THEME GUIDE

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REFUGEE & MIGRANT HEALTH

PROMOTING ACCESS, QUALITY, & REFORM

AMWHO

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INTRODUCTION

The rapid increase of population movement is a defining feature of the twenty-first century. An estimated 258 million people are international migrants and roughly 70.8 million people have been forcibly displaced, with 26 million being refugees. Each day, 37,000 individuals flee their homes and communities to escape conflict, such as war and persecution; to avoid political turbulence; or to seek jobs and educational opportunities. Current solutions that offer short-term refugee camps, limited legal protections for migrants and inadequate access to healthcare services are insufficient to address this global issue.[1] In recognition, the 72nd World Health Assembly (WHA) drafted a global action plan on **'Promoting the health of refugees and migrants.'** The report states,

> The goal of this proposed global action plan is to assert health as an essential component of refugee assistance and good migration governance. The aim of the plan is to improve global health by addressing the health and well-being of refugees and migrants in an inclusive, comprehensive manner and as part of holistic efforts to respond to the health needs of the overall population in any given setting, including the coordination of international efforts to link health care for refugees and migrants to humanitarian programmes. It acknowledges that the entitlement of and access to health services by refugees and migrants vary by country and are determined by national law. Implementation of the plan, once adopted, will take account of specific country situations and be in accordance with national legislation, priorities and circumstances and international instruments on equal access to public health care services.[2]

Therefore, long-term solutions that protect human rights and ensure the well-being of every individual are required, regardless of their nativity or legal status. In order to achieve equitable access to health and ensure the highest attainable standard of living, the collaborative effort of many sectors is required to address the legal, financial, linguistic and cultural barriers to refugee and migrant health–even beyond the physical borders that separate nations.

258 million

An estimated 258 million people are international migrants.[5]

86%

Developing countries host 86% of the forcibly displaced population.[5]

763 million

Global estimates indicate that 763 million are internal migrants.[5]

Since there are many terms used to describe the movement of people, here are some frequently used terms:

Refugee: Forced to flee their home because of war, violence or persecution; often without warning.[3]

Asylum Seeker: Seeks international protection from dangers in their home country, but whose claim for refugee status has not been determined legally.[3]

Internally Displaced Person (IDP): Stays within the borders of their country under the protection of their government, even if the same government is the reason for their displacement; often moving to areas where it is difficult to access humanitarian aid.[4]

Immigrant: Often undergo lengthy vetting process to immigrate and become permanent residents, eventually becoming citizens; typically research their destinations, study the language of their new country and seek employment opportunities; free to return home whenever they choose.[3]

Economic Migrant: Moves from one country to another to improve their standard of living.[3]

Migrants face a unique set of health challenges in both the relocation and resettlement processes, which affect their mental and physical health. Throughout the conference, make sure to address the considerations that specifically apply to **at least one of the following vulnerable populations:**

Refugee Health: Refugees are at a disproportionately higher risk of contracting communicable and non-communicable diseases than their host population counterparts. Conditions of poverty increase the risk of cardiovascular disease, stroke and cancer. Lifestyles of poor diet and minimal exercise also increase the risk of diabetes. And, the relocation process poses the risk of refugees contracting communicable diseases such as tuberculosis (TB) and HIV/AIDS.[3]

Women's Health: Women face unique health needs, concerns and challenges–including reproductive health, childbirth, sexual, intimate partner violence and cervical/breast cancers. Migrant women, in particular, face barriers to healthcare such as transportation, language and culture. They also face a higher risk of sexual harassment and human trafficking.[4]

LGBTQ+ Health: LGBTQ+ refugees flee their home countries from persecution due to their sexual orientation and gender identity. This population faces challenges in the healthcare systems that receive them and need health and settlement services to broaden their understanding of SOGIE (Sexual Orientation, Gender Identity and Gender Expression) to ensure competent care.[5] This population requires specific attention to issues of HIV/AIDS prevention and treatment and mental health services.

Pediatric and Child Health: Children crossing borders face challenges in resettlement and issues of detainment. They are at risk for various chronic or acute physical and mental health conditions, such as asthma, dental problems, psychological trauma and infectious diseases. Physical and neurological development delays or hindrances are also prevalent.[6] Relevant to the outbreak of infectious diseases, proper vaccination and accurate vaccination records are significant issues.

