁸ This will require a coordinated, international and inter-sectoral repository for migration health knowledge, lessons and best practices. The recent entrance of IOM as UN Related Agency provides an increased capacity to integrate health elements in global migration discussions. The UN New York Declaration of September 2016 also offers opportunities to create global migrant health standards and policies with cross-jurisdictional application.

Also recently summarized and prioritized by WHO,⁴⁹ there are needs for:

1. The identification of priority indicators and outcome measurements

A major goal in this regard a major goal is to insure that international studies of migrant resettlement and integration include standardized basic health indicators. The systematic use of those indicators would identify and reduce differences in national surveys that make data comparison challenging.

National and institutional interests can continue to generate basic information and serve national health and public health needs but a coordinated globalized should focus on health issues of the greatest collective importance. Standardized migrant health indicators derived from local or national data can support the identification of the most important health needs in a global context.

2. Better coordinated and globally integrated monitoring of migration-relevant health policies, programmes and health outcomes.

The use of standardized national and international data in a relational context will support the coordinated and systematic monitoring of relevant health needs and outcomes. Where possible the phases of the migratory process should be included in this analysis.

Given the role of cyclical or recurrent migration, where individuals may cross the same or different borders multiple times, systems involving portable or easily accessed health information for migrants require development and implementation. Guidelines do exist for some individual diseases such as tuberculosis,⁵⁰ but the processes and practices should be expanded to include a broader range of health information. The importance of the smooth trans-border flow of health information between countries and stakeholders is very important during large, regional movements.⁵¹

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

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

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

The explosive growth in the importance, interest and study in health and migration is generating large amounts of information, some data and a variety of conclusions. In the absence of a systematic approach to global migrant health the volume alone of this information can be challenging to interpret and consider in the global context. There are examples of how guidelines and indicators for similarly complex issues, such as global development goals can be prepared.⁵²

Global and regional strategies and programmes working to reduce the prevalence and burden of diseases and improving health such as the Global Fund have components that recognize or include migrants as key or important populations.⁵³ Similarly, many programmes focused on specific diseases of global importance such as malaria,⁵⁴ tuberculosis,⁵⁵ hepatitis⁵⁶ and HIV⁵⁷ contain migration-relevant or migrant-targeted components. Bringing the experience and knowledge of all of these endeavors together and exploring commonalities and identifying opportunities for programme symmetry will be an important building block of a uniform global migration health strategy.

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

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

It has become clear that it is necessary for health systems to improve both the access to and migrant-friendly aspects of services available to mobile populations. At the same time it is apparent that nations have to begin to improve the social and economic determinants of health affecting migrants across both the health and social services sectors.⁵⁸ Experience and practical knowledge varies between nations. Global migration health would improve through the organized review, assessment and evaluation of the programmes, practices and policies involved in migration health at the national and institutional level.⁵⁹ The goal in this regard is enhanced programme and policy coordination with the avoidance of both redundancy and gaps in approach.⁶⁰

Some collaborative activities in this regard are underway. For example, the Migrant Integration Policy Index (MIPEX), provides a systematic comparison of policies associated with migrant integration in nearly 40 nations.⁶¹ Several of the MIPEX indicators are health related and the index allows for systematic comparison between the national approaches and outcomes for the selected indicators. Additionally, recently the European Region of Who prepared a regional roadmap for the implementation of the 2030 Agenda for Sustainable Development that had an associated strategy and action plan for refugee and migrant health in that region.⁶²

5. Consideration of New and Novel Migration Health Partnerships

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

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

ANNEX

The annex paper, “Monitoring progress towards ‘migrant-friendly’ health systems, with particular emphasis on Europe,” by David Ingleby at the University of Utrecht, traces out a ‘road map’ showing how ideas about desirable policies on migrant health have developed, focusing particularly on Europe. The milestones on this map take the form of legal instruments (treaties, conventions and regional laws), ‘soft’ instruments (declarations, recommendations and guidelines), and practical actions such as conferences, research programmes and the setting up of networks.

From this foundation, two EU-subsidized projects (the IOM’s EQUI-HEALTH⁶³ and COST Action IS1103, ‘Adapting European health services to diversity’)⁶⁴ decided to combine forces with a third, the Migrant Integration Policy Index or MIPEX,⁶⁵ to introduce a new MIPEX strand on Health.

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

The current MIPEX Health strand measures policies in force at 1st January 2015 in 38 countries;⁶⁶ full details can be found in the Summary Report (IOM, 2016). It is intended to repeat the survey along with the rest of MIPEX in 2019, which will show whether policies have been improving or deteriorating. The instrument does not simply provide qualitative data on each of the questionnaire items; it also provides scores on the four dimensions and a total score obtained by summing these. Some of the findings are described here:

- Regarding entitlements, legal migrants enjoy the best coverage, asylum seekers somewhat less good, and undocumented migrants much worse than both. In all but a handful of countries, coverage for the latter group is below the standard required by human rights law (see also Ingleby and Petrova-Benedict, 2016). Even for legal migrants, coverage tends to be less than for nationals, in particular for migrants with shorter stays and lacking an employer who pays premiums.
- Concerning accessibility, countries differ greatly in the efforts that are made to inform migrants about their rights to health care and how to exercise them, as well as other measures to help them find their way into care. Often, health workers appeared to be as badly informed about entitlements as migrants themselves.
- The responsiveness of health services to migrants’ needs varied even more widely. Eight countries scored zero, i.e. nothing whatsoever was done to adapt services, while six scored 70 or more out of a possible score of 100.
- Measures to achieve change were, somewhat surprisingly, only related to accessibility and responsiveness – not to entitlements. On this scale too there were very wide differences.

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

- Some countries (e.g. France and Ireland) place a higher priority on good entitlements than on the adaptation of services, while in others (e.g. the United Kingdom) these priorities are reversed.
- Examining the relationship of Health strand scores to background variables immediately runs into the problem that the latter tend to be correlated with each other. A country’s per capita Gross Domestic Product (GDP), the number of migrants it attracts, the amount of money it spends on health, its average scores on the other strands of MIPEX, and public opinion concerning migrants, all tend to be positively correlated. This makes it difficult to find out which of them is exerting the most direct influence on policies: though MIPEX scores are fairly robust, they do not have the metric properties required by most multivariate analysis methods

- One finding to which this problem does not apply is that measures to achieve change are more often found in tax-based health systems than insurance-based ones. This may have to do with the fact that top-down planning is more characteristic of the former.

Total scores for the so-called ‘traditional countries of immigration’ (Australia, Canada, New Zealand, the United States of America) are slightly higher than those for the EU15 and EFTA countries; the difference is mainly due to the emphasis placed on the responsiveness of services, not to access – which is in fact slightly better in Europe. Countries which joined the EU since 2004 score markedly lower than EU15/EFTA countries. Indeed, they score even lower than neighbouring non-EU countries such as Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Georgia⁶⁷ and Turkey, despite the fact that the average per capita GDP of the latter countries is only two-thirds that of the EU13.

NOTES

- ¹ A PubMed search using the terms Global Migration Health Policy revealed 301 articles, a second using the terms Global Migration Health Programs revealed 141. Articles deemed relevant were selected by the author for reference use consistent with the TOR. In addition, “grey” literature and organizational and agency literature sources were utilized.
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- ¹⁴ In this section global public health importance is used in the context of the international spread of disease that requires a coordinated international response.
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VULNERABILITY AND RESILIENCE

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This thematic paper examines migration health from the perspectives of vulnerability and resilience, proposing a conceptual model for migrant populations that seeks to better understand and manage health vulnerabilities of migrant populations through resilience-enhancing approaches. It then applies the model to the key elements of the 2010 Global Consultation on Migrant Health Operational Framework: monitoring migrant health, policy-legal frameworks, migrant sensitive health systems, and partnerships/multicountry frameworks.

Developing a migration health vulnerability and resilience model

We seek to provide a clearer understanding of health vulnerabilities and resilience of migrant populations through developing a ‘migration health vulnerability and resilience model’. The model is based on a social determinants of health approach. The role played by social determinants of health was recognized in the 1948 Constitution of the World Health Organization (WHO), and extensive research conducted particularly from the 1970s onwards highlighted the importance of social determinants of health, demonstrating the persistence of large inequalities in health between and within societies.¹⁻⁴ A variety of theories have been invoked to explain this phenomenon.^{5,6} Some emphasize the physical and psychological toll of poverty and inequality on individuals and communities, leading to hazardous exposures and psychosocial stress that, in turn, predispose to greater vulnerability to poor health.³⁻⁷ Other approaches focus more on the ‘social production of disease’ following a political economy perspective, arguing that the structural causes of inequality should be given primacy, even if not exclusively.⁸⁻¹¹ Another theoretical approach is ‘ecosocial theory’. This emphasizes the importance of exposures over the entire life course, seeking to integrate biological, ecological and social factors throughout an individual’s lifetime as determinants of their health.⁵

The theories on social determinants of health have been brought together in various ways, of which the most widely used is the ‘main determinants of health’ image developed by Dahlgren and Whitehead (12). This depicts the individual and their microlevel features; surrounded by a mesolevel layer of lifestyles, social and community networks, living and working conditions; and a macro-level layer of socioeconomic, cultural and environmental conditions.

The ‘migration health vulnerability and resilience model’ is presented in Figure 1. It broadly follows Dahlgren and Whitehead’s model of concentric circles of micro, meso and macrolevel influences,¹² with the migrant at the centre, and which has also been applied elsewhere to migration.¹³ These influences vary over time, as the migrant moves through successive phases of migration, from their country of origin to their destination, reflecting the heterogeneity of the migration process and migrant populations. The model indicates how social determinants of health can be both negative and positive, such as through increasing health vulnerability or supporting resilience. It must be recognized that the majority of migrants (including forced migrants experiencing highly traumatic events) do not experience adverse health effects, including mental disorders. Factors such as better initial health, supportive networks in transit or on arrival, and access to medical care can support resilience. Indicative examples of vulnerability and resilience factors are shown in Figure 7, p.34.

Drawing on the thinking of Dahlgren and Whitehead, we see the health of the migrant as determined by the circumstances in which they live and work including the influence of events across the life course. Thus, the health needs of migrants are a product of:

- microlevel factors such as genetic inheritance, age (e.g. under-fives, adolescents, and older populations all experience different vulnerabilities) and gender (including both biological differences but also discrimination and gender-based violence);
- mesolevel factors such as living conditions, income, life events, sources of support, and social inclusion/exclusion;
- macrolevel factors such as systems of governance, labour market policies, social and economic policies, migrant-hostile political discourse, and culture.

† The Organizers would like to convey their deepest sympathies for the sudden and tragic loss of Dr. Chesmal Siriwardhana. He was committed to helping advance the domain of migration health research to the forefront of global health attention. We highly value Chesmal’s contribution to building a stronger evidence-base within migration health. We extend our deepest sympathies and condolences to his family, friends and colleagues.

