

# Beyond the barriers

Framing evidence on health system strengthening to improve the health of migrants experiencing poverty and social exclusion



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Beyond the barriers: framing evidence on health system strengthening to improve the health of migrants experiencing poverty and social exclusion  
ISBN 978-92-4-151336-4

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Printed in Switzerland

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# Acronyms

- ASEAN** Association of Southeast Asian Nations
- GRADE** Grading of Recommendations Assessment, Development and Evaluation
- GDP** gross domestic product
- ILO** International Labour Organization
- IMF** International Monetary Fund
- IOM** International Organization for Migration
- JUNIMA** Joint United Nations Initiative on Migration, Health and HIV in Asia
- NHPSPs** national health policies, strategies and plans
- OECD** Organization for Economic Co-operation and Development
- OHCHR** Office of the High Commissioner on Human Rights
- PAHO** Pan-American Health Organization
- SEKN** Social Exclusion Knowledge Network
- SDG(s)** Sustainable Development Goal(s)
- UN** United Nations
- UNHCR** United Nations High Commissioner for Refugees
- WHO** World Health Organization



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# INTRODUCTION

## Aims

Target 3.8 of the Sustainable Development Goals (SDGs) focuses on achieving universal health coverage. Universal health coverage means that *all people* can use the health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship (WHO, 2017a). While universal health coverage is the goal embodied in target 3.8, *health systems strengthening* is a means through which that goal can be achieved, acknowledging also the important role that intersectoral action plays (Kieny et al., 2017; De Paz et al., 2017). The term “all people” in the definition of universal health coverage means that health systems strengthening should be underpinned by the commitment to health as a fundamental human right. It also means that specific attention should be paid to populations experiencing marginalization, poverty and vulnerability in order for them to fulfil the right to health and other interrelated, interdependent and indivisible rights (IOM/WHO/OHCHR, 2013)

“Leaving no one behind” is a centrefold principle in the Sustainable Development Agenda. Those “left behind” are a vastly heterogeneous group. They face a wide range of barriers to health services that differ across countries, communities and individuals. As such, approaches to health system strengthening to leave no one behind need to account for this heterogeneity and the complexity of barriers. Some migrants,<sup>1</sup> in particular those experiencing poverty and social exclusion, face intersecting and compounding barriers (see examples in subsequent sections).

Against the backdrop of leaving no one behind on the path to universal health coverage, this paper aims to:

1. present information on barriers to health services faced by some migrants, in particular those experiencing poverty and social exclusion;
2. acknowledge that some barriers are faced by multiple subpopulations and others are unique to migrants, and that both types of barrier should be addressed to overcome inequities;
3. provide a framing for addressing these barriers in health systems strengthening for universal health coverage, and provide a non-exhaustive synthesis/scoping of existing evidence using this framing;
4. highlight areas where more research is needed, to further contribute to the evidence base for leaving no one behind in progress towards SDG target 3.8 on universal health coverage.

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1 At the end of 2015, there were estimated to be over 244 million international migrants (about 3.5% of the world's population) (UNDESA, 2015). For more information, see: <http://gmdac.iom.int/global-migration-trends-factsheet>

## Global context

This paper contributes to follow-up to *Equality and non-discrimination at the heart of sustainable development: a shared UN framework for action* (UN, 2016a). This emphasizes that leaving no one behind entails *full realization of human rights, without discrimination on the basis of sex, age, race, colour, language, religion, political or other opinion, national or social origin, property, birth, disability or other status*. The World Health Organization (WHO), through its Constitutional<sup>2</sup> mandate and its work on equity, gender and human rights, is committed to its part in operationalizing this framework.

With its explicit focus on health systems strengthening for universal health coverage and equity, the paper contributes to follow-up to the:

- United Nations General Assembly resolution on universal health coverage (UN, 2012a);
- World Health Assembly resolution WHA69.11 on Health in the 2030 agenda for sustainable development;
- World Health Assembly resolution WHA65.8 on the Outcome of the World Conference on Social Determinants of Health;
- World Health Assembly resolution WHA62.14 on Reducing health inequities through action on the social determinants of health.

Specifically, resolution WHA69.11 stresses the importance of health system strengthening for universal health coverage while giving a special emphasis to segments of the population experiencing marginalization, poverty and vulnerability (WHO, 2016a). Resolutions WHA65.8 and WHA62.14 highlight the need for reorienting health systems to overcome health inequities (WHO, 2012a and 2009).

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<sup>2</sup> This recalls the commitment in the WHO Constitution, towards the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (WHO, 1946).

The paper also provides inputs to the synthesis of evidence on “migrant-friendly health systems”. In conjunction with many other resources, it feeds into the situation analysis now underway by WHO and partners following up on World Health Assembly resolution WHA70.15 on Promoting the health of refugees and migrants (WHO, 2017b). In May 2017, resolution WHA70.15 was adopted by the Seventieth World Health Assembly. In this resolution, Member States took note with appreciation of the *Framework of priorities and guiding principles to promote the health of refugees and migrants* (WHO, 2017c).

Resolution WHA70.15 urges Member States, in accordance with their national context, priorities and legal frameworks, to consider promoting the framework of priorities and guiding principles, as appropriate, at global, regional and country levels including using it to inform discussions among Member States and partners engaged in the development of the global compact on refugees and the global compact for safe, orderly and regular migration (WHO, 2017c; UN, 2017b). An element of the *Framework of priorities and guiding principles to promote the health of refugees and migrants* that is particularly pertinent to the focus of this paper is:

*[...] promoting equitable access to quality essential health services, financial risk protection and access to safe, effective, quality and affordable essential medicines and vaccines for all (SDG target 3.8), including refugees and migrants.*

Box 1 highlights select resolutions, declarations and statements on migrant health that are relevant to the scope of this paper.



## ■ Box 1. Select relevant resolutions, strategies, policies, declarations and statements on migration and health

- World Health Assembly resolution WHA70.15 on Promoting the health of refugees and migrants, which took note with appreciation of the *Framework of priorities and guiding principles to promote the health of refugees and migrants*.
- The global compact for safe, orderly and regular migration, consultations for which are now underway. An interagency working group is feeding into the health component.
- The Colombo Statement, which was adopted by the 19 countries attending the High Level Meeting of the 2<sup>nd</sup> Global Consultation on Migrant Health: Resetting the Agenda, in Colombo, Sri Lanka on 23 February 2017. The Consultation was jointly organized by the Government of Sri Lanka, the International Organization for Migration (IOM) and WHO.
- The WHO *Strategy and action plan for refugee and migrant health in the WHO European Region* (EUR/RC66/8), adopted by the Regional Committee for Europe in 2016 through resolution EUR/RC66/R6. This was informed by the Outcome document of the High-level meeting on Refugee and Migrant Health, 23–24 November 2015, Rome, Italy.<sup>3</sup>
- The policy document Health of migrants (document CD55/11) supported by the PAHO Directing Council/Regional Committee of WHO for the Americas in 2016 through resolution CD55.R13.
- United Nations resolutions A/RES/71/1 adopting the New York Declaration for Refugee and Migrants and A/RES/71/237 on International migration and development.
- World Health Assembly resolution WHA61.17 on the Health of migrants, adopted at the Sixty-first World Health Assembly in 2008.

Sources: WHO, 2017b and 2017c; WHO Regional Office for Europe, 2016a; WHO Regional Office for Europe, 2015; PAHO/AMRO, 2016; IOM/WHO, 2017; UN, 2016b; UN, 2017a; UN, 2017b; WHO, 2008.

## Scope of the paper, rationale and limitations

This paper was informed by a rapid scoping review of literature. The review focused on ways in which health systems are attempting to enhance effective coverage for migrants, in particular those experiencing poverty and social exclusion. The review was done in 2016, with a commenting period and revision in 2017 (see “Methods” section).

<sup>3</sup> The WHO European Region as a whole and particularly countries closest to North Africa and the Middle East face large influxes of migrants. Therefore, the Member States of the WHO European Region agreed on the need for a common framework for collaborative action on refugee and migrant health during a high-level meeting on refugee and migrant health, held in Rome, Italy, on 23–24 November 2015. The Strategy and Action Plan for Refugee and Migrant Health was consequently developed and adopted during the WHO Regional Committee for Europe in September 2016.

At the international level, there is no universally accepted definition of the term “migrant” (WHO, 2017d). IOM defines<sup>4</sup> a migrant as *any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person’s legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is* (IOM, 2011a; IOM, 2017h). For the purpose of this paper, the IOM definition is applied with one exception: the paper focuses on international migrants (rather than also covering internal migrants).

<sup>4</sup> For more information, see: <https://www.iom.int/who-is-a-migrant>

The paper is informed by multiple sources that covered international migrants as a whole (without differentiation/delineation between labour migrants, refugees, asylum seekers, migrants in regular and irregular situations, etc.), as many of the health system strengthening approaches to reduce inequities will be relevant across these subpopulations. That said, the sources reviewed did not look *in-depth* at the provision of immediate humanitarian assistance, medical examination and urgent treatment, such as in the case of health system responses to large-scale arrivals resulting from war and conflict and natural disasters. This is indeed an essential component of health system strengthening, including for resilience and safeguarding the right to health, but this was beyond the scope of the review conducted to inform this paper.

It should be emphasized that this paper specifically focuses on health system strengthening approaches to better meet the needs and rights of migrants who are experiencing poverty and social exclusion. **The paper does not address the situation of all migrants**, simply because some migrants (e.g. internationally transferred professionals with substantial benefits packages and integration support) have levels of economic well-being and education, supportive study/labour and living conditions, and other circumstances that enable them to be in more advantaged positions in relation to accessing and benefitting from needed health services as well as underlying determinants of health.

Within the paper's focus on migrants experiencing poverty and social exclusion, poverty is defined as a *pronounced deprivation in wellbeing* (Haughton & Khandker, 2009), and *social exclusion manifests as both a cause and a result of inequities in access to resources (means that can be used to meet human needs), capabilities (the relative power people have to utilize the resources available to them), and fulfilment of human rights* (SEKN, 2008).

Global policy deliberations on *migrants in vulnerable situations* are relevant to the focus of this paper (UNHCR, 2017; IOM, 2017d and 2017f; IOM/WHO/OHCHR, 2013). Both *situational* and *individual vulnerability* are explored through the analysis of different types of barriers. Also explored are the ways in which health interventions can contribute to resilience (IOM, 2017f). Work on health inequities in relation to social exclusion explores barriers linked to political, social, cultural and economic spheres, emphasizes the continuum of inclusion to exclusion that is relevant for policy-making and programming, and describes how exclusionary processes can compound and intersect (SEKN, 2008). Social exclusion influences health directly, through manifestations in the health system, and indirectly, through affecting health determinants in other sectoral domains (SEKN, 2008). Gender inequality and gender norms, roles and relations, given their intersecting role in multidimensional poverty and social exclusion, are also taken into account in this conceptualization. The cultural dimension of social exclusion is noteworthy for configurations of gender norms and how people experience and negotiate opportunities in the context of multidimensional poverty (PAHO/AMRO, 2017).

The paper's focus on barriers experienced by some migrants also draws from conceptual thinking on the impact of poverty – whether absolute, relative, or multidimensional – on health equity. It examines the role of health systems in responding to poverty, both directly and through their stewardship function for inter- and cross-sectoral work (Yazbeck, 2009; WHO Regional Office for Europe, 2010a; WHO Regional Office for the Western Pacific, 2016a; WHO, 2010a; CSDH, 2008).

This paper draws from:

- a. research on equity, gender and human rights (also in relation to health systems strengthening for universal health coverage);
- b. research on migration and health.

By doing this, it illuminates the need to *synergistically* address barriers that may be more specific to migration processes and those that are faced by multiple subpopulations in a country (e.g. populations experiencing lower income levels, lower education levels, adverse employment conditions, lack of adequate personal identification, language barriers or discrimination on different grounds). By advancing these approaches in tandem, systems can be – cohesively and coherently – made more responsive to population needs and health inequities can be reduced. This is also important as some barriers linked to migration may in fact influence other barriers and/or exacerbate their effect, such as those linked to cultural and gender discrimination barriers (Castaneda et al., 2015; Fleischman et al., 2015). Conversely, poverty and social exclusion can also exacerbate barriers linked to migration.

This concept can best be articulated through examples. For instance, an intervention to provide multilingual health services to better respond to population needs would benefit not only some migrants, but also other national minority groups who do not speak the majority language. Strengthening primary health care services in disadvantaged neighbourhoods (for instance, in a hypothetical neighbourhood comprising 35% migrants experiencing poverty and social exclusion and 65% other persons experiencing poverty and social exclusion) underpins social cohesion

in that it benefits all of the people living there. Likewise, the above two interventions will be of little use to improving the health of migrants in vulnerable situations if in fact barriers remain with regard to basic entitlements and limited access to financial protection, and if undue attention is given to reducing vulnerabilities and enhancing resiliencies across the migration cycle. Hence, the need to advance a comprehensive approach to inequities experienced by some migrants (and other subpopulations) is emphasized in this paper.

This type of coherent approach, which emphasizes the capacity of health systems to respond to the heterogeneity of populations and draws from barrier analysis, is central on the path to truly leaving no one behind. The aims of this paper are grounded in the notion that understanding and creating systems capable of overcoming (often intersecting and compounding) barriers is necessary to ensure the right to health.

Finally, it should be noted that the paper does not provide an exhaustive overview of all literature on this subject, nor in-depth analysis of specific updated country case-studies. It is one of numerous resources feeding into the global consultative process now underway to inform the situation analysis called for by resolution WHA70.15 (as explained in the section “Further consolidation of the evidence base”).

## Structure

Following this introductory section, an overview is given of the conceptual underpinnings for the paper. These include those related to equity-oriented, rights-based and gender transformative health system strengthening, and non-discrimination, accountability and empowerment. It then provides a brief synopsis of evidence on barriers to health services, with examples of those impacting some migrants, particularly those experiencing poverty and social exclusion. The paper proceeds to frame and show a non-exhaustive compilation of

evidence on measures taken across the health system building blocks that aim to address these barriers. While acknowledging that actions must be synergized and advanced in parallel across the health system functions, separate sections are dedicated to governance, service delivery, human resources, essential medicines and technologies, health financing, and health information systems. The paper concludes with a brief summary of findings, and discussion on next steps in terms of advancement of the evidence base.



