

A Rapid Review of Evidence-Based Information, Best Practices and Lessons Learned in Addressing the Health Needs of Refugees and Migrants

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Abbreviations

AGDM	Age, Gender and Diversity Mainstreaming
AIDS	Acquired Immune Deficiency Syndrome
ASEAN	The Association of South East Asian Nations
CAIM	Centre for Investigation and Actions for Latin American Women
CESCR	Committee on Economic, Social and Cultural Rights (UN)
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
ECHR	European Convention on Human Rights
ECRI	European Commission Against Racism Intolerance
ETHEALTH	ETnicity & HEALTH
EU	European Union
EU-MIDIS	European Union Minorities and Discrimination Survey
FBO	faith-based organization
FRA	Agency for Fundamental Rights (Europe)
GFMD	Global Forum on Migration and Development
GIFW	General Initiative Fund for Women
HIA	Health Impact Assessment
HIATUS	health information assessment tool on asylum seekers
HIS	health information systems
HIV	human immunodeficiency virus
HUMA	Health Access to Migrants
HRH	Human Resources for Health Observatory
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDP	Internally displaced person
IOM	International Organization for Migration
MISP	minimum initial service package
MMR	measles, mumps and rubella
NCD	non-communicable disease

NGO	non-government organization
ODIHR	Office for Democratic Institutions and Human Rights
OHCHR	Office of the High Commission for Human Rights (UN)
PAHO	Pan American Health Organization
PAIS	Public Health Information Service
RAISE	reproductive health access information and services in emergencies
SDH	social determinants of health
SGBV	sexual and gender-based violence
SIAs	supplementary immunization activities
SDG	Sustainable Development Goals
SEP	socioeconomic position
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization

Glossary

Asylum seeker:	An asylum seeker is an individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum seeker (1).
Country of origin:	The country that is a source of migratory flows (legal or illegal) (2).
Country of transit:	The country through which migratory flows (legal or illegal) move (2).
Health:	Health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (3).
Irregular migrant:	Someone who, owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country’s admission rules and any other person not authorized to remain in the host country (also called clandestine/ illegal/undocumented migrant or migrant in an irregular situation) (2).
Member State:	A Member State of the United Nations is a State that accepts the obligations contained in the United Nations Charter and, in the judgement of the Organization, is able to carry out these obligations (4).
Migrant:	At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of “personal convenience” and without intervention of an external compelling factor. This term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family (2).
Migrant worker:	A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national (2).
Migration:	A process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people, and economic migrants (2).
Refugee:	A person who meets the eligibility criteria under the applicable refugee definition, as provided for in international or regional refugee instruments, under UNHCR’s mandate, and/or in national legislation (1).

State:	A political entity that has legal jurisdiction and effective control over a defined territory, and the authority to make collective decisions for a permanent population, a monopoly on the legitimate use of force, and an internationally recognized government that interacts, or has the capacity to interact, in formal relations with other entities. The criteria of statehood for purposes of international law are commonly held to be possession of a permanent population, a defined territory, government and capacity to enter into international relations with other States (2).
Xenophobia:	At the international level, no universally accepted definition of xenophobia exists, though it can be described as attitudes, prejudices and behaviour that reject, exclude and often vilify persons, based on the perception that they are outsiders or foreigners to the community, society or national identity. There is a close link between racism and xenophobia, two terms that are hard to differentiate from each other (2).

Executive Summary

Background

Across the world there is an increasing trend in human migration. In 2017, 258 million people lived outside their country of origin, an increase of almost 50 per cent since the year 2000. Major increases have occurred across Asia, Europe and Northern America, with most migration occurring between countries of the same region (5).

Migration can deliver social and economic benefits for individuals, families and host countries. Nevertheless, migrants and refugees may experience inadequate access to health services, disruptions in care, human rights violations and discrimination. Large or rapid changes in the number, distribution and demographics of migrants and refugees across the globe can create new and increasing challenges for national health systems in the setting of limited resources and technical expertise.

In keeping with international human rights frameworks (6) and to achieve the vision of the Sustainable Development Goals to end poverty, protect the planet and ensure prosperity for all (7), it is important that the health needs of migrants and refugees are adequately addressed.

In May 2017, the Seventieth World Health Assembly (WHA) endorsed resolution WHA70.15 on “Promoting the health of refugees and migrants” (8). The resolution urged Member States to strengthen international cooperation on the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants (9); to consider providing necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants; and to consider promoting the World Health Organization (WHO) framework of priorities and guiding principles to promote the health of refugees and migrants.

The resolution urged Member States and requested the WHO to identify and collect evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants to inform Member State responses; the development of the Global Compact on Refugees, and the Global Compact for Safe, Orderly and Regular Migration; and the Draft Global Action Plan to Promote the Health of Refugees and Migrants to be considered for adoption at the Seventy-second World Health Assembly.

This technical report to the WHO contains the findings of a series of rapid reviews of peer-reviewed, English language literature and reports on policies, interventions and practices for addressing the health needs of refugees and migrants. It addresses research questions based on the priority areas articulated in the WHO framework of priorities and guiding principles to promote the health of refugees and migrants (10).

Key considerations

The following is a summary of key considerations in addressing the health needs of refugees and migrants.

Promoting the right to health

The right to health and the right to access health services should be considered in the development of the Global Compact on Refugees, the Global Compact for Safe, Orderly and Regular Migration, and the Draft Global Action Plan to Promote the Health of Refugees and Migrants.

In accordance with international human rights frameworks, Member States should commit to protecting the right to health and the right to access health services for migrants, refugees and asylum seekers regardless of migration status. Member States should consider strengthening constitutional, legislative, policy, judicial and institutional mechanisms for protecting these rights and addressing discrimination and exclusionary processes. Approaches should include applying rights principles consistently across sectors and at subnational levels, and monitoring and reporting on implementation.

Promoting access to health services

Access to health services for migrants, refugees and asylum seekers is a human right and should be supported through national leadership to ensure consistent and equitable application of health service access policies within countries. Adequate health system funding is required to support policy implementation and the delivery of health services at the local level. Service access can be improved through health workforce development in understanding service eligibility and access policies; cultural competence training including the use of interpreters, translated information and cultural mediators; and addressing stigma and discrimination. Collaboration between health services, social welfare agencies and communities can assist in understanding entitlements and how to access local health services.

Addressing the social determinants of health

Member States should ensure that improving the health of migrants and refugees goes beyond providing access to health services. It includes ensuring that the basic needs of migrants and refugees are addressed including adequate nutrition, water, sanitation, hygiene, housing, education and employment. It involves addressing the complex upstream political and socio-economic factors that affect a person's health.

Member States should support the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) to end all forms of poverty and fight inequalities, including those related to migrants, refugees and health (7). Member States should uphold the resolutions of the World Conference on Social Determinants of Health, and the Rio Political Declaration on Social Determinants of Health. This includes strengthening global governance, multi-sector collaboration and coordination; enhancing national governance to address the root causes of health inequalities; promoting the participation of non-government agencies and civil society in policy development and action; and increasing accountability, monitoring and research.

Strengthening health monitoring and health information systems

Member states should strengthen health information systems for national health system development and as a requirement for addressing the health needs of migrants and refugees. Accurate, representative information on migrants and refugees is required to identify population health needs, inform health policy and program development, monitor interventions, measure health outcomes and contain public health expenditure.

Member States should share expertise and guidance for developing health information systems for capturing migrant and refugee issues, particularly in low income countries. International consensus is required on the use of data variables for identifying migrants and refugees and their needs, such as country of birth, ethnicity, immigration status, length of time in country and language fluency. Member States should consider developing health monitoring and information systems that can work across national borders.

Promoting Universal Health Coverage

Member States should consider including migrants, refugees and asylum seekers in national Universal Health Coverage policies and financial protection mechanisms to uphold their right to access health services. This includes consideration of access to essential health services and health related goods such as medicines and vaccines.

Reducing mortality and morbidity among refugees and migrants through public health interventions

Public health interventions to reduce morbidity and mortality among migrant and refugee populations should not only include emergency responses but also consider integrated prevention and treatment services linked to culturally appropriate health education. Targeted screening programmes for tuberculosis (TB) and human immunodeficiency virus (HIV), and immunization for vaccine preventable diseases should be considered in migrant and refugee populations where appropriate. Non-communicable diseases screening, including mental health, should be considered according to migrant and refugee population demographics and burden of disease.

Protecting and improving the health and well-being of women and girls

Member State policies should ensure migrant and refugee women and girls have access to sexual and reproductive health programmes and services as part of their right to health. Programmes and services should be developed in collaboration between government and non-government organizations, and in consultation with women and their communities to ensure they are flexible, accessible and culturally responsive. Essential service packages for migrant and refugee women should include culturally accessible antenatal and postnatal care, emergency obstetric care, family planning, sexually transmissible infection prevention and treatment, and strategies for addressing gender-based violence. Culturally appropriate sexual and reproductive health education should be provided to empower women and girls and improve health outcomes.

Promoting continuity of care

Continuity of health care for migrants and refugees requires government policy and resource allocation beyond the provision of emergency and short-term care. It requires developing integrated health systems that address the full range of emergency, preventive, curative, rehabilitative and palliative health care needs, and ensuring that migrants and refugees are eligible to access the full range of services. Sustainability can be enhanced through developing culturally responsive mainstream services that are able to address both the needs of migrants and refugees as well as the general population. Coordination between governments, non-government organizations and other agencies is required in delivering health services to migrants and refugees.

Promoting gender equality and empowering women and girls

Government policies, legal standards and local programmes can address the inequality, disempowerment and limited access to health services that migrant and refugee women and girls can experience in forced displacement and migration settings.

At the societal level, gender mainstreaming which recognizes that gender equality is not simply a female issue and can only be achieved through partnership between women and men can be applied to national institutions, policies and programmes. Capacity building programmes for women migrants and refugees, and strategies for strengthening women's participation and leadership can be adapted for different cultures and local contexts. Evaluation and accountability processes are essential to success.

Improving communication and countering xenophobia

Strong political leadership with a commitment to universal human rights and non-discrimination is required for improving communication and countering xenophobia. Member States should work to strengthen policies, legislation and legal frameworks to address xenophobia, and use media to affirm human rights, dismantle fears and counter negative stereotypes. Local activities can include training professionals and community members in delivering education and counselling for the victims and perpetrators of xenophobia, with monitoring and evaluation to ensure health and social inequalities are addressed.

Strengthening partnerships, coordination and collaboration

Addressing migrant and refugee health issues requires international collaboration between governments, non-government agencies and civil society. Partnership, coordination and collaboration can be promoted through formal agreements and clear governance arrangements for migrant and refugee issues; strong leadership and central coordination functions; stakeholder and community engagement; clear communication, respectful dialogue and trust building; collaborative decision making; and regional coordination, cross-border collaboration and information sharing.

Conclusions

Addressing the health needs of refugees and migrants is a complex task requiring multiple, intersecting approaches. It requires a commitment to human rights and equality, consistently applied health access policies, culturally responsive health programmes and services, integrated prevention and treatment approaches, strategies for addressing the social determinants of health, health information systems for monitoring migrant population needs, and strong collaboration between Member States.

The findings of this rapid review of English language literature and reports can be used to inform policies, interventions and practices for addressing the health needs of refugees and migrants, including the development of the Global Compact on Refugees, the Global Compact for Safe, Orderly and Regular Migration, and the Draft Global Action Plan to Promote the Health of Refugees and Migrants. It should be supplemented by additional systematic reviews of literature and reports, and by consultations with migrant and refugee communities, technical experts, stakeholder organizations, Member States, WHO region offices, WHO departments and UN agencies.