Some of these factors continue to act during the migration process while some are in the past, and thus unable to be addressed for those now migrating. This highlights the importance of measures such as effective development assistance to reduce vulnerability in populations affected by threats that can be anticipated, such as political tensions leading to persecution and armed conflict.^{2,14} It is thus necessary to address these inter-related political, environmental, economic, social and cultural determinants if we are to improve people's health, and help prevent or reduce adverse influences on health in the future.¹⁵ It is also important to recognize that health differences in migrant groups do not necessarily disappear when social determinants (e.g. socioeconomic status) are controlled. Instead, such determinants act not just as confounders but also as mediators influencing health outcomes on the causal pathways between migration status and health.

MIGRANT HEALTH VULNERABILITIES

Adverse individual, meso and macro level factors, each creating vulnerabilities among migrants, act during the classic phases of migration (origin-pre migration, transit-migration, destination-post migration, return). These different phases of migration are associated with specific vulnerabilities that can influence subsequent health outcomes. Thus, health problems already present at the pre-migration phase (e.g. endemicity of disease, availability of health services, living with chronic disease, exposure to traumatic events) may impair health during migration, which may in turn be exacerbated by physical/psychological trauma, injury, or deprivation during the process of migration. All these factors may influence health on settlement in the destination country, which themselves may be worsened by post-migration experiences (e.g. deprivation, lack of services, lack of protection, broken social networks).¹⁶

Different migratory phases are associated with distinct physical health issues, influenced by the type, duration and methods of migration.¹⁷ Behavioural, environmental, genetic, biological, socio-economic and cultural factors can influence the manifestation of physical illnesses in migrating individuals and populations, and can be compounded by migration-specific factors.¹⁷ Those experiencing complex emergencies, such as conflict-related displacement, are often especially vulnerable, for example, to increased risk of infectious diseases due to lack of access to clean water, sanitation, nutrition, shelter and health care.¹⁸⁻²⁰ Children and elderly people who have been forced to migrate are especially vulnerable to malnutrition and related illnesses, and may have come from settings where immunization programmes were sub-optimal.²¹ Migrants from those middle-income countries afflicted by conflict have benefited from functioning health systems that have allowed them to survive with chronic conditions such as heart disease, chronic respiratory diseases and diabetes¹⁸ but are now vulnerable to lack of life-sustaining medicines – particularly older people. Women who lack access to essential reproductive health services are at risk for unwanted pregnancies, maternal and infant mortality, and sexually transmitted infections. Women and children are also extremely vulnerable to sexual abuse, physical abuse, slavery, and other assorted forms of violence.²²

Individuals may be especially vulnerable to mental disorders during certain phases of migration, and when engaged in certain types of migration, each of which may exacerbate existing vulnerabilities. Mental disorders come in many forms among migrants, with different types of disorder, range of symptoms and time to symptom manifestation since the flight phase. Several characteristics are associated with greater vulnerability to mental disorders in migrant populations. These include: female gender, older age, widowed/divorced marital status, lower education, lower socioeconomic status, living conditions, cumulative trauma exposure and type of trauma, duration of forced migration, post-migratory detention and asylum processes, fluency in the required foreign language/s, occupation, family and household factors, and support systems.²³⁻³¹ Psychological adaptive mechanisms, resources that are available or utilized, and degree of individual adjustment can influence resilience and all influence mental health outcomes.^{32,33}

The model also highlights the importance of meso and macro level factors influencing health vulnerabilities of migrant populations. For example, the lack of a legal framework and denial of rights can increase vulnerability through reduced access to protection and social support, such as for IDPs when compared with the greater legal protection provided for refugees. The power of companies and corporations and weak accountability and enforcement mechanisms are linked with exploitative working conditions and consequently negative physical and mental health effects for labour migrants. Discrimination and stigma can increase stress and reduce access to health services. Populist responses to migration can also lead to further social discrimination and restrictive government policies.³⁴ Low and middle income countries hosting large numbers of migrants (e.g. IDPs or refugees) may have weak health systems and so struggle to meet their health needs or instead rely on parallel services provided by international agencies which can cause inequitable health-care access between migrant and host populations.

MIGRANT HEALTH RESILIENCE

Resilience has been defined in different ways. At its heart, it is the ability to recover from shocks and overcome adversity.³⁵ Current conceptualization of resilience involves a multidimensional construct that includes individual capacities and social and environmental support.³⁶ It is a dynamic phenomenon and one that can vary across cultures, age groups, and gender.^{36,37} The ability of groups of individuals or populations to recover from hardship is termed as community resilience.³⁸⁻⁴⁰ There has been a continuing evolution of concepts of both individual and community resilience.

The role of resilience in producing health, especially mental health has been extensively researched among forced migrant groups, leading to its recognition as an important protective factor for psychosocial health among forced migrants.^{30,32,41} As with vulnerability, it varies according to certain individual characteristics, with older age, protracted displacement and on-going hardship decreasing resilience while better living/working conditions, being younger and having higher levels of support can enhance resilience and, ultimately, improve mental health.^{30,42,43}

Consistent with our multilayered model, resilience of individuals and communities is also affected by a number of social, economic, cultural factors acting at the meso and macro levels.³⁷ Understanding the role of resilience as a key protective or modifying factor between migration-related experiences and the development or exacerbation of poor health can aid the development of cost-effective interventions, and especially those that are non-medicalized and operate at the community-level.³⁰ Examples include psychosocial support interventions such as self-help groups, safe spaces for meeting and discussions, and community empowerment programmes. Participants in a Canadian study of resilience among migrants and refugees highlighted the importance of services that are linguistically and culturally adapted, anti-discrimination training for service providers, and programmes that educate about Canadian systems, culture and civic engagement.⁴⁴ Good communication channels with families and home communities provides a critical foundation for migrants and the families they leave behind.⁴⁵ And the Women's Refugee Commission has identified promising approaches to fostering reliance among Syrian refugee women, children, and youth with disabilities that take an assets-based approach to support that includes building individual skills, incorporating social programmes, and ensuring access to safe and well-equipped physical spaces.⁴⁶

All of these models highlight the need for resilience-enhancing responses that are culturally appropriate and take account of the particular circumstances that prevail in any migration context. Such responses must, of course, be embedded in international law on migration, human rights, and the right to health (see below), recognizing that the obligations that arise may need different strategies to achieve them. Too few people understand that, contrary to the populist rhetoric that refugees/asylum seekers increase the burden on the host country's health systems, migration typically makes a positive contribution to economic development. Improving access to care, providing preventive services and granting universal health coverage to refugee populations can produce savings on health expenditure.³⁴ More could be achieved by emphasizing prevention and health promotion rather than treatment; in other words, promoting resilience instead of focusing on vulnerability.⁴⁷

A well-managed, humane migration process can reduce vulnerability and enhance resilience and human and economic well-being for migrant groups and their families. Some destination countries, recognizing the particular needs of migrants, have established systems that, at least for those with the appropriate status, can more easily access some services. However, negative perceptions of migrants, for example as vectors of disease, still prevail in many countries, and are often exacerbated in times of health or political crisis or economic austerity, with adverse consequences for the health of migrants.⁴⁸ Contrary to these assumptions, extensive reviews have revealed little evidence of systemic association with migration and public health security threats from communicable diseases spreading to host communities.⁴⁹ European agencies have acted to counter such scaremongering about migration and perceived risks of infectious disease,^{50,51} while highlighting the broader health needs of migrant populations, including those factors that increase vulnerability and reduce resilience.

APPLYING THE HEALTH VULNERABILITY AND RESILIENCE MODEL

In this section we examine the extent to which vulnerabilities of migrant populations can be tackled, and resilience enhanced, by means of the 2010 Operational Framework.⁵² This Framework includes four priority action areas: policy-legal frameworks, partnerships/multicountry frameworks, migrant sensitive health systems and monitoring migrant health. These will be discussed in turn.

Policy-legal framework

Addressing health vulnerabilities requires engagement with international, regional and national laws and policies. Human rights law is the most important basis for protection of migrants. In accordance with the principles and provisions set out in core universal human rights instruments, states have an obligation to protect the human rights of all individuals within their territory, including migrants, regardless of their migration status. More specifically, General Comment 14 on the 'The Right to the Highest Attainable Standard of Health' (the Right to Health) elaborates on Article 12 of the UN International Covenant on Economic, Social and Cultural Rights (ICESCR), noting that the right to health extends to migrant populations, including asylum seekers and illegal immigrants. It addresses not only access to health services but also health vulnerability by recognizing the underlying determinants of health such as living conditions, occupational health, impoverishment and discrimination. Other key instruments of human rights and international law and key regional policies are provided in the Annex of the Health, Health Systems and Global Health discussion paper of the 2nd Global Consultation on Migrant Health. In practice, however, migrants in many countries face many practical barriers to accessing care,⁵³ with signs that recent policies are exacerbating this problem.⁵⁴

Above all, coherent public policy responses are required, involving the health, education, social, welfare, and finance sectors. The health sector has a key role in ensuring that the health aspects of migration are considered in the context of broader government policy and in engaging and collaborating with other sectors to find joint solutions that benefit the health of migrants. While studies are available on migrant health policies, it is difficult to integrate and synthesize these findings due to the selection of different countries, concepts, categories and methods of measurement across these studies. However, the Migrant Integration Policy Index (MIPEX) which evaluates policies to promote the integration of migrants now has a Health Strand, helping to surmount this obstacle by collecting information on carefully defined and standardized indicators across 40 countries on health-care entitlements, access, and responsiveness for migrants.

Partnerships, multicountry frameworks

As noted above, current multicountry frameworks and partnerships have focussed predominantly on the link between communicable disease and migration. There is a need to extend such frameworks and partnerships beyond communicable disease surveillance and take a more comprehensive public health approach, including on recognizing the full range of social determinants of health in migrants. There are few multicountry or multisectoral partnerships on migrant health that include the full spectrum of sectors and actors required to adequately address health vulnerabilities. Some rare exceptions are in relation to HIV/AIDS, widely seen as a challenge whose solutions demand a multisectoral response.⁵² Other examples can be found in the Development thematic paper.⁵⁵

In terms of regional responses, the European Union provides some of the best examples of multicountry frameworks that take a broader approach to health vulnerabilities, including recognizing the need to include migrants within its programme on the social determinants of health. UN-led networks also offer potential to address migrant health vulnerability. However, such networks have generally lacked adequate financing, enforcement and reporting mechanisms.⁵² Recent measures such as the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration may also offer the opportunity to better address the health needs and vulnerabilities of migrant populations.

There is an opportunity to strengthen global and regional responses to migration that do not consistently include health but have a direct influence on health vulnerabilities, such as labour rights, and occupational health and safety. For example, the Global Forum on Migration and Development and the Global Migration Group could provide important means of ensuring health vulnerability is integrated into other sectors and processes.