SUBTHEME #1

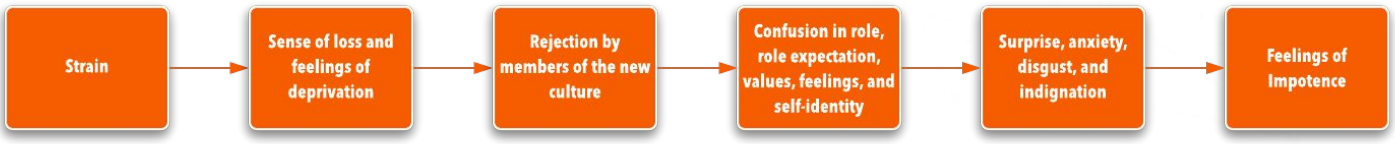
MENTAL HEALTH

Movement is an inherently stress-inducing process, causing mental health to be a pinnacle challenge of refugee and migrant health. Social isolation, poverty, loss of status, hostility from the local population and low quality of life are amongst the various factors that affect poor mental health. Therefore, in an environment that can induce serious mental illness, it is important to increase efforts in improving the mental health of refugees and migrants.

MIGRANT HEALTH

Mental health affects both adults and children. Difficulties often result from poor social skills in their new environment; exposure to psychological, social and biological vulnerabilities and retraumatization; and the concept of self as a migrant.[7] These challenges have manifested in notable increases in schizophrenia, depression and anxiety in migrant populations in recent years.

Cultural shock is a major challenge to migrant mental health that occurs during the resettlement process and it has been hypothesized to occur in six stages, illustrated below.[10]



REFUGEE HEALTH

Acclimating to a new environment also brings about emotional distress resulting from concerns regarding residential status, limited access to health services and the living conditions in provisional refugee shelters. For this reason, mental disorders have increased in prevalence. Trauma, in particular, is prominent in refugee

populations and can be categorized into either **collective traumas**, which are shared injuries to a population's social, cultural and physical ecologies, or **social suffering,** which is defined as interconnected adversities on the levels of individual, family, community and society.[11]

The effect of refugee mental health begins pre-departure in cases of exposure to war and conflict such as witnessing torture, killings, starvation, rape and physical beatings–often resulting in post-traumatic stress disorder (PTSD). The process of travel and relocation adds additional physical and mental stresses to this population and resettlement involves four main stressors predictive of PTSD: 1) social and economic strain, 2) loss of status corresponding with racism and discrimination, 3) threats and violence and 4) alienation.[12]

It is important to recognize how these factors of mental health affect refugees and migrants at every level of the **social-ecological model**. For example, poor mental health can stem from separation from one's family at the *interpersonal level*, inability to access or navigate health insurance plans at the *organizational level* and stress from law enforcement and concerns of detention/deportation at the *policy level*.

CASE STUDY #1 | MENTAL HEALTH OF SOMALI REFUGEES (EMRO)

The past two-and-a-half decades of armed conflict in Somalia have forced the displacement of over 870,000 Somalis[1] to neighbouring countries including Kenya, Ethiopia, Yemen and Djibouti.[2,4] One of the greatest challenges health professionals face in addressing the mental health disorders of Somali refugees is the conceptualizations of health and psychosocial well-being in the religious and cultural contexts.

Though there is limited data collected on the mental health status of people in Somalia, risk factors for developing mental disorders are high considering loss of people, recurring traumatizing experiences, displacement, insecurity, violence and substance abuse.[2] Traditional conceptions about mental distress affect the way that they are viewed and treated; many Somali people have difficulty defining their distress in psychological terms. Some of the specific mental health issues include psychosis, depression, stress-related disorders, anxiety, autism, dementia and epilepsy.