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**CONCEPTUAL  
UNDERPINNINGS**

## Equity-oriented, rights-based and gender transformative health system strengthening

Before exploring what equity-oriented, rights-based and gender-transformative health systems strengthening means in practice, it is first necessary to ensure a common understanding of the terms.

*Equity* is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically, or by other means of stratification (WHO, 2017f). Health systems strengthening towards universal health coverage should aim to overcome health inequities, including those experienced by some migrants. A key way to achieve this is through adopting a *progressive universalism* approach, thereby meaning that in reforms towards universal health coverage, subpopulations experiencing disadvantage benefit at least as much as subpopulations in more advantaged situations (Gwatkin & Ergo, 2011). Progressive universalism has implications across the health system building blocks and requires synergistic linking of these actions, as adjusting the approach for one function alone – while important – is often insufficient to adequately overcome inequities. This paper provides a synopsis of evidence on entry points across the building blocks to take a progressive universalism approach with regard to improving the health of migrants, in particular those experiencing poverty and social exclusion.

The goal of the *human rights-based approach* to health is that all health policies, strategies and programmes be designed with the objective of progressively improving the enjoyment of all people to the right to health and other health-related human rights (WHO and OHCHR, 2015). Like other human rights, the right to health has particular concern for persons experiencing disadvantage (Backmann et al., 2008). The framework for the right to health is based on Article 12 of the International Covenant on Economic, Social and Cultural Rights (UN, 1966). The right to health is subject to progressive realization and acknowledges

resource constraints. However, it also imposes on states various obligations which are of immediate effect, such as the guarantee that the right to health will be exercised without discrimination of any kind and the obligation to take deliberate, concrete and targeted steps towards its full realization (WHO and OHCHR, 2015). The IOM/WHO/OHCHR report on international migration, health and human rights (IOM/WHO/OHCHR, 2013) further defines a human rights-based approach to migrant health. This paper echoes this framing, linking it to current WHO work on health system strengthening for universal health coverage.

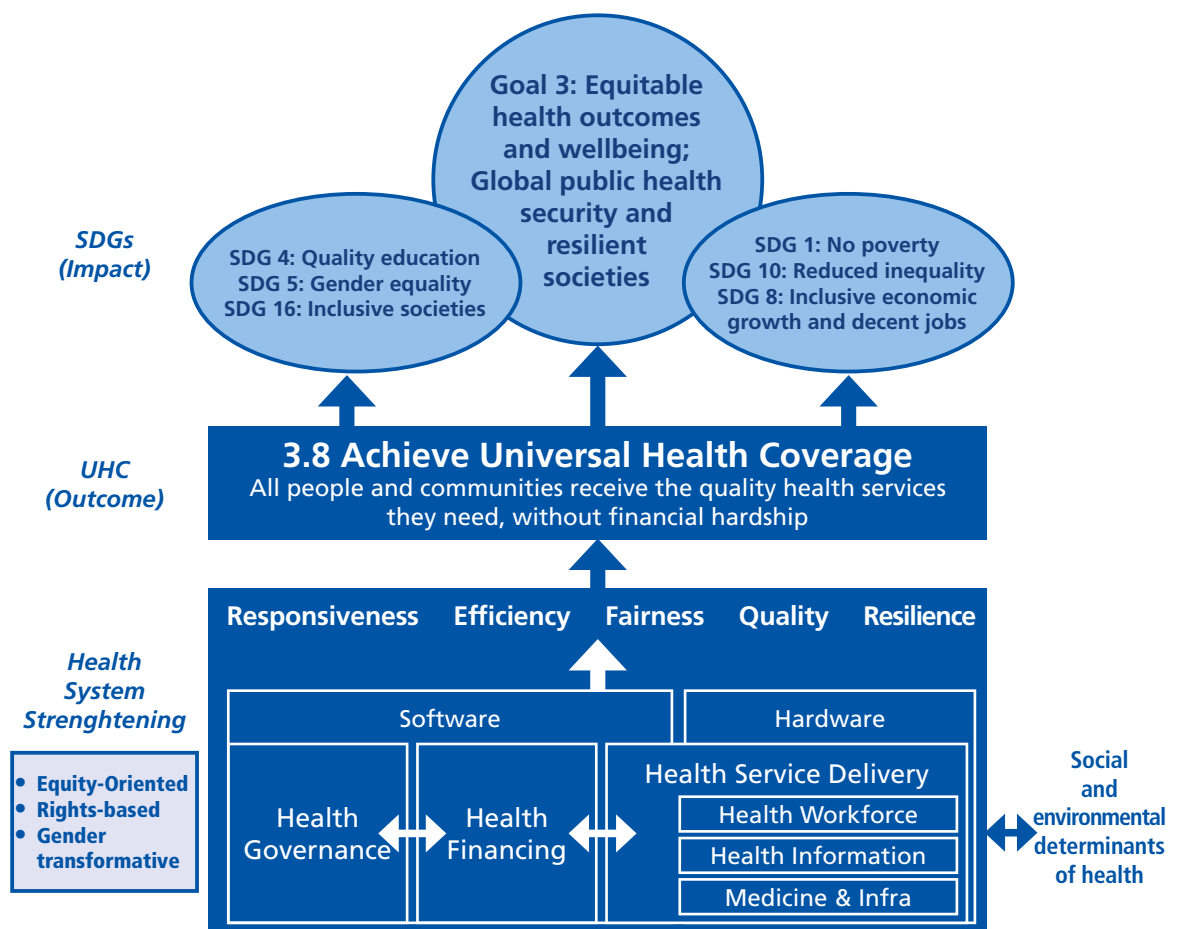
*Gender* refers to the socially constructed norms, roles and relationships of and between groups of women, men, boys and girls (WHO, 2011a). Gender is inextricable from the social and structural determinants shaping health and equity, and can vary across time and place. Health system strengthening is ideally done in ways that are gender transformative (WHO Regional Office for Europe, 2009). Gender transformative approaches address the causes of gender-based health inequities; include ways to transform harmful gender norms, roles and relations; promote gender equality; and include strategies to foster progressive changes in power relationships between women and men. To illuminate the importance of this, Witter et al. (2017) state some of the links between gender and universal health coverage, which this paper aims to reflect in its content:

*[...] unless explicit attention is paid to gender and its intersectionality with other social stratifications, through explicit protection and careful linking of benefits to needs of target populations (e.g. poor women, unemployed men, female-headed households), movement towards UHC can fail to achieve gender balance or improve equity, and may even exacerbate gender inequity.*

Fig. 1 provides an overview of how health system strengthening across the building blocks contributes to SDG target 3.8, as well as achievement of SDGs 1, 3, 4, 5, 8, 10 and 16. The fundamental principle applied in this paper is that – in order to advance towards target 3.8

– health system strengthening must be done in ways that are equity-oriented, rights-based and gender transformative. This paper further examines these issues from the perspective of barriers faced by some migrants, in particular those experiencing poverty and social exclusion.

■ Fig. 1. Health systems strengthening in relation to SDG target 3.8 and beyond



Source: Adapted from WHO/HQ Health Governance and Financing Department, 2017.

As highlighted in IOM (2017b), actions for the health of migrants will also depend on (and contribute to) progress towards other SDG targets, beyond target 3.8 and other targets in Goal 3 on health. While addressing this issue is beyond the core focus of this paper, it is important that it is emphasized. Health inequities require

comprehensive action towards equity within the health sector, and action in other sectoral domains linked to social and environmental determinants of health. The latter is a critical part of equity-oriented, rights-based and gender transformative approaches to improving the health of all people, including migrants.

## Non-discrimination

Throughout this paper, the overarching principle of *non-discrimination* has been applied. This is in keeping with multiple human rights conventions and treaties, the WHO Constitution (WHO, 1946), the *Framework of priorities and guiding principles to promote the health of refugees and migrants* (WHO, 2017c), and the New York Declaration for Refugees and Migrants (UN, 2016b), the latter of which states:

*Everyone has the right to recognition everywhere as a person before the law. We recall that our obligations under international law prohibit discrimination of any kind [...].*

The considerations set forth in this paper follow from the premise that Member States,

autonomously and collectively, are at a critical juncture to further define ways to uphold commitment to the right to health of all persons (including migrants), without discrimination. New guidance issued by the United Nations on ending discrimination in health care settings (WHO, 2017g) highlights the role of discrimination as a barrier to accessing quality health services, and hence to universal health coverage. This report also acknowledges that discrimination on multiple grounds can contribute to the compounding and intersecting of barriers; for example, some individuals (such as irregular migrant women) may find themselves in extremely vulnerable positions if discriminated against on multiple grounds (IOM/WHO/OHCHR, 2013).

## Accountability

Another key concept applied in this paper is *accountability*. Reforms done in the name of expanding coverage should not compromise equity (Kutzin, 2012; Gwatkin & Ergo, 2011; Jamison et al., 2013). This notion raises a critical and much-debated question with regard to migrants: in pursuing health reforms towards universal health coverage, what are governments' (as duty bearers) obligations related to migrants' entitlements?

The *Strategy and action plan for refugee and migrant health in the WHO European Region* emphasizes that every country involved in the migration process must meet its obligation to respect, protect and fulfil the right to health of all persons within its jurisdiction (WHO Regional Office for Europe, 2016a). While these population groups also have responsibilities, such as complying with the laws of the country in which they reside, they are – primarily – rights

holders under international human rights law (WHO Regional Office for Europe, 2016a).

A recent article by Rumbold et al. (2017) on universal health coverage, priority setting and the right to health identifies the potential complementarity of rights-based approaches and priority setting so that limited resources are used to support progressive realization of the right to health. Chapman (2016) makes specific recommendations for equitable rights-based progress towards universal health coverage, while highlighting that coverage *would be based on a true universality, providing benefits to all residents of a country regardless of their legal status*.

Lougarre (2017) has highlighted that, globally, while human rights treaties recognize the universal scope of the rights that they enshrine, more can be done by human rights bodies to clarify the



implications of these treaties with regard to nationals and non-nationals. For instance, the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families indicates that migrant workers *shall enjoy equality of treatment with nationals in relation to access to social and health services,*

*provided that the requirements for participation in the respective schemes are met* (UN, 1990). However, numerous countries have not ratified or acceded to this Convention, and likewise the scope of “requirements for participation” leaves considerable space for restrictive requirements.

## Participation and empowerment

*Participation* and social inclusion are prominent in the Colombo Statement and the WHO *Framework of priorities and guiding principles to promote the health of refugees and migrants* (IOM/WHO, 2017; WHO, 2017c). The framework calls for participatory approaches across the programming cycle. Linked to this is the need to empower migrants and other users of health care services so that they are aware of and able to demand their rights (WHO, 2017g). This will enable them to hold those responsible accountable for discrimination-free health care settings through rights literacy, patient charters, social accountability monitoring, community support and other tools (WHO, 2017g).

SDG 16 underlines the importance of responsive, inclusive, participatory and representative decision-making at all levels. Persons experiencing poverty and social exclusion typically have fewer opportunities for meaningful participation in decision-making. Therefore, concerted approaches to enable empowerment are needed, from a rights perspective and to facilitate social inclusion and cohesion (Henning & Renblad, 2009).

*Empowerment* is a debated term with many definitions (Ibrahim & Alkire, 2007). A frequently used definition is “the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control and hold accountable institutions that affect their lives” (Narayan, 2005). Across this paper, efforts have been made identify entry points by which the health sector can contribute to empowerment and resilience of migrants (IOM, 2017f). In viewing the entry points, it is important to consider the two distinct elements that emerge in Narayan’s definition of empowerment. One is related to agency<sup>5</sup> (influenced by people’s assets and capabilities) and the second relates to the institutional environment (which offers people opportunities to exert agency) (Narayan, 2005; WHO, 2016b). In designing participatory approaches, health authorities can take into account these two distinct elements as well as their linked and reinforcing nature (WHO, 2016b).

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5 Amartya Sen, in his development of the capability approach, describes agency as “what a person is free to do and achieve in pursuit of whatever goals or values he or she regards as important” (Sen, 1985). This definition links agency to the ability to participate in economic, social and political actions (WHO, 2016b; Abel & Frohlich, 2012).



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# EXAMPLES OF BARRIERS

Analysis of barriers and means to overcome them is central to equity-oriented, rights-based and gender transformative health system strengthening towards universal health coverage. Barriers are understood as those factors that hinder the target population from appropriate use of an offered health service or a social guarantee, thus diminishing effective coverage of a health service (Tanahashi, 1978; WHO, 2016b). Similarly, General Comment No. 14 on the right to health draws attention to four types of barriers in access: physical, financial, information and discrimination (UN, 2000; WHO, 2016b). It is important to note that there are gender-based and cultural capital-related barriers in access to and use of health services, which can intersect with other barriers (WHO, 2011a; WHO, 2016b; WHO, 2017e; Abel & Frohlich, 2012; WHO Regional Office for Europe, 2009).

Barriers that may be faced by some migrants, in particular those experiencing poverty and social exclusion, can be divided into two categories: those particularly related to migration processes and the way in which they are managed, for instance legislation on entitlements; and those that are shared by other subpopulations who may face one or more of the same dimensions of poverty and social exclusion. To actually enable universal health coverage – and from a people-centred perspective – it is important that both categories of barriers are considered synergistically, especially in light of their compounding and intersecting nature (Castaneda et al., 2015; Fleischman et al., 2015; IOM/WHO/OHCHR, 2013).

Various sources drawn from across this paper point to the need to address the following types of barriers:<sup>6</sup>

- restricted legal entitlements;

6 WHO, 2017d; WHO Regional Office for Europe, 2010a; Viruell-Fuentes, Miranda & Abdulrahim, 2012; O'Donnell et al., 2016; Gil-Gonzalez et al., 2015; Norredam & Krasnik, 2011; Médecins du Monde, 2013; IOM, 2009b; Suess, 2014; IOM, 2013b; IOM, 2016; IOM, 2017a; WHO, 2017e; Castaneda et al., 2014; Fleischman et al., 2015; IOM/WHO/OHCHR, 2013; IOM, 2017e).