Migrant sensitive health systems

Migrant sensitive health systems and programmes aim to incorporate the needs of migrants into all aspects of health services, financing, policy, planning, implementation, and evaluation. This includes aspects such as: language services; culturally informed care, health promotion and prevention; accessible primary care; capacity-building within the systems to support migrant responsive systems; and data to monitor and plan for migrant needs.^{52,56} There is, however, enormous diversity in the extent to which health systems have implemented these measures.⁵⁷ Some best practice approaches to the development of migrant sensitive health systems include measures to:

- Expedite the process to allow physicians from other countries (including migrants' countries of origin) to practice in the countries of destination, and facilitate and prioritize their incorporation into the health systems;
- Use technology (e.g. tele-health) to support services to mobile populations, including the support that providers from the countries of origin can offer in monitoring health problems in a culturally and linguistically sensitive manner;
- Train migrants to become community health workers and incorporate them into health systems that serve populations originating from same country/culture;
- Conduct cultural competency training among health and social work providers;
- Promote exchanges between health professionals from countries of origin and countries of destination;
- Develop and incorporate public health practices such as health literacy campaigns for migrants, guides to accessing health services, engaging migrants in planning/implementation of health services, and use of cultural mediators.

However, it is critical to recognize that mitigating health vulnerability goes beyond ensuring responsive health services and systems, and requires engagement in the underlying drivers of poor health that reach beyond the health system. This would include addressing micro level determinants such as age and gender, meso-level determinants such as social and community networks and capital, poor housing, food, and education, and unemployment, and poverty; and macro-level determinants such as legal frameworks around asylum, discrimination, and legal entitlements, and the role of corporations. This requires the health systems to engage with other key sectors such as welfare, housing, education, and legal protection.

Monitoring migrant health

Migrant health metrics have historically focused on disease-based indicators, particularly communicable disease surveillance and control. Addressing health vulnerabilities requires a broader understanding of how migrant health is affected by the social determinants of health, including migration-related social determinants. This recognition must be matched by redesign of information systems to include these broader social determinants of health. Given their wide scope and challenges in collecting 'gold standard' epidemiological data on social determinants of health, it is advisable to take a broad approach by including a range of data sources and assuming chains of plausible reasoning.⁵⁸ The ability to monitor migrant health vulnerability would also be strengthened by using internationally applicable indicators related to key health vulnerabilities and agreed methodologies to support comparisons between countries. Central to such work will also be development and application of routine health metrics that record the different subgroup classifications of migration in order to capture their different experiences and related vulnerabilities, including key migrant-relevant indicators such as origin, duration of residence or migration history. Such work requires political and financial support to ensure effective implementation.

An ongoing process of systematically collating, synthesizing and analysing empirical research on migrant health vulnerability is also needed, linked to activities that can address it. This would provide an important resource to understand better the major barriers that inhibit progress in addressing migrant health vulnerability and resilience.⁵⁹ There is also a clear need to train researchers in migrant population specific aspects and methodologies. The Migration Health and Development Research Initiative (MHADRI) is a recently established research network that seeks to address above-mentioned issues and to promote shared research activities and approaches in migration health.

Monitoring of how policies address or affect migrant health vulnerabilities is also required. Currently, systems monitoring the implementation and enforcement of health policies focuses principally on health services, such as legal entitlements (e.g. for services), access policies (e.g. language and cultural support for services), and responsive services (e.g. how services and staff are adapted to the needs of migrants). Monitoring of laws and policies and their enforcement should focus not only on health services, but also other services and activities that influence health vulnerability such as labour laws, anti-discrimination laws, asylum processes, and how these then may influence health outcomes. A similar view was expressed by the Canadian Minister of Health who stated that 'every policy is ultimately a health policy' at the OECD Policy Forum on the Future of Health in January 2017. Whether in the field of education, employment, or anti-discrimination, they are ultimately all health decisions. This same rationale has also been developed

and incorporated in the conceptualization of the Health Vulnerability Model, presented in this paper. While valuable qualitative policy evaluations are present, the availability of quantitative tools to conduct cross-national comparative research and explore the effect of policy on immigrant health outcomes is more limited.

As noted above, the Migrant Integration Policy Index (MIPEX) provides an example of a migration policy monitoring initiative that could be used to monitor health. MIPEX addresses a broad range of policies and contextual factors which are crucial to understanding policy implementation related to health vulnerability. For example, it monitors policies and their implementation related to labour markets, education, political participation, and anti-discrimination. Beyond policy indicators, MIPEX allows for multivariate analysis to establish the independent effect of policy and other contextual level factors on migrant health outcomes.

To inform this thematic report, a systematic review of available evidence on the association between health outcomes and integration policies was conducted (Annex A in the full paper). This notes a lack of any existing theoretical framework and of empirical research. Consequently, existing analyses of macro influences of health differences between migrants and non-migrants are exploratory in nature. Overall, as compared to non-immigrants, immigrants experience a clear disadvantage for most health outcomes considered. Disparities were generally reduced in countries with a strong integration policy. This trend was maintained even after adjustment for relevant individual- and contextual-level factors.

The majority of studies identified in our search included MIPEX, in one form or another, as a measure of national migrant integration policies. While the global MIPEX score failed to show a relationship with depression in immigrants,⁶⁰ the overall MIPEX score has been found to be related with a smaller disadvantage as compared to non-migrants in subjective well-being.⁶¹ The relationship between integration policies and subjective well-being has further been studied through a focused analysis amongst older migrants and non-migrants in Europe, revealing that the immigrant/non-immigrant gap is bigger in countries with restrictive family reunion policies.⁶²

MIPEX has also been operationalized through a policy model approach, as proposed by Meuleman with the three typologies, namely: the inclusive model, the assimilationist model and the exclusionist model. Results revealed that migrants in countries with a exclusionist policy model had poorer self-rated health and larger inequalities, as compared to migrants in countries with other policy models.⁶³ Building on this research,⁶⁴ one could operationalize MIPEX in the same manner in order to analyse whether the effects of discrimination on health outcomes change in countries with different integration policies. The associations between perceived group discrimination and poor health outcomes in first generation immigrants are indeed more significant in countries with assimilationist immigration policies.

Taken together, these results suggest that integration policies, beyond simply health integration policies, are important for reducing health inequalities between immigrants and non-immigrants, and are needed in order to tackle inequalities in health and ultimately to improve equity in health. Further work would also be required linking the current policy measures with health outcomes. Such work would be critical in documenting and comparing good policy practice by governments in addressing migrant health vulnerability and resilience and holding governments and other key actors to account.

Conclusion

This paper explored the health of migrants from the perspectives of vulnerability and resilience, and presented a conceptual framework by which to understand vulnerability of migrant populations and how measures to promote resilience can counteract them. The framework was then applied to legislative, monitoring, health systems, and partnerships/multicountry frameworks. These elements will be crucial in documenting and comparing good policy practice in addressing migrant health vulnerability and resilience and holding governments and other key actors to account. We conclude with key questions whose answers will inform the development of priorities for work in this area.

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DEVELOPMENT

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Introduction

Development is a major driver of migration, both as a response to conditions at home as well as opportunities available abroad. Migration carries the potential for substantial development benefits, powered by the physical, intellectual, social, and financial capital that migrants offer. All this rests on good health. Without health, migrants cannot work, be productive, or contribute to the social and economic development of their communities of origin and destination.

Migration in a development context can lead to improved health status through access to higher income, better housing, improved nutrition, and a higher standard of health care. Migrants also face many challenges to accessing health services and staying healthy, endangering both their productivity as well as their development potential. In fact, the vulnerabilities inherent in the migration process and the kinds of work migrants do can endanger their physical and psychological health. The migration process itself is a social determinant of health. The health disparities arising between migrants and native populations demonstrate the power of this, often altering the overall health status of a country, which in turn affects the ability of countries to reach development goals.¹

This paper looks at the health of migrants in the context of development, from pre-departure to return. It will review mechanisms of social protection for health available to migrants, examine the opportunities to support the health of migrants through social and technological innovations, and place migration health issues in the context of the Sustainable Development goals.

HEALTH OF MIGRANTS IN A DEVELOPMENT CONTEXT

There are many ways that migration in a development context affects health, and there are economic, social, legal and other determinants that add complexity. This paper will look at three considerations: the conditions that compel people to move to seek a better life, the effects of the kind of work they do in the place they have moved to, the impact of their migration on the families and communities they have left behind, and what happens when they return to their home countries.

Pre-departure health

People leave their homes for many reasons, moving from one country to another, or to another part of the same country. They may be fleeing violence or persecution, escaping a situation that is not adequate to meet their needs, or seeking better opportunities for education and employment. In developing countries, the level of health in their communities, and the resources available to meet them, is often lacking. The burden of disease is can be high, and basic health needs may be left unattended. These factors may have an impact on migrants' ability to leave their countries in search of work, as pre-departure and arrival medical assessments may screen out migrants with health problems.^{2,3} In countries where health status and health resources are higher, people may leave with an adequate level of health, but acculturation and exposure to unhealthy lifestyles in destination countries may erode their health status. The migration process itself can expose some migrant groups to health risks through unsafe travel, changes in disease epidemiology, poor nutrition or living conditions, and psychosocial stress. Some migrants may be especially vulnerable, such as those forcefully displaced, or being trafficked, or in an irregular status. Already traumatized families and children escaping from dangerous regions, such as the Middle East, East Africa or Central America, face additional risks from depression, anxiety, and suicide when faced with violence or detention during the migration process.

Destination country health factors

Upon arrival in the destination country, the kind of work migrants do in a development context may have a detrimental impact on their health. For low-skilled or irregular migrants, many jobs are dirty, dangerous, and demeaning (DDD), do not have occupational health protections, and may be exploitative. Occupational risks are common in mining, construction, manufacturing and agriculture, including inadequate training, lack of protective gear, and exposure to toxic agents and conditions.⁴ For example, in Africa, while migrants are commonly drawn to mining and agricultural work, migration also has a powerful impact on urban areas. Living in impoverished situations in dense urban slums, migrants are exposed to a variety of communicable

diseases, malnutrition, and poor sanitation. They may have limited access to health services that are already quite strained.⁵ Migrant domestic workers often face physical, verbal, and sexual abuse at the workplace.^{6,7}

In addition, many migrant workers have limited awareness of or access to health and social services due to a combination of legal, structural, sociocultural, linguistic, behavioural, and economic barriers. These factors are multiplied in consequence for migrants in an irregular situation and for those who have been trafficked or forced to move.⁸ In some countries, migrants are seen as difficult to treat, carriers of disease, and a burden on the health system.⁹ Xenophobic discourse and attitudes from health-care providers and the surrounding community compounds the psychological stress that migrants experience. Thailand has attempted to address the issues of sociocultural and linguistic barriers to health care for migrants by identifying 11 components of migrant-friendly health services, highlighting the need for building staff capacity to improve attitudes and cultural awareness. They have developed indicators for client-friendly health services for migrants that include attention to lifestyle and culture, occupation and living conditions, convenience of access, cooperation with migrant work employers, and cross-border linkages of health systems. They credit improvements toward better client-friendly health services in Thailand to the close public-private collaboration between non-governmental organizations (NGOs) and the health sector at all levels.¹⁰

Impact on families and communities left-behind

Finally, the departure of a key family member who seeks work abroad can both positively and negatively affect the family members left-behind. Family visits are infrequent and regular communication can be difficult. There may be little or no possibility of family reunification in the host country. This results in an emotional gap between migrants and their family members. Migrants leaving families behind have an impact on the household structure, gender roles and relationships, and intergenerational relationships. Children and the elderly are particularly at risk when female migrants working as caregivers abroad are constrained in their ability to care for their own extended families. In places where there are many such emigrants, the multiplier effect of so many individuals in prime working ages missing can have a devastating impact on social cohesion and the psychosocial profile of a community.