Prior to migrating or seeking asylum, the people of Somalia have suffered from armed conflict, natural disasters and hardships–impacting the collective well-being of Somalis. Cultural and religious values and the understanding of mental disorders affect the health behaviors, treatment expectations and coping strategies Somali refugees practice. It is common for mental distresses to be communicated as somatic jargon instead of in psychological terms. Resultantly, Somali refugees avoid pursuing help from the formal health sector. Individuals with chronic mental health disorders, in particular, are at an increased risk for maltreatment and human rights violations. This is especially the case upon entering refugee camps where they may face xenophobia and stigma.[3] For this reason, there is a need for mental health and psychosocial support services to include interventions to foster community and family support beyond clinical services. Patients and families must be engaged in a system of care that provides non-stigmatizing information about mental illness, which includes acceptable Somali concepts of illness. For example, the Somali word *waalan* is used in refugee communities to describe people suffering from mental illness and carries a stigma. The symptoms of depression–including sadness, loss of appetite and sleep disturbances–are described as *murugo*.[2] Additionally, suicide is seen as religious taboo in Islam states like Somalia, leaving affected individuals unable to express suicidal thoughts openly. In Somali culture, the mind, body and spirit are interconnected as a whole and it may be difficult to define distress in psychological terms.[2]

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SUBTHEME #2

EQUITABLE ACCESS

Large-scale population movement presents epidemiological and health challenges. For this reason, public health and health systems must adjust to include and recognize the health needs of incoming populations.[13] According to the World Health Organization, **universal health coverage (UHC)** aims to ensure that all individuals have access to the necessary promotive, preventative, curative, rehabilitative and palliative health services without incurring any financial hardship.[14] Yet, current national health systems often discriminate against refugee and migrant populations. Compared to host populations, refugees and migrants are more likely to experience poorer access to health care and coverage.[14] Without adequate access, refugees and migrants face excessive medical costs–with many expected to pay out-of-pocket.[13]

MIGRANT HEALTH

The General Assembly recognizes the positive contributions made by migrants to a nation's inclusive growth and development, as stated in the **2030 Agenda for Sustainable Development**. However, current national legal frameworks delineate the treatment of migrants, which contrasts the justice for universal human rights and fundamental freedoms.[15] Policies targeting the unique health needs of migrants should ensure people-centered, relevant and sensitive, humane, dignified, gender-responsive and prompt reception for all individuals in the process of relocation and resettlement. Legal status should not disqualify the protection of their human rights and fundamental freedoms, which includes the right to proper health care access.

There is an undeniable need to ensure equitable access to health services and coverage for the migrant population. In addition to non-inclusive national plans that discriminate against migrants, language barriers and lack of awareness about government and non-government health programs withhold migrants from accessing health care. Even more, legal status affects whether migrants can seek medical advice and diagnosis from health care providers. As a result, chronic health problems may remain unidentified or receive delayed medical attention and treatment.

REFUGEE HEALTH

It is important to note that refugees are among the world's most vulnerable populations. As stateless peoples unprotected by the fulfillment of their positive rights by their home country, refugees require the protection of international law. They are the most susceptible to be denied healthcare services due to the cost of care. This increases the risk for untreated progression of disease and poor quality of living, which have larger social and economic implications.

The host state is primarily responsible for protecting and assisting refugees. Although the host government typically pledges to provide an adequate level of funding, no standardized reporting systems of funding exist. Thus, traditional refugee funding comes from risk-transfer instruments such as insurance, reinsurance, bonds, swaps or donations by high-income countries (HICs).[16] A few programs that have been suggested by research include:

Microinsurance

Public, private, not-for-profit and community-based insurance schemes with service operations at the local level, specifically targeted for the poor; low premiums to a small pool are charged and the fund pool provides limited coverage with meaningful payout.[16,17]

Grants for Refugee-Hosting Governments

Under the World Bank, the 2016 Global Concessional Financing Facility was initiated and provides financial support to middle-income countries to address humanitarian crises. Grants and low-interest, long-term concessional loans are provided to low and middle-income countries to incentivize host governments to develop strategies that integrate the national health plan for refugees.[16,17]

Pay for Performance Financing Initiatives

These methods of purchasing projects and services aim to improve the quality, efficiency, effectiveness and value of health services. Financial risk is shifted from the government to a new investor. The new investor provides upfront capital to scale an evidence-based program to improve health outcomes and aims to reduce costs with effective delivery. Additionally, the savings generated by the local government are used to pay back the investors over time.[16,17]

Yet while such programs exist, the health systems of host countries are still unequipped to meet the needs of refugees, leaving them in an even more vulnerable position. The current humanitarian system is overburdened, underfunded and unable to address the increasing number of humanitarian emergencies. Refugee camps are often faced with the issue of insufficient resources and typically generate poor health outcomes, both physically and mentally. Crowded living spaces, poor sanitation and longstanding solutions are becoming increasingly more important. Therefore, solutions require innovative ideas and integrative efforts from multiple actors and disciplines.