- high out-of-pocket costs, combined with lack of eligibility for mechanisms providing sufficient financial protection for public sector services;
- language differences and lack of translation/interpretation services;
- discrimination (both perceived and real) based on different grounds (nationality, religion, ethnicity/race, income, education level, disability, sex, health status, etc.);
- lack of culturally appropriate services (including those that account for gender considerations, e.g. the desire to be seen by a same-sex provider) and inadequate intercultural mediation;
- cultural and social norms, including those related to gender and age (e.g. autonomy of women in decision-making, access by adolescents to sexual and reproductive health services);
- administrative complexities;
- opening hours of services are not adjusted to working hours of migrants, or location of services that make access difficult;
- low information accessibility and lack of awareness and/or clarity by health professionals, administrative staff and migrants themselves about health entitlements;
- low health literacy (including perception of health needs) and limited support/capacity to navigate the health system (in terms of entry points, referrals, etc.);
- opportunity costs (e.g. missed work) and indirect costs (e.g. cost of transit to service points), that impede initial access and pose challenges to treatment adherence;
- change in or absence of permanent residence;

- lack of trust in providers and fear that privacy and confidentiality will not be respected; linked to this, fear of being reported to migration authorities due to having an “irregular” situation, and/or fear of losing one’s job or being deported due to health status;
- absence of services to meet specific needs (e.g. health issues that may be common in the country of origin, but for which the health system in the destination country has limited capacity);
- overarching weak system capacities (e.g. weak financial protection mechanisms in general, shortage of adequately skilled human resources, insufficient availability and accessibility to medicines and technologies, etc.), which also affect others living in the country.

Migrants are very heterogeneous, both within and between countries. Hence, barriers will vary depending on the migrants’ characteristics and the country context, as well as the differing dimensions (and experiences) of poverty and social exclusion migrants may face. Within this, understanding the different barriers, or different ways of experiencing the same barriers, between men/boys and women/girls is important. Barriers will compound and intersect in different ways in different contexts, hence emphasizing the need for an intersectional and context-specific approach (WHO Regional Office for Europe, 2010a; Viruell-Fuentes, Miranda & Abdulrahim, 2012; Rechel et al., 2013).



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# HEALTH SYSTEM GOVERNANCE

Health system governance is particularly important for addressing barriers experienced by some migrants due to its:

- critical role in specifying entitlements;
- oversight for a system-wide approach to reducing inequity across subpopulations and addressing population mobility;

- stewardship to address social and environmental determinants of health through cooperation with sectors other than health;
- oversight for international cooperation.

While the discussion of governance issues could be extensive, this paper is limited to these four areas.

## Entitlements and political economy

The literature reports a range of complex entitlement issues with regard to access to services and financial protection by some migrants, in particular those experiencing poverty and social exclusion. Entitlement issues vary by country context and how a health system is organized. Examples of some entitlement issues are given below.<sup>7</sup>

- Limited effective access to social security for migrant workers and their families in destination countries because of their status, nationality or insufficient duration of employment and residence. Temporary workers (who form a majority of migrant workers in some contexts) and their dependants may not be entitled for benefits.
- Weak enforcement of entitlements for health services (and other social services) in labour migration policy. Employers that do not wish to pay contributions on behalf of their migrant employees may take advantage of the lack of enforcement.

- Unregulated informal sector employers may provide no or limited employment-linked entitlements or benefits.
- Legislation that requires health providers to ask migrants their status in the country or to see documents before providing services.
- Legislation that restricts access to health care for migrants in “irregular” situations,<sup>8</sup> or for their children (even if born in the destination country).
- Inconsistent and changing legislation on entitlements to health services for migrants, including restrictions and retrogressions introduced in the context of economic downturns.
- Refusal of entry or deportation of migrants, and/or denial of or restricted entitlements for migrants with certain diseases, including infectious diseases (that, if left untreated, can pose a public health threat).

7 Sources: Zimmerman, Kiss & Hossain, 2011; Gil-Gonzalez et al., 2015; Swedish Agency for Public Management, 2016; O’Donnel et al., 2016; Magalhaes, Carrasco & Gastaldo, 2010; Doctors of the World UK, 2015; Cook, 2014; Cuadra, 2012; Deblonde et al., 2015; Fleischman et al., 2015; Guinto et al., 2015; Huffman et al., 2012; Lougarre, 2016; Martinez et al., 2015; Norredam & Krasnik, 2011; Simon et al., 2015; Suess et al., 2014; IOM, 2013b; ILO, 2015; Suphanchaimat et al., 2015.

8 For instance, a 2012 comparative study by Cuadra for the European Union indicated that states could be grouped into three clusters: in 5 countries undocumented migrants had the right to access care that was more extensive than emergency care; in 12 countries they could only access emergency care; and in 10 countries they could not even access emergency care.

- Local-level variations in the application of national legislation on entitlements due to lack of knowledge about it, lack of clarity in how to interpret it, and other factors including discrimination or differing views on health as a right or a privilege.
- Legislation, including that which requires health professionals to report to immigration authorities, that puts health professionals in a compromised position with regard to professional and moral codes of conduct about providing treatment.
- Roadblocks to registering in local areas and with general practitioners due to periods of absence, temporary addresses and other factors.

In light of the above entitlement issues, United Nations (UN) human rights mechanisms have called on UN Member States to acknowledge

that migrants should be treated as equal rights holders, stating *that when migrants are viewed as equal rights holders, a duty to protect them at all stages of the migration process naturally follows* (UN, 2016c).

Discussion on entitlements is inherently linked to the political economy. Migration is a topic that is frequently politicized, and can be even more so in the context of economic downturns (IOM, 2011b; OECD, 2014; UN, 2016c; UN, 2017d). Box 2, extracted from the World Migration Report 2011, explores some of the issues around the politicization of migration. Without directly acknowledging politicization processes, it is difficult to understand the complexities that many national health authorities face around the issue of migrants' entitlements to services – an issue that is at the centre of health system governance for migrant health.

#### ■ Box 2. Politicization of migration and the need for evidence-based decision-making

The populist nature of migration debates in many parts of the world today has created a climate in which migration is often the catch-all issue that masks the public's fears and uncertainties relating to unemployment, housing or social cohesion (in destination countries), and loss/waste of human capital or economic dependency (in countries of origin). These concerns, rooted in much more complex processes of change, will not be dispelled simply by making migration policies more restrictive. By unilaterally addressing migration, the wrong message is sent: that migration was indeed the cause of the perceived problem.

Policies and political discourse can play a major role in shaping the image of migrants in home and host societies. One of the biggest challenges in this regard is what and how governments communicate about migrants and migration policy to the wider public. The limited use of evidence in migration policy-making (or the misuse of evidence for political purposes) and the lack of evaluation of the impact of migration policies can also mean that any policy failures are more easily attributed to the migrants themselves. Distorted communication about migration can trigger a vicious cycle that leads to misinformation being perpetuated through government policy, the mass media, the public at large and vice versa, which can, in turn, skew discourse at all levels.

Source: IOM (2011b).

Linked to the politicization processes described in Box 2, the WHO *Framework of priorities and guiding principles to promote the health of refugees and migrants* (WHO, 2017c) explicitly calls for:

*measures to improve communication and counter xenophobia by making efforts to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement; and share accurate information on the impact of refugees and migrants on the health of local communities and health systems, as well as to acknowledge the contribution of refugees and migrants to society.*

There is a growing body of literature on political economy analysis for universal health coverage, including in relation to specific equity-oriented reform measures (for example: Reich, 2016; Fox & Reich, 2015; Kelsall, Hart & Laws, 2016). This offers insights into some of the variables (such as interests, institutions, ideas and ideology) that affect reform, including those reforms that are more equity-oriented in nature. However, the topic of entitlements for migrants is underdeveloped in the literature, pointing to a need for more research to aid understanding of how decisions related to legislation on entitlements for migrants are made.

## System-wide approaches

To overcome the barriers experienced by some migrants, oversight of a system-wide approach to reducing inequity across subpopulations and addressing population mobility is relevant. This entails governance for coordinated and synergistic actions across health system functions and levels of care, avoiding the creation of parallel systems where feasible. This governance approach needs to be informed by evidence of demand- and supply-side factors influencing both barriers to services and underlying determinants.

Governance priorities emphasizing system-wide approaches are offered in key documents such as the *Framework of priorities and guiding principles to promote the health of refugees and migrants*, the Colombo Statement, the WHO Regional Office for Europe strategy and action plan for refugee and migrant health, and the Pan-American Health Organization policy document (WHO, 2017c; IOM/WHO, 2017; WHO Regional Office for Europe, 2016a; PAHO/AMRO, 2016). WHO's *Action framework for the Western Pacific Region on universal health coverage*:

*moving towards better health* (WHO Regional Office for the Western Pacific, 2016a) calls for a whole-of-system approach to improving health system performance and health outcomes, while explicitly underlining the importance of non-discrimination (including in relation to migrants).

The need for a systems-wide approach is also backed by a wide range of sources (including those featured across this paper) as well as specific projects such as the Migration Integration Policy Index (MIPEX, 2015). The MIPEX Health Strand 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.

National health policies, strategies and plans (NHPSPs) provide a good framework for capturing the vision of a system-wide approach (WHO, 2016c).



As governance mechanisms, NHPSPs should be inclusive, taking into account all relevant aspects of both refugee and migrant health (WHO Regional Office for Europe, 2016a). It is also important to consider mechanisms to empower migrants who may be experiencing poverty and social exclusion and other communities experiencing disadvantage to become active protagonists in engaging in the NHPSP process, as part of a human rights-based approach (OHCHR, 2012; Potts, 2010; WHO, 2016c). WHO guidance on NHPSPs, *Strategizing national health in the 21st century* (2016d), provides examples of equity-oriented participatory consultation approaches.

In addition, assessments can be conducted to gauge health systems' capacity for responding to the needs and rights of migrants. Such assessments provide intelligence for improving overarching system governance, architecture and operationability. Box 3 provides an example of how a type of assessment is advancing in one WHO region, with a specific focus on capacity for managing large influxes of migrants and refugees.

### ■ Box 3. Examples of health system assessments conducted in the WHO European Region

The WHO Regional Office for Europe has conducted a series of assessments in 12 European countries to understand the national health system capacity to manage large influxes of migrants and refugees. Common findings include: poor information flow on migrant and refugee health within and between countries, including data disaggregated by sex and other stratifiers; shortage of cultural mediation services, including those necessary to address gender equity issues; inconsistent migrant health screening procedures, including those related to gender-based violence; and contradictory risk communication messages. Country assessments were conducted using an assessment toolkit developed by WHO Regional Office for Europe (2016b).

Source: paper co-authors and WHO Regional Office for Europe (2016b).

## Stewardship role of health authorities in engaging other sectors

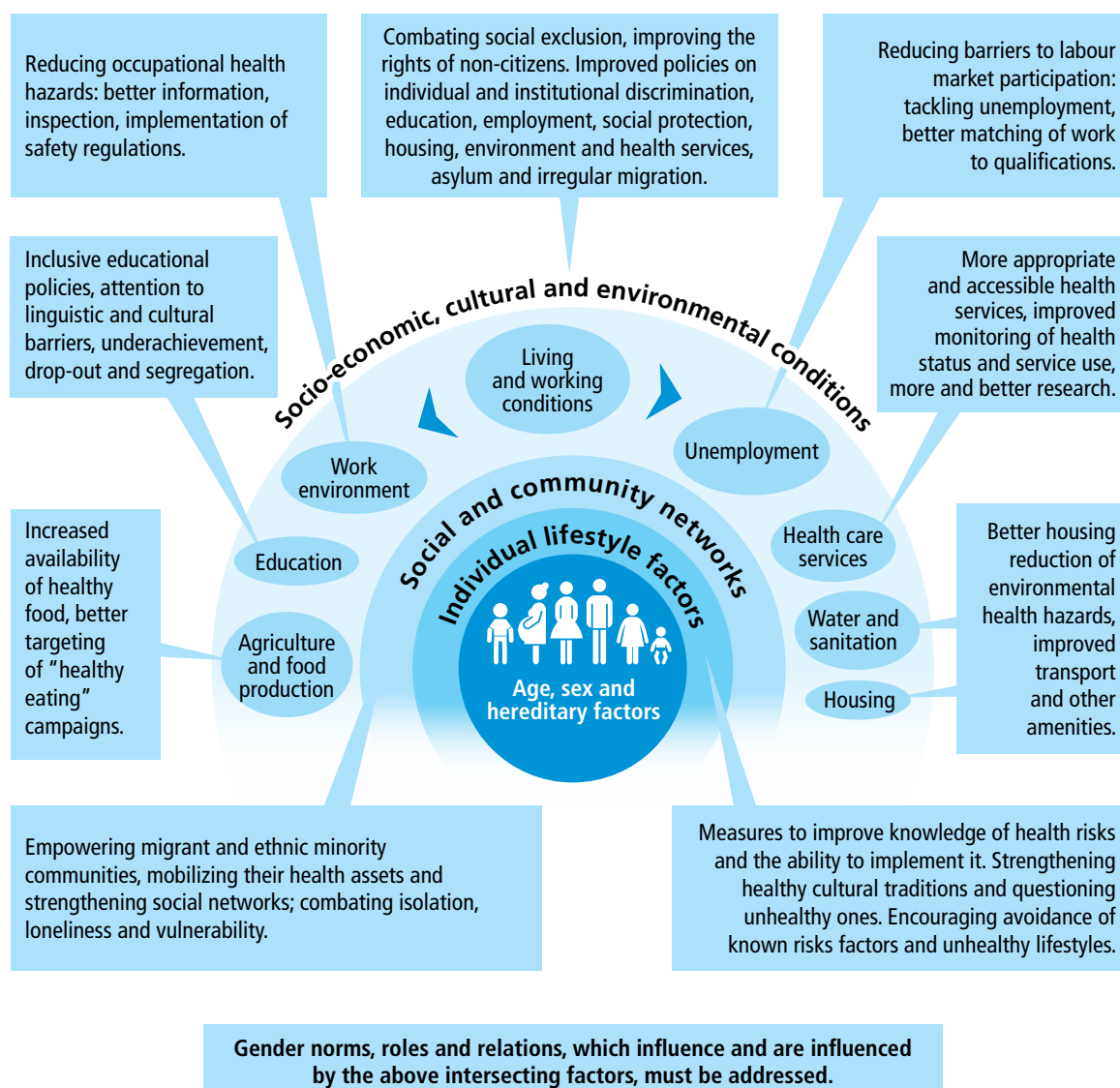
The health sector has an important role in working across sectors, and breaking sector-specific silos, to address determinants of migrant health (Kontunen et al., 2014; Castaneda et al., 2015; Fleischman et al., 2015; WHO Regional Office for Europe, 2014; Zimmerman, Kiss & Hossain, 2011; WHO, 2017c; IOM, 2017e and 2017f). This will require *joint and integrated action and coherent public policy responses involving multisector collaboration such as the health, migration, social, welfare and finance sectors, together with the education, interior and development sectors, as called for by the Framework of priorities and guiding principles to promote the health of refugees and migrants* (WHO, 2017c).