I. Introduction

In a world experiencing increasing migration, addressing the health needs of migrants and refugees is imperative for eliminating poverty and inequality. Many migrants cross borders in search of better economic and social opportunities, while others are forced to flee crises as refugees. Their differing migration experiences and varying degrees of access to health care through countries of origin, transit and resettlement can profoundly affect their health. Member States of the United Nations have an obligation to uphold the right to health of all and to provide appropriate policies, programmes and services to address their health needs.

Global migration context

The global migration context shows an increasing trend in migration and displacement due to conflict, persecution, environmental degradation and change, and a profound lack of human security and opportunity (11).

In 2017, 258 million people (approximately 1 in every 30) lived outside their country of origin. This was an increase of almost 50 per cent since the year 2000. Major increases occurred across Asia, Europe and Northern America regions (as defined in the UN International Migration report, 2017), with most international migration taking place between countries in the same region (5).

In 2017, Asia was the region of origin of the largest number of international migrants at an estimated 106 million, followed by Europe (61 million), Latin America and the Caribbean (38 million), Africa (36 million), Northern America (4 million) and Oceania (2 million). Major countries of origin included India (16.6 million), Mexico (13.0 million), the Russian Federation (10.6 million), China (10.0 million), Bangladesh (7.5 million), the Syrian Arab Republic (6.9 million) and Pakistan (6.0 million) (5).

In 2017, Asia hosted the largest number of international migrants (80 million), followed by Europe (78 million), Northern America (58 million), Africa (25 million), Latin America and the Caribbean (10 million) and Oceania (8 million). Major host countries included the United States (49.8 million), Saudi Arabia (12.2 million), Germany (12.2 million), the Russian Federation (11.7 million), the United Kingdom (8.8 million), the United Arab Emirates (8.3 million), France (7.9 million), Canada (7.9 million) and Australia (7.0 million) (5).

The global number of refugees and asylum seekers increased to approximately 26 million people (approximately 1 in every 10 migrants, and approximately 1 in every 300 people across the globe) in 2017. Asia hosted the largest refugee population (14.7 million), followed by Africa (6.3 million), Europe (3.5 million), Northern America (970,000), Latin America and the Caribbean (420,000) and Oceania (70,000). The largest numbers were people who had fled from conflict in Syria and related crises to Turkey (3.1 million), Jordan (2.9 million) the State of Palestine (2.2 million) and Lebanon (1.6 million). Large numbers were also found in Pakistan (1.4 million), Germany (1.3 million) and Uganda (1.2 million) (5).

Global migrant and refugee health frameworks

International migration is a complex phenomenon involving social, cultural, economic and geopolitical dimensions and requiring renewed public policy responses (11). In 2015, the global importance of coherent and comprehensive responses to address the needs of migrants and refugees in countries of origin, transit and destination was recognized in the 2030 Agenda for Sustainable Development (7). As part of efforts to end all forms of poverty and fight inequalities, including those related to health,

Governments pledged to “facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies” (Goal 10.7) (5, 7).

In 2016, the General Assembly adopted the New York Declaration for Refugees and Migrants, including commitments of Member States to protect the human rights of all refugees and migrants; support countries rescuing, receiving and hosting large numbers of refugees and migrants; strengthen the contributions made by migrants to economic and social development of host countries; and strengthen the global governance of migration (9). The Declaration called for the development of the Global Compact on Refugees to be prepared under the auspices of the United Nations refugee agency (UNHCR), and the Global Compact for Safe, Orderly and Regular Migration to be negotiated by the General Assembly (5, 9).

In May 2017, the Seventieth World Health Assembly (WHA) endorsed resolution WHA70.15 on “Promoting the health of refugees and migrants” (8). The resolution urged Member States to strengthen international cooperation on the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants (9); to consider providing necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants; and to consider promoting the WHO framework of priorities and guiding principles to promote the health of refugees and migrants (10). The resolution also urged Member States and requested the WHO to identify and collect evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants. This is to inform the development of the two Global Compacts in 2018 and the development of a Draft Global Action Plan to Promote the Health of Refugees and Migrants to be considered for adoption at the Seventy-Second World Health Assembly in 2019.

Global migrant and refugee health challenges

While migration can deliver economic benefits for individuals, families and host countries (11), large or rapid changes in the number, distribution and demographics of migrants and refugees across the globe can create new and increasing challenges for national health systems. The WHO framework of priorities and guiding principles to promote the health of refugees and migrants outlines priority areas for collecting evidence-based information, best practices and lessons learned and for addressing these challenges (10).

On the global level, the right to health for refugees and migrants is recognized in the international framework of human rights elaborated by the Member States of the UN, and is upheld by international human rights law, national constitutions and legislation. However, the right to health for refugees and migrants is at times violated through the inconsistent application of human rights law and discrimination within countries (see Section 4.1, Promoting the right to health).

Equitable, acceptable and affordable access to health care for migrants and refugees can be hindered by practical barriers such as limited service availability, cultural differences and cost. The legal status of migrants and refugees within countries can further affect their eligibility to access health services (see Section 4.2, Promoting access to health services) and Universal Health Coverage through financial protection mechanisms (see Section Promoting Universal Health Coverage). Continuity of health care can be disrupted by a combination of these factors experienced through the migration journey, resulting in acute and chronic health conditions not being adequately addressed or followed up (see Section 4.8, Promoting continuity of care).

Migrant and refugee populations can experience a higher burden of communicable diseases, chronic diseases and mental illness compared to non-migrant populations requiring the provision of emergency

and targeted health programmes (see Section 4.6, Reducing mortality and morbidity through public health interventions). Women and girls may experience limited access to necessary sexual and reproductive health services (see Section 4.7, Protecting and improving the health and well-being of women) and may experience gender inequality and disempowerment in migration and forced displacement settings (see Section 4.9, Promoting gender equality and empower refugee and migrant women and girls).

The health of migrants and refugees is further affected by the social and economic conditions in which they live in countries of origin, transit and settlement. They may experience poverty, food insecurity, limited access to safe drinking-water and sanitation, and limited opportunities for education and employment, further exacerbating health issues (see Section 4.3, Addressing the social determinants of health). This can be compounded in settlement countries by fears of foreigners eroding national identity, culture and political systems, resulting in anti-migrant sentiment and policies and further discrimination (see Section 4.10, Improving communication and countering xenophobia).

Addressing these complex issues requires international and national government and non-government agencies and communities working in collaboration and partnership. Competing priorities and approaches, unclear governance arrangements, unequal decision-making powers, and reluctance to share limited resources can make progress challenging (see Section 4.11, Strengthening partnerships, coordination and collaboration).

Migrant and refugee health information and monitoring systems are required to identify population and individual health needs, monitor health service implementation and utilization, and measure health outcomes. Improved cross-border and national systems are required to inform migration policy, design health programmes, contain public health expenditure and ensure the right to health for all is upheld (see Section 4.4, Strengthening health monitoring and health information systems).

2. Aims

This report aims to collect and analyze evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants. The report is intended to inform Member State responses; the development of the Global Compact on Refugees, and the Global Compact for Safe, Orderly and Regular Migration; and the Draft Global Action Plan to Promote the Health of Refugees and Migrants.

3. Rapid review methods

The research team conducted a series of rapid reviews of English language, peer-reviewed literature and reports from 1 January to 31 March 2018. The research questions were developed in consultation with the WHO and were based on 11 the 12 priority topics of the WHO framework of priorities and guiding principles to promote the health of refugees and migrants (10).

Data sources included electronic, peer-reviewed literature databases Ovid Medline, Scopus, Global Health and Public Health Information Service (PAIS) Index. Web searches were conducted using Google Scholar and Google Search to further identify relevant peer-reviewed literature and reports. Relevant UN and related websites including WHO and International Organization for Migration (IOM) were consulted (see Annex 8). Relevant reports and documents provided by the WHO were also reviewed.

Key word searches were constructed around population description variations of “refugee”, “asylum seeker” and “migrant”, and topic research questions. Key words were matched to subject headings where possible. A full list of key words for each topic is in Annex 9.

The literature included peer reviewed, English language papers and reports published from 1998 to 2017 inclusive. For each topic, literature from each database were combined and duplicates removed. Titles were screened and excluded where not relevant to the population, priority topics or research questions, or where full text papers or reports were not available. Full-text articles were further reviewed for evidence-based policies, interventions and practices for addressing the health needs of refugees and migrants. The numbers of papers reviewed for each topic are in Annex 9.

The analysis for each priority topics includes context, findings and implications. The context provides background information about each priority area to illustrate the range of issues relevant to understanding the problems in the context in which they occur. The findings section outlines the evidence found by the rapid review search including public health policies, interventions and practices implemented to address the health needs of refugees and migrants. The implications section condenses some of the lessons that can be learned from the literature. Where evidence is strong, the implications can be clear and confidently articulated. In many places the evidence base is weak and therefore the implications must be proposed cautiously.

It is important to note this rapid review did not include a comprehensive review of all sources of English language literature and did not examine non-English language literature. It did not involve expert consultations. (See Section 5, Limitations of the literature).

4. Rapid review findings

4.1. Promoting the right to health

What are the current frameworks (e.g. constitutions, standards, resolutions, conventions, global and regional initiatives) that promote the right to health of refugees and migrants, and how do countries implement them in national health planning?

Context

The right to health

The right to health for refugees and migrants is promoted through the internationally recognized framework of human rights elaborated over the past decades by UN Member States. The framework brings together a comprehensive set of binding human rights and related instruments together with non-binding standards of best practices and principles (12) (Annex 1). These rights are further affirmed by the United Nations High Commissioner for Refugees (UNHCR) Convention Relating to the Status of Refugees (13), and the “Report of the UN High Commissioner for Human Rights to the Human Rights Council on Principles and practical guidance on the protection of the human rights of migrants in vulnerable situations” (14).

The right to health is recognized in the inherent dignity of the equal and inalienable rights of all members of the human family in the Universal Declaration of Human Rights. Article 25 of the declaration states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family” (6). It is also affirmed in the WHO Constitution which affirms “the highest attainable standard of health is one of the fundamental rights of every human being” (3, 15).

The provision of the International Covenant on Economic, Social and Cultural Rights (ICESCR) clearly expresses that the right to health obligates governments to ensure that “health facilities, goods and services are accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds” (16). States must make sure that health facilities, goods and services are available, accessible, acceptable, of good quality and applicable to all sectors of the population, including migrants (17). (see Section 4.2, Promoting access to health services).

The UN Committee on Economic, Social and Cultural Rights acknowledges that the right to health must be interpreted broadly to also embrace key socio-economic factors that promote conditions in which people can lead a healthy life. These underlying determinants of health include “food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment” (18).

The full realization of the right to health further includes respect for and fulfilment of several other rights in parallel, such as the right to an adequate standard of living, the right to work and the freedom of expression (17).

International human rights and migration frameworks

International human rights law provides that all persons must have access to all fundamental human rights provided in the International Bill of Human Rights. Migrants are therefore protected by international human rights law regardless of their migration status (17).