CASE STUDY #2 | EQUITABLE ACCESS TO MEDICAL SERVICES IN ZAMBIA REFUGEE CAMPS (AFRO)

Refugee populations are at the greatest risk of mortality upon arriving at their country of asylum. The living conditions at refugee camps–in addition to their attenuated immunity–make refugees susceptible to infectious diseases, respiratory infections and STIs like HIV.[1] Furthermore, the extent of medical services available and quality of care vary greatly across camps. Refugee camps pose barriers to care, as they are located in remote regions with limited electricity and running water and they are often difficult to access by road. Basic necessities such as food and water are scarce in remote, densely-populated camps–let alone medical care. Additionally, the rotation of people cycling in and out of the camps on a regular basis makes it difficult to deliver sustained care over time.[1] With respect to Zambia, specifically, refugee settlements lack the financial resources to provide adequate services and medical care.

The Meheba Refugee Settlement in Zambia is exemplary of the UNHCR's efforts to increase awareness of sexual health, HIV and broadly promote health education.[1] Pamphlets to increase health literacy in the camp are distributed in French, Swahili, Lingala, Lunda and a number of other dialects to ensure people understand HIV and other diseases, the respective signs and symptoms and preventative measures. Weekly free screenings and health talks are hosted and have contributed to the significant reduction of the HIV infection rate in the camp as compared to surrounding regions.

Beyond refugee populations located in camps, UNHCR is working with governments to link refugees to national health services. Their goal is to ensure that refugees are integrated under the national health insurance scheme within the AFRO region and around the world.[2] Since 2018, the health status of Zambia's refugees have been monitored by national health information surveillance systems. Other countries in the AFRO region have also taken action on expanding coverage and therefore, access to healthcare. For example, the Republic of Tanzania has since integrated refugees into their National Malaria Control Programme, through which camps receive anti-malaria medications and diagnostic kits. Additionally, Kenya's government has identified Universal Health Coverage (UHC) as one of its pillars and is taking action to achieve this goal by 2030. They aim to have their citizens register with the National Health Insurance Fund, a government-subsidized health insurance scheme, that ensures sustainable financing.[2]

These steps ensure that refugees have equitable access to preventative and curative health services through a UHC model. UHC strives to improve infrastructure, increase human resource capacity and financing and ensure the protection of human rights for all– including refugees and migrants.

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SUBTHEME #3

CULTURAL INTEGRATION

Conversations around migration and refugees rarely exclude the topic of cultural conflict. Refugees and migrants tend to be stigmatized due to their non-native identity. Traditionally, economists and policy-makers have been interested in the direct impact of immigration on the labor market or fiscal transfers and public goods provision.[18] However, non-market socio-cultural interactions play an important role in determining socioeconomic and social class status as determinants of refugee and migrant health.

The assimilation of refugees and migrants into the cultures of their new host countries occurs in three pathways, with social stratification influencing the accessibility to health services and other resources contributing to the social determinants of health.

Traditional Assimilation: Refugees and migrants become part of the dominant culture and reap the benefits of upward mobility.[19]

Downward Assimilation: Opportunities for social mobility are restricted and immigrants are marginalized and disadvantaged.[18]

Selective Acculturation: Immigrants reinforce the importance of maintaining cultural values while simultaneously adopting the conventions around their host-nation.[18]

In many cases, the pathway refugees and migrants take is dependent upon their country of origin and the host country's perceptions around it. In situations where the host country creates an unwelcoming environment, refugees and migrants are subjected to inequitable access to health services and experience social polarization. Refugee and migrant health disparities may also be attributed to **health literacy**, the ability to obtain, understand and use the information needed to make wise health choices.[19] A variety of obstacles stand in the way of

developing basic health literacy, including poverty, limited education, low literacy levels and inadequate English-language skills.[19] The healthcare system is particularly difficult to navigate for newcomers who are not accustomed to its structure and medical terminology. In addition to gaps in education and literacy, healthcare professionals often make it difficult for people to understand diagnosis and treatment regimens.[19]