Fig. 2 gives an overview of some of the intersecting factors influencing migrant health, many of which lie outside the health sector. The work of IOM (2017b & 2017c) shows how migrant health is influenced by and influences multiple SDGs, beyond SDG 3. IOM further defines the role of a Health in All Policies approach to migrant health in Kontunen et al. (2014). Work by OECD/European Commission (2015) provides examples of the role of multiple sectors in facilitating migrant integration to address key determinants of health and well-being, including poverty. Additional work by WHO on occupational health emphasizes

the importance of cooperation between the labour and health sectors to improve the health of migrants, given their greater concentration in high-risk sectors and hazardous occupations (WHO, 2007; WHO/Government of Chile, 2009).

For intersectoral action, evidence is needed on health impact, adequate resources and cross-sectoral mechanisms. Mechanisms can include joint steering committees, joint budgeting, joint training of staff, and shared monitoring and evaluation frameworks (WHO, 2015a). These are tools to operationalize an approach to “equity and health in all policies” (WHO Regional Office for Europe, 2010a; Council of the European Union, 2010). For input into migration and social inclusion policy (as well as other relevant policies such as labour policy), national health authorities will be required to engage in the cross-government coordination mechanisms for elaborating, costing, implementing, monitoring and evaluating policies (see the section on “Health information systems” for details on the information requirements for facilitating this). Issues related to cross-sectoral approaches to improve the health of migrants will be expanded on in other resources contributing to follow-up to World Health Assembly resolution WHA70.15 (WHO, 2017b).

■ Fig. 2. Policy measures to tackle the intersecting factors influencing migrant health



Source: WHO Regional Office for Europe (2010a). Elaborations for migrant health done by T Koller, with improvements by D Ingleby. Inner rainbow from Dahlgren & Whitehead, 1991.

In an era of increasing incidences of xenophobia and racism in some countries (FRA, 2016), it is relevant for the health sector to be actively engaged in enforcing cross-sectoral anti-discrimination measures as part of their governance function. This requires measures to prevent discrimination and ensure redress (UN, 2016a; WHO, 2017g; WHO Regional Office for Europe, 2016a). It also entails contributing – through evidence and advocacy – to cross-sectoral discussion on the need for proactive measures to

prevent and respond to discrimination. This may, for instance, be through highlighting the role of discrimination and racism as adverse determinants of health and providing evidence on the need for prevention rather than just response to the consequences (WHO, 2012b; Berger & Sarnyai, 2014; Ferdinand, Paradies & Kelaher, 2015). As noted in the PAHO/AMRO (2017) policy document on ethnicity and health, social participation and intercultural approaches are key components of the response to discrimination.

## Strengthened capacity of national health authorities for international cooperation

Beyond working nationally, governance for migrant health entails international cooperation across countries of origin, transit and destination (WHO, 2017c; IOM, 2017e; WHO, 2010b; WHO, 2008; Zimmerman, Kiss & Hossain, 2011). This requires that national health authorities – working in conjunction with other sectors – have the necessary capacity and coordination mechanisms. While detailed coverage of this is outside of the scope of this paper, it is important to emphasize that action that focuses solely on host countries will be less effective than integrated global, interregional and cross-border public health interventions and programmes (WHO Regional Office for Europe, 2016a; WHO Regional Office for Europe, 2015). Likewise, due attention is required to the health of families left behind (IOM, 2017e; Wickramage, Siriwardhana & Peiris, 2015; Wickramage et al., 2015).

Examples of cross-border cooperation and collaboration are cited in McMichael & Healy (2017) on migrant health and health service access in the Greater Mekong Subregion. The Greater Mekong Subregion comprises Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam, as well as Yunnan Province and Guangxi Zhuang Autonomous Region in China. The article highlights bilateral collaboration and memoranda of understanding between Thailand and neighbouring countries that

focus on migrant workers. Showing the role of multilateral partners in supporting these efforts, the following initiatives all incorporate a focus on migrant health<sup>9</sup>: the Mekong Basin Disease Surveillance network; the Joint United Nations Initiative on Migration, Health and HIV in Asia (JUNIMA); various initiatives by the Association of Southeast Asian Nations (ASEAN); the WHO *Strategy for malaria elimination in the Greater Mekong Subregion, 2015–2030* and related resources; regional frameworks and resources on tuberculosis control; *Universal health coverage: moving towards better health – action framework for the Western Pacific Region*; and the *Regional action agenda on achieving the Sustainable Development Goals in the Western Pacific*.

Additional cooperation by health programme managers across countries is exemplified in the European Union by the Wolfheze group of experts and national tuberculosis programme managers to ensure cross-border tuberculosis control and care (Dara et al., 2012). The *Strategy for refugees and migrant health in the WHO European Region* (2016) specifically calls for enhanced international coordination relating to communicable disease aspects of human mobility in accordance with the national and international framework and principles established by the International Health Regulations (2005).

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9 Sources: McMichael and Healy, 2017; WHO Regional Office for the Western Pacific, 2013, 2016a, 2016b, 2016c, 2016d, 2017a, 2017b; and WHO Regional Office for the Western Pacific, forthcoming.



# SERVICE DELIVERY

*Integrated health services* are health services that are managed and delivered so that people receive a continuum of care (WHO, 2016d). This continuum includes health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care. Services are coordinated across the different levels and sites of care within and beyond the health sector, and according to people's needs and preferences throughout the life course (WHO, 2016d). *People-centred care* refers to an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems. Such systems are organized around the comprehensive needs

of people rather than individual diseases, and respects social preferences (WHO, 2016d).

The WHO framework on integrated, people-centred health services proposes five interdependent strategies: 1) engaging and empowering people and communities; 2) strengthening governance and accountability; 3) reorienting the model of care; 4) coordinating services within and across sectors; and 5) creating an enabling environment (WHO, 2016d). These five strategies are relevant when considering progressive universalism and integrated, people-centred health services in relation to barriers experienced by some migrants.

## Reorienting the model of care

Particularly critical is strategy 3 on reorienting the model of care, and the need to shift models of care to account for the living and working conditions of the people they serve. This approach reinforces the capacity of the health system to be responsive to population needs, rather than promoting isolated parallel systems that may not be sustainable or efficient.

According to a range of sources, adaptations that can overcome barriers to health services faced by some migrants, as well as improve service responsiveness to their needs, include:<sup>10</sup>

- ensuring non-discriminatory, gender transformative and age-sensitive treatment, including incorporation of measures to account for differential ability to access and receive the full benefits of services across the continuum;

- respecting choice/consent, privacy, confidentiality and dignity, and ensuring non-stigmatization (including in screening approaches);
- providing culturally and linguistically appropriate services;
- adapting services for adverse living and working conditions (e.g. working hours, service locations, community outreach dimensions);
- establishing health system-navigation support services;
- offering peer support groups;
- ensuring that information is conveyed at the appropriate literacy level and provided through accessible means (accounting for such issues as lack of permanent address);

<sup>10</sup> Sources: WHO, 2017c; WHO Regional Office for Europe, 2010b; Suphanchaimat et al., 2015; Martinez et al., 2015; Seedat, Hargreaves & Friedland, 2014; Pottie, 2014; WHO, 2016f; WHO Regional Office for Europe, 2016a; IOM, 2013b; O'Donnell et al., 2016; Gil-Gonzalez, 2015; Huffman et al., 2012; Davies et al., 2011; UNHCR, 2017.

- addressing resource constraints that cause supply-side bottlenecks particularly at primary health care level, including those resulting in heavy workloads and inadequacy of human resources;
- building capacity of local-level providers to understand national legislation on entitlements and on opportunities for treatment of migrants;
- addressing fears of sanctions and deportation that inhibit accessing care;
- increasing capacity of providers to diagnose and treat diseases or conditions that may be more prevalent in migrants' countries of origin (e.g. Chagas disease, complications from female genital mutilation).

A review of 17 studies by Joshi et al. (2013) highlights interventions in models of care that can be beneficial for overcoming barriers faced by migrants, including: use of interpreters and bilingual staff, no-cost or low-cost services, outreach services, free transport to appointments, longer consultation hours, patient advocacy and use of gender-sensitive providers. These strategies had a positive impact on patient satisfaction and increased utilization of services (Joshi et al., 2013).

Such models of care also integrate health service adaptations for migrants, as much as is feasible, into mainstream services to facilitate quality control, guarantee sustainability and avoid institutionalizing social exclusion. For instance, Wickramage & Mosca (2014) emphasize the need for greater integration of pre-departure and upon-arrival screening for migrants<sup>11</sup> into the

11 IOM provides ongoing Migration Health Assessments, which consist of an evaluation of the physical and mental health status of migrants, made either prior to departure or upon arrival, for the purpose of resettlement, international employment, enrolment in specific migrant assistance programmes, or for obtaining a temporary or permanent visa (IOM, 2013a). Wickramage & Mosca (2014) argue that better linkages between health systems and migrant health assessment processors at the country level are needed to shift these from being limited as an instrument of determining non-admissibility for purposes of visa issuance, to a process that may enhance public health.

wider health system. In some cases, models of care go beyond the health sector (e.g. through “joined up” service provision with social protection and employment sectors).

The WHO *Framework of priorities and guiding principles to promote the health of refugees and migrants* (2017c) explicitly highlights the need to deliver people-centred (including culturally, linguistically and gender- and age-responsive) health services. The 2017 *Policy on ethnicity and health* of the WHO Region of the Americas (PAHO/AMRO 2017) describes differentiated sociocultural approaches to improve health. The Policy recognizes the need – from the standpoint of equality and mutual respect – for an “intercultural approach” that promotes *coexistence, respect, and mutual acceptance between the culture of the conventional health system and other cultures through collaboration between human resources for health and the community, the family, and social leaders*.

Evidence suggests that models of care should also account for the compounding and intersecting nature of risk factors and health determinants, as well as co-/multimorbidities associated with social disadvantage (WHO, 2010e). In many health systems, there is a need to strengthen service integration towards this end. This is particularly critical for populations experiencing social disadvantage (including some migrants). The presence of co-/multimorbidities is often higher in more disadvantaged populations (Violan et al., 2012).

Despite potential for the “healthy migrant effect” in some contexts (Fennelly, 2005), accumulated vulnerabilities over time can render some migrants more at risk for co-/multimorbidities. For example, while a migrant woman/girl in a vulnerable situation may come into contact with health services in a destination country for a reproductive health issue, she may also be in need of mental health services (for depression, anxiety, etc.) due to loss of family, friends, cultural norms and language, as well as experiences of

discrimination based on ethnicity and nationality. Another, and potentially linked, example relates to the need for integrated services to address gender-based violence, as evidence suggests that women migrants face higher rates of exposure (Keygnaert & Temmerman, 2007; IOM, 2009a; Inter-Agency Standing Committee, 2015; WHO, forthcoming).

Accounting for accumulated vulnerabilities (including those outlined in IOM, 2017f) is also crucial when adapting and implementing WHO guidelines. For instance, see *Guidelines on the management of latent tuberculosis infection*, which highlights the need for migrant-inclusive national tuberculosis programmes (WHO, 2015b; Dhavan et al., 2017).

## Creating an enabling environment, in particular through stronger primary health care

Strengthening primary health care – in general, and with particular focus on maximizing accessibility to marginalized populations – is central to reducing health inequities, including those experienced by migrants. Approaches for strengthening primary health care to overcome inequities should be based on an understanding of the local population and an assessment of local health and social needs. Patient rostering and population risk stratification are important components in enabling services to better respond to local needs (WHO, 2016d). That said, patient rostering comes with some risks, particularly in the case of migrants in “irregular situations”: it assumes the system is able to ensure privacy and confidentiality of stored information, and that there are no adverse incentives for information to be shared outside the health system. These issues need to be accounted for in the design of a patient rostering approach.

Evidence highlights the important role of strong multidisciplinary primary health care teams in improving health and reducing inequities (see “Human resources” section). Linked to this is the capacity of primary health care to provide outreach and community-based services to help eliminate demand-side barriers (CSDH, 2008; Joshi et al., 2013; WHO Regional Office

for Europe, 2010a and 2010b). Outreach and community-based services that engage migrants, as well as non-migrants who live in the same areas, can increase levels of knowledge on entitlements and obligations. They can also enhance delivery and uptake of promotion and prevention services. As such, strengthened primary health care has potential to reduce delays in treatment-seeking behaviour by some migrants. It can also curb bypassing of primary health care to higher levels of care (e.g. by redirecting inappropriate dependence on emergency services by subpopulations experiencing disadvantage in some contexts) (Numeroso, 2015; WHO Regional Office for Europe, 2010a and 2010b; Norredam, Nielsen & Krasnik, 2010).

Across the continuum of care it is important to incorporate mechanisms to improve referral systems and empower patients, in particular patients experiencing disadvantage, to adequately navigate the health pathway (including from primary to secondary and tertiary care, and with back referral to primary health care as appropriate). Some migrants, in particular those experiencing poverty and social exclusion (and in light of the barriers identified earlier), face greater challenges in following through and understanding where/how to go on their next



step along the health pathway (Joshi et al., 2013; O'Donnell et al., 2016). Case management and care planning may support system navigation (Joshi et al., 2013). The capacity of multidisciplinary primary

health care teams to engage with other social sectors (e.g. social protection, housing, education, food security) to address the determinants of health will also be important.

## Engaging people and communities

Engaging local communities (potentially comprising migrants, as well as other subpopulations) in the design, implementation, monitoring and evaluation of health services can (WHO, 2017c; WHO Regional Office for Europe, 2010a; Potts, 2010):

- provide more nuanced and contextual information about living and working conditions, and other underlying determinants of health;
- identify barriers to effective coverage with health services, and how these intersect for different subpopulations, and also highlight differences among men and women/girls and boys;
- contribute to co-development of locally owned solutions to challenges identified by situation analysis and needs assessment through a facilitated process of participatory planning, and engage migrants in the co-production of care;
- strengthen short-route accountability (between patients and service providers);
- empower individuals and communities as agents of change and as rights holders.