The International Covenant on Economic, Social and Cultural Rights affirms that States cannot limit the enjoyment of any human right or discriminate against non-nationals on the grounds of “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (19). In the setting of international migration, the entry into and exit from a sovereign territory is intimately related to legal and sociological notions of nationality and sovereignty. However, the UN Committee on Economic, Social and Cultural Rights (CESCR), which is the UN treaty body monitoring the implementation of the ICESCR, has articulated that nationality must not be used as a ground for discrimination in relation to health care and other rights (20).

More broadly, the international normative framework on international migration supports the right to health for all refugees and migrants. It includes treaties, conventions and instruments pertaining to the human rights of migrants, the rights of migrant workers and the protection of refugees, as well as instruments designed to combat migrant smuggling and human trafficking (9, 12) (Annex 1). As of September 2017, 37 Member States had ratified all five core legal instruments, while 13 Member States had ratified none (21).

UN Member States reaffirmed the human rights of all refugees and migrants in the New York Declaration for Refugees and Migrants adopted by the UN General Assembly in 2016. The declaration sets out principles and recommendations applying to both refugees and migrants, including addressing basic health needs and access to health care for these populations. Its annexes pave the way towards the development and adoption of the Global Compact on Refugees, and the Global Compact on Safe, Orderly and Regular Migration, in 2018 (9).

Limited application

Despite international human rights conventions, instruments, and standards to protect the right to health of migrants and refugees, these populations can lack access to health services and financial protection for health. They can also experience considerable delays in access to treatment (10).

Limitations in the right to health for refugees and migrants may be related to their legal status within those countries (15, 22). Some States have declared before international human rights bodies or in national legislation that they cannot or do not wish to provide the same level of rights to migrants as to their own citizens. Some countries have limited their health obligations towards non-citizens in terms of “essential care” or “emergency health care” only. These laws and limited practices may be discriminatory (22).

Findings: implementing frameworks that promote the right to health

Multinational, regional human rights approaches

The European Union (EU) provides an example of a multinational, regional approach to upholding the right to health. All EU member states have formally recognized the right of everyone to achieve the highest attainable standard of physical and mental health. This right is enshrined in European legal

instruments including the European Convention on Human Rights and Fundamental Freedoms, and the Lisbon Treaty, by which European countries have agreed to be bound (23). All EU member states are also members of the UN and have acceded to most of its core international human rights treaties including the ICESCR. The European Court of Human Rights rules on alleged violations of the European Convention for the Protection of Human Rights and Fundamental Freedoms at the EU level.

The Pan American Health Organization (PAHO) provides an example of regional leadership in realising a rights-based approach to health across the Americas (24). As an organization of Member States, it mainstreams the rights-based approach in its policies and programmes and promotes human rights through regional health governance. The leadership shown by the organisation has helped to afford legitimacy to efforts to mainstream human rights, and to overcome resistance in international relations for implementation. The collaborative development and sharing of technical and legal expertise has assisted governments to build capacity in human rights policy and legislation, strengthen national health systems, and improve determinants of health and health outcomes. Collaboration with the inter-American human rights system has improved accountability for human rights implementation.

National human rights approaches

National constitutions and legislation

Individual Member States assume obligations under international law to respect, protect and fulfil human rights where international treaties, conventions and instruments are adopted (17). This is applied through national policies, legislation and regulation, and through organizational structures that regulate and shape how states act in response to international migration, addressing rights and responsibilities and promoting international cooperation (12). States are obliged to monitor the effects of their policies and actions to ensure they do not allow inequalities in the enjoyment of human rights. They are compelled to collect and analyse data on the realization of the right to health, with indicators that recognize the diversity of population groups without discrimination (17).

Human rights are expressed and guaranteed in national constitutions and legislation in many countries (25). For example, in many EU member states there are legal provisions at the national, regional, and local levels that are relevant to the right of migrants to health. The constitutions of Belgium, Hungary, Italy, the Netherlands, Portugal and Spain recognize the right to health of everyone living in their territories. In countries whose constitution or legislation does not specifically recognize the right to health, elementary health care issues may be derived from more general human rights provisions, such as in Germany (23).

In Italy, under Article 34 of the National Migration Act of 1998, foreigners have the obligation to register with the National Health Care Service, after which they are granted equal treatment and have the same rights and duties as any Italian citizen. Health assistance is also granted to dependent minors living in Italy, regardless of legal status. Children of foreigners registered with the National Health Care Service are entitled from birth to the same treatment conferred on any minor of Italian nationality. Irregular migrants are entitled to urgent outpatient and hospital treatment or any other basic urgent treatments, including long hospitalizations and preventive medicine. Preventive, necessary and urgent treatments are expressly defined by law (23).

In Switzerland the right to health is enshrined in the Swiss Federal Constitution. The State has a duty to protect and promote the health of its population and to provide support in situations of distress. Discrimination is prohibited on the bases of origin, race, language, way of life, religious, philosophical or political beliefs. The constitution is supported by national laws, regulations and policies. The Federal Law on Health Insurance obliges every person who lives in Switzerland for more than 3 months to have his or her own health insurance, and for health insurance companies to accept all requests for enrolment irrespective of residence status. The Asylum Act directs subnational cantons to grant

financial social aid for the daily needs and housing of asylum seekers awaiting decision of their asylum applications. Public law obliges public hospitals to provide health care to all people (26).

Consistency of service eligibility

While numerous countries around the world have adopted and ratified international human rights treaties that include right of access to health care services, there are varying degrees of eligibility for irregular migrants to health care services (including emergency care) and subsidized health care (27-30). Differences appear related to migration control practices, the types of irregular migrants present and basic welfare norms (31). The articulation or exclusion of types of migrants in legislation results in differences in health care entitlement (32).

National laws, regulations and policies are at times interpreted and applied differently in sub-national regions resulting in further differences in health care entitlements. Consistent definitions, interpretations and application are required at national and subnational levels to consistently uphold the right to health (26). Sub-national legislative differences may allow for the supporting of rights where they are not supported at the national level (33). The right to health may also be upheld directly by health programmes, services or providers (34, 35), or by non-government organisations (36).

In Belgium, the Ministry of Public Health commissioned the ETnicity & HEALTH (ETHEALTH) group to formulate relevant recommendations to the public authorities within the country with a view to reducing health inequalities among ethnic minorities including both irregular migrants and migrants. The recommendations supported the need to combine universal approaches to health care with more specific approaches. Approaches included health care as well as prevention, health promotion and access to health care. Political commitment of executive agencies was identified as a requirement (37).

Mechanisms for protecting rights

National government reviews of policies, budgets or public expenditure, and monitoring mechanisms are important for holding the government to account in relation to its obligations towards the right to health. Political mechanisms, such as democratic processes, and the monitoring and advocacy performed by non-government organizations (NGOs) can further contribute to human rights accountability (22).

Judicial mechanisms within national legal systems are crucial for domestic enforcement and the provision of remedies to individuals if their right to health is violated. The incorporation into domestic laws of international instruments recognizing the right to health can significantly strengthen the scope and effectiveness of these measures. For example, courts in Argentina have referred to the nation's ratification of the International Covenant on Economic, Social and Cultural Rights and other treaties to reaffirm the constitutional status of the right to health. The courts have previously ordered the State to ensure an uninterrupted supply of medicines to persons with HIV/AIDS, to ensure the manufacturing of vaccines against an endemic disease, and to prevent the exclusion from and termination of health coverage for some groups (22).

National human rights institutions such as human rights commissions and ombudsmen are important domestic mechanisms promoting and protecting human rights. They can ensure the ratification and implementation of international human rights treaties, advise governments on policy or legislative changes, handle complaints, carry out investigations, and provide training and public education. For example, the National Human Rights Commission of India has protected and promoted the right to health guaranteed by India's Constitution and international treaties. The commission has advocated for upgrading health-care facilities, the availability of essential drugs at primary health centres, and for regular immunization programmes to contain childhood diseases at the earliest opportunity (22).

Other approaches

Beyond formal human rights frameworks and institutions, political stability and good governance are also required for valuing, promoting and protecting human rights (38). Health services can establish internal or independent systems to receive complaints or suggestions to offer redress to human rights violations (22). At the community level, human development opportunities, rights education, community cohesion and fostering community responsibility further facilitate the right to health (38).

International human rights monitoring

Implementation of the UN's core human rights treaties is monitored by UN committees (treaty bodies) composed of independent experts. The committees examine regular reports from Member States and other relevant information regarding their compliance with treaty provisions and national implementation. The treaty bodies issue observations in the form of constructive dialogue which details positive aspects, concerns and recommendations for further action. Implementation of the right to health has principally been considered by the Committee on the Elimination of Racial Discrimination, the Committee on Economic, Social and Cultural Rights, the Committee on the Elimination of Discrimination against Women, and the Committee on the Rights of the Child. The Committee against Torture has focused on access to health for persons in detention, including those in psychiatric institutions, and rehabilitation for victims of torture and sexual violence (22).

Additional complaint mechanisms are provided by the Human Rights Committee, the Committee against Torture, the Committee on the Elimination of Racial Discrimination, the Committee on the Elimination of Discrimination against Women, the Committee on Migrant Workers, the Committee on the Rights of Persons with Disabilities, and the Committee on Enforced Disappearances. Where domestic remedies are exhausted, persons claiming to be victims of human rights violations may submit a complaint to the relevant treaty body, which will then issue its findings and recommendations to the State party concerned (22).

Implications

Promoting a human rights approach to migration

The United Nations High Commissioner for Human Rights has recommended that Member States and other stakeholders “recognize that all persons in the context of large movements are rights holders and commit to full protection of their human rights and fundamental freedoms, regardless of status or other circumstance” (39). Efforts should be firmly based in international human rights law and other relevant normative standards. The Office of the High Commissioner for Human Rights has provided clear principles and practical guidance on the protection of the human rights of migrants in vulnerable situations (14) (Annex 2) and further recommends the development of the global compact on safe, regular and orderly migration should include actions to ensure human rights-based governance of migration, and ensure that all relevant stakeholders, including OHCHR, the United Nations human rights mechanisms and civil society, including migrants' groups, are fully involved (39).

States should ratify and implement all relevant international instruments related to international migration, and respect, protect and fulfil the human rights of all migrants, regardless of their legal status (12). States should consider strengthening constitutional, legislative, policy, judicial and institutional mechanisms for protecting the right to health for refugees and migrants, including upholding the right to access health services, and addressing discrimination and exclusionary processes (40). Immigration law and law enforcement should be supportive of these rights. Multinational, regional collaborations can be developed to strengthen national approaches (23, 24).

Coherent and consistent implementation

At the national level, it is important to promote coherence among the policies of the various sectors beyond health that may affect the ability of refugees and migrants to access health services. This may involve ministries of finance, interior, foreign affairs and immigration (40).

Within States the right to health should be upheld consistently. National laws, regulations and policies should be consistently defined, interpreted and applied at national and subnational levels to ensure equitable delivery of health care entitlements to refugees and migrants. Regional governments, health programmes, services and non-government organisations should align with promoting these rights. The capacity of health care providers to protect the right to health can be enhanced to identify and address local barriers to health service access. Migrants and refugees can be empowered through community development, rights education and fostering community responsibility to further facilitate the realisation of the right to health.

Enhanced cooperation on migration and mobility is required at the national, bilateral, regional and global levels as no country can manage international migration alone. Cooperation requires the involvement of all stakeholders, including governments, the private sector, employer and worker organizations, civil society and the research community. The United Nations can play a key role in facilitating Member State cooperation to respond to the opportunities and challenges of migration through a rights-based approach (12).