Furthermore, practitioners may approach refugee and migrant patients with **implicit biases** which affect the quality of care and patient health outcomes. Negative provider-patient interactions could reduce patient satisfaction and compliance. Disincentivizing the experience of seeking medical care also increases the risk of patients avoiding interactions with medical professionals, allowing disease symptoms to progress and complicate. Many refugees and migrants may also practice rituals of healing outside of the conceptions of **Western biomedicine** which further complicates their interactions with the healthcare systems in their host countries; yet, health providers of host countries are often uneducated on the cultural context of disease for this given population.

CASE STUDY #3 | CULTURAL CONFLICT CONSEQUENCES OF THE ROHINGYA REFUGEE CRISIS (SEARO)

The Rohingya are a Muslim ethnic minority group who have fled persecution in Myanmar's Rakhine state. Myanmar is a predominantly Buddhist nation with respect to its population ethnic, linguistic and religious practices.[1] In 2017, Myanmar's military forces initiated a genocidal intent on the Rohingya people, who are Sunni Muslims. Consequently, they fled and sought asylum in the neighboring countries of Bangladesh, India, Indonesia, Malaysia and Thailand.[1] By legal definition, the Rohingya have been denied Myanmar citizenship and are effectively stateless people. Instead, the Muslim minority is issued identification cards as temporary residents of Myanmar[1]. Even prior to seeking asylum in surrounding nations, the Rohingya suffered from poverty, poor infrastructure, limited employment opportunities and ostracization as a result of religious friction, all of which negatively impact health.

The Rohingya refugees face various challenges depending on the country in which they migrate to. India's Hindu nationalist government has reportedly sent refugees back to Myanmar. Malaysia has excluded the refugees from obtaining legal status, thus preventing them from seeking employment, education, or healthcare.[1] The refugee camps where the Rohingya reside have poor hygiene and sanitation conditions, which make communicable diseases easily transmittable. The lack of resources, the remote location of the camps and lack of legal status prevented the refugees from receiving healthcare.

The majority of Rohingya refugees flee to Bangladesh, which took in 750,000 refugees as of 2019. Despite the generous acceptance of the refugees, Bangladesh is quickly losing patience for them. The Rohingya have been blamed for the death of a prominent politician, were accused of smuggling drugs from Myanmar into the camps and for agitating police forces.[2] Bangladesh officials ordered that telecommunication operations be shut down in the camps for a week in September 2019, cutting off communications with security, health and other services .[3] Furthermore, military presence in the camps has been increased and Bangladeshi officials and citizens are increasingly more hostile toward the Rohingya refugees.

Current efforts are targeted toward short-term repatriation despite there being no end in near sight. The sustainable solution would require the establishment of durable shelters and developing programs that would help refugees obtain legal rights under a formalized status, enabling them to access healthcare and be self-sufficient through education and employment opportunities.[4] The current situation is restricting the ability of NGOs to step in and contribute, making the situation more burdensome for both the Rohingya and the host nation, Bangladesh. Strategic and sustainable efforts toward a longer-term approach would allow the mobilization of government capabilities and donor resources while helping prepare the Rohingya for a successful return once the situation improves in Myanmar .[4]

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SUBTHEME #4

LABOR & WORKFORCE

Employment opportunities can enhance resilience, secure dignity and allow individuals to escape economic inequalities.[20] However, refugees and migrants experience higher rates of work-related injuries and illnesses, marking occupational health safety as a critical aspect of refugee and migrant health. Often, power-dynamics arise between the employee and their foreign employer as a result of their non-native identity. This places refugees and migrants in a particularly vulnerable position. Yet, systematic monitoring and occupational guidelines typically do not exist to ensure that their rights are protected–even when their work environments often increase exposure to risks that endanger their health. And in most cases, workers are either legally restricted in their access to health benefits or workers opt to void existing benefits.[21]