Two areas of health, child nutrition and mental health, illustrate some of the complex effects of migration on families left-behind. Enhanced purchasing power for food from remittances can improve nutritional status in children left-behind, but the care burden created by having one parent gone can create greater strains in attending to the feeding and physical care of these children. Little research has been done on the nutritional and health status of children left-behind, and the studies that exist show mixed effects.¹¹

With respect to mental health, there is a complex web of relationships between migrant parents, left-behind partners and children, and extended family members who may provide care or be in of need care themselves. Similar to the literature on the nutritional status of the left-behind child, studies on the migration impacts on mental health of left-behind family members shows a variety of effects.^{12,13}

Caregivers as well as children are affected by the absence of a migrant family member. A review of data from Viet Nam, Indonesia, and Philippines shows that stay-behind mothers with husbands working overseas are most likely to experience poor mental health, although in Indonesia all carers are adversely affected.^{14,15}

The authors of the Sri Lanka study advocate for a multisectoral approach to monitoring and supporting the health of left-behind families to be adopted at district and national levels. Community programmes are needed to identify and address the social, health, and nutrition issues of families with a parent working abroad. These could be carried out by public health midwives, child protection officers, school counselors and foreign employment agency welfare officers. Programmes include mapping and vulnerability assessments of children of migrant families at the pre-departure phase; case management or care plans for left-behind children using community participatory approaches; information for prospective migrant families; and guidance for primary caregivers of left-behind children.^{16,17}

Return migration and health

Migrants returning to their countries of origin may also face significant health related challenges.¹⁸ For those previously living in destination countries with a higher standard of health care, they may have difficulty maintaining a continuity of care that is at the same level, and may even face eligibility barriers after not working at home for many years. Those who have worked in economically, physically or emotionally difficult situations may return home because of health problems, injuries or abuse acquired while living

abroad. Migrants in some countries are screened for diseases and health conditions and can be summarily deported, plunging them into a situation without security or resources while facing illness. And mental health problems and psychosocial adjustment issues are common in those repatriating, regardless of their previous circumstances.¹⁹ More work needs to be required to identify strategies to support the health of returning migrants. The Philippines offers a compulsory insurance programme for migrants that covers the cost of repatriation and medical repatriation, and has several government programmes that provide repatriation and reintegration assistance, including psychosocial services.²⁰

With respect to addressing the mental health and reintegration needs of returning domestic workers who may have suffered abuse in their overseas placements, the Indonesia Red Cross worked with the Indonesia Department of Manpower to organize support group sessions in which returnees could share their experiences with other women and mental health professionals. The programme also provided psycho-educational sessions for family members in cases of severe psychological problems.²¹

Movement of health workers and health infrastructure

The “brain drain” caused when health and social care workers leave to take more attractive jobs in other countries is another negative impact on the health of communities left-behind. The increased demand in the health and care industry around the world, especially in the aging global north, has led women from the Asia-Pacific region to fulfill that need. The departure of skilled migrant workers from developing countries causes workforce shortages in those countries, which is often filled by migrant workers from other developing countries.²² Over the last decade, there has been an 84 per cent increase in the number of migrant doctors and nurses in OECD countries from health workforce shortage countries.²³

On the other hand, successful migrants also fit into the intersection of health and development by making direct investments in health-care infrastructure, (such as building clinics and hospitals), and engaging in philanthropy with a health and health education focus, (e.g., disaster relief, reconstruction, training initiatives through diaspora foundations, and joint public-private initiatives).²⁴ There is also the potential of migrants returning home with skills needed in the health sector. While the focus is often on the impact of the brain drain in the health sector, some migrants return to their home countries after seeking education or work opportunities abroad. Health professionals with training and experience in more developed countries can enhance the capacity of their home countries upon their return.^{25,26}

Remittances and health

While migration is a risk for left-behind families, migrants contribute to improving the socioeconomic development of those in their home countries. Sending of remittances to home countries is widely seen as having a positive impact on the health and socioeconomic status families and communities connected to the migrant abroad. In 2015, worldwide remittance flows are estimated to have exceeded USD 601 billion. Of that amount, developing countries are estimated to receive about USD 441 billion per year, a figure three times the volume of official development aid. These inflows of cash constitute more than 10 per cent of GDP in some 25 developing countries and lead to increased investments in health, education, and small businesses in various communities.²⁷ Although the literature is very limited, these remittances may support positive outcomes on some health measures, such as children’s birth weight and mortality, women’s reproductive health and nutritional status, and health care utilization.²⁸

In summary, the health, education, and social needs of left-behind family members need to be viewed in balance with the lost opportunities of not having someone migrate for work. For remittance-dependent economies, this is an important consideration for governments and international agencies seeking to better manage migration for development and poverty alleviation. Labour migration involves balancing foreign exchange gains against negative social and health impacts.²⁹

SOCIAL PROTECTION IN HEALTH AND THE ROLE OF PUBLIC-PRIVATE PARTNERSHIPS IN SUPPORTING MIGRANT HEALTH

It is difficult for migrants to stay healthy and work productively if they cannot afford health services, whether prevention and basic care or costly hospitalizations due to injury or catastrophic illness. To reach the goal of universal health coverage, social protection in health, through public or private insurance schemes, is particularly important for migrants who are away from their home health systems. A spectrum of responses to the need for health coverage have been instituted, from allowing migrants full participation in a country’s universal health system to only covering health services in emergency situations.

Types of social protection for health for migrants

The discussion below will identify examples different mechanisms of social protection for health available to migrants, but not provide a comprehensive list of each type.

Only a handful of countries, including, (but not limited to), France, the Netherlands, and Denmark, give legal migrant workers unconditional inclusion in a system of health coverage.³⁰ Other countries, such as Sweden, allow equal access for regular migrants but more limited access for undocumented migrants. In Italy, for example, undocumented migrants are entitled to essential and urgent basic health-care services, such as maternity care and health care for infectious diseases. After a three-month waiting period legal migrants in Canada are entitled to the same health-care coverage as Canadian nationals, but the entitlements of undocumented migrants and certain asylum seekers are less comprehensive. In Costa Rica and Morocco, foreigners who are in the country irregularly can access the health system for emergency services.³¹

Some countries require migrants or their employers to purchase health insurance, which may be private or sponsored by the government. Malaysia has a mandatory private medical coverage scheme for all foreign workers, and Singapore has a similar requirement for semi-skilled workers. Thailand allows undocumented migrants to opt into its Compulsory Migrant Health Insurance scheme, which regular migrants obtain through their employers, often having to pay part of the premium. However the scheme does not have the same benefits as those available to Thai citizens. In countries where insurance schemes are private for migrants, even when they are mandatory, workers may be dependent on employers for registration and maintenance. Without proper monitoring and enforcement, employers may attempt to reduce costs by under-insuring workers or, for irregular migrants, not insuring them at all.³²

A few countries offer health protection for their citizens who move abroad, including Sri Lanka and the Philippines. The Overseas Filipinos Programme (OFP) covers nationals living or working abroad, including irregular migrants, emigrants, dual citizens, and international students. Land-based overseas workers are required to pay their premiums individually, while shipping companies cover the cost for sea-based workers.³³

Some countries offer private insurance with provisions especially for migrants (Australia),³⁴ or allow migrants the option to buy into national insurance schemes (Republic of Moldova).³⁵ Other countries allow migrants to pay into a social security system that includes health benefits, and then carry some of those benefits when they move to other countries. This occurs primarily within the European Union, and between countries that have negotiated specific bilateral agreements. The concept of portability of health insurance is an attractive one, but economists Holzmann and Koettl outline the complexity of this approach among countries with varying benefit levels, health-care costs, financial resources for social protection programmes, and political will to include migrants.³⁶

With respect to health coverage for refugees, in 2012 the United Nations High Commissioner for Refugees (UNHCR) released an analysis of different options and examples of insurance schemes in nine countries, from special schemes for refugees in the national health system to small self-insured schemes supported by nongovernmental health organizations.³⁷ One that is promoted as a model is the inclusion of refugees in Iran's Universal Public Health Insurance (UPHI) scheme, also known as Salamat Health Insurance. Another model of health protection is offered in Kinshasa, Democratic Republic of the Congo, where refugees benefit from a voluntary mutual health insurance scheme run by the Catholic diocesan health system.

In the realm of public-private partnerships, trade unions in Argentina advocated for the creation of The National Registry of Rural Workers and Employers to support an unemployment scheme for farm workers facilitates access to social security and health benefits. In South Africa, TEBA Ltd, the mining sector recruitment and labour management agency, offers employees pre and post employment medical assessment, emergency medical transport, and home-based HIV/AIDS services.³⁸

Barriers, benefits and principles of social protection for health

Outside these few examples, the vast majority of migrants, and nearly all irregular migrants, do not have access to adequate, affordable health protection. Social and political antagonisms towards migrants have stripped many health benefits from national health programmes that previously offered them, and the trends in this direction seem to be gaining force in many countries. Even when they do have access to insurance, migrants often have difficulties accessing health services. Health-care providers may discriminate, and there are linguistic and cultural barriers to care for migrants accessing foreign health systems.³⁹ An IOM review of migrants' access to health and social security in South America reports that migrant's lack of financial resources, inadequate information, and geographic constraints also impede access to health services.⁴⁰ These factors will all need to be considered in the drive to achieve the goal of universal health coverage.

Aside from the public health and human rights arguments for providing equitable health coverage to migrants, the case for economic benefits is increasingly strong. The recent IOM consensus document on access to health services for migrants in an irregular situation reports that numerous recent studies show that providing access to primary services is less expensive than restricting migrants to emergency only services.⁴¹ Some studies use data on actual expenditure from health service accounting systems,⁴² and others are based on theoretical models or estimates.⁴³

In “Social Protection for Migrant Workers: National And International Policy Challenges” van Ginneken identifies five major policy challenges to extending and improving the social protection for international migrant workers and their families: defining the basic floor for social protection for migrants; providing access to social security in countries of employment; providing social protection for families left-behind and preserving migrants’ rights to benefits there; improving the portability of benefits; and offering basic social protection to all migrants, regardless of their status.⁴⁴ While these recommendations address all forms of social and labour protection, they can be applied to health coverage as well, and are in fact essential principles in the pursuit of universal health coverage.

SOCIAL AND TECHNOLOGICAL INNOVATIONS TO SUPPORT MIGRANT HEALTH

Facilitating communication with and among migrants has taken off with the widespread use of mobile phones and internet-enabled devices. Access to information and communication across the globe not only supports migrants’ connections with their families, but also offers an opportunity to link them to health information and services as never before.