Technical support and evaluation

To foster informed policy making, technical knowledge and implementation, the WHO European Region Office has undertaken to develop regional guidance, evidence, models, standards and good practices; provide technical support to review and amend health policies and plans to apply human rights-based approaches; support national and intercountry monitoring and reporting mechanisms; monitor the implementation of relevant national policies, legislation and regulation and respond to the health needs of refugees, asylum seekers and migrants. Similar technical support could be of benefit to Member States in other WHO regions (40).

The Committee on Economic, Social and Cultural Rights (OHCHR) has underlined that States should set indicators and benchmarks to monitor national strategies and measure realisation of the enjoyment of the right to health. The Office of the High Commission for Human Rights (UN) (OHCHR) has been developing a conceptual and methodological framework. The framework includes acceptance of international human rights standards (structural indicators); efforts to meet the obligations that flow from these standards (process indicators); and the results of those efforts from the perspective of the population (outcome indicators). It is important that indicators are disaggregated by relevant population groups to monitor for possible discrimination (22).

Limitations

Within the English language health literature databases, the peer-reviewed literature on the right to health for migrants and refugees mostly referred to only English speaking and European countries, with very little literature from non-English speaking countries. The available literature focused on describing national and sub-national approaches. There were a small number of comparative studies between European national policies and very few broader international comparisons.

Many papers articulated the general implications of international human rights law and national policies on the right to health and access to health services, but few were able to measure the direct impact of human rights policies and violations on migrant and refugee health outcomes.

The limitations of the literature suggest that a systematic review on the right to health for migrants and refugees including papers in languages other than English may be useful. Further research measuring the impact of human rights policies and policy changes on the health outcomes of migrants and refugees may be beneficial for demonstrating their effectiveness. (See Section 5, Limitations of the literature).

4.2. Promoting access to health services

What is the evidence on promoting refugee- and migrant-sensitive health policies and legal and social protections to improve access to health services and programs for refugees and migrants?

Context

The human rights approach: rights and access

The right to health is defined by the UN Committee on Economic, Social and Cultural Rights in its comments on implementing International Covenant on Economic, Social and Cultural Rights as “being able to receive care which is available, accessible, acceptable and of good quality”. Accessibility is further broken down into four dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility. Accessibility is therefore understood as an essential component of the right to health (41, 42).

Although the ideals outlined in human rights frameworks (31) (see Section 4.1, Promoting the right to health) imply a standard approach to migrant and refugee entitlement to health care, these entitlements vary depending on the national context. The tension between international obligations and conflicting national legislation across health and immigration is evident in the formal and informal barriers to accessing health care for refugees and migrants. “Some international treaties specify that health care is a right independent of the lawfulness of a person's situation of stay (see, for instance, Article 35 of the Charter of Fundamental Rights of the European Union)” (43). However, each nation-state develops its own approach to the right of the individual to health care and most approach the provision of health services through a tiered system, where health care is more accessible to some people than others. Key contextual factors that may influence accessibility include legal systems and political context, and informal barriers to access.

Legal context

Legal status is one of the most significant factors determining access to affordable and adequate health services for migrants and refugees (44). The literature distinguished between three groups: migrants and refugees with residency status, asylum seekers and irregular migrants.

Migrants and refugees with residency status

Globally, 37 countries accept refugees for resettlement under the UNHCR resettlement programme (45). However, entitlements to social benefits and health care vary among these countries. Although migrants and refugees with residency status are entitled to the same access rights as the nationals in countries of settlement, they face significant barriers in accessing health care. Key barriers pertain to policy, service structure, mode of service delivery, location, the financial attributes of the services and cost, communication and culture and health literacy. Sub-groups within this population who face additional barriers include minors, women, elderly and the disabled (46).

Asylum seekers

Access rights for asylum seekers varies depending on the context. For example, there were changes to the Australian policy for protection in the 1990s restricting access to health care for asylum seekers depending on visa type. Complexities in visa types leads to confusion among refugees and asylum seekers, health providers and community workers alike. For example, comparison of health policies in the UK, Canada, and New Zealand indicated that asylum seekers in Australia have the most restricted/limited access to basic health care (42).

Irregular migrants

Barriers for refugees and migrants accessing health care have been well documented internationally, at times contravening both local laws and international resolutions. In particular, irregular migrants are at the greatest risk of disadvantage, including difficulties in accessing required care (47-49). In some contexts, there is “no viable health care option for undocumented immigrants of low socioeconomic status” (50). Known as “undocumented”, “irregular” or “illegal”, with the latter term discouraged due to stigmatization, irregular migrants are defined differently by different legal frameworks across Europe but generally considered to be “people who enter a country without the necessary documents and permits” (44, 51). The varying definitions of migrant categories in legislation and policy results in differences in health service and programme eligibility and access. This also differs widely between different countries and even within some countries.

Irregular migrants are considered the most excluded from access to health care. In the majority of countries they can only access health care if they can cover the full cost, except for emergency care which is free of charge (52). (See Section 4.5, Promoting Universal Health Coverage).

Access to health care for irregular migrants is determined on the legal entitlements recognized by the host country, the administrative conditions required, and the existence of active policies seeking to improve access for the population to mainstream health services (12). Access is hampered by and is directly linked to the arguments against illegal immigration and the recent development of detention and deportation of irregular migrants. “In this context, no room has been left for debate on the question of rights (including health care) of undocumented migrants” (6). Under these circumstances, the legal system, migration and asylum history and geographical location have taken precedence over humanitarian and human rights considerations.

There is great variation in how the health needs of irregular migrants are addressed in the USA and in different European countries. Services vary between countries according to: subcategories of irregular migrants, for example children and pregnant women; types of services, such as prevention or treatment of infectious disease; and types of funding arrangements. Even with supportive policies in place, irregular migrants face legal, bureaucratic, language and cultural barriers to care (53, 54).

There is also great diversity in access rights to health services across member states of the EU. Variations in access can be broadly divided into three clusters: where they have access to health care that is more extensive than emergency care; where they can only access emergency care; and where not even emergency care can be accessed (49, 55). The Health Access to Migrants (HUMA) network provides a more detailed description of entitlements for various groups in EU countries (56).

Coverage for only emergency care ignores the importance of access to prevention, primary care and early intervention, and forces people to wait until diseases are advanced and more complex to treat. Gaps also exist in the safety net related to effective management of chronic illness and the treatment and management of life threatening conditions.

Policy context

Different countries have, not only, different approaches to migrant and refugee health policy and variations in access but there are also differences in how long countries have had a focus on migrant access to health care. “In the Netherlands, for example, migrant health has been the subject of sustained and systematic attention since 2000, while Italy has been setting migrant-related health policy targets since the 1990s. In 2008 Spain, on the other hand, started to include migrant health and health-care issues in national and regional plans for the integration of immigrants” (57). By 2009 only 11 countries in Europe had established national policies to improve migrant health, beyond their statutory or legal entitlement to care (55). “Access to health care by undocumented migrants, and to a lesser extent by asylum seekers, is not guaranteed in the EU. The standards set by the main international treaties are far from being respected and member states instead of working on the “progressive realisation” of this right, are increasingly using it as a tool to discourage the entry of new migrants (56).

Across Europe, the formal barriers to accessing health care vary greatly. Forced reporting of irregular migrants is an example of this variation. Some countries require health care providers to report irregular migrants, and some take legal action against health care providers who provide care to irregular migrants. On the contrary, other countries forbid health care providers to report irregular migrants (44, 58). Sometimes care is restricted at the point of service, and at others restricted through necessary payment for services (59).

In another context, Ecuador, the Latin American country which receives the largest number of refugees, recently announced “their new internationally acclaimed law on human mobility.” In this law migrants, refugees and asylum seekers can access the National System of Public Health Care in a non-discriminatory and undifferentiated fashion.” (60).

National policies addressing access to health care change often. For example, in one country irregular migrants and failed asylum-seekers (and their children) were excluded since 2004 from free hospital treatment and diagnosis, including secondary care, nonurgent treatment, antenatal and postnatal care, medicines, and antiretroviral treatment. Charges for health care were extended in 2015 to some accident and emergency and some primary care, dentistry, ophthalmology, and community pharmacy prescription medicines, with only GP consultations remaining cost-free (43). Other countries have changed policies over time to become more inclusive for irregular migrants.

Service availability and barriers

There are many informal barriers and they are internationally reported with some consistency. These include language barriers, poor doctor-patient relationships, and the lack of cultural competency of health workers (61). Informal barriers that contribute to poor access have a variety of consequences. They may prevent refugees, asylum seekers and other migrants “from being or feeling entitled” to access the health care that they are entitled to (44, 58) and may result in unsafe and alternative health care seeking (62). Even when they are entitled to services, there are barriers due to fear of being denounced, lack of personal information, or the high costs of medical care which they cannot afford (56).

Findings: policies and interventions that improve access

Despite identified access barriers, there are measures that can substantially improve access to care for migrants (53). Universal Health Coverage and financial protections will be considered separately (see Section 4.5, Promoting Universal Health Coverage).

Equitable and consistent policies

The development of equitable health service access policies can result in better health outcomes. In Belgium, the ETHEALTH (Ethnicity and Health) expert group was commissioned by the Ministry of Public Health to formulate recommendations to reduce health inequalities among ethnic minorities and provides a proof of concept for a successful strategy for the development of policy in this area (see Annex 3) (37).

Changing policies, particularly in a decentralised policy setting, can have negative effects of refugee and migrant access to health care. Differences across countries or regions in access to care or nationwide changes to policy, particularly changes to eligibility requirements, can be extreme and can cause confusion for all involved (33).

Changes to policy can lead to problems related to access, but the attitude of the population toward refugees can also impact on the implementation of policy changes. Policy change itself may not have a great effect on the level of coverage provided to asylum seekers, but the negative representations encountered in the host country can result in reduced access (63). That is, in one study, the attitude of the host country had an impact on access levels of asylum seekers. Negative public discourses can have deleterious effects on discrimination and therefore access to health care (64).

Collaboration and community responsiveness

While structural barriers must be addressed at the highest government levels, other barriers can be overcome at the local level and through collaboration and community engagement (see Section 4.11, Strengthening partnerships, coordination and collaboration). At this level, care must be taken to not only frame the policy to deliver access rights, but consistent planning must be undertaken to ensure implementation at the local level. For example, state-based health care policies are often based on the principle that health care is a right by law but limited planning can mean that implementation or the delivery of required resources and evaluation were not easily accomplished (65).

The 2017 Policy on ethnicity and health of the WHO Region of the Americas describes sociocultural approaches to improve health. The Policy acknowledges an “intercultural approach” that involves “collaboration between human resources for health and the community, the family, and social leaders” (64).

In the UK context collaboration between the Department of Health and the Refugee Council led to the development of a resource pack “for use by all frontline staff in contact with people seeking asylum.” This publication assists with health care access thorough education for health care professionals who may have otherwise been unfamiliar with this part of the system. (66). In general, training can be given to providers to better care for immigrant populations (55).

Practical interventions proven to assist services in overcoming access barriers faced by migrants include: 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 (67). Policies that support the provision of practical mechanisms to assist patients to register, make appointments and attend services could alleviate some of the barriers in accessing care (68).