MIGRANT HEALTH

In many cases, migrant workers are economically exploited, suffer from wage theft and have limited access to information about their rights. However, given the employee-employer power-dynamics, many do not file complaints about exploitation, as they risk losing finances in seeking legal support and may confront losing their jobs or being deported. The majority of migrant workers who perform low-skill or low-wage jobs do not have access to permanent residence and tend to be denied access to federally-funded settlement services. Even more, migrant workers often do not receive any form of health insurance.[22]

Within the migrant worker population, the recruiter-driven exploitation of migrant workers becomes a modern form of slavery, especially without appropriate government regulation and monitoring. Male migrant workers often work in high-risk labor-intensive occupations such as construction and manufacturing; and, many female migrant workers are at increased risk of human trafficking or being absorbed into the sex work industry.[23] Sectors with large rates of migrant workers–agriculture, construction and transportation–place migrant employees at high-risk for work-related injuries and health conditions. For example, agricultural workers suffer

from higher rates of heat stress, dehydration and chronic kidney diseases of unknown origin.[22] Scarring of lung tissues and lung hypersensitivity is also common among migrant workers exposed to dust and debris through their occupations.[22] And, other respiratory or communicable diseases are more transmittable among migrant workers, as they are often housed in close-quarters or communal living facilities provided by their recruiters.

REFUGEE HEALTH

Refugee integration into the host country and its labor market primarily fall in the hands of host governments and their respective asylum policies.[24] Geographic dispersal policies for refugees and asylees often require settlement of those seeking humanitarian aid to specific regions. Designated regions tend to be located far from major cities to prevent the development of ethnic enclaves. However, the dispersal of refugees has implications on their ability to seek out employment opportunities through social networks, limits their access to jobs outside of metropolitan cities and restricts their geographic mobility, which could also reduce their employability.[24]

This often leaves refugees in a vulnerable position without health insurance coverage or benefits. Dispersal policies that keep refugees out of large cities also keep them away from healthcare services and quality care. There are fewer services and resources available at hospitals and clinics more distant from densely-populated urbanized areas. Apart from hospitals, dispersal also limits access to education, language classes and essential services like food markets; factors that increase health disparities and inequality for refugees. A lack of access to nutritious food has negative consequences for refugee physical health, while a lack of access to education and employment has negative consequences for refugee social and mental well-being. Unlike their immigrant counterparts, refugees arrive to host countries with very few resources and are often barred from sufficient public assistance benefits.[25]

CASE STUDY #4 | MIGRANT WORKERS IN SINGAPORE (WPRO)

In the country that captivated mass media with the cosmopolitan movie *Crazy Rich Asians,* migrant workers suffer harsh working conditions and poor health outcomes. Singapore depends on a large population of predominantly male migrant workers from Bangladesh, China and Myanmar to power the construction industry. There is no minimum wage in Singapore, leaving migrant workers with a mere $13-$15 USD per 12 hour shift. Low wages result in little money to spare for food, resulting in catered meals of low-nutrition and sometimes low nutrition and poor quality. Sometimes when workers cannot even afford meals, they consume sugary caffeinated energy drinks for energy; increasing their risk for high blood pressure and diabetes.[1]

Many of these workers come from Bangladesh or India, where alternatives to working abroad include farming or fishing for a fraction of what they would earn abroad. Thousands of young men leave their families and children behind to attempt to earn a higher income abroad to support their loved ones back home. Recruiters in Singapore charge migrant workers thousands of dollars for processing work visas and arranging their dormitories and working conditions, leaving many workers in debt upon arrival. It is also common practice in Singapore for employers to cheat workers out of their wages with little repercussions because of the power dynamic. The process of selling family and personal assets to afford work visas to migrate for work in addition to receiving less than the agreed-upon salary adds pressure and mental distress to these migrant workers.[3] Furthermore, construction work results in frequent injuries, which diminish the productivity of the worker, allowing employers to cancel work permits and deport migrant workers without medical compensation or medical treatment, with outstanding debt.[2] Many young men share dormitory rooms with as many as sixteen other migrant workers, which denies them any privacy and increases their risk for transmission of communicable diseases.