Creative applications of internet- and mobile phone-based technologies for health have been under development for many years, and are increasingly supported in both developed and developing countries. Notwithstanding the passion for joining health and technology for humanitarian purposes, the evidence base for the field is still emerging.^{45,46,47}

There are very few studies that focus specifically on mobile health applications with migrant populations. Among them, a multimedia HIV testing campaign for Latino immigrant men in the United States found an immediate impact on attitudes and beliefs towards testing, with HIV testing rates increasing over time.⁴⁸ Another project, focusing on Turkish migrants in the Netherlands and the United Kingdom, is testing whether a culturally adapted cognitive behavioral therapy-based online programme can help reduce suicidal ideation in this population, which may avoid face-to-face mental health services for cultural reasons.⁴⁹ There are other examples of custom-designed tools as well as applications adapted for the cultural and linguistic needs of migrants in developed countries, but there is little information about using tech tools to support the health of migrants in the developing world despite the high prevalence of mobile phone use in this population.

There has been a recent surge in experimenting with mobile technologies to support health in refugee populations, and the success or failure of these interventions could be relevant for use with all populations on the move. The Syrian refugee crisis in particular has inspired a variety of tech tools to support refugees at all stages of their journey, from the war-zone to resettlement communities. Some interventions are cutting edge, and others are new iterations of strategies used in other health settings or in other sectors.

Applications for providers

Among the applications developed for providers, a tablet-based tool for clinicians working with refugees in Lebanon combines cloud-based patient record information with SMS technology to track and connect patients with their medical history, prescriptions and appointments.⁵⁰ In Jordan, WHO is partnering with the Ministry of Health to implement public health monitoring of refugees through real-time reporting from primary and secondary care facilities via mobile technology. Providers also have access to diagnostic algorithms, prescription recommendations, disease management modules, and a mental health service programme.^{51,52} This is similar to an earlier programme implemented to monitor and report on infectious diseases among displaced people in South Darfur. E-learning, telemedicine, and telesurgery support are being offered to health professionals working in conflict areas in the Syrian Arab Republic,⁵³ a model that based on years of experience in disaster, rural, and other low-infrastructure settings. A multicountry intervention, Re-Health, supported by the EU and the IOM, combines an online health database of information and health assessment records for providers and other stakeholders with a portable migrant personal health record, supported by health promotion and support activities from health mediators/interpreters.⁵⁴

In Germany, social entrepreneurs, a university hospital, the Red Cross, local government, and a translation company have collaborated to set up mobile medical clinics repurposed from shipping containers that offer primary care supported by video interpretation services for asylum seekers.⁵⁵

Applications for migrants

For migrants themselves, Hababy is a web app in development that is intended to offer pre- and post-natal information for refugee women. The information will be country-specific and in multiple languages, with an emphasis on visual communication, and an option for live chat with a health-care professional, as well as offline features. In the area of psychosocial support, “Karim” is an Arabic-language personalized text message programme based on artificial intelligence software to support dialogue about emotional problems.⁵⁶ In the Netherlands, an online mental health information and advice platform for Moroccan-Dutch migrants has been active since 2012, and in the first year had nearly 10,000 unique visitors who sought counsel on topics from puberty to bewitchment.⁵⁷ IOM has developed a smartphone application called MigApp designed to help migrants make informed decisions throughout the migration process and to access services, including health care.⁵⁸

The design of tech tools for migrants and refugees must take into consideration not only the practical realities of access to internet/mobile devices and networks, access to electricity for charging, and data security, but also age, acculturation, literacy levels, health beliefs and experiences, and acceptance of digital technology.^{59,60,61,62,63} It is critical to rigorously assess the utility and efficacy of these tech applications. They may be effective for facilitating the work of health professionals working with migrants (monitoring, information transfer, coordination), and engaging and educating migrants about health issues. But the hurdles to effective and appropriate customization, implementation and evaluation are quite high, and it is premature to expect a significant impact on health outcomes.

MIGRANT HEALTH AND THE SUSTAINABLE DEVELOPMENT GOALS

As a successor to the Millenium Development Goals, in 2015 the UN General Assembly adopted 17 Sustainable Development Goals (SDGs) as part of a global agenda for sustainable development.⁶⁴ The SDGs offer a unique and far-reaching framework for addressing migrant health issues that will engage the attention, efforts and resources of national and international actors as they work to achieve the SDG targets. Two key points in the agenda open the door for migrant-oriented efforts – the overarching goal of ‘leave no one behind’ and the inclusion of a first time, explicit goal related to migration – SDG 10 – to “facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies.” These two imperatives compel communities, national governments, humanitarian, and development stakeholders to work together to integrate the health needs of migrants into national plans, policies and strategies across sectors. A number of goals and targets of particular relevance to the migrant health domain illustrate the multisectoral nature of the topic.

Health of migrants in SDG 3

Starting with SDG 3, which has 13 targets related to health and well-being, migrants have specific health vulnerabilities that can be addressed in the context of achieving these targets. For example, migrant women often have poor access to reproductive health care, resulting in higher maternal and infant mortality rates (also addressed in Target 5.6). Living in poverty and without a regular source of primary care can result in poor health outcomes for the children of migrant parents, both those in host countries and those left-behind. Due to their mobility in regions where these diseases are more prevalent, migrants are may be more vulnerable to acquiring and transmitting infectious diseases such as HIV/AIDS, tuberculosis, and malaria. Sri Lanka, for example, has recently seen that returning migrants account for a significant majority of new malaria cases in the country.⁶⁵ And the challenging migration and resettlement process can exacerbate stress-fuelled substance abuse and mental health problems, especially for those in an irregular situation or in precarious employment circumstances. The call for universal health coverage in SDG 3.8 is particularly important to migrants, as detailed in the previous section on social protection (reflected as well in Target 1.3).

As discussed previously, managing the mobility of health workers is critical issue that affects both migrating health professionals in their destination countries as well as the health systems of the countries they have left-behind, and is addressed in Target 3.c as well as in numerous international collaborations and policy statements.⁶⁶

Migrant health in other SDGs

In addition to Target 10.7, which directly addresses the need for migration policies to ensure the safe and orderly movement of people, the needs of migrants related to health can be traced throughout the other SDGs. For example, Target 1.5 addresses the need for strengthening resilience to economic, social, and environmental shocks and disasters, which often compel the flight of migrants and refugees in health-threatening circumstances. Calls for the elimination of violence against women (Target 5.2) and forced labour and trafficking of children (Targets 8.7 and 16.2) recognize the vulnerability of migrants to these harms throughout the migration process. Access to adequate housing and basic services addressed in Target 11.1 is pertinent to rural to urban migrants who often live in slums, and to internally displaced persons and refugees who may be living in camps or migration centres with little access to formal health services. Promoting safe and secure working environments for all workers, including migrant workers, (Target 8.8) specifically addresses the health needs of migrants who are exposed to multiple health risks due to unsafe working and living conditions.

There are many models that attempt to address the migrant health needs invoked in the SDG goals and targets. In Sudan, IOM supports a mobile health clinic focused on sexual and reproductive health needs, including maternity, infant feeding, and HIV/AIDS prevention services.⁶⁷ In Myanmar, outreach health workers were trained to identify and refer for treatment migrants with TB. Screening, treatment, and health education sessions are provided to migrants and host community members.⁶⁸ Migrant Health Forums in different areas of South Africa provide information sharing and programme coordination between migrant communities, local government, health-care providers, NGOs, and researchers.⁶⁹

Strategies for data collection and monitoring

At the national, regional and international levels, data gathering and analysis is critical to advancing the migration health agenda. SDG 17.18 explicitly includes migratory status and ethnicity in its call to build capacity for producing high-quality, timely and reliable data. Mechanisms for addressing this are in the Global Health paper excerpts. An example of including migrants in early warning and risk reduction/management systems (also SDG 3.d) is the Mekong Basin Disease Surveillance (MBDS) programme involving Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam. The goals of this network are to improve cross-border infectious disease outbreak investigation and response by sharing surveillance data and best practices in disease recognition and reporting; develop expertise in epidemiological surveillance across the countries; and enhance communication and cooperation between the countries.

Collaboration and coordination

Migrants and their representative organizations must be involved in goal-setting for the Sustainable Development Agenda at all levels and across organizations and sectors. Multilateral and regional collaboration, including the participation of civil society organizations, is critical to developing policies and programmes that address the health needs of migrants, from global targeted health initiatives to harmonized social protection mechanisms to timely response to emerging migrant or refugee influxes.⁷⁰ For example, the Joint UN Initiative on Migration and Health in Asia (JUNIMA) governments, civil society organizations, regional associations, development partners and UN agencies to develop and promote policies, build partnerships, share information and support action on disease prevention, treatment, care and support services for migrant populations in Asia.⁷¹ In Africa, The South African Development Community (SADC) ratified the Declaration on Tuberculosis in the Mining Sector, and health ministers from South Africa and other SADC member states have signed bilateral agreements that aim to address collaboration on a range of health issues, including the treatment of patients, between countries.⁷²

PROGRESS ON MIGRANT HEALTH SINCE THE FIRST GLOBAL CONSULTATION

With respect to efforts on migrant health since the 2010 Global Consultation, there has been no systematic effort to track progress on the recommendations, but several countries have worked to define strategies based on the Consultation framework. Many of the activities described throughout the paper have taken place in the time since the consultation, and many of the rationales for their programmes reference the recommendations of the Consultation.

Additional national and regional actions include:⁷³

- ongoing commitment by the government of Thailand to a multiyear master plan on border and migrant health, including provisions for a health insurance scheme for undocumented migrants and their families;
- the development of a migrant health strategic plan in Bangladesh that focuses on policy frameworks, monitoring, and promoting multisectoral partnerships;
- the adoption of a migrant health resolution⁷⁴ by the WHO Region of the Americas that places future action in the context of existing strategies for universal health coverage;
- in Europe, a wide range of interventions, policy development, research, data collection and monitoring tools implemented by international organizations, state actors, NGOs, and collaborations between them;⁷⁵
- national scoping projects and consultations on migrant health following the 2010 Global Consultation in several African countries (e.g. South Africa⁷⁶ and Kenya⁷⁷) and regional compacts focused on communicable diseases;
- multilateral and multisectoral collaboration in the Middle East and Southern Europe to manage the health and psychosocial needs of the Syrian and other refugees.

At the national level, the Government of Sri Lanka has made a dedicated effort to create a participatory, evidence-based and intersectoral National Migration Health Policy. The programme features a

- broad definition of migration dynamics;
- commissioned national research agenda that informed policy development;
- focus on needs that could benefit from immediate action;
- reporting and accountability framework;
- national interagency coordination;
- engagement with regional and international partners.

The effort has resulted in an impressive list of milestones and actions over the seven-year development and implementation process.⁷⁸

Conclusion

Migration offers many opportunities for individuals, communities and countries to advance development. Proactively addressing the health needs of migrants in a development context can support their health and well-being, enhance their societal and economic contributions, and help countries meet their overall health and development goals. Addressing these needs is challenging, given the complexity of migrant flows and characteristics, the multiplicity of health and psychosocial concerns, and an overall environment that makes raising migrant issues difficult. Since the first Global Consultation, considerable efforts have been made by civil society, national, and international parties to include migrants in development and public health agendas, and the momentum has accelerated recently. Practice, policy and strategic lessons from these efforts must be examined, consolidated, and disseminated to support future action. The 2030 Sustainable Development Agenda offers a leverage point that migrant advocates across sectors can use to press for the inclusion of migrant concerns in health and development focused initiatives. Advancing the goal of universal health coverage that includes migrants, coupled with collaborative action on health issues across the SDGs, will support the progressive integration of migrant issues in health planning and policymaking in all national, regional and international agendas.