Methods to empower local communities can incorporate an “assets” approach, which entails treating community members (migrants and others) as a source for joint solutions and as partners for a cohesive health-promoting society (WHO Regional Office for Europe, 2010a). This same principle is applied in human rights-based approaches to health. “Assets” models accentuate positive capability to identify problems and activate solutions, promoting salutogenic resources including the resilience and coping abilities of individuals and communities (Morgan & Ziglio, 2007). Evidence suggests that resilience and social capital can modify the effect of risk factors on health (Lecerof, 2016; Arnetz et al., 2013; Johnson, 2017; Uphoff et al., 2013). Work done on social capital emphasizes the importance of “bridging” social capital for social cohesion, and states that enhancement of social capital is best combined with efforts to address wider social determinants of health, such as integration levels in education, employment and housing (IRIS, 2015). Additional work highlights the important role of “bonding” social capital for resilience for mental health and well-being, as well as the combined positive effects of bonding, bridging and linking social capital (Johnson, 2017).

## Intersectoral platforms for service delivery

Platforms for service delivery can be intersectoral in nature to expand reach and/or address risk factors (WHO, 2010e; WHO, 2017c; IOM, 2016). For policies that promote social inclusion of migrants, cooperation of the health sector with relevant social service providers is very important. This can facilitate access to social services that influence determinants of health (such as housing, nutrition, etc.) in keeping with a rights-based approach to health (IOM/WHO/OHCHR, 2013).

In addition, workplace-based interventions are needed, with due attention to the reality that – in both formal and informal working environments – low-skilled migrant workers may be disproportionately exposed to occupational hazards and have lower access to health services (e.g. due to lack of/restricted health care protection and sick pay, as well as exploitation by employers) (WHO/Government of Chile, 2009; Migrant Forum in Asia, 2013; ILO, 2015; Huffman et al., 2012).



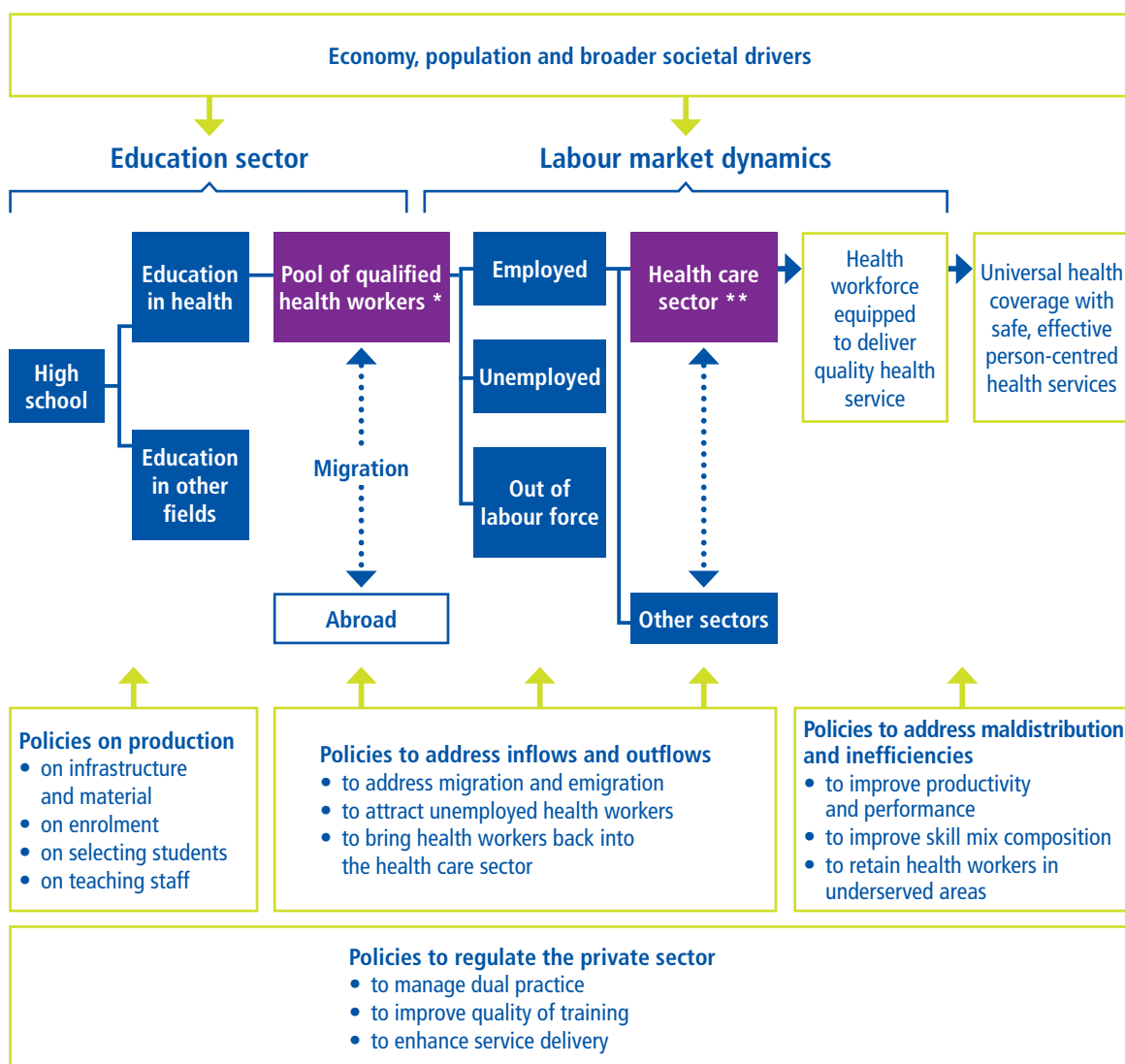


# HUMAN RESOURCES FOR HEALTH

WHO's *Global strategy on human resources for health: workforce 2030* (WHO, 2016e) aims to ensure universal availability, accessibility, acceptability, coverage and quality of the health workforce. This can be achieved through promoting adequate investments to strengthen health systems and implementing effective

policies around four objectives: optimizing the health workforce; aligning investments in human resources for health with current and future needs; building the capacity of institutions; and strengthening data. The strategy focuses on the policy levers that shape health labour markets, as shown in Fig. 3.

■ Fig. 3. Policy levers to shape health labour markets



\* Supply of health workers = pool of qualified health workers willing to work in the health-care sector.

\*\* Demand of health workers = public and private institutions that constitute the health-care sector.

Source: Sousa A, Scheffler M R, Nyoni J, Boerma T "A comprehensive health labour market framework for universal health coverage" Bull World Health Organ 2013;91:892–894

Source: WHO (2016e).

The strategy emphasizes that responding to twenty-first century priorities will require effectively matching the supply and skills of health workers with population needs (WHO, 2016e). In countries with substantive and growing migrant populations, this will also mean matching the supply and skills of health workers to migrant needs. In countries with different subpopulations (including some migrants) experiencing poverty and social exclusion, this will require a strong focus on overcoming barriers in the approaches to governance and management of the health care workforce, including its stock, skill mix, distribution, productivity and quality (Campbell et al., 2013; WHO, 2016e). An analysis of needs

for human resources for health by disadvantaged subpopulations can feed into national human resources for health plans (WHO, 2016e).

The paragraphs that follow describe how select literature relevant to the health of some migrants (in particular those experiencing poverty and social exclusion) adds to the discussion under the following items in Fig. 3, while acknowledging the synergies between them:

- policies on production;
- policies to address inflows and outflows;
- policies to address maldistribution and inefficiencies.

## Policies on production

Student selection and the process by which health professionals are educated, trained and supported throughout their careers are critical on the path to universal health coverage (McPake, Araujo & Le, 2017). For some migrants and other subpopulations that may experience barriers in accessing services, important questions on health workforce production include:

- are training institutes and public subsidies for health professionals' education being prioritized for areas experiencing disadvantage?
- are students with relevant experience (e.g. living in disadvantaged areas) and capacities (e.g. cultural, linguistic) being enrolled, hence contributing to workforce capacity to understand the diversity of, and effectively engage with the heterogeneity of, the population it serves, while also combating discrimination within the health system?
- is student selection and training of cadre being done in a way that best addresses population

needs (e.g. to ensure sufficient numbers of certain cadre needed for primary health care services and not an oversupply of tertiary care specialists)?

- do training curricula and ongoing professional education opportunities enable health providers to have the skills necessary to address equity, gender and human rights issues?

Leaving no one behind in terms of access to skilled health professionals will require redirecting public investment in education to primary care, low- and mid-level providers and innovative pedagogy, as well as making low-income areas attractive from a labour market perspective (WHO, 2016e; MCPake, Araujo & Le, 2017). There is evidence that training institutions located among underserved populations, and focused on primary and community care, are more successful in encouraging careers in those areas (McPake, Araujo & Le, 2017). MCPake, Araujo and Le also suggest that allocation of public subsidies for the education of health professionals should

reflect recognition that students from lower socioeconomic backgrounds are more willing to take up community-based practice. Institutions in more disadvantaged settings should be prioritized for public investment over those in higher socioeconomic settings.

In some countries, measures have been taken to increase the enrolment and completion of educational tracks for health careers by minority subpopulations (Sullivan 2004; Cooper & Powe, 2004; Pottie, 2014). Such measures – in addition to those highlighted above – may help to address the second question above in relation to responsiveness to the needs of migrants, in particular those experiencing poverty and social exclusion. This is in addition to the reality that many migrants are in fact already providing services for the general population (see following subsection).

The use of other types of professional as bridge-builders (including cultural mediators and community health workers) recruited from migrant populations in destination countries is an additional approach (WHO, 2010b; WHO Regional Office for Europe 2010a and 2010b). WHO is supporting the development of guidelines for health policy and system support for community-based health workers, i.e. cadres that can increase access to care for the most marginalized populations.<sup>12</sup> Community health workers have the potential to increase availability as well as demand and acceptability of services, thus potentially reducing inequities (Perry, Zulliger & Rogers, 2014; Perry & Crigler, 2014). Within migrant communities, they have the potential for contributing to empowerment and building of social cohesion between migrants and social services providers (WHO Regional Office for Europe, 2010b).

Some evidence suggests that – to be effective – the process of establishing the community health worker cadre requires attention (as part of a

coherent national human resources for health strategy) to a range of issues, such as: clear selection criteria for community health workers; clear task definition; accreditation processes; supervision mechanisms and standard procedures for how they will integrate/interact with other health professionals; ongoing capacity-building and career pathways; adequate reimbursement and incentives; gender norms, roles and relations that impact productivity and well-being; clear indications on how to access supplies needed for their work; and approaches to enable their voices to be heard in health sector planning, review, and monitoring and evaluation processes (Zulu et al., 2014; Perry & Crigler, 2014; WHO Regional Office for Europe, 2010).

Also related to “policies on production” is the incorporation of curricula on relevant subject matter into pre-service and continuing education. For instance, pre-service and continuing education curricula can cover such topics as (WHO, 2016e; CSDH, 2008; Powell Sears, 2012; Shaya & Gbarayor, 2006; van den Muijsenbergh et al., 2014; WHO, 2011a; Swedish Agency for Public Management, 2016; PAHO/AMRO, 2017; WHO, 2017g; UN, 2017a):

- intersecting social determinants of health, cultural norms, and gender norms, roles and relations, and how these influence barriers to services and health inequities across different subpopulations (not only migrants);
- the rights of migrants, national/interregional/international legislation and migrants’ entitlements to health services (with updates available through continuing education programmes to keep professionals’ knowledge up-to-date);
- approaches to liaising/linking with civil society organizations and professionals in other sectors (e.g. social workers) to help meet the needs of disadvantaged populations;

12 <http://who.int/hrh/community/en/>

- human rights education, with special focus on non-discrimination (including in relation to gender), free and informed consent, confidentiality, privacy and what the Human Rights Council calls “the duty to provide treatment” (UN, 2017c);
- education specific to addressing disease burden and health issues that may be more prevalent in migrants’ countries of origin (e.g. Chagas disease, female genital mutilation) as well as an emphasis on multimorbidity and social disadvantage;
- cultural competency and intercultural approaches to health.

Pre-service learners can be given opportunities to work on these issues during clinical training, which can increase their capacity to address them when in practice (Pottie, 2014). With regard to curricula on cultural competency and intercultural

approaches to health, Powell Sears (2012) suggests that there is a need to apply an intersectional framework. Such a framework accounts for the impact of multiple interacting experiences based on migration, race, ethnicity, gender, social class and sexuality (which are experienced multiplicatively, not additively, within a context) as well as intercultural approaches (Shaya & Gbarayor, 2006; Powell Sears, 2012; PAHO/AMRO, 2017). Health professionals’ ability to understand, communicate with and enable effective coverage for diverse subpopulations can be improved by applying an intersectional framework (Powell Sears, 2012). Examples showing why this is important can be found in WHO’s *Women on the move: migration, care work and health* (WHO, 2017e), where the situations of migrant women who are care workers – often experiencing adverse employment conditions, living arrangements and discrimination based on gender and other grounds – are explored.

## Policies to address inflows and outflows

Evidence indicates that many health professionals providing services for the general population are migrants themselves; it is therefore important to maximize benefits from such migration, including in relation to recruitment- and labour-related rights. It is beyond the scope of this paper to cover this issue in depth; more information can be found in WHO’s Global Code of Practice on the International Recruitment of Health Personnel (<http://www.who.int/hrh/migration/code/practice/en/>), which was adopted by the Sixty-third World Health Assembly through resolution WHA63.16, and the work of the High-Level Commission on

Health Employment and Economic Growth (<http://www.who.int/hrh/com-heeg/en/>).

Another critical issue for low- and middle-income countries experiencing high emigration of health professionals (while concurrently receiving migrants) is whether there are sufficient numbers of health workers to meet all population needs. This issue reinforces the premise that countries should discourage active recruitment of health personnel from other countries facing critical shortages of health workers.

## Policies to address maldistribution and inefficiencies

To ensure return on investment in policies on production, it may be necessary to address maldistribution and inefficiencies through retaining workers in underserved areas, improving skill mix composition, and improving productivity and performance (WHO, 2016e). For instance, if unattractive pay and difficult working conditions are maintained in primary and community care settings, this could result in a supply of trained personnel who are hard to attract to empty posts, difficult to retain and likely to seek further training to redirect their careers (McPake, Araujo & Le, 2017).