Community based participatory approaches and strong social networks can improve access to health care, especially for asylum seekers (69). An integrated approach with dedicated refugee health clinics and refugee health staff can also improve access. A Canadian partnership was formed between a dedicated health clinic for government assisted refugees, a local reception centre and community providers on wait times and referrals. The before and after, repeated survey study found that wait times decreased by 30% with the introduction of a dedicated refugee health clinic (70). This kind of “integrated community based primary health care intervention that includes dedicated health system navigators” may “support timely, more culturally appropriate care and successful integration.” Similarly, the provision of an Asylum Seeker nurse was a facilitator to accessing primary medical care (71). Educating immigrant populations is also required (61).

Implications

Several policies, legal frameworks and social protections have been identified which may improve access to health care for migrants, refugees, and asylum seekers.

Develop equitable and consistent access policies

Health service access policies for migrants and refugees need to be equitably and consistently applied at sub-national levels. Clarifying legal ambiguities and regulating, designing and adopting national policy directives can solve problems that occur with unclear or incoherent policies that have been found to contribute to inadequate services and treatment delays (58, 72). Centralisation helps to protect access consistently, whereas decentralisation can result in inconsistent and different approaches within countries (33, 65, 73).

Health professionals and service providers can be provided with training to better understand service eligibility and access policies to assist this population in receiving better access to health care.

Collaborative policy development and implementation

It is clear from the literature that successful initiatives often involve collaboration between health services and other groups, such as refugee councils or patient advocates. These collaborations can produce frameworks or documents that can be used to both assist policymakers to frame policy as well as inform frontline health workers and contribute to training for clinicians and office staff. Community engagement and integrated approaches should be considered. Vertical collaboration between national health services, social services and local service providers should also be explored for use in appropriate settings. Solid, collaborative planning, alongside committed policy makers can ensure consistent implementation of recommendations (37). (see Section 4.11, Strengthening partnerships, coordination and collaboration).

Health system strengthening and capacity building

To achieve equitable access, broader health system development needs to be considered (64). This includes strong national leadership, sub-national governance and adequate health system funding to support policy implementation at the service level. Health workforce development can include cultural competence training for providers; the use of interpreters, translated information and cultural mediators; and addressing stigma and discrimination.

UNHCR provides operational guidelines and strategies to meet the health needs of urban refugees: these include strategies to achieve access, integration into the public health system, equity, prioritisation, rationalisation, partnerships, participation, communication, and evidence-based decision making (74).

Limitations

This rapid review does not include literature on all aspects of policies that improve access and programmes for refugee and migrant health. Some areas that are not included involve literature on health care utilisation and health status. Also, studies that involve specific diseases (such as HIV, TB, sexual health, mental health and substance use) were not reviewed. Literature related to education, patient experience or patient satisfaction were excluded unless they were specific to refugees and migrants and involved a direct analysis of access to services. There was a large body of literature on access to health care for disadvantaged groups generally, however this was excluded as they were also not specific to refugees and migrants. Finally, literature that was specifically about women or children were excluded as they are covered in other sections of this report or are deemed not to be included in the topics for this report. (See Section 5, Limitations of the literature).

4.3. Addressing the social determinants of health

What is the evidence on policies and interventions that improve social determinants of health for refugees and migrants?

Context

According to the WHO, social conditions are the single most important determinant of good health or ill health. The WHO has described social determinants as “the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness” (75).

The social determinates of health are well explained by the Universal Declaration of Human Rights which acknowledges that:

“everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (76).

The Commission on Social Determinants of Health has called on Member States to address the social determinants of health to reduce health inequities (77). The need to address them for improved health outcomes is paramount in achieving the Sustainable Development Goals (SDG's) (78). Therefore, it is closely linked to the World Conference on Social Determinants of Health and in the Rio Political Declaration on Social Determinants of Health, at the Sixty-Fifth World Health Assembly (WHA) (76, 79).

Member States of the WHA expressed their political will to improve public health and reduce health inequities through a resolution for action on the social determinants of health (SDH) (80). The focus is on addressing the challenges of eradicating hunger and poverty; ensuring food security; enabling access to health care and affordable medicines; and improving daily living conditions through provision of safe drinking-water and sanitation, employment opportunities and social protection. The resolution commits Member States to implement the pledges made in the Rio Political Declaration.

Migration is a social determinant of health that can impact the health and well-being of individuals and communities. Migration-related barriers included a lack of clear or consistent legislation; the threat of deportation; the inability to obtain work permits and resulting poverty and harsh living and working conditions; and discrimination. Barriers exacerbated by migrant status included prohibitive cost; poor and confusing organization of services; language barriers; perceived low quality of care; and social isolation. These findings support recent arguments that migrant status itself constitutes a social determinant of health that can intersect with other determinants to adversely affect health care access and health outcomes (81).

The migration process may expose migrants to health risks (e.g. such as psychosocial stressors and abuses, nutritional deficiencies and changes in lifestyle). Alternatively, migration may be an opportunity

to improve an individual's social determinants of health. Migrants' motives for leaving their countries of origin may include employment and education opportunities, escape from conflict and discrimination and the desire to raise families in economically and politically stable environments. At times, new migrants may be healthier than the general population on arrival, but their health may deteriorate after settlement, due to unfamiliar social conditions, infectious diseases, or restricted access to health services (82).

The relationship between socioeconomic position (SEP), migration and health is dynamic, difficult to predict, multifactorial and poorly studied. According to international evidence available, migration has a direct impact on health outcomes in a population and, in turn, on public health policy decisions in each locality. The available evidence on this issue affects multiple parts of the social sciences. The "healthy migrant" effect is not consistently observed among immigrant populations, particularly after adjusting for SEP. Moreover, in terms of risk factors and morbidity, the immigrant population tends to assimilate to the local population after about 10 years of stay in the settlement country (83).

Findings: approaches to addressing the social determinants of health

Findings suggest that any meaningful effort to improve migrants' health will depend on the willingness of policymakers, public health officials and clinicians to address the complex array of upstream political and socio-economic factors and institutions that effect migrants' health rather than focusing on narrower questions of migrant access to health care (81). Health policy and health equity depend on decisions made in sectors other than health, and are fundamentally linked to several interrelated issues such as governance, environment, education, employment, social security, food, housing, water, transport and energy. Health outcomes cannot be achieved by taking action in the health sector alone. Without addressing the full range of factors that affect health, including social determinants of health, it is difficult to achieve universal access to health or reduce preventable morbidity and mortality (84).

Major policy changes can have a detrimental or beneficial impact on the health of recent immigrant and refugee communities. For example, reductions in funding for welfare, hospitals and community agencies can have major effects on the health of newcomers, including the erosion of the social determinants of health, reduced access to health care, increased need for advocacy, deterioration in mental health and family violence (85).

The Helsinki Statement, "Health in all policies", provides a cross sectorial approach to public policies that takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, with an emphasis on health systems, determinants of health and well-being (86). Health Impact Assessment (HIA) can furthermore improve health equity by mitigating unintended harms and maximizing the benefits of policies and programmes for migrants (87). However, there are few explicit decision-support tools for policy-makers to ensure health equity for migrants (88).

Nutrition, water, sanitation and hygiene

Access to adequate nutrition and water, sanitation and hygiene (WASH) are related human rights articulated in Article 24.2(c) of the Convention on the Rights of the Child (89). Adopted by many countries in the world, it urges States to ensure "adequate nutritious foods and clean drinking-water" to combat disease and malnutrition. WASH can improve a person's health and well-being through the prevention of diarrheal diseases, intestinal parasite infections and environmental enteropathy, and reducing the need to travel long distances in search of water and sanitation facilities (90). In addition, the International Covenant on Economic, Social and Cultural Rights affirms the rights to adequate food and emphasizes the role of WASH practices in achieving optimal nutrition and health (19).

When people flee their homes, they can struggle to safely and easily access adequate nutrition, drinking-water, sanitation and hygiene facilities, endangering their health and survival (91). Successful programmes to address malnutrition, macro and micro nutrient requirements, breast-feeding, food production and food security for refugees and migrants have been described by the United Nations High Commissioner for Refugees (UNHCR), the World Food Programme (WFP) and other agencies (92, 93). The evidence regarding the gains associated with integrating WASH with nutrition efforts is also growing, as is the policy basis for such common sense preventive health efforts (90).

Progress on WASH requires addressing social, economic and environmental aspects of development (94). Successful programmes for providing access to WASH have been described by the UNHCR and other agencies (91).

Housing

Adequate housing is important for the physical and mental health of migrants, refugees and asylum seekers living in transition and resettlement countries. Improving housing quality, affordability and tenant security all have the potential to lead to better health outcomes (95). Programmes for delivering emergency shelter, providing transitional housing, and constructing accommodation are detailed by the UNHCR and other agencies (96).

Education

Education is essential to fully participating in society and can lift economically and socially marginalized children and adults out of poverty. Refugee and migrant children and adults may be deprived of educational opportunities because of their refuge and migration circumstances (97).

All refugees and migrants have the right to education as articulated in the Universal Declaration of Human Rights (6) and other international human rights instruments including the International Covenant on Economic, Social and Cultural Rights (19), the Convention on the Rights of the Child (98), the Convention on the Elimination of All Forms of Discrimination against Women (99) and the Convention on the Rights of Persons with Disabilities (100). It is supported by the United Nations Educational, Scientific and Cultural Organization (UNESCO) mission and is one of the key principles underpinning the Education 2030 Agenda and Sustainable Development Goal 4 adopted internationally (97, 101). These instruments lay down international legal obligations which recognize and develop the right of every person to enjoy access to education of good quality.

Evidence increasingly shows that it is the quality of this learning rather than the number of years in school that is the strongest determinant of individual potential to live a productive and happy life. Quality education is an anchor that will attract and keep children in school, encouraging their persistence through to the end of primary school and their transition to secondary school and beyond (102).

Refugee and migrant children and young people who have missed out on school for long periods may benefit from accelerated learning programmes that provide opportunities to complete the primary education cycle in a shorter amount of time or catch-up classes to re-enter the formal primary education system and receive certification that allows continuation in formal post-primary education (102). These programmes might also include intensive language training for young people to access post-primary educational opportunities.

The integration of migrant and refugee learners within national systems may be the optimal approach to ensuring quality and protective education. Refugee children attend public schools where UNHCR provides support to improve education systems and learning conditions for both refugee and host community children. In parallel education systems, efforts are necessary to ensure that students follow

a certified curriculum of either the host country or the country of origin, which may need to be accompanied by intensive support for language skills in the host country language (102).

Implications

It is imperative that member states address and account for the social determinants of health to improve the health outcomes of refugees and migrants. Member States should continue to uphold the resolutions of the World Conference on Social Determinants of Health and the Rio Political Declaration on Social Determinants of Health (76). This includes strengthening global governance and collaboration, including coordinated global action on SDH aligned with global priorities; adopting better national governance for health and development to tackle the root causes of health inequalities; promoting participation of non-government agencies and civil society in policy-making and implementation of action on SDH; and increasing accountability and monitoring progress to inform action on SDH (76).

As part of this approach, Member States should ensure they address the basic needs of refugees and migrants regarding nutrition, water, sanitation, hygiene, housing, education and employment. Partnerships, technical expertise and information on evidence-based approaches are available through the UNHCR, WFP, UNSECO, WHO and other agencies.

Although immigration and immigrant populations have become increasingly important foci in public health research and practice, a social determinants of health approach has seldom been applied in this area. Increasing dialogue and research between migration and the social determinants of health provides an opportunity to for greater clarity for decision-making and improved public policy public and action.