NOTES

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- ⁷² Walls, H, Vearey, J, Modisenyane, M, Chetty-Makkan, C, Charalambous, S, Smith, R, et al. Understanding healthcare and population mobility in southern Africa: The case of South Africa 2016 [Cited February 7, 2017]; *South African Medical Journal* 106(1):14-15. DOI:10.7196/SAMJ.2016.v106i1.10210.
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- ⁷⁷ World Health Organization. Kenya National Consultation on Migration Health. 2011, Mombasa, WHO. Available from: www.who.int/hac/techguidance/health_of_migrants/kenya_national_consultation_communique.pdf
- ⁷⁸ Wickramage, K, Perera, S, Peiris, S. Migration health policy development process in Sri Lanka. In: Wickramage, K. Ed. *Migration Health Research to advance evidence based policy and practice in Sri Lanka*, Vol 1. (pp 12-17). 2017, Geneva, International Organization for Migration Publications.

ANNEXES

CONSULTATION AGENDA

DAY I Tuesday 21 February 2017	
07:00-9:00	Registration
09:00 - 9:15	OPENING: CEREMONIAL PROCESSION, LIGHTING OF THE OIL LAMP AND NATIONAL ANTHEM
09:15–09:45	<p>WELCOME ADDRESS by Anura Jayawickrama, Secretary, Ministry Of Health, Nutrition and Indigenous Medicine, Sri Lanka</p> <p>KEYNOTE ADDRESS by Hon. Dr Rajitha Senaratne, Minister Of Health, Nutrition and Indigenous Medicine, Sri Lanka</p> <p>STATEMENTS VIA VIDEO by Ambassador William L. Swing, Director General, IOM and Dr. Margaret Chan, Director General, WHO</p>
09:45-10:30	<p>SETTING THE SCENE</p> <p><i>Despite known linkages between Migration and Health, international human rights standards, a 2008 World Health Resolution on Migrant Health, and the recognized role of migrants for sustained social and economic development, the process has been slow in meeting the health needs of migrants, adjust and develop conducive policies across sectors, and equip health systems to respond to contemporary migration and human mobility. The Consultation objectives, underlying conceptual framework and intended outcomes will be presented against a background of Global Health and Global Migration Initiatives emphasizing recent milestones and near future key processes to jointly work towards.</i></p> <ul style="list-style-type: none"> • Chair: Hon. Dr Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Sri Lanka • Speakers: Davide Mosca, Director, Migration Health Division, IOM and Kanokporn Kaojaroen, Migration and Health Officer, WHO • Discussion
10:30–10:45	Coffee Break
SESSION I: HEALTH, HEALTH SYSTEMS AND GLOBAL HEALTH	
10:45-11:30	<p>PLENARY SESSION WITH PANEL AND DISCUSSION</p> <p>Ensure health and well-being for all, in line with the achievement of Universal Health Coverage, through financial risk protection, access to quality essential health-care services, prevention and health promotion is the overarching health-related approach of the Development Agenda 2030. This session will explore the place of migration health within current health strategies, public health principles, relevant indicators and gaps.</p> <p>Chair for Session I: Hon. Dr. Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Sri Lanka Co-Chair: Kiran Regmi, Chief Specialist from Ministry of Health, Nepal Moderator: Rudi Coninx, Chief (a.i) Humanitarian, Policy and Guidance, WHO</p> <ul style="list-style-type: none"> • Presentation on topic for Session I: Michael Knipper, Institute of the History of Medicine of the University of Giessen, Germany • Panel discussion: Lisa Rotz, Associate Director for Global Health and Migration, Division of Global Migration and Quarantine, Centers for Disease Control and Prevention (CDC) Ibrahim Abubakar, Director, Institute for Global Health and Chair, Lancet Commission on Migration and Health, University College London Ursula Trummer, Head of Center, Center for Health and Migration, Austria Herve Isambert, Senior Regional HIV/AIDS Coordinator, UNHCR • Q&A <p>Rapporteur for Session I: Daniel Lopez Acuña, Adjunct Professor. Andalusian School of Public Health, Spain</p>

11:30-12:45	<div>3 BREAK OUT GROUPS</div> <div>Three breakout groups based on the expected outcomes:</div> <table><tr><td>Expected outcome/Role</td><td>Chair (Government)</td><td>Break out group rapporteur</td><td>Facilitator</td></tr><tr><td>Actionable policy objectives</td><td>Ferchito L. Avelino, Director III, Bureau of Quarantine, Philippines</td><td>Patrick Taran, President, Global Migration Policy Associates</td><td>Davide Mosca, Director, Migration Health Division, IOM Santino Severoni, Coordinator, Regional Office for Europe, WHO</td></tr><tr><td>Research agenda</td><td>Victor Arturo Cabrera Hidalgo, Minister, Permanent Mission to the UN Geneva, Ecuador</td><td>Anthony Zwi, Professor of Global Health and Development, University of New South Wales</td><td>Kol Wickramage, Migration Health and Epidemiology Coordinator, IOM Lin Aung, Coordinator, Communicable Diseases Department WHO</td></tr><tr><td>Progress monitoring framework</td><td>Susie Perera, Deputy Director General(Planning), Ministry of Health Nutrition and Indigenous Medicine, Sri Lanka</td><td>Charles Hui, Associate Professor of Pediatrics and Chief of Infectious Diseases, University of Ottawa</td><td>Poonam Dhavan, IOM Migration Health Programme Coordinator, IOM Kanokporn Kaojaroen, Migration and Health Officer, WHO</td></tr></table>	Expected outcome/Role	Chair (Government)	Break out group rapporteur	Facilitator	Actionable policy objectives	Ferchito L. Avelino, Director III, Bureau of Quarantine, Philippines	Patrick Taran, President, Global Migration Policy Associates	Davide Mosca, Director, Migration Health Division, IOM Santino Severoni, Coordinator, Regional Office for Europe, WHO	Research agenda	Victor Arturo Cabrera Hidalgo, Minister, Permanent Mission to the UN Geneva, Ecuador	Anthony Zwi, Professor of Global Health and Development, University of New South Wales	Kol Wickramage, Migration Health and Epidemiology Coordinator, IOM Lin Aung, Coordinator, Communicable Diseases Department WHO	Progress monitoring framework	Susie Perera, Deputy Director General(Planning), Ministry of Health Nutrition and Indigenous Medicine, Sri Lanka	Charles Hui, Associate Professor of Pediatrics and Chief of Infectious Diseases, University of Ottawa	Poonam Dhavan, IOM Migration Health Programme Coordinator, IOM Kanokporn Kaojaroen, Migration and Health Officer, WHO
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12:45-14:00	Lunch Break																
14:00-15:00	<div>PLENARY REPORTING FROM THE GROUPS</div> <div><div><div><div>Actionable policy objectives</div><div>Patrick Taran, President, Global Migration Policy Associates</div></div><div><div>Research agenda</div><div>Anthony Zwi, Professor of Global Health and Development, University of New South Wales</div></div><div><div>Progress monitoring framework</div><div>Charles Hui, Associate Professor of Pediatrics and Chief of Infectious Diseases, University of Ottawa.</div></div></div><div><div><div>Chair: Lisa Rotz, Associate Director for Global Health and Migration, Division of Global Migration and Quarantine, Centers for Disease Control and Prevention</div><div>Breakout group rapporteurs present their reaction:</div></div><div><div>Rapporteur for Session I: Daniel Lopez Acuna, Adjunct Professor, Andalusian School of Public Health, Spain</div><div>Discussion</div></div></div></div>																
SESSION II: VULNERABILITIES AND RESILIENCIES																	
15:00-15:45	<div>PLENARY SESSION WITH PANEL AND DISCUSSION</div> <div>Reducing vulnerability and enhancing resilience of migrants, communities and health systems, requires action on the social and environmental determinants of health and equity in migrant health. It implies inclusive and participatory processes, active engagement of multiple sectors and adequate monitoring of policies in place and progress made.</div> <div>Chair for Session II: Honourable Aldrin Musiiwa, Deputy Minister of Health and Child Care Zimbabwe</div> <div>Co-Chair: G.S. Withanage, Secretary, Ministry of Foreign Employment, Sri Lanka</div> <div>Moderator: Nenette Motus, Regional Director of Asia-Pacific, IOM</div> <div><div><div>Presentation on topic for Session II: Chesmal Siriwardhana, Associate Professor, London School for Hygiene and Tropical Medicine</div><div>Panel discussion:<div>Phusit Prakongsai, Director, Bureau of International Health, Ministry of Public Health, Thailand</div><div>Moises Uamusse, General Secretary, Mozambican Mine Workers Association</div><div>Chan Chee Khoo, Research Associate, University of Malaya, Malaysia</div><div>Santino Severoni, Coordinator, WHO Regional Office for Europe</div></div><div>Q&A</div></div><div>Rapporteur for Session II: Mariam Sianozova, Senior Regional Director for Europe/Eurasia, Project Hope</div></div>																

15:45-16:00	Coffee break									
16:00-17:15	3 BREAK OUT GROUPS Three breakout groups based on the expected outcomes.									
	Expected outcome/Role	Chair (Government)	Break out group rapporteur	Facilitator						
	Actionable policy objectives	Safaa Mourad, Undersecretary of Foreign Health Affairs Dep. The Minister Sector office, Egypt	Stefano Nobile, Advocacy Officer and Focal Point for Health and HIV, Caritas Internationalis	Roumyana Petrova-Benedict, Senior Migration Health Advisor, IOM Francois Nguessan, Regional Adviser, Emergency Operations, AFRO WHO						
	Research agenda	Knut Nyflot, Chargé d'affaires, Royal Norwegian Embassy in Sri Lanka	Jo Vearey, Associate Professor, African Centre for Migration and Society (ACMS), University of the Witwatersrand	Kol Wickramage, Migration Health and Epidemiology Coordinator, IOM Lin Aung, Coordinator, Communicable Diseases Department WHO						
	Progress monitoring framework	Dr. Kiran Regmi, Chief Specialist from Ministry of Health, Nepal	Brahm Press, Executive Director of MAP Foundation/Co-chair of JUNIMA/convenor of the task force on Migration Health and HIV in CARAM Asia, Thailand	Sharika Peiris, National Migration Health Physician, IOM Qudsia Huda, Regional Adviser, Preparedness, EMRO WHO						
17:15-18:15	PLENARY REPORTING FROM THE GROUPS <ul style="list-style-type: none">• Chair: Gaudy Calvo, Minister Councillor, Permanent Mission in Geneva, Costa Rica• Co-Chair: Lakshman Siyambalagoda, Additional Secretary (Medical services), Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka• Breakout group rapporteurs present their reactions: <table><tr><td>Actionable policy objectives</td><td>Stefano Nobile, Advocacy Officer and Focal Point for Health and HIV, Caritas Internationalis</td></tr><tr><td>Research agenda</td><td>Jo Vearey, Associate Professor, African Centre for Migration and Society (ACMS), University of the Witwatersrand</td></tr><tr><td>Progress monitoring framework</td><td>Brahm Press, Executive Director of MAP Foundation/ Co-chair of JUNIMA/ convenor of the task force on Migration Health and HIV in CARAM Asia, Thailand</td></tr></table> <ul style="list-style-type: none">• Rapporteur for Session II: Mariam Sianozova, Senior Regional Director for Europe/Eurasia, Project Hope• Discussion				Actionable policy objectives	Stefano Nobile, Advocacy Officer and Focal Point for Health and HIV, Caritas Internationalis	Research agenda	Jo Vearey, Associate Professor, African Centre for Migration and Society (ACMS), University of the Witwatersrand	Progress monitoring framework	Brahm Press, Executive Director of MAP Foundation/ Co-chair of JUNIMA/ convenor of the task force on Migration Health and HIV in CARAM Asia, Thailand
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Research agenda	Jo Vearey, Associate Professor, African Centre for Migration and Society (ACMS), University of the Witwatersrand									
Progress monitoring framework	Brahm Press, Executive Director of MAP Foundation/ Co-chair of JUNIMA/ convenor of the task force on Migration Health and HIV in CARAM Asia, Thailand									