Professional guidelines and training initiatives on migrant health may exist, but there can be bottlenecks to their actual impact on service provision (van den Muijsenbergh et al., 2014). These may include limited institutional capacity, in terms of time and/or resource constraints (Suphanchaimat et al., 2015); or, in some situations, discrimination by providers and feelings of cultural differentiation with migrants seen as being the “other” (Martinez et al., 2015; Abrahamsson, Andersson & Springett, 2009). Conversely, at times, health professionals may want (and feel obliged by professional and ethical codes of conduct) to respond to the needs of migrants, including those in irregular situations. However, as suggested by a recent systematic review (Suphanchaimat et al., 2015), health care providers can face a challenging contradiction between their professional ethics and the laws that limit migrants’ right to health care.

The review reports that health professionals address such problems by partially ignoring migrants’ precarious legal status and use numerous tactics, such as seeking help from civil society groups, to support their clinical practice (Suphanchaimat et al., 2015). Further sources (UN, 2016c; UN, 2017d) call for the development and implementation of clear and binding procedures and standards on the establishment of “firewalls” between immigration enforcement and public services, including health services, at all levels.

To improve productivity and performance, it may be necessary to reduce language barriers for some migrants through interpreter services and translated materials. Interpreters thus become part of the multidisciplinary health professional team, and quality of translation has important implications for the overarching quality of care. Box 4 provides an overview of some approaches to interpretation (Rechel et al., 2013). O’Reilly-de Brún et al. (2015) reports findings from a participatory action learning project indicating that, while informal interpreters had uses for migrants and general practice staff, they were not considered acceptable as best practice. Rather, formal interpreters who were trained and working as per a professional code of practice were acceptable as best practice (O’Reilly-de Brún et al., 2015). Suess et al. (2014) highlights that children of migrants or migrant children may also be put in challenging situations by carrying the weight of language and cultural translation in some contexts.



■ **Box 4. Overcoming language barriers in the provision of health services to migrants through the use of interpretation**

- Professional face-to-face interpretation is the most accurate method, but has many drawbacks such as organizational requirements, training and costs.
- Professional interpretation by telephone can offer much the same services at lower cost, but is associated with a loss of information associated with face-to face interactions.
- Informal face-to-face interpretation is perhaps the most widely used method and, at the same time, the most widely criticized.
- Bilingual professionals with a command of the migrant's language can fill gaps left by the scarcity of professional interpreters.
- Cultural mediators are health workers who not only provide linguistic interpretation, but also mediate between health professionals and service users.

Source: Rechel et al. (2013).



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**ESSENTIAL  
MEDICINES  
AND  
TECHNOLOGIES**

Access to essential medicines can be obstructed for some migrants at different stages of the migration process. Potential barriers include: limited entitlements, financial barriers (including inhibitive out-of-pocket costs of medicines), language barriers, differing cultural perceptions on treatment approaches, gender-related barriers (e.g. lack of autonomy or gender roles influencing treatment compliance), and low levels of literacy in navigating the local health system (Naing, Geater & Pungrassami, 2012; Gil-González et al., 2015; Håkonsen & Toverud, 2011; Peng et al., 2010; PAHO/AMRO, 2017). These barriers can result in:

- patients going without needed medicines;
- patients faltering on adherence;
- patients resorting to self-medication (including with inappropriate drugs).

In the case of the latter, self-medication including with antibiotics among migrants (as described in Hu & Wang, 2015) can contribute to antimicrobial resistance. This and lack of adherence to appropriate treatment can also contribute to multidrug resistance.

Of pressing concern is the risk of lack of provision and continuity of needed treatment for migrants. For example, as Deblonde et al. (2015) report, from a clinical and public health perspective, early HIV care and treatment is associated with viral suppression, improved health outcomes and reduction in transmission risks. While authorities in some destination countries may regard migrants as an important subpopulation for their national response to HIV, a significant number do not provide antiretroviral treatment to migrants in “irregular” situations (Deblonde et al., 2015).

Likewise, for tuberculosis patients crossing international borders, treatment can be postponed or interrupted due to limited access to early diagnosis, lack of continuity of care when patients move to another country, and little or no information for health providers in

the countries of transit, destination and return (Dara et al., 2012). In some countries, denial of entry of tuberculosis suspects is enforced and if migrants in vulnerable situations are diagnosed with tuberculosis they may be extradited without continuity of treatment being ensured (Dara et al., 2012). Fear of discrimination and/or deportation due to tuberculosis may result in the hiding of symptoms and delay in diagnosis, commencement of self-treatment, or discontinuation of treatment, which can lead to development of (multi)drug-resistant tuberculosis (Dara et al., 2012). WHO guidelines on HIV/AIDS and tuberculosis treatment highlight the importance of addressing such issues (WHO, 2015b; WHO, 2016h; WHO, 2017h).

Limited access to or interruption in medication/treatment for chronic conditions – including noncommunicable diseases – must also be cited (Montesi, Caletti & Marchesini, 2016; Marchesini et al., 2014; André & Azzedine, 2016). Underutilization of drugs, combined with underutilization of primary health care preventive services, has potential for producing higher hospitalization rates due to disease progression and complications (Montesi, Caletti & Marchesini, 2016; André & Azzedine, 2016). It is, therefore, important to integrate the health needs of refugees and migrants within national action plans for the prevention and control of noncommunicable diseases (WHO Regional Office for Europe, 2015).

Migrants experiencing poverty and social exclusion can face many of the same barriers to essential medicines as non-migrants in disadvantaged situations. Availability, accessibility, accommodation (matching of services and patients’ practical circumstances), acceptability and affordability of essential medicines (Magadzire et al., 2014) will influence how migrants and others receive effective coverage. Likewise, if other medical inputs, technologies and devices are generally not accessible in certain parts of the country for low-income groups, low-income migrants will also be impacted (and possibly more so, due to intersecting factors).

Research from South-East Asia on access to malaria control measures (including insecticide-treated nets) shows that the cumulative vulnerabilities (of which lower access to/use of nets is part) faced by mobile populations working in forests put them at particular risk of ill-health (Guyant et al., 2015). The WHO publication *Malaria in the Greater Mekong Subregion: regional and country profiles* (WHO Regional Office for South-East Asia, 2010) highlights how the provision of quality diagnosis and antimalarial medicines (and ensuring adequate coverage of vector control measures) can be particularly challenging in forested areas where migrant workers live, and gives examples of how migration has contributed to the spread of mefloquine-resistant *Plasmodium falciparum*.

In the area of technological innovation for health – and while there is a clear need for more research – emerging evidence from some countries shows potential for the use of eHealth interventions for migrant health (IOM, 2017g; Price et al., 2013; Vu et al., 2016). It should be noted, however, that entitlement issues based on irregular status/lack of local civil registration can restrict the success of these initiatives. Additional

factors may also limit their success as a means to deliver services and information, such as lack of familiarity with the internet – particularly among older persons. Goodall, Ward & Newman (2010) note that there is a need for more research on the effects of intersecting factors such as ethnicity, migration, socioeconomic status, education or gender of older people on the use of information and communication technology. There is also a need to make confidentiality and data storage measures robust (e.g. secure storage of personal information such as telephone numbers, and non-sharing of information).

In terms of health technologies that can be useful in facilities to reduce language barriers to services, there is increasing evidence that using eHealth and mHealth innovations such as electronic translation/interpretation services, mobile applications and video interpretation can contribute to enhanced communication with some migrants (Albrecht et al., 2013; Randhawa et al., 2013; Masland, Lou & Snowden, 2017; Lion et al., 2015). That said, this is an area requiring more research, and efforts to ensure privacy and confidentiality of information (as well as quality of translation) are needed.



# HEALTH FINANCING

To reduce financial hardship as well as inequities in service use experienced by some migrants, it is first relevant to consider the health financing context of the country in general. Attention to equity is required in relation to the following health financing functions (McIntyre & Kutzin, 2016; WHO, 2016g):

- *revenue raising* (e.g. is this done in a way that is progressive, so that those who are able to will contribute more towards funding health services than those with less ability to pay, and are public sources such as direct taxes a preferred means to out-of-pocket expenditure?);
- *pooling* (e.g. is fragmentation avoided and effort made to ensure a pool is large, compulsory and represents diverse needs, avoiding an adverse selection scenario in which persons with higher health risks enrol but healthy persons do not – as in the case of voluntary pools – and in which health inequities can be exacerbated due to providers taking measures to respond to high risk by raising premiums or making it difficult for people with pre-existing conditions to join?);
- *purchasing* (e.g. is this done in a way that facilitates equity-oriented resource distribution while maintaining efficiency, with strategic purchasing that supports adaptations to service delivery approaches, particularly in terms of strengthening primary health care, so that barriers are overcome, inequities are reduced and adverse consequences such as overtreatment and unnecessary referrals are avoided?);
- *benefit package design* (e.g. is this done in a way that ensures transparency in terms of entitlements and obligations, taking into account the barriers that populations experiencing poverty and social exclusion may face in relation to those obligations, and is rationing of services done in the most fair and equitable way possible?).

How migration processes are managed may add to or exacerbate some of the other barriers to financial protection and equity in financing issues that are already experienced by disadvantaged populations in a country. Drawing from different sources,<sup>13</sup> health financing-related challenges faced by migrants include:

- annual premiums or co-payments that are unaffordable to some migrants;
- migrants in irregular situations are excluded or fear expulsion if they claim entitlements, contributing to a situation of underutilization;
- portable insurance for persons who are emigrating does not have the depth of coverage or entitlements to services needed by some migrants;
- claims are left unprocessed by insurers;
- without proper monitoring and enforcement, employers try to reduce costs by under-insuring workers or, for migrants in irregular situations, not insuring them at all;
- migrants employed in the informal sector are not eligible for employment-linked entitlements;
- difficulties and delays in reimbursement processes;
- restrictions in eligibility linked to, for example, length of stay in a country or at an address;
- lack of clarity on obligations and entitlements, which may result in no financial protection or double-coverage through different pools;
- being just above the threshold for eligibility;
- language barriers and complex documentation requirements that may make obligations difficult to fulfil;

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13 Guinto et al, 2015; André & Azzedine, 2016; Tangcharoensathien, Thwin & Patcharanarumol, 2017; Dzurova, Winkler & Drbohlav, 2014; Simon et al, 2015

- low enrolment to migrant health insurance schemes, with limited population coverage, inhibits large pooling of risks thus adversely affecting the financial viability of a scheme;
- gender-related barriers linked to women being secondary beneficiaries reliant on male primary beneficiaries, which can affect their knowledge and rights as well as put them in a position of dependency.
- countries have put in place (portable) insurance schemes for their departing migrant workers, or have worked with governments of destination countries to provide health care strategy and low-cost insurance for migrants;
- categories of migrants are covered through a compulsory migrant health scheme in a destination country.

Efforts for financial protection of migrants are being advanced and offer important insights. A scoping review by Quinto et al. (2015) of current migration trends, policies and migrant inclusion in universal health coverage reforms in Indonesia, Malaysia, Philippines, Singapore and Thailand shows that, in general, all five countries – whether receiving or sending – have schemes that cover migrants to varying extents. Tangcharoensathien, Thwin and Patcharanarumol (2017) describe lessons learned from the Thai Ministry of Public Health’s migrant health insurance scheme for all migrants (with regular and irregular status) who are not covered by social health insurance; this was established in 2001 and extended to migrants’ dependants in 2005. Additional examples of advances towards financial protection of migrants are found in sources including WHO, 2010d; Simon et al., 2015; André & Azzedine, 2016; and IOM, 2017g. These describe scenarios in which:

- labour migrants with regular status in a destination country are given the same financial protection entitlements as non-migrants;
- countries have established policies providing a level of financial protection for health services for all migrants, irrespective of their regular or irregular status;
- publically-funded schemes exist in destination countries for financial protection of migrants with irregular status (a specific benefits package);

There is a need for further research on which model is most appropriate in terms of its contribution to ensuring the right to health, to “leaving no one behind” on the path to universal health coverage, and, in tandem, is the most cost-effective. Attention must be given to avoiding modalities that contribute to fragmentation, institutional isolation or avoidable parallel (and potentially unsustainable) systems. Likewise, there is a need to ensure that migrants do not *only* have access to private health services, which in some contexts are not sufficiently regulated and may make out-of-pocket expenditure even higher (alongside quality concerns). It can be noted that recent austerity measures in some countries, combined with politicalization of migration, has contributed to cutting back/minimizing of some financial protection measures that were previously in place, with the effect on individuals’ rights to health, public health and social cohesion yet to be seen (Rechel et al., 2013; Mladovsky et al., 2012; Cook, 2014).

Within efforts to further understand the promising models for financial protection for migrants, there is a need to take gender into account. Witter (2015) provides examples of critical financing questions from a gender perspective, with select ones being: How do different payment systems affect men and women’s access to health care? Who is protected under different risk-pooling systems (tax-based, insurance, prepaid mechanisms etc.)? Are gender-sensitive services being purchased (e.g. facilities which provide confidentiality, sensitivity and right staffing mix, at appropriate opening times etc.)?

These types of questions are particularly relevant to some migrant women, as exemplified by the WHO report *Women on the move: migration, care work and health* (2017e).

Lack of financial protection can limit an individual's ability to access services, and lead to excessive costs through out-of-pocket payments for health services if, and when, they are accessed. Delay in treatment-seeking often exacerbates health conditions that could have been prevented at a reduced cost if services had been accessed in a timely way (WHO, 2010d). Evidence suggests that neglecting access to primary health care and leaving migrants' health to be managed only at the emergency level is costly (WHO, 2010d). Lack of financial protection also influences self-diagnosis and medication, as touched upon in the previous section.

Due to such issues, recent global and regional resolutions and declarations have emphasized the importance of financial protection for migrant health. The Colombo Statement (IOM/WHO, 2017) recognizes 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*. Likewise, PAHO/AMRO (2016) highlights the need for improving *health financing systems so that migrants have the same level of financial protection in health that others living in their country have, regardless of their migratory status, as appropriate to national context, priorities, and institutional and legal frameworks*.