While Singapore does have some protections for workers, disadvantaged migrant workers are often left in the dark about them. Singaporean law rules that employers are required to cover at least $15,000 of medical insurance for each Work Permit holder and have at least $36,000 of medical expenses coverage for workplace-related injuries.[4] Migrant workers are, however, often unaware of their medical coverage and employers are keen to ensure they remain unaware. In fact, employers often withhold letters of proof of insurance from workers, preventing them from filing claims.[4] Doctors and other healthcare providers in Singapore are typically unaware of the legalities and insurance process of treating migrant workers, which can cause friction between the doctor and the worker, as well as between the worker and their employer.

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SUBTHEME #5

DISEASES CROSSING BORDERS

Many individuals and families crossing borders to flee from their homes and seek asylum often do not have legal documents with them. This includes medical records or vaccination history. Issues further arise from varying vaccination requirements and access from country to country. Contrary to xenophobic depictions of refugees and migrants in the media today, the main concern is not that refugees and migrants are disease-ridden. Rather, the bigger concern is that they are not vaccinated against diseases they could contract in their host-country [26]. Additionally, migrants and refugees often depart from regions of poor sanitation infrastructure and limited access to medical services and aren't aware that they are at risk for infection. Beyond the concerns of infectious disease, it is also important to recognize high incidence rates of noncommunicable diseases among migrant and refugee populations. With globalization and mass-migration as some of the defining features of the 21st century, it is important for countries to take public health actions to prevent the dissemination of infectious diseases and address the globalization of noncommunicable diseases.

MIGRANT HEALTH

High-income countries (HICs) in the 21st century are increasingly more ethnically and culturally diverse due to migration flows. Studies have shown that rates of noncommunicable diseases vary between migrants and host populations in HICs, which tend to receive influxes of immigrants [27]. Migrants have been found to have elevated risk of developing diabetes and have earlier onset of diabetes as compared to the host populations [27]. Furthermore, migrants often face income inequality, physically strenuous work, housing insecurity and other social issues that increase levels of stress which increases the risk for chronic noncommunicable diseases such as hypertension and cardiovascular disease. Such housing and income conditions also isolate migrants from early disease detection and interventions, which could lead to further complications and sequela.

REFUGEE HEALTH

Similarly, refugees are exposed and are vulnerable to noncommunicable disease risk factors. They are often faced with poverty, political conflict and limited access to healthcare in their countries of origin. The process of transit and adapting to a new host-country could also result in the adoption of unhealthy lifestyle choices that could exacerbate the risks [28]. Language and cultural barriers, a lack of resettlement services and a lack of health literacy pose substantial risks to refugee populations upon arriving in a new country. Lifestyle choices such as unhealthy diets, physical inactivity, substance abuse and risky sexual behaviors are determinants of noncommunicable diseases that must be addressed with targeted and appropriate approaches. Multi-sectoral dialogue and action are required to develop national surveillance systems to track NCD trends in refugee populations, to train clinical professionals and public health workers and to deliver programs to empower refugee communities and promote health in origin and host communities [28].

Additionally, this concern of infectious disease is especially relevant in the case of refugee camps, where poor sanitation and close quarters increases the risk of communicable disease transmission. Researchers have concluded that international movement of people is a significant factor in disease outbreaks; mobile populations can link zones of disease emergence to low prevalence or non-endemic areas through rapid, high-volume movements.[26] Public health screening measures such as high-tech breath analyzers for diseases, disease-sniffing dogs at ports of entry, higher-regulated vaccination records, prophylactic treatment for travelers from high-risk areas and provision of personnel trained in infectious disease detection and containment at ports of entry are all measures that can be taken and enforced through policy to prevent outbreaks.

CASE STUDY #5 | MEASLES IN EURO

National efforts toward vaccination programs across the globe eliminated, but did not eradicate, measles in the early 2000s. In 2019, the WHO reported an increase in measles cases in Europe, with the majority of the cases coming from Ukraine at over 25,000 cases in just two months.[1] In 2017, the second dose of the measles vaccine was administered at 90% in EURO, but has since been challenged with a decline in immunization coverage–raising the potential of a decline in vaccination. Most measles outbreaks have been reported in unvaccinated or under-vaccinated individuals, often as a result of poor immunization coverage.[1] Although it is a completely preventable disease, suboptimal vaccination of measles, particularly in marginalized groups and refugees, has greatly contributed to the outbreak.