DAY II Wednesday 22 February 2017

SESSION III: DEVELOPMENT

09:00-09:45

PLENARY SESSION WITH PANEL AND DISCUSSION

Migration has an acknowledged development potential and migrant health is a requisite for social and economic development in our diverse society. This session will also address the place of migrant health within the 2030 Agenda for Sustainable Development and in addition will discuss the health of migrants' families left-behind and the role of social and technological innovation.

Chair for Session III: Nicolae Jelamschi, *Chair of Executive Committee of the South-eastern Europe Health Network, Republic of Moldova*

Co-Chair: Dr. Kiran Regmi, *Chief Specialist from Ministry of Health, Nepal*

Moderator: Poonam Dhavan, *Migration Health Programme Coordinator, IOM*

- **Presentation of topic for Session III:** Julia Puebla Fortier, *Executive Director, Diversity Rx - Resources for Cross Cultural Health Care*

- **Panel discussion:**

Amuerfina R. Reyes, *Assistant Secretary, Department of Labour and Employment Philippines*

Daniela Núñez Pares, *Director of Institutional Coordination for Migrants Health in the Ministry of Health of Mexico*

Amara Quesada-Bondad, *Executive Director, Philippines/Action for Health Initiatives (ACHIEVE), Inc.*

Brianna Harrison, *Regional Programme Adviser, UNAIDS*

- **Q&A**

Rapporteur for Session III: Jocalyn Clark (*The Lancet*)

10:15-11:45

3 BREAK OUT GROUPS

Three breakout groups based on the expected outcomes:

Expected outcome/Role	Chair (Government)	Break out group rapporteur	Facilitator
Actionable policy objectives	Maimoona Aboobakuru, <i>Director General of Public Health, Health Protection Agency, Ministry of Health, Maldives</i>	Ayesha Iskander, <i>Project Officer, Political and Economic Department Asia-Europe Foundation</i>	Carlos van der Laat, <i>IOM Regional Migration Health Officer for the Americas, IOM</i> Rudi Coninx, <i>Chief a.i, Humanitarian Policy and Guidance, WHO</i>
Research agenda	Aldrin Musiiwa, <i>Deputy Minister of Health and Child Care, Zimbabwe</i>	Courtland Robinson, <i>Associate Professor, USA/ Johns Hopkins Bloomberg School of Public Health</i>	Kol Wickramage, <i>Migration Health and Epidemiology Coordinator, IOM</i> Santino Severoni, <i>Coordinator, WHO Regional Office for Europe</i>
Progress monitoring framework	Sarath Samarage, <i>Institute for Health Policy, Sri Lanka</i>	Anita Jain, Editor, <i>BMA House, Tavistock Square, London, Mumbai, India</i>	Poonam Dhavan, <i>Migration Health Programme Coordinator, IOM</i> Qudsia Huda, <i>Regional Advisor, Preparedness, WHO EMRO</i>

11:45-12:45	<p>PLENARY REPORTING FROM THE GROUPS</p> <ul style="list-style-type: none"> • Chair: Saira Afzal Tarar, Minister of National Health Services, Regulation and Coordination of Pakistan • Co-Chair: Jayasundara Bandara, Director General Health Services, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka • Breakout group rapporteurs present their reactions: <table border="1"> <tr> <td>Actionable policy objectives</td><td>Ayesha Iskander, Project Officer, Political and Economic Department Asia–Europe Foundation</td></tr> <tr> <td>Research agenda</td><td>Courtland Robinson, Associate Professor, USA/ Johns Hopkins Bloomberg School of Public Health</td></tr> <tr> <td>Progress monitoring framework</td><td>Anita Jain, Editor, BMA House, Tavistock Square, London, Mumbai, India</td></tr> </table> <ul style="list-style-type: none"> • Rapporteur for Session III: Jocalyn Clark, Executive Editor, <i>The Lancet</i> • Discussion 	Actionable policy objectives	Ayesha Iskander, Project Officer, Political and Economic Department Asia–Europe Foundation	Research agenda	Courtland Robinson, Associate Professor, USA/ Johns Hopkins Bloomberg School of Public Health	Progress monitoring framework	Anita Jain, Editor, BMA House, Tavistock Square, London, Mumbai, India
Actionable policy objectives	Ayesha Iskander, Project Officer, Political and Economic Department Asia–Europe Foundation						
Research agenda	Courtland Robinson, Associate Professor, USA/ Johns Hopkins Bloomberg School of Public Health						
Progress monitoring framework	Anita Jain, Editor, BMA House, Tavistock Square, London, Mumbai, India						
12:45-14:00	Lunch break						
Session IV: BREAKOUT GROUPS FOR CONSOLIDATION							
14:00-15:30	<p><i>Objective of this session is to continue interactive discussions and to begin to identify common themes across the three themes under the outcomes. These will provide the first elements of the consolidated matrix. Discuss whether there are any missing elements, issues of concern, or priorities/obvious opportunities to move forward.</i></p> <p>1) ACTIONABLE POLICY OBJECTIVES Chair: Thet Khaing Win, Permanent Secretary, Ministry of Health and Sports, Myanmar Moderator: Daniel Lopez Acuña Thematic Rapporteurs: Patrick Taran President, <i>Global Migration Policy Associates</i> Stefano Nobile, <i>Advocacy Officer and Focal Point for Health and HIV, Caritas Internationalis</i> Ayesha Iskander, <i>Project Officer, Political and Economic Department Asia–Europe Foundation</i></p> <p>2) RESEARCH AGENDA Chair: Kevin Pottie, <i>Associate Professor, Faculty of Medicine, University of Ottawa</i> Moderator: Kol Wickramage, <i>Migration Health and Epidemiology Coordinator, IOM</i> Thematic Rapporteurs: Anthony Zwi, <i>Professor of Global Health and Development, University of New South Wales</i> Jo Vearey, <i>Associate Professor, African Centre for Migration and Society (ACMS), University of the Witwatersrand</i> Courtland Robinson, <i>Associate Professor, USA/Johns Hopkins Bloomberg School of Public Health</i></p> <p>3) PROGRESS MONITORING FRAMEWORK Chair: Anura Jayawickrama, <i>Secretary/Health, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka</i> Moderator: Qudsia Huda, <i>Regional Advisor, Preparedness, WHO EMRO</i> Thematic Rapporteurs: Charles Hui, <i>Associate Professor of Pediatrics and Chief of Infectious Diseases, University of Ottawa</i> Brahm Press, <i>Executive Director of MAP Foundation/Co-chair of JUNIMA/ convener of the task force on Migration Health and HIV in CARAM Asia, Thailand</i> Anita Jain, <i>Editor, BMA House, Tavistock Square, London, Mumbai, India</i></p>						
15:30-16:00	Coffee Break						
Session V: RAPPORTEUR CONSOLIDATION (PARALLEL SESSION)							
16:00-17:30	<p><i>Rapporteurs from the three outcomes (as above) will meet to consolidate the elements and prepare for the Combined Plenary Feedback Session.</i></p> <p>1) ACTIONABLE POLICY OBJECTIVES 2) RESEARCH AGENDA 3) PROGRESS MONITORING FRAMEWORK</p>						
16:00- 18:00	<p>INFORMAL CONSULTATION ON THE COLOMBO STATEMENT</p> <p><i>This session will aim at finalizing the text of the Colombo Statement and will provide the opportunity for Governments to discuss the Statement content.</i></p> <ul style="list-style-type: none"> • Chair: Hon. Dr Rajitha Senaratne • Resource persons: Kanokporn Kaojaroen, <i>WHO</i> and Davide Mosca, <i>IOM</i> 						

DAY III Thursday 23 February 2017

Session VI: COMBINED PLENARY FEEDBACK SESSION

9:00-10:30	<p><i>A rapporteur from each outcome breakout session will report back to the plenary.</i></p> <p>Chair: Paul Douglas, Assistant Secretary, Department of Immigration and Border Protection, Australia</p> <p>Co-Chair: Jayasundara Bandara, Director General Health Services, Sri Lanka</p> <p>Moderator: Qudsia Huda, Regional Advisor, Preparedness, WHO EMRO</p> <ul style="list-style-type: none"> 1) ACTIONABLE POLICY OBJECTIVES 2) RESEARCH AGENDA 3) PROGRESS MONITORING FRAMEWORK
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10:30-11:00	Coffee break
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Session VII: Way Forward

11:00-12:00	<p>PLENARY SESSION</p> <p><i>This session will review the consolidated outcomes in the context of major near future milestones such as Global Compacts processes, governing bodies and international development debates.</i></p> <ul style="list-style-type: none"> • Chair: Daniela Núñez Pares, Director of Institutional Coordination for Migrants Health in the Ministry of Health of Mexico • Co-Chair: Heinz Walker-Nederkoorn, Ambassador, Embassy of Switzerland to Sri Lanka and the Maldives in Colombo • Moderator: Davide Mosca, Director, Migration Health Division (IOM) • Presenters: <ul style="list-style-type: none"> Gervais Appave, Special Policy Adviser to the Director General, IOM Allen Gidraf Maina, Senior Public Health Officer, UNHCR Kanokporn Kaojaroen, Migration and Health Officer, WHO • Discussion
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12:00-14:00	Lunch Break
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Session VIII: High-Level Panel on the Colombo Statement