Reasons for not including migrants among the population entitled to financial protection and services often relate to the political economy in a country, and are not necessarily based on migrants' contribution to national economies, labour markets and fiscal space (WHO, 2010d; ILO, 2015; OECD, 2014). Vargas-Silva (2017) presents some of the emerging research in the field of fiscal impact of immigration, consolidating results

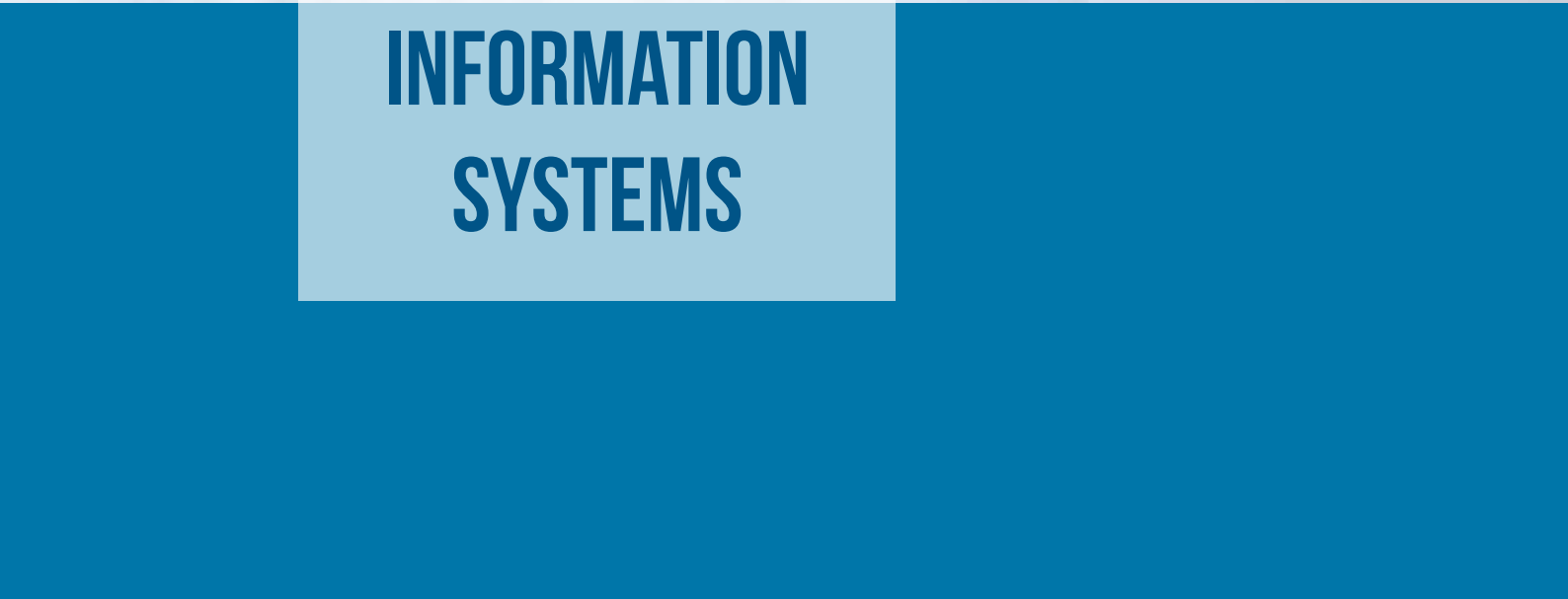
from different perspectives and methods, while highlighting the need for more research. Other sources point to the need to consider potential long-term effects, such as forecasts that higher net migration can reduce pressure on government debt over time (Office for Budget Responsibility, 2013), and note positive fiscal impacts in the short term (HM Revenue and Customs, 2016). Linked to the latter, immigration can increase gross domestic product (GDP) per capita in advanced economies because skill levels and complementarities boost labour productivity, and because (in some places) an influx of working-age migrants helps counteract labour shortages linked to demographic developments (IMF, 2016; IMF 2017). OECD (2013) reports that employment is the single most important determinant of migrants' net fiscal contribution, particularly in countries with "welfare states", while IMF (2017) underlines that the process of integration is critical if countries are to secure maximum economic benefits from migration. Research is underway to look more at these issues in terms of "South-South migration" (OECD/ILO, 2015). Advancement of research in these areas will contribute evidence on fiscal space relevant for health financing and financial protection for all, including migrants.

Addressing financial protection for migrants will require improved cooperation with the sectors governing finance, migration and labour policies, as well as multilateral and bilateral dialogue as countries redefine universal health coverage beyond the basis of citizenship and reimagine universal health coverage systems that transcend international borders (Guinto et al., 2015; ILO, 2015). Discussions with other sectors can cover issues such as eligibility requirements (e.g. registration) that may prevent migrants from accessing financial protection; coordination to ensure that migrants are aware of their entitlements and obligations with regard to financial protection; and, as appropriate, streamlined and efficient approaches to joint budgeting.





**HEALTH  
INFORMATION  
SYSTEMS**



Strengthening health information systems to understand who is being missed and the barriers that they face is a central component of progressive realization of the right to health and universal health coverage.<sup>14</sup> Progressive universalism is facilitated by monitoring health inequalities, with indicators disaggregated by income or wealth, sex, age, disability, place of residence, migrant status and ethnic origin (WHO, 2013; WHO, 2014; PAHO/AMRO, 2017). Additional gender-sensitive health indicators can identify differences between women/girls and men/boys (WHO Regional Office for Europe, 2009). Data disaggregated by ethnicity are important for the provision of intercultural services (PAHO/AMRO, 2017).

Data on the health of migrants, including on health determinants and access to health services by migrants, are lacking in many countries (Rechel et al., 2013; WHO, 2010b; WHO, 2017d, MIPEx, 2015). The *Framework of priorities and guiding principles to promote the health of refugees and migrants* (WHO, 2017c) explicitly calls for strengthening health information systems. This echoes the New York Declaration for Refugees and Migrants, which recognizes *the importance of improved data collection, particularly by national authorities, and will enhance international cooperation to this end, including through capacity-building, financial support and technical assistance* (UN, 2016b). Resolution WHA61.17 on the health of migrants also emphasizes this important issue (WHO, 2008).

In the process of building/strengthening a health information system for progressive universalism – i.e. one that has capacity to provide information on the situation of migrants and others, including ethnic minorities – data protection issues are central (UN, 2016b; WHO Regional Office for Europe, 2016a). The New York Declaration for Refugees and Migrants highlights the need for abidance with national legislation on data protection and international obligations

related to privacy (UN, 2016b). Given historical misuses of data that contributed to some of the darkest events in human history (as cited in UN, 2012b), particular attention must be given to ensuring adequate personal identity protection measures and safe data storage. In addition, ethical safeguards – such as the Fundamental Principles of Official Statistics or the Declaration on Professional Ethics of the International Statistical Institute – should be adopted and enforced with a view to creating an institutional framework that helps in preventing future misuse of data (UN, 2012b). A human rights-sensitive approach to data collection, analysis and dissemination can help to ensure protection against potential misuse of data and invasions of the right to privacy (UN, 2016b).

Taking into account the necessary protective measures, data collection by relevant equity stratifiers can be integrated in the overarching health information system (WHO, 2010c; WHO, 2014) under a health information systems strategic plan and/or policy. Collection can span all data sources including censuses, civil registration and vital statistics, facility-generated data and administrative data. Linkages to the information systems of other sectors can be put in place when appropriate. For instance, relevant equity stratifiers can be integrated into existing health surveys rather than separate/parallel surveys being undertaken. Many countries have opportunities to step up their organizational and regulatory efforts for information on migrant health, including through inclusion of improved questions on migration in existing data collection processes (Rechel et al., 2013). In areas experiencing large regular influxes of migrants, the health information system may be overwhelmed, and strong coordination among stakeholders is required to establish and maintain the needed information flows (WHO Regional Office for Europe, 2016b).

<sup>14</sup> Sources: WHO, 2013; MA4Health, 2015; WHO Regional Office for the Western Pacific, 2016a & 2017a.

At a local level, providing integrated people-centred health services may require local health needs assessment, with due attention to the heterogeneity of people living in a given area (including migrants). Health needs assessment can look into inequities in exposure to risk factors, inequities in access to services and effective coverage, and consequences (including impoverishment and stigmatization) as a result of illness (WHO, 2010e; WHO Regional Office for Europe, 2010; WHO, 2013; WHO, 2016b). They can also capture data on “why” people are not accessing and benefitting from health services.

Such assessments can draw from both quantitative and qualitative measures. Qualitative approaches are particularly important to understand barriers and determinants, including in relation to the gendered sociocultural and economic contexts in which people live their lives and make their decisions. Without use of qualitative sources, key information is often missing on the intersecting effects of disadvantage. For instance, qualitative information can help explain increased exposure and vulnerability to risk factors for ill-health for some migrants, and the impact of lower entitlements for access to services in the face of ill-health (Huffman et al., 2012; Doctors of the World UK, 2015; Fleischman et al., 2015).

Not only is equity-relevant information necessary for universal health coverage, it is critical to consider how it feeds into ongoing monitoring, evaluation and review processes (WHO, 2016b; WHO 2016c; WHO, 2011b; O’Neil et al., 2016; WHO, 2013). From a human rights perspective, states are obliged to monitor the effects of their public health policies and actions and, more broadly, their social policies, to ensure that these are anchored in a system which does not allow inequalities in the enjoyment of human rights (IOM/WHO/OHCHR, 2013). As such, it is important to ensure capacity for analysing, disseminating and using information about the health of migrants in regular policy and programme planning cycles. Information can be

used at various levels of the health system for planning and delivery of services, management and allocation of resources, and policy dialogue. Such data can contribute to health programme evaluations that ask questions regarding who is and is not accessing and fully benefitting from needed services, and why (WHO, 2016b). Evaluations are important to assess the cost-effectiveness of health interventions. They are also important for assessing how interventions address equity, rights, gender and intercultural care issues (Coates, Del Pino & Vitoy, 2016). They offer important lessons for adapting health systems to become more “migrant friendly”. *WHO’s Innov8 approach for reviewing health programmes to leave no one behind* is an example of a way through which such data can be used for redesigning programmes to close coverage gaps, including those faced by some migrants (WHO, 2016b). Likewise, data on the health of migrants can also feed into health impact assessments (Jandu et al., 2014).

It is important to engage migrants (as well as other groups, as part of a comprehensive approach to participation) in the process of designing, explaining and conducting monitoring and evaluation processes (WHO, 2010b; WHO, 2017c). Strategies can include community-based monitoring and participatory consultation with all stakeholders, acknowledging that different people may have different opportunities and/or face barriers to participation (e.g. fear of being deported, working conditions, gender norms, language capacities and literacy). If the goal is to engage persons experiencing poverty and social exclusion, participatory modalities and mechanisms should be adapted to account for such barriers and circumstances. Participatory action research can also be used; it prioritizes the formation of partnerships between researchers and participants to identify issues of local importance, determine ways to understand these issues and formulate strategies for taking action (Lykes & Mallona, 2008).



**FURTHER  
CONSOLIDATION  
OF THE  
EVIDENCE BASE**

Resolution WHA70.15 urges Member States to, among other actions, *identify and collect evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants in order to contribute to the development of a draft global action plan on promoting the health of refugees and migrants* (WHO, 2017b).

At the time of writing, WHO is collecting evidence for a situation analysis that will contribute to the development of the draft global action plan on promoting the health of refugees and migrants. The authors encourage readers of this paper to consider its contents in the context of the wider WHO *Framework of priorities and guiding principles to promote the health of refugees and migrants* (WHO, 2017c), the priorities of which are elaborated in Box 5. The forthcoming situation analysis will expand upon the evidence base in these areas.

■ **Box 5. Priorities identified in WHO's *Framework of priorities and guiding principles to promote the health of refugees and migrants***

- 1. Advocate mainstreaming refugee and migrant health in the global, regional and country agendas and contingency planning.** Special attention should be given to promote and monitor the health of refugees and migrants, as part of efforts to achieve the SDGs. Efforts should also be made to ensure that the health aspects of refugees and migrants are included in the global compact on refugees and the global compact for safe, orderly and regular migration.
- 2. Promote refugee- and migrant-sensitive health policies, legal and social protection and programme interventions** that incorporate a public health approach and that can provide equitable, affordable and acceptable access to essential health promotion, disease prevention, and high-quality health services, including palliative care for refugees and migrants. This may require modifying or improving regulatory and legal frameworks to address the specific health needs of these populations, consistent with applicable national and international laws.
- 3. Enhance capacity to address the social determinants of health** to ensure effective health responses and health protection in countries of origin, transit and destination. This includes improving basic services such as water, sanitation, housing and education. Priority should be given to implement a Health in All Policies approach to promote health equality for refugees and migrants. This will require joint and integrated action and coherent public policy responses involving multisector collaboration such as the health, social, welfare and finance sectors, together with the education, interior and development sectors.
- 4. Strengthen health monitoring and health information systems** in order to: assess and analyse trends in refugees' and migrants' health, disaggregate health information by relevant categories, as appropriate; conduct research; and identify, collate and facilitate the exchange of experiences and lessons learned among Member States, and generate a repository of information on relevant experiences in the affected countries.
- 5. Accelerate progress towards achieving the SDGs including universal health coverage** by promoting equitable access to quality essential health services, financial risk protection, and access to safe, effective, quality and affordable essential medicines and vaccines for all (target 3.8), including refugees and migrants. This may require strengthening and building the capacities and resilience of health systems. As a part of these efforts, priority should also be given to developing sustainable financial mechanisms to enhance social protection for refugees and migrants, and to strengthen the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