Limitations

This rapid review was not intended to be a comprehensive, cumulative review of evidence across all social determinants of health. This section was designed to identify current programmes and approaches and it highlights the need for a systematic review of the research literature to more comprehensively capture the evidence on the effect of social determinants of health on refugees and other migrants. Given the nature of this rapid review there is a need to review broader literature databases to gather evidence on addressing issues such as the provision of safe drinking water, sanitation, housing and education, using broader literature databases beyond health. (See Section 5, Limitations of the literature).

4.4. Strengthening health monitoring and health information systems

What is the evidence on policies and interventions that improve health monitoring and health information systems for refugees and migrants? – data collection, data analysis, indicators, sharing of health information (patients and population health information, etc.)

Context

Population health monitoring and health information systems

To support policy-makers in strengthening or introducing health policies to improve health outcomes in refugee and migrant groups, health information systems (HIS) are identified as the key tool to ensure relevant health outcomes can be measured and monitored. Recognizing the need for additional data on migrants' health and their access to health care in order to substantiate evidence-based policies, the Sixty-First World Health Assembly endorsed resolution 61.17 on the 24 May 2008, which calls upon Member States to establish HIS to assess and analyse trends in migrants' health, disaggregating health information by relevant categories (103).

Relevant population categories are clearly outlined in the New York Declaration for Refugees and Migrants:

“We recognize 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. Such data should be disaggregated by sex and age and include information on regular and irregular flows, the economic impacts of migration and refugee movements, human trafficking, the needs of refugees, migrants and host communities and other issues. We will do so consistent with our national legislation on data protection, if applicable, and our international obligations related to privacy, as applicable” (9).

There are now several WHO publications that highlight the importance of monitoring migrant health data with HIS such as “International migration health and human rights” (17) and “Beyond the barriers: framing evidence on health system strengthening to improve the health of migrants experiencing poverty and social exclusion” (64).

Depending on the specific policy, the outcomes that are targeted may include treatment uptake (e.g. vaccinations), prevalence of health conditions (e.g. mental illness), equity of health services use, and service accessibility. HIS have the potential to capture multiple types of information about service users and clinicians, as well as service and organisational factors including costs (to patient/government/etc.) and regional information (e.g. monitor disease outbreaks) (104, 105).

HIS data is needed for monitoring and evaluation. This includes data on the health of individual refugees and migrants, information on service types and performance, and the overall health of groups within

regions. It is imperative for evaluations into quality and equity of care, and accurate evaluations of public health expenditure (104, 105).

A multitude of new HIS are being developed worldwide. In the international literature it is recognized that HIS systems must be responsive to the unique and specific needs of all people and perhaps more importantly those who are the most at-risk including refugees and migrants. If national systems are to remain accurate and representative, then it is important for statistics from refugee services to be included within national HIS (106). Despite this, HIS systems continue to face challenges in being appropriately adapted to identify refugee status and monitor the specific health needs unique to this at-risk population (104, 105).

Findings: Improving population health monitoring and health information systems

Guidance for establishing HIS to capture refugee and migrant issues

Countries and regions need relevant guides on HIS evolution and adaptation that will support policy-makers to achieve goals concerning better refugee and migrant health. This is now relevant to all countries as HIS are used worldwide, and many mid and low-income countries are developing HIS.

Low (and mid) income countries need to determine the best strategies for HIS evolution, adoption and adaptation. For example. A sociotechnical step-by-step approach of HIS development can help policy makers and health managers (107).

Development of a framework for effective use of HIS within diverse and underserved populations is a way to support countries with developing HIS. This would be informed by the identification of core system and implementation requirements for HIS, and establishment of consensus on migrant and refugee variables to be entered into the HIS (44).

To address the need for a well-functioning HIS, a Health Information Assessment Tool on Asylum Seekers (HIATUS) was developed to assess at the national level the HIS capacity to support asylum seeker health (108). The 50 item HIATUS tool produces a summary score in the range: 0–97, where 0 represents no HIS capacity and 97 is full capacity. Piloting it in two European countries revealed substantial limitations in HIS capacity to assess the health situation of asylum seekers in both countries. The tool highlighted the areas having the greater shortfalls in HIS capacity, which were: HIS coordination, planning and policies, and limited coverage of specific indicators such as self-reported health, mental health, socio-economic status and health behaviour. This tool shows that it is possible to monitor and benchmark gaps in HIS capacity at the national level, and tools such as HIATUS can be used to help strengthen HIS in the future. This tool is included in Annex 4.

Minimum data sets for health information systems

Sufficient information in HIS that can identify an individual as a refugee or migrant can be collected, but to date even when this is done it is not done in a consistent manner. Across Europe, reports of routinely collected health data had no universally accepted definition for migrant at an international level (44, 109).

Seeking consensus on important migration-related variables for collection across health information systems has been done in perinatal health surveillance prior to 2010. An international Delphi survey was conducted by the EURO-PERISTAT project, which convened an expert panel to recommend migration indicators for monitoring of migration and perinatal health surveillance (110). The results showed that country of birth was considered “essential” or “recommended” for routine collection by 100% of respondents, followed by length of time in country (88%), language fluency (70%), immigration

status (67%), and ethnicity as defined by maternal parents' place of birth (55%). Feasibility with “minor” or “no modifications” to current data collection systems was highest for country of birth (69%), followed by length of time in country (61%). Other indicators were judged to be less feasible.

In Australia, identifying refugee-background populations in health survey and service datasets is limited. However, recently, maternity hospitals and maternal and child health centres in Melbourne’s south-eastern and western suburbs (both areas of high refugee settlement), trialled the use of four data items in routinely collected HIS to identify women of refugee background (111-113). Previously there were challenges to ascertainment of refugee background, with sensitivities for both migrants and providers about the way questions are asked. The trialled data items are: maternal country of birth, year of arrival in Australia, requirement for an interpreter and preferred language. The results support that these are straightforward items to collect and acceptable to service administrators, care providers and to women.

Health information systems operating across countries

A functioning HIS system between two countries has been reported: A Binational Health Information System was piloted with Mexican migrant workers for case detection and management of communicable diseases. The computerized health information data were encrypted and communicated electronically between the U.S. Centers for Disease Control and Preventive Evaluation of the Guanajuato-Pennsylvania Binational Health Information Systems. This was reported as the first project that successfully demonstrated the technological feasibility of a binational disease control system linking a state in the interior country with a state in the interior of another country, rather than just states in the border region. The project also advanced the understanding of health service organizational issues that facilitate or hinder communication, outreach, disease prevention, and organization of care services for migrant workers in both Mexico and the United States. Despite the success and potential bilateral benefits demonstrated by this project, serious structural and organizational deficits in the public health systems of both countries must be addressed before epidemiological surveillance can be achieved binationally (114).

Evidence of HIS health monitoring for migrants and refugees

HIS are reliable data capturing systems and are responsive to health monitoring for refugees and migrants. There is a wide variety of research that demonstrates the broad range of uses for HIS data. HIS can be used to: assess and monitor health status (115, 116), conduct cost-benefit analyses for refugee populations (117), understand vaccination coverage, monitor the impact of policies to reduce inequalities (118) and monitor health systems in refugee camps. One example is The Avian and Human Influenza Preparedness and Response in Refugee Setting, supported by the UNHCR as a component of the UN System consolidate Action Plan for Influenza, and initially formed in 2007, primarily in camp-based refugee populations. The HIS surveillance monitoring system was established in 95% of refugee camps. With its links to national HIS systems of the Ministries of Health, it provides the ability to observe trends, coordinate and report cases (119).

Implications

Strengthening health information is key to national health development and it is a principal requirement in addressing the health priorities of migrants and refugees. Today more than 60% of refugees live in urban areas and not in camps. Capturing migrant and refugee related information within existing national health systems should be the priority for countries, because then these datasets will be accurate and representative.

Evidence indicates that countries, states and regions would like clear guidance for establishing HIS to capture refugee and migrant issues. More comprehensive and readily obtained guidelines are now needed. Consensus is also needed on universally accepted definitions for migrant and refugee at an international level to be used in routinely collected health data for monitoring and evaluation across countries.

Limitations

The peer-reviewed literature revealed far more literature coming from European, USA and other high-income countries, and little literature from low-income countries. The implications of this are that the findings may not be generalizable to other regions. (See Section 5, Limitations of the literature).

4.5. Promoting Universal Health Coverage

What is the evidence on policies and interventions that improve universal health coverage and financial risk protection for refugees and migrants?

Context: Universal Health Coverage

Universal health coverage (UHC) is a key aspect of the right to health. UHC is defined as “ensuring that all people have access to needed promotive, preventative, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services” (120). The inclusion of migrants and refugees in UHC is a human rights imperative because they may be vulnerable to discrimination and exploitation, and their access to health care may be hampered by political, legal, economic, cultural and practical barriers (see Section 4.1, Promoting the right to health, and Section 4.2, Promoting access to health services).

Structural barriers to UHC include excluding migrants from national health insurance systems, limiting their access to emergency services only, excessive use of immigration detention as a tool for migration management, and lack of cultural competency training for health workers. These barriers not only violate compliance with human rights obligations but are also poor public health practices which could ultimately create greater financial burden on the host country (121).

The location of refugees and migrants can vary widely, for example whether they reside in urban areas, in refugee camps, or in urban areas in the poor versus wealthy countries. There are different financial challenges to achieving the goal of UHC in low- and middle-income countries compared to high-income countries. The former struggle to provide adequate health services for their citizens, let alone migrants who are often regarded as having a lesser claim (122).

Findings: health insurance and financial protection

Government funded national health insurance schemes are a key enabler of improving universal health coverage for migrants and refugees (123). Measures that can improve access for this population may include linking funding, in the form of insurance, to the recipient. Funding can also be linked to the providers. State health policy providing health insurance for migrants has led to better access outcomes (69).

In countries that have universal health coverage irregular migrants may benefit more readily and with less opposition, as “that coverage negates arguments that undocumented migrants are getting privileges not available to citizens” (53). Some EU countries provide irregular migrants with insurance coverage in the national health system even without their financial contributions (53). There is also strong evidence that demonstrates the role of health insurance policy to improve access to health services for irregular migrants (124). In 2010, five of 27 EU member states (France, Italy, Netherlands, Portugal and Spain) gave “undocumented migrants access to virtually the same range of services as nationals of that country” (55). One country implemented a “plan to provide an additional source of

funding to ensure that physicians and hospitals receive compensation for providing services to undocumented migrants” (53).

Ensuring the health of refugees and other forcibly displaced people is a key priority of UNHCR which advocates the following services for refugees: cost free essential primary health care and emergency services during an emergency, childhood vaccinations, antenatal and delivery care, communicable disease control. Fees for these services depend on the context but UNHCR advocates that they be equivalent to those charged to other nationals (58). In addition, UNHCR argues that refugees should be provided with a suitable safety net such as health insurance to ensure access to preventative and curative care (125).

Asylum seeker access to national health insurance is impacted by the political and legal context in the host country. Granting cost free access to health care for asylum seekers is politically sensitive and is bound up with discourses around sovereignty, membership rights and justice (126). There are also medical and ethical implications (126). In some cases, asylum seekers were interested in purchasing health insurance independent of their employment or income status (127).

The Association of South East Asian Nations (ASEAN) includes Indonesia, Malaysia, Philippines, Singapore and Thailand. Migrant inclusion varies between countries though all five have schemes that cover migrants. Irregular migrants in Thailand can opt into its Compulsory Migrant Health Insurance scheme, while Malaysia and Singapore have not yet included migrants in their government-run UHC systems. A scoping review of ASEAN member countries in 2015 and migrant inclusion in universal health care schemes found that Filipino outbound migrants receive “portable insurance” with “limited benefits”. Indonesia has compulsory migrant insurance with limited health insurance. “Overall, the five ASEAN countries continue to face implementation challenges, and will need to improve on their UHC design in order to ensure genuine inclusion of migrants, including undocumented migrants” (128).