14:00-15:15	<p><i>This session will hear the interventions from Government representatives from various sectors and regions of the world with a focus on the need for harmonized policies and approaches, challenges faced by policymakers to reach a unified agenda, and the roles of involved Stakeholders in enhancing the health of migrants.</i></p> <p>HIGH-LEVEL POLITICAL PANEL SESSION TO LAUNCH THE COLOMBO STATEMENT</p> <ul style="list-style-type: none"> • Chair: Hon. Dr. Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Sri Lanka • Statements by Governments
15:15	<p>ARRIVAL OF HON. MAITHRIPALA SIRISENA, His Excellency The President of The Democratic Socialist Republic of Sri Lanka</p> <p>WELCOME REMARKS by Hon. Dr. Rajitha Senaratne, Minister of Health, Nutrition and Indigenous Medicine, Sri Lanka</p> <p>Launch of Sri Lanka's Migration Health Research Compendium</p> <p>ADDRESS by Nenette Motus, RD ROAP</p> <p>ADDRESS by Dr. Poonam Khetrapal Singh, RD SEARO</p> <p>COLOMBO STATEMENT read by Dr. Alan Ludowyke, Director, International Health, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka</p> <p>ADDRESS BY HON. MAITHRIPALA SIRISENA, His Excellency The President of The Democratic Socialist Republic of Sri Lanka</p>
17:00	<p>CLOSING REMARKS by Jayasundara Bandara, DGHS, Sri Lanka</p>

PARTICIPANTS

GOVERNMENTAL OFFICIALS

Australia

Paul Douglas
Assistant Secretary, Department of Immigration
and Border Protection

Brazil

Elizabeth Sophie Balsa
Ambassador, Sri Lanka

Davino De Sena
Deputy Head of Mission, Brazil

Costa Rica

Gaudy Calvo
Minister Counselor, Permanent Mission to the UN,
Geneva

Ecuador

Victor Arturo Cabrera Hidalgo
Minister, Permanent Mission to the UN, Geneva

Egypt

Safaa Mourad
Undersecretary of Foreign Health Affairs

Germany

Joern Rohde
Ambassador, Sri Lanka
Michael Dohman
Deputy head of Mission, Sri Lanka
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Setiorini Sulistio
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Kartini Rustandi
Director for Occupational Health and Sports
Directorate, Ministry of Health
Astuti M.KKK
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Imamura Kayo
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Maimoona Aboobakuru
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Protection Agency, Ministry of Health

Hameed Abdul

Senior public Health Programmed Officer, Health
Protection Agency, Ministry of Health

Mexico

Daniela Núñez Pares
Director of Institutional Coordination for Migrants
Health, Ministry of Health

Myanmar

Thet Khaing Win
Permanent Secretary, Ministry of Health and
Sports

Tun Min

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Secretary, Ministry of Labour and Employment
Tarun Paudel
Director, Nepal National Center for AIDS and STD
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Chief Specialist, Ministry of Health

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Deputy Director General
National Department of Health,

Moeketsi Modisenyane

National Department of Health,

Sri Lanka

Maithripala Sirisena

President of Sri Lanka

Rajitha Senaratne

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Susie Perera

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Jayasundara Bandara

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Alan Ludowyke Director

International Health, Ministry of Health, Nutrition and Indigenous Medicine

Anura Jayawickrama

Secretary, Ministry of Health, Nutrition and Indigenous Medicine

G.S. Withanage

Secretary

Ministry of Foreign Employment

Lakshman Siyambalagoda

Additional Secretary (Medical Services), Ministry of Health, Nutrition and Indigenous Medicine

Switzerland

Heinz Walker

Ambassador, Embassy of Switzerland to Sri Lanka and the Maldives in Colombo

Benil Thavarasa

Head of Migration and Development Unit, Embassy of Switzerland to Sri Lanka and the Maldives in Colombo

Kay-Nina Forrer

Immigration Liaison Officer, Embassy of Switzerland to Sri Lanka and the Maldives in Colombo

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Helder Juvinal Neto Da Silva

Head of Department of Non-Communicable Diseases and Mental Health, Ministry of Health

United States Of America

Lisa D. Rotz

Associate Director for Global Health and Migration, Division of Global Migration and Quarantine, Centers for Disease Control and Prevention

Zimbabwe

Aldrin Musiiwa

Deputy Minister of Health and Child Care

Goldberg Tendai Mangwadu

Director Environmental Health Services, Ministry of Health and Child Care

ACADEMIC INSTITUTIONS, PROFESSIONAL ASSOCIATIONS AND EXPERTS

Ibrahim Abubakar

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Anjali Borhade

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RESOLUTION WHA61.17 ON THE HEALTH OF MIGRANTS

The Sixty-first World Health Assembly,

Having considered the report on health of migrants;

Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue on the multidimensional aspects of international migration and development (New York, 23 December 2003);

Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;

Recognizing that the revised International Health Regulations (2005) include provisions relating to international passenger transport;

Recalling resolutions WHA57.19 and WHA58.17 on international migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;

Recognizing the need for WHO to consider the health needs of migrants in the framework of the broader agenda on migration and development;

Recognizing that health outcomes can be influenced by the multiple dimensions of migration; Noting that some groups of migrants experience increased health risks;

Recognizing the need for additional data on migrants' health and their access to health care in order to substantiate evidence-based policies;

Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;

Mindful of the role of health in promoting social inclusion;

Acknowledging that the health of migrants is an important public health matter for both Member States and the work of the Secretariat;

Noting that Member States have a need to formulate and implement strategies for improving the health of migrants;

Noting that policies addressing migrants' health should be sensitive to the specific health needs of women, men and children;

Recognizing that health policies can contribute to development and to achievement of the Millennium Development Goals,

1. CALLS UPON Member States:

- (1) to promote migrant-sensitive health policies;
- (2) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;
- (3) to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
- (4) to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
- (5) to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;
- (6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;

- (7) to train health professionals to deal with the health issues associated with population movements;
- (8) to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;
- (9) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

2. REQUESTS the Director-General:

- (1) to promote migrants' health on the international health agenda in collaboration with other relevant international organizations;
- (2) to explore policy options and approaches for improving the health of migrants;
- (3) to analyse the major challenges to health associated with migration;
- (4) to support the development of regional and national assessments of migrants' health status and access to health care;
- (5) to promote the inclusion of migrants' health in the development of regional and national health strategies where appropriate;
- (6) to help to collect and disseminate data and information on migrants' health;
- (7) to promote dialogue and cooperation on migrants' health among all Member States involved in the migratory process, within the framework of the implementation of their health strategies, with particular attention to strengthening of health systems in developing countries;
- (8) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations and considering the impact of other policies;
- (9) to encourage the exchange of information through a technical network of collaborating centres, academic institutions, civil society and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;
- (10) to promote exchange of information on migrants' health, nationally, regionally, and internationally, making use of modern information technology;
- (11) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

Eighth plenary meeting, 24 May 2008

COLOMBO STATEMENT

High-level meeting of the Global Consultation on Migrant Health, Colombo, 23rd February 2017

We, the Ministers and Government Representatives, meeting in Colombo, Sri Lanka on 23rd February 2017 at the High-Level meeting of the 2nd Global Consultation on Migrant Health, hosted by the Government of the Democratic Socialist Republic of Sri Lanka, with the support of the International Organization for Migration (IOM) and the World Health Organization (WHO), having deliberated on how to globally enhance the health of migrants, adopt the following political Statement;

I. INTRODUCTION

1.1. Noting the increase of international migrants, by 41 per cent between 2000 and 2015, reaching 244 million, creating new challenges and opportunities, including in the health sector, acknowledging the inherent connection between migration and health, as well as recognizing that migration is a health determinant which can impact the well-being of an individual as well as the public health of communities at large;

1.2. Recalling the 61st World Health Assembly (WHA) Resolution on the Health of Migrants (WHA.61.17) of May 2008, the Operational Framework outline of the 1st Global Consultation on Migrant Health held in 2010 in Madrid based on Resolution WHA.61.17, the 140th WHO Executive Board report on the Health of migrants (EB140/24) of January 2017, and the New York Declaration for Refugees and Migrants adopted by the High-Level Plenary Meeting of the United Nations General Assembly on large movements of refugees and migrants in September 2016 (A/RES/71/1);

1.3. Noting the events relevant to migration and health that have recently occurred, such as: the event on Health in the Context of Migration and Forced Displacement held on the sidelines of the 71st UN General Assembly High-Level Plenary Meeting on large movements of refugees and migrants in September 2016; the High-Level Technical Briefing on Migration and Health held at the 69th WHA in May 2016; the 69th WHA agenda item on Promoting the Health of Migrants; the 106th IOM Council High-Level Panel Discussion on Migration, Human Mobility and Global Health in November 2015; at regional level, the WHO Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region (EUR/RC66/8) in September 2016 and the Pan American Health Organization Policy on Health of Migrants (CD55.R13) adopted in October 2016, as well as Regional Consultative Processes (e.g. Colombo Process, Puebla Process) that have initiated discussions on migration and health;

1.4. Appreciating the initiative by the Head of State of the Democratic Socialist Republic of Sri Lanka in hosting the 2nd Global Consultation on Migrant Health in Colombo.

2. GUIDING PRINCIPLES

2.1. We reaffirm that the enjoyment of the highest attainable standard of physical, mental, and social well-being is a fundamental right of every human being, including migrants, regardless of their migratory status, and we recall all international instruments that recognize the rights of migrants;

2.2. We recognize that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families;

2.3. We reaffirm the importance of multisectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration;

2.4. We recognize the role of WHO, in collaboration with other relevant international organizations, to promote migrants' health on the international health agenda.

2.5. We strongly reaffirm the development potential that migration and health carries for countries of destination, transit and origin, as well as our political commitment to the realization of the Sustainable Development Goals;

2.6. We recognize that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard;

2.7 We recognize the importance of dialogue and cooperation on migrants' health among all member states, within the framework of the implementation of their health policies and strategies, with particular attention to strengthening of health systems in developing countries.

2.8 We also recognize the pertinence of global health initiatives and priorities to address emerging and global health trends to migrant health, including through identifying and filling gaps in health service delivery with particular attention to the needs of migrants in vulnerable situations

2.9 We acknowledge the relevance of migration and population mobility in disease surveillance and response plans in accordance with the International Health Regulations (2005), and we recognize that States have rights and responsibilities to manage and control their borders, in conformity with applicable obligations under international law, including international human rights law, furthermore, we reaffirm the individual and collective commitments under 2030 Agenda for Sustainable Development as per target 10.7.

2.10 We encourage migrant engagement in policy formulation, consultation and policy dialogue as well as monitoring and evaluation.

3. WE AGREE

3.1. To consider this Colombo Statement and take note of the other outcomes of the 2nd Global Consultation on Migrant Health, including the consolidated elements of a Progress Monitoring Framework, Research Agenda and Actionable Policy Objectives, in order to improve the health and well-being of migrants and their families throughout the migration cycle, as appropriate;

3.2. To continue the implementation of WHA 61.17 and other relevant WHA resolutions and initiatives.

3.3. To lead in mainstreaming the migration health agenda within key national, regional and international fora, in domains such as migration and development, disease control, global health, health security, occupational safety, disaster risk-reduction, climate and environmental change, and foreign policy as guided by the 2030 Agenda for Sustainable Development;

3.4. To promote the principles and agreements reached at the 2nd Global Consultation on Migrant Health as inputs to future global initiatives, intergovernmental consultations, and Governing Bodies processes contributing to the formulation of a meaningful Global Compact on Safe, Orderly and Regular Migration and where health responses share common elements to the Global Compact on Refugees in 2018 as appropriate.