6. **Reduce mortality and morbidity among refugees and migrants through short- and long-term public health interventions**, aimed at saving lives and promoting the physical and mental health of refugees and migrants. Rapid and effective emergency and humanitarian responses is essential to saving lives and relieving suffering, but longer-term planning for more systematic development-oriented approaches to ensure the continuity and sustainability of the response should begin early. Priority should be given to efforts to enhance local capacity to address public health issues such as communicable and noncommunicable diseases, with an emphasis on disease prevention, for example through vaccination. Vaccines should be provided for refugees and migrants in an equitable manner, with a systematic, sustainable, non-stigmatizing approach. As vaccination is a health intervention that requires a continuum of follow-up until the full schedule is completed, there must be cooperation among the countries of origin, of transit and of destination.
7. **Protect and improve the health and well-being of women, children and adolescents living in refugee and migrant settings**. Priority should be given to the provision of essential health services such as: a minimum initial service package for reproductive health, sexual and reproductive health information and services; maternal health care including emergency obstetric services, pre- and postnatal care; prevention, treatment, care and support for sexually transmitted infections including HIV, and specialized care for survivors of sexual violence, as well as supporting for child health activities.
8. **Promote continuity and quality of care** delivered by public and private institutions and providers, non-State actors and other service providers for refugees and migrants, in particular for persons with disabilities, people living with HIV/AIDS, tuberculosis, malaria, mental health and other chronic health conditions as well as those with physical trauma and injury. It is important to ensure that adequate information on continuity of care is provided and is adhered to, especially during mobility, and particularly for the management of chronic health needs. Access to adequate mental health care, including at reception and through referrals to appropriate secondary services, should be provided. Priority should be given to ensure that children have access to specific care and psychological support, which takes into account the fact that they experience and deal with stress differently than adults do.
9. **Develop, reinforce and implement occupational health safety measures** in work places where refugees and migrant workers are employed, in order to prevent work injuries and fatal accidents. Provide information and training to educate refugee and migrant workers about occupational health and safety risks in hazardous occupations. Refugee and migrant workers should have equal access to treatment of work-related injuries and disability, rehabilitation and death compensation according to national contexts.
10. **Promote gender equality and empower refugee and migrant women and girls** including through recognizing gender differences, roles, needs and related power structures among all relevant stakeholders and mainstreaming gender into humanitarian responses, and longer term policy development and interventions. Also consider implementing the recommendations of the High-Level Commission on Health Employment and Economic Growth (2016), which call for tackling gender concerns in the health reform process and the health labour market.
11. **Support measures to improve communication and counter xenophobia** by making efforts to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement; and share accurate information on the impact of refugees and migrants on the health of local communities and health systems, as well as to acknowledge the contribution of refugees and migrants to society. Provide appropriate, accurate, timely and user-friendly information on the health services available in countries of origin, transit and destination to refugees and migrants.
12. **Strengthen partnerships, intersectoral, intercountry and interagency coordination and collaboration mechanisms** to achieve synergies and efficiency, including within the United Nations system, with IOM and UNHCR in particular, and with other stakeholders working towards improving the health of refugees and migrants; strengthen the humanitarian–development nexus to enhance better coordination between humanitarian and development health actors; and foster the exchange of best practices and lessons learned on the health of refugees and migrants among relevant actors. Also strengthen resource mobilization for flexible and multi-year funding to enable countries and communities to respond to both the immediate and the medium/longer term health needs of refugees and migrants; identify gaps and innovative financing to ensure a more effective use of resources.

Source: WHO, 2017c.

Contributing to consolidation of the evidence base, the UN Migration Agency/IOM has developed an open-source migration and health research portal containing a routinely updated repository of over 320 publications (from 2006 to present), from all regions of the world, where IOM was a primary contributor. Publications include: peer-reviewed scientific papers; technical reports on migration health published with Member States and regional governance mechanisms; migration health training manuals; policy briefs; and evidence reviews. The publications are categorized by country, topic, author, region, year of publication and type of publication. Further indexing will be done in the second phase to enable greater search functionality. See: <https://migrationhealthresearch.iom.int/publications-search>. The portal also contains a platform for scholars/researchers from all parts of the world who are advancing research on migration and health: <https://migrationhealthresearch.iom.int/mhadri-users>.

Additional work by partners, such as the work of the Migrant Health Subgroup of the Campbell and Cochrane Equity Methods Group, can also be noted. The vision of the Migrant Health Subgroup is to use Cochrane evidence-based methods and equity methods to prioritize, and synthesize quality evidence on migrant health. Working with WHO, IOM, GRADE Methods Group, and stakeholders in a range of country contexts, the group will: (1) develop high-quality international and national GRADE guidelines for migrant populations; (2) synthesize evidence and develop a migrant equity lens to support policy and practice.

To support continual research and production of evidence, the report of the 2nd Global Consultation on Migration and Health (IOM, 2017e) sets forth a composite research framework and a range of example actions (at national, regional and global levels) to advance migration health research. Example actions at national level (only) are given below (IOM, 2017e).

- Identify a national focal point to establish a national multisectoral 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 migrant health to drive policy-making 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 undertake an analysis of existing service priorities/gaps to identify research priorities.
- 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 migrant been included within health sector plans and 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?
- Research mapping – identify researchers across disciplines such as medicine, law, economics, and social and political science, to drive a research agenda.

Additional information on research priorities for universal health coverage, including in relation to equity, can be found in WHO (2013).



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# CONCLUSION



Drawing from a rapid scoping review, this paper presented information on barriers to health services faced by some migrants (in particular those experiencing poverty and social exclusion). The paper acknowledged that some barriers are faced by multiple subpopulations experiencing poverty and social exclusion, and others are unique to how migration processes are managed. These barriers often compound and intersect, with potential to affect some migrants disproportionately.

The paper also presented information on interventions and approaches aiming to overcome these barriers, in the context of health systems strengthening for universal health coverage. Addressing barriers in synergy is required if the actual aim is to provide people-centred health services and reduce inequities in effective coverage, while safeguarding the right to health and promoting gender equality. This is also relevant from a policy coherence and social cohesion perspective, with social cohesion being “the capacity of a society to ensure the welfare of all its members, minimizing disparities and avoiding polarization” (Council of Europe, 2004). This concept helps illuminate the link between the fulfilment of basic human rights for all people and the role that reducing inequities plays in societal stability. It calls out the importance of non-discrimination, which has been a key underpinning concept in this paper.

The paper used the health system building blocks in its framing of the evidence, covering governance; service delivery; human resources for health; essential medicines and technologies; financing; and health information systems. Summary points are listed below for each building block.

- **Governance.** The literature delineates the role of health system governance in specifying entitlements, overseeing system-wide (rather than siloed/isolated) responses, engaging in intersectoral cooperation, and providing oversight for international cooperation for migrant health. Political economy issues,

and politicization of migration, influence decision-making on entitlements. National health policies, strategies and plans as well as system assessments can provide entry points for supporting system-wide approaches. Specific mechanisms (e.g. joint steering committees, joint budgeting, joint staff training) for operationalizing intersectoral action can be useful to address determinants of migrant health. The literature provides multiple examples of international cooperation that can help overcome barriers to services experienced by some migrants.

- **Service delivery.** Viewing the literature through the lens of integrated people-centred health services, multiple examples were found on how to adapt models of care to overcome types of barriers experienced by some migrants. To adjust services to local population needs, risk stratification and patient rostering were highlighted, with measures in place to ensure data protection. Measures to enhance outreach, community-centred services and intercultural approaches, as well as measures to improve health system literacy and navigation capacity among migrants, were touched upon. There is also a need to ensure service delivery capacity to address compounding risk factors and co-/multimorbidities, which can be more pronounced in subpopulations experiencing social disadvantage, as well as specific morbidities that may be more prevalent in migrants’ countries of origin. Strong multidisciplinary primary health care teams were noted in the literature as important to ensure delivery capacity matching population needs (linking to the “Human resources” section).

- **Human resources for health.** Taking a health labour market perspective, the literature was reviewed in terms of its implications for (a) policies on production (b) addressing inflows and outflows (c) addressing maldistribution and inefficiencies. Across these areas, the issue of effectively matching the supply and

skills of health workers with the needs of migrants, in particular those experiencing poverty and social exclusion, was explored. The literature addressed issues including: more equity-oriented student selection; redirecting public investments in education to primary care, low- and middle-level providers; and incorporation of cadre such as cultural mediators, community health workers and interpreters, as means being undertaken to help match the workforce with migrant population needs. Incorporation of curricula on migration, intercultural care and other equity, gender and human rights issues into pre-service and continuing education for health professionals was also explored. The issue of discordance between professional codes of conduct (e.g. on the obligation to treat) and migration law was also touched on, highlighting that some sources are now calling for “the establishment of firewalls” between immigration enforcement and public health services.

■ **Essential medicines and technologies.**

The literature suggests that barriers in this domain can result in migrant patients going without needed medicines, faltering on adherence and resorting to self-medication. Implications of this were cited as increased risk of advanced-stage morbidity and mortality, increased risk of transmission of communicable diseases, development of drug resistance, and higher hospitalization rates (and costs) due to disease progression and complications (also in the case of noncommunicable diseases). Sources highlighted the importance of ensuring continuity of treatment between borders, and general approaches to enhance medicine availability, accessibility, accommodation (matching of treatment and patients’ practical circumstances), acceptability and affordability for all persons, including migrants.

■ **Health financing.** The literature described a range of challenges faced by migrants in relation to obtaining financial protection. Unaffordable co-payments, exclusion from coverage based on irregular status, employers under-insuring workers, ineligibility based on length of stay, and insufficient depth of coverage available through portable insurance modalities were some of the challenges. Sources that profiled select efforts to expand financial protection were shared and evidence on fiscal space contributions by migrants was highlighted; however, clearly this is an area where much more research is required.

■ **Health information systems.** Multiple sources have highlighted the need to monitor health inequalities, with indicators disaggregated by income or wealth, sex, age, disability, place of residence, migrant status and ethnic origin. Such monitoring could support a stronger focus on migrant health and the factors (such as poverty and gender) that may intersect with migration to contribute to and compound barriers to services. Sources on equity-oriented health information systems indicate equity measures can be incorporated across data sources including censuses, civil registration and vital statistics, facility-generated data and administrative data sources as appropriate. Sources indicate that it is important that ethical safeguards and institutional frameworks that prevent future misuse of data are applied in this process. Data can be supplemented with local health needs assessments, including qualitative inputs, and fed into ongoing monitoring, evaluation and review processes.

It becomes clear, when looking across the evidence gathered through this rapid scoping review, that coherent “systems thinking” is required; action linked to one building block alone will often be insufficient to reduce health inequities experienced by some migrants. The building blocks are intrinsically linked and mutually reinforcing. In addition to a systems-wide approach, the paper has also pointed to the critical role of

liaising across sectors and countries for reducing the inequities experienced by some migrants. To ensure the progressive realization of both universal health coverage and the right to health for all, concerted continued work on health system strengthening to improve the health of migrants, in particular those experiencing poverty and social exclusion, will be required.

# Methods

This paper reflects a rapid scoping review of literature undertaken in October 2016, a commenting period by WHO staff during mid-2017, and supplementary revision to align with select recent documents in mid-2017. The initial search used PubMed, with additional manual reviews of key publications such as Health Policy and Planning. The search was limited to articles in English published after 2005. Publications from WHO, IOM, ILO and other partner agencies were also reviewed.

The search criteria were grounded in the health system building blocks and key words reflected intervention areas informed by current and previous WHO work on health equity and select pre-2016 work by WHO and partners on migration and health. Given the timing of the search in October 2016, primary sources that grounded the search terms included: work on poverty, social exclusion and migration (WHO Regional Office for Europe, 2010a and 2010b); World Health Assembly resolution WHA61.17 on the health of migrants (WHO, 2008); and the report of the Global Consultation on the Health of Migrants (WHO, 2010b).

Originally, this was designed to be an unpublished background paper to inform the publication *Women on the move: migration, care work and health* (WHO, 2017e). In early 2017, it was decided to publish the paper as a standalone piece.

A delay was introduced in the methodology during January to July 2017 to enable the contents to feature and align with requests to WHO through World Health Assembly resolution WHA70.15, adopted in May 2017. During July and August 2017, WHO staff at global and regional levels working on “leaving no one behind” from the perspective of equity, gender and human rights and select health system strengthening areas, as well as staff working on migrant health, were asked to provide written contributions and/or review the paper. The end result is a paper that draws from select Organizational expertise of staff involved in leaving no one behind activities as well as migrant health activities.

This paper corresponds to the mandate of the Gender, Equity and Human Rights team (WHO headquarters) in light of the explicit focus on the right to health, progressive universalism, and other equity, gender and human rights considerations. The paper represents the output of cooperation between the Gender, Equity and Human Rights team and the Migration and Health Area, the latter of which is led by the Service Delivery and Safety Department (WHO headquarters). This paper also benefitted from inputs from colleagues from regional offices in both areas and WHO headquarters Health Systems staff. Counterparts from IOM also provided comments. Please see “Contributors” for details.

# Contributors

This report was developed under the overarching leadership of Veronica Magar (Team Leader for Gender, Equity and Human Rights (GER), at WHO headquarters (HQ) in Geneva), with guidance and strategic direction from Flavia Bustreo, Assistant Director General (ADG) of the Family, Women's and Children's Health Cluster (WHO/HQ/FWC).

Theadora Swift Koller (Technical Officer, Equity, WHO/HQ/FWC/GER) is the lead author on this paper; she was responsible for conceptualizing the paper, overseeing the rapid scoping of literature, writing and revising contents, and coordinating inputs.

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The following collaborators from IOM also reviewed and commented on the text: Jacqueline Weekers, Senior Migration Health Policy Advisor; Kolitha Wickramage, (Global) Migration Health and Epidemiology Coordinator; Eliana Barragan, Migration Health Project Officer; and Davide Mosca, Director, Migration Health Division.

The paper draws on a rapid scoping review done by Alexander d'Elia (external consultant to WHO on equity) in October 2016, which was overseen and then supplemented with article searches conducted by Theadora Swift Koller.

Yeonjoo La (Intern, WHO/HQ/FWC/GER) also contributed to article searches. Thanks goes to Adama Diop (Consultant, WHO/HQ/FWC/GER) and Gemma Hunting (former Technical Officer, Gender, WHO/HQ/FWC/GER) for their coordination work related to the project through which this report was produced.

Special acknowledgement also goes to the following members of the WHO/HQ team coordinating work on migration, for their partnership: Edward Kelley (Director, Service Delivery and Safety, WHO/HQ/HIS/SDS); Kanokporn Kaojaroen (Technical Officer, Service Delivery and Safety, WHO/HQ/HIS/SDS); Shamsuzzoha Babar Syed (Coordinator, WHO/HQ/SDS/QHC); Felicity Pocklington (Technical Officer, WHO/HQ/SDS/QHC); and Ashton James Kelly (Intern, WHO/HQ/SDS/QHC).

For the conceptual underpinnings in this report, it should be noted that the authors drew from current and previous (2008–2011) work of the WHO Regional Office for Europe Migrant Health Working Group around issues of health systems strengthening for migrant health, as well as work of the WHO European Office for Investment for Health and Development on health system strengthening to address poverty and social exclusion (2005–2012) (see WHO Regional Office for Europe, 2010a & 2010b).

The production of this report was facilitated by financial support received from the Bill and Melinda Gates Foundation.

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