Thailand has had universal health coverage since 2002. An increased labour demand over the last couple of decades has led to an increased number of migrant workers from Myanmar, Lao PDR and Cambodia. Since 2005 the number of migrant workers who are registered for the Universal Health Coverage Scheme has been declining (129). In 2015, one report shows that “to date only about 60,000 out of a targeted one million migrant enrollees have registered with the scheme. The barriers to its uptake include the restricted portability of the coverage, annual medical examinations for policy renewal, and reluctance of undocumented migrants to identify themselves.” (130).

Financial concerns operate within the broader social context which means that other barriers that influence access must be addressed alongside financial barriers. For example, understanding of and trust in the health care system is a “central factor influencing willingness to pay” (127).

Implications

The inclusion of migrants, refugees and asylum seekers in UHC policies and financial protection is imperative to upholding the right to health and access to health services for these populations. States should consider linking UHC for migrants and refugees to the entitlements of the local population. Depending on context, funding can successfully be linked to the recipient or to the provider. Reforms to include migrants, refugees and asylum seekers in universal health coverage schemes “will require strong political decisions from agencies outside the health sector that govern migration and labour policies.” (128).

Limitations

This section provides evidence from a variety of regions on health insurance and financial protections for migrants and refugees, however, the scope was limited. A more comprehensive review could be undertaken to systematically scope not only best practice but also a more detailed understanding of the programmes in place, the barriers to uptake and the transferability of programmes between contexts. (See Section 5, Limitations of the literature).

4.6. Reducing morbidity and mortality through public health interventions

What is the evidence on policies and interventions that reduce mortality and morbidity of refugees and migrants including those in need of humanitarian assistance and with communicable, non-communicable diseases?

Context

Migrant and refugee populations can experience a higher burden of communicable diseases, chronic diseases and mental illness compared to local populations (131-133).

Burden of communicable disease

A particular concern regarding migrant health is communicable or infectious disease (51). Communicable diseases have been identified as significant factors of morbidity and mortality among migrant and refugee communities (133). Measures have been taken around the world to combat this, taking many different forms. One of the foremost priorities of the WHO is on vaccination and immunisation against vaccine-preventable diseases (134). Key infectious diseases such as measles, mumps, rubella, polio and hepatitis B are high-priority targets for vaccination, particularly in migrant communities (51, 135-137). While these are proven methods to reduce morbidity and mortality, some migrants may not have access to vaccines, or may not understand local vaccination programmes (138). Additionally, high rates of dropout from universal vaccination programmes has meant that many migrant children remain unvaccinated, while incomplete records and lack of information sharing make this difficult to follow up (136). Migrant children may have lower likelihood of complete immunisation compared to locally-born children (139). Further protections against transmission of disease among migrant populations such as hygiene, environmental measures and vector control are also target areas for preventative interventions. Other communicable diseases however currently lack a vaccine, instead placing the focus of health interventions on screening, early detection, and quality of care programmes (140).

Another concern specific to communicable diseases are preventable outbreaks of highly transmissible diseases, such as HIV/AIDS and TB, particularly during emergencies involving the displacement of people (141, 142). Malaria also represents a large burden of morbidity and mortality for migrants in Africa and Asia, and merits specific attention from health intervention programmes (10). Analysing trends in all these diseases, and responses to them, is necessary to provide insight into future directions and solutions.

Burden of non-communicable disease

As well as acute and chronic infectious diseases, migrants and refugees may also be more vulnerable to non-communicable diseases. Chronic conditions like cardiovascular disease, diabetes, or musculoskeletal conditions often have higher prevalence in migrants compared to native populations

(143-145). Morbidity and mortality from non-communicable diseases is not only influenced by pre-migration determinants of health, but also by issues of access, quality of care and other determinants both during the migration process and post-settlement (131, 146). However, this is not a unidirectional trend. A trend described as the “healthy migrant effect” results in lower prevalence and better outcomes of non-communicable diseases in migrants compared to native populations. This effect is largely attributed to migration mediated by “pull factors”, and has been documented in the literature, although it is highly specific to time and place, both in terms of source and destination countries of migration (146-148).

An important subset of non-communicable disease is mental health and well-being. There are many well-documented factors intrinsic to migration which can predispose migrants to mental health problems or increase the morbidity associated with them (149). Social isolation, barriers to access, discrimination, and irregular utilisation of health care are experiences common to migrants of all kinds which can precipitate negative mental health outcomes (150). Refugees and asylum seekers can have further complicating factors like histories of torture, trauma, or post-migration detention, which can result in even higher morbidity and mortality for this already vulnerable population (151).

Findings: interventions to reduce mortality and morbidity

Strategies to reduce morbidity and mortality among refugees and migrants include: immunisation, communicable disease control programmes, health screening, targeted mental health care and health care in emergency situations.

Immunisation programmes

Immunisation-based interventions specifically for migrants have seen significant successes. Targeted, Supplementary Immunization Activities (SIAs) for migrants in China have shown increased uptake in immunisations among migrants in the past decade (152). Likewise, successful systems-based approaches in the Chinese context include better management of immunization certificates, extra focus on the immunization of migrant children, and not charging immunization fees or insurance (153). However, legal barriers of refugees may be responsible for lower rates of vaccination among this population (154). Target areas for improvement have been identified in better follow up and tracking of dropouts, and improved cold chain maintenance (136).

Current guidelines recommend and support catch-up immunisation for migrant children with incomplete or absent vaccination records, which has been shown to be effective (155). However, adherence to this policy is patchy, leading to missed chances for immunisation in some children (139).

Some vaccination programmes have met with success among migrant women due to positive attitudes around the availability of health care, however they could be improved by the provision of translated information about the health system and vaccination programmes. The provision of better and more accessible information for migrants may strengthen the successes already seen in this area and could also improve levels of trust in health professionals and lead to improved vaccination rates (138, 156, 157).

More rigorous and cooperative national and international health information systems may also aid in ensuring migrant vaccine coverage. The US shows vaccination programmes for measles, mumps and rubella (MMR) were typically successful, but could be improved by further collaboration between different health information systems – both internal systems, and between international agencies (158).

Vaccines are also a vital tool for controlling and preventing outbreaks of infectious diseases, especially in emergency situations and camps for refugees or displaced people. In Africa, evidence suggests

population-level deployment of the oral cholera vaccine has been effective in halting transmission during cholera outbreaks in displaced persons camps (159). While this is a feasible approach, high cost and the absence of quickly accessible stockpiles may limit the oral cholera vaccine's large-scale use (160). Oral cholera vaccination has also been successful in Iraq, where the Iraqi Ministry of Health initiated a large-scale response to cholera outbreak including effective deployment of vaccines to refugee and internally displaced person (IDP) camps (161). Analysis from Thailand shows not only that deployment of oral cholera vaccine in refugee camps was effective, but importantly that it also may provide an opportunity to reinforce and encourage other preventative measures (157).

Mass vaccination campaigns can be beneficial in some refugee settings, however in Macedonia, greater success was seen in refugee camps with weekly immunisation clinics as opposed to mass vaccination campaigns, and the deployment of both remained problematic and required cooperation between government and non-governmental agencies (161, 162). In Germany, analysis of a measles outbreak among asylum seekers showed that mass-vaccination, rather than serological testing and targeted vaccination, may have been a more cost and time effective strategy (163).

Communicable disease control programmes

Communicable disease control programmes, along with vaccines, are a proven preventative strategy for many infectious diseases when properly deployed at an individual and population level. They are particularly important where vaccines are unavailable or are not effective enough to entirely prevent disease in populations. Malaria is a disease where non-pharmacological interventions are essential and proven in migrant populations (164).

South-East Asia has seen mixed results in controlling malaria in refugee and migrant populations. Using malarial prevention measures in IDP camps along the China-Myanmar border, the prevalence of malaria among IDPs was reduced to below that of surrounding villages (165). The same benefits from deployment of insecticide-treated nets were not found in migrant workers in Myanmar, a population that could benefit from continued distribution of NPIs including behaviour change interventions (166). Migrant populations are particularly at risk in the south-east Asian region; a major lesson from Cambodia is the need to specifically account for mobile populations in the development and planning of interventions (167). Mobile Malaria Workers were particularly effective for this population, while mass media campaigns had little impact (167).

Evidence from Africa, meanwhile, showed that a protocol of routine malarial diagnostic tests prior to administration of anti-malarial treatments had significant effects on reducing over-diagnosis of malaria among refugees. In the context of continually developing resistance, along with health care costs, this is a significant lesson for other irregular populations (168).

Interventions in the Africa region for the provision of clean water and hand washing, an important intervention for waterborne diseases like cholera, showed broadly poor results. Portable handwashing stations in Ethiopia showed good initial uptake but diminishing long-term use (169). Refugee camps in South Sudan were similarly resistant to educational interventions around handwashing (170).

Screening programmes

National screening programmes are one of the mainstay measures for reducing morbidity and mortality for chronic communicable conditions including HIV/AIDS and TB. Screening policies vary widely between countries (171). There is evidence that the uptake of screening in migrants can be improved by decreasing the barriers to health care access for migrants (44).

In the USA, evidence based national screening protocols recommend screening of persons born in countries with high TB rates regardless of time since arrival in the USA (172). In 2012 the United

Kingdom moved from routine screening for TB in new entrants to screening specifically for arrivals from high TB incidence countries. This approach has been found to be a cost-effective means of TB control (173). The importance of continuing screening for (and treating) TB during complex emergencies must not be neglected; this has resulted in increased morbidity and mortality for migrants and displaced people (142).

In Europe, there are many policies on screening for TB and latent TB infection (LTBI) across countries. Most of these policies meet both national and international guidelines (fewer for LTBI), however several countries still have suboptimal infection control measures (174). The WHO regional office for Europe has recently launched a new service under the TB Consilium for diagnosing and treating TB, however no outcome data exists at this stage. Case finding interventions specifically for urban migrants in Italy have shown similar yield to other interventions at a lower cost, however with poorer adherence to diagnostic workup (175).

Screening is a pertinent intervention for many areas of health. In Greece, routine screening for immigrant and refugee children has been shown to identify and address multiple shortcomings in pre-migration health care (176).

Cross-border health information systems can enhance the effectiveness of screening and tracking chronic diseases. In Europe, the need for health information systems tracking this has been identified, with multi-dimensional frameworks being one such feasible method (177). Internationally, there is good evidence to support the use of transnational record linkage as a feasible, sensitive and specific programme for tracking TB in migrants (178).

Screening for chronic, non-communicable diseases amongst migrants has also been recommended in multiple areas. However, this frequently varies based on country of origin of migrants, rather than country of destination. For instance, data from Australia recommend routine screening for dyslipidaemia in Afghan refugees, while data from the United Arab Emirates has identified a higher prevalence of hypertension in South Asian immigrants (143, 144). In Europe, Turkish and Moroccan migrants have been identified as being at risk of cardiovascular disease (179). As such, more granular and individual data is required to recommend targeted screening for most chronic non-communicable diseases (NCDs).

Mental health services

Provision of mental health for migrants remains an area with large gains to be made internationally, however several key recommendations recur in the current literature on the topic. Globally, universal strategies for improving migrant access to health care centre on improved communication between organisations, as well as specific, cultural training for mental health staff (150). Data from the USA support the strong benefit to culturally adapted mental health treatment for migrants (180). Particularly for refugees, culturally tailored interventions targeting culturally homogenous groups of migrants have been shown to be most effective (181). Reductions in morbidity have been shown when refugees and asylum seekers are treated within the general health care system in Norway, suggesting that improving access and cultural sensitivity can occur within existing health care structures (182).

Health care in emergency situations

Emergency situations frequently occur for refugees, asylum seekers and particularly IDPs which can put them at higher risk of poor health outcomes. Many interventions in these emergency situations have led to a reduction in morbidity and mortality from both communicable diseases and NCDs. Integrated use of health data in emergency responses has been particularly effective in establishing early-warning systems for outbreaks of communicable diseases, although without measuring mortality

as a specific outcome (183). In outbreaks of communicable diseases, mass and targeted vaccination programmes have been shown to be effective (161, 163). Environmental interventions have tended to be less effective in emergency settings, however more streamlined and culturally relevant provision of information and education provided to vulnerable migrants may increase the effectiveness of these measures (184).

Health responses to chronic and non-communicable diseases is an area with great potential gains to be made. Current literature shows relatively high rates of depression among refugees in camps, with more granular data able to provide further risk factors like being female, divorced or deprived of shelter (185). Efficient screening strategies for moderate and severe mental disorders have been identified in humanitarian settings in Lebanon (186). Along with mental health, women's health needs often remain unmet in emergency situations (187). Ongoing gathering of reliable data and consistent use of health information systems are a current strength and may prove an important asset in improving morbidity and mortality for especially vulnerable migrants, like women, in emergency situations (115).

Implications

Public health responses to emergency situations for migrants and refugees have a major role in reducing morbidity and mortality. While there is a clear need to provide treatment services, approaches can be strengthened by linking and integrating preventative and curative services. Evidence for the need for and efficacy of these approaches has been highlighted in the recent mass-movement of migrants through the Middle East, Mediterranean and Europe. Culturally relevant educational interventions and ongoing qualitative research to uncover barriers to health behaviours are required (170).

Communicable disease prevention through immunisation should continue to be used where practical as a preventative measure for vulnerable refugee and migrant populations. The Asia and US regions provide good exemplars of this. There should be strong linkages between communicable disease surveillance and early warning systems, immunisation programmes, and chronic infectious disease programmes, such as have been effective in South-East Asia and Africa.

Screening programmes for communicable disease including TB and HIV should be linked in with accessible treatment. OECD nations and other countries with firm border policing and screening programmes are particularly well positioned to assist with this. Targeted screening for non-communicable diseases should be considered based on population demographics and health needs and updated according to the latest geographically specific research.

Ongoing research into the health status of migrants and refugees is also vital to expand our understanding of the health needs of these vulnerable populations. Granular analyses of migrant and refugee sub-populations and health outcomes should be considered to assess whether services and programmes are addressing their specific health needs. These may be radically different depending on the combination of destination and origin countries for migrants and refugees.

Limitations

The literature surrounding mortality and morbidity for migrants and refugees contains a number of gaps and limitations. Information and research can be inconsistent between global regions – for instance while areas like Europe or North America may have a good amount and level of research on chronic diseases or long-term vaccination follow-up, regions like Africa or South-East do not have as much. The opposite can be true for more acute concerns, which are the predominant focus in areas

with a high burden of migration. Similarly, regions with bursts of migration (such as the Middle East or Mediterranean region) during times of upheaval may result in a greater quantity of research on migrant health. These factors not only result in knowledge gaps in certain geographical regions and topic areas, but also risks skewing the overall picture based on temporally or geographically unique factors. A more thorough analysis involving an in-depth comparison of regions and points in time may help to negate this.

Similarly, many migrants or refugees have health issues specific to their country of origin, destination, or factors in transit. Understanding this further would require more granular research which does not exist at present within the published literature. Likewise, using proxy outcome measures for morbidity and mortality (e.g. vaccination coverage, service uptake) risks oversimplifying the picture, given the multiple other factors unique to migrant health which may impact on morbidity and mortality. All these factors affect not only the content of published literature, but also the level of evidence, as fewer high-level studies exist in some areas limited by resource constraints. (See Section 5, Limitations of the literature).

4.7. Protecting and improving the health and well-being of women and girls

What is the evidence on the reduction of inequalities in accessibility and quality of maternal and reproductive health care delivery for refugees and migrants?

Context

Sexual and reproductive health (SRH) is a broad construct that includes gynaecological health from menarche to post-menopause, abortion rights, infertility, sexually transmitted infections, gender-based power relations and sexual violence. Across the spectrum of SRH it is important to acknowledge the heterogeneity of women's beliefs and the influence these beliefs have on how, when and why women access SRH services (188, 189).

Sexual and reproductive health care for refugee and migrant women

SRH care is intertwined with economic and migration status as well as gender, ethnicity, religion and culture (190). Migrant women are a diverse group but are often from a background of economic hardship, arriving in their destination country with limited local knowledge and the skills and resources required to access health care (190). Issues such as unfamiliarity with a new health care system, language barriers and lack of awareness of rights and entitlements create barriers for these women.

Refugee women experience barriers to SRH due to the perilous circumstances around conflict and movement. Armed conflict disrupts access to essential services and distribution of health care. Prolonged emergencies weaken health systems and can affect women's health in a variety of ways, such as access to family planning; safe motherhood; increasing sexual and gender-based violence; increased risk of sexually transmitted infections (STIs), and the daily risk of sexual, physical and mental abuses (191). In these contexts, there is often poor reproductive health care due to lack of access to basic hygiene needs such as water, sanitary products and bathing facilities (191). In addition, pregnancy represents a serious threat to women's health due to high maternal mortality rates in refugee source countries (192).

Both refugee and migrant women experience separation from community leading to social isolation and the need to meet costs and continue to support their families can lead some refugee and migrant women to engage in risky sexual behaviour such as sex work (191, 193), which may result in increased vulnerability of the transmission of STIs, including HIV (194).

Girls under 18 years of age are vulnerable to rape and undertaking prostitution as a means to support their families and underage marriage as preservation of family honour. These girls are less likely to use family planning, and are at greater risk of inadequate antenatal care, preterm labour and neonatal complications (191).

Different conflicts and countries impact on SRH differently. For example, mobility restrictions for Palestinian women can affect access to services, resulting in reduced access to antenatal care and an increasing home birth rate (195). Syrian women in Lebanon have been reported to have reduced rates of HIV testing through fear of being deported and rarely accessing health services unless they are pregnant, due to stigma and lack of knowledge about reproductive health (191). Whilst countries such as Lebanon and Jordan have laws that require antenatal coverage, the financial costs are not fully covered for many refugee women (191). Other factors include cost, distance to travel, fear of mistreatment and discrimination, lack of appropriately trained and preferred gender health providers. There is an underreporting of sexual violence due to fear and shame (191).

Seeking asylum brings stress, sadness and frustration which can have a negative impact on sexual health and create barriers to sexual activity and intimacy. Privacy for couples cannot be guaranteed even once in westernised countries such as Australia. Often, couples are separated from one another (193).

Limited access to health care for women

There are many access issues and barriers to care for migrant and refugee women. Many of these overlap with access issues for all migrants and refugees, such as, language barriers, access to interpreters, low levels of health literacy, discrimination, health professionals lack of understanding the rights of migrant and refugee women and other challenges in navigating complex health systems such as cost, differing views and perceptions of health care and scarcity of female medical practitioners (see Section 4.2, Promoting access to health services) (196, 197).

Migrant and refugee pregnant women are less likely to access antenatal care or seek care later in pregnancy than other women resulting in poor perinatal outcomes (188). Asylum seeking pregnant women may experience reduced access to antenatal care due to limitations in service eligibility and fears associated with registering with authorities for risk of deportation (198). Fear and confusion of health care policies for these women, in both communities and the health care workforce often inhibit women from receiving appropriate care (198). Migrant women who live in rural areas, are younger than 20 years, have limited language proficiency and education, are single, multiparous and have an unplanned pregnancy are even more vulnerable (197).

Migrant women have higher levels of maternal morbidity and mortality; poorer pregnancy outcomes (188, 193), higher levels of HIV and STIs, and less access to SRH services. Furthermore, they are more likely to become victims of sexual and interpersonal violence and female genital mutilation (193). Differing health care entitlements according to immigration status leads to confusion among health providers (188).

Findings: sexual and reproductive health services

The rapid review literature search yielded several examples of good practices for promoting access, implementation and utilization of sexual and reproductive health services for migrant and refugee women in both humanitarian and resettlement countries.

Improving access to maternity care

Providing maternity care to migrant and refugee women requires health care professionals to engage with specific training opportunities that address: the use of interpreters, culturally competent care and how to involve migrant women and communities in planning and implementing sexual and reproductive health services (197). Consideration must be made for the migrant women's perceptions, previous experiences, attitudes and awareness of SRH as these are likely to be different to that of the resettlement country. In addition, comprehensive policy and programmes tailored to meet the needs

of migrant women in improving access to maternity care must include familiarity, comprehensibility, affordability, availability and acceptability which is both physical and culturally appropriate (197).

In Turkey, health policy entitles Syrian women to universal health coverage, although this is not always well applied (191). Most women access health care at field hospitals in government run camps with very few NGOs involved in delivering health care. However, in 2014, aiming to improve health care, the Turkish Ministry of Health signed a memorandum of understanding with the United Nations Population Fund (UNFPA) to coordinate delivery of women's health services (191). In Jordan the Ministry of Health responded early in the humanitarian crisis and works with a number of organisations, showing a strong commitment to women's health. A number of clinics or mobile teams are dedicated to reproductive health (191).

The complexities of the Israeli-Palestinian conflict have resulted in reduced mobility and resultant barriers to maternity care for women living in the West Bank and Gaza. Responses to improve women's access to maternity care at the time of labour and birth has seen the development of programmes whereby access to health professionals has increased through staff staying at the hospital during times of curfew; setting up a hotline and network of volunteers to assist home births over the phone; staff to live close to health centres; training midwives to attend home births and provide clean birthing kits (195).

Delivering service packages

Collaborative programmes that involve NGOs, UN agencies, government and have a community focus have been shown to assist women with SRH needs in emergency and humanitarian situations. The UK NICE guideline "Care for women with complex social factors" stipulates the need for inter-agency arrangements for women from disadvantaged groups (such as migrant and refugee women) to ensure adequate support and benefit from other agencies; provide flexible, accessible and culturally sensitive services to motivate all women to engage in maternity services; and provide interpreting services for women whose first language is not English.

Minimum Initial Service Package (MISP)

NGOs, UN agencies and governmental donors worked together to develop the Minimum Initial Service package (MISP) (194, 199). MISP are a set of actions at the time of a humanitarian crisis that build the foundation for comprehensive reproductive health care for women, girls and newborns (191). The MISP objectives are to identify an agency to lead the implementation of the MISP, prevent and manage the consequences of sexual violence, reduce the transmission of HIV, prevent maternal and infant mortality and plan for comprehensive reproductive health services integrated into primary health care (200).

The Reproductive Health Access, Information and Services in Emergencies (RAISE)

Initially a joint initiative of the Colombia University Mailman School of Public Health and Marie Stopes International, RAISE has the primary aim of ensuring good quality comprehensive reproductive health