The European Vaccine Action Plan 2015-2020 (EVAP) was adopted in 2014 and aimed to achieve a region free from vaccine-preventable diseases including Hepatitis B, Measles, Rubella and Poliovirus.[2] Through adopting EVAP, the EURO Member States pledged to ensure long-term domestic funding and a longstanding commitment to vaccination.[2] The second goal of the program, in particular, was to eliminate measles and rubella with the target that all Member States would have interrupted endemic transmission of measles and rubella for 12 months by 2015 and verify elimination by 2018. However, the midterm report conducted in 2017 found that this target was not met, particularly due to persistent immunity gaps and the resulting risk of re-establishment of endemic transmission.[2]

Ukraine is a middle-income country with a near-universal public health care system and for some time before 2014, it was considered the gold standard of herd immunity.[3] However, in 2019 it became the poster child of measles outbreaks. The conflict between Russia and Ukraine in 2014 resulted in the suspension of the Ukranian Ministry of Health budget and cessation of measles vaccination procurement until late 2015.[3] Children, the elderly and other marginalized populations were particularly vulnerable. Today, much of the suboptimal coverage for immunization is attributed to having poor access to health services, including vaccinations.[4] More than 54,000 cases of measles were reported in Ukraine, which has been affected by conflict for over three years - with 1.5 million Ukrainians under the IDP category.[7] In addition to the internally displaced, many Ukrainians have been forced to seek asylum and refugee status in neighboring countries due to the conflict with Russia and are left with minimal access to medical services like vaccinations.[4] Furthermore, studies have been conducted in Germany, Spain, Italy and various other EURO countries that found that migrant children are significantly less likely to be vaccinated than their national counterparts.[5] Cultural and linguistic barriers, socioeconomic exclusion and discrimination are some barriers that ethnic minorities and refugees face which prevent access to immunization and other health services.[5] Additionally, these barriers become more insurmountable for undocumented migrants who find themselves even more disinclined from seeking out healthcare services, or internally displaced people who are located in remote regions.

Moving forward, the WHO EURO Regional Office must enhance immunization of disease and surveillance systems, especially emphasizing suboptimal immunization coverage for migrants. Public health efforts must ensure that "all population groups have equitable and convenient access to vaccination services; strengthen trust and the public perception of vaccines and health authorities; improve outbreak detection and response and improve surveillance methods to identify who has been missed in the past and reach them with the necessary vaccines".[6]

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CONCLUSION

The WHO Constitution of 1948 declared the right to health for everyone to enjoy the highest attainable standard of physical and mental health. Under this clause, refugees and migrants have the same right to health services and the financial and social protection for health as every other human being. In May 2019, a global action plan on the health of refugees and migrants from 2019-2023 was drafted. The plan set out to achieve Universal Health Coverage for "all" - including refugees and migrants, regardless of their migratory status. Delegates can draw on the priorities set out in the plan to devise regional and national policies that protect the physical, mental and social well-being of all who enter their borders. This includes addressing the underlying social determinants of health.

Through this international conference, delegates will be challenged to evaluate how to dismantle barriers to health that migrants face, whether it be a matter of social stigma, limitations due to migration status, a lack of cultural competence, or economic barriers. It will also be their responsibility to account for particularly vulnerable migrant groups, such as women and children. The conventional solutions to the global migration predicament have focused on short-term solutions like poorly resourced refugee camps that have left refugees and migrants in a vulnerable position. Therefore, delegates must evaluate the short-term solutions, but are encouraged to focus on the development of sustainable, long-term interventions.

Each region and nation has its own unique challenges to face in the age of global migration, as well as individualized systems of government and national infrastructure. Consequently, each country will be tasked with finding and implementing solutions that will be effective in the context of their nation's situation. Furthermore, it will be important to ensure systems of evaluation and accountability are put in place for effective delivery of policy aims. Delegates will need to work together to draft policies that will prioritize the well-being of the world's population over the priorities of nation-states. We hope that you come together willing to innovate new solutions, while also remembering the core values of the country or organization you may represent.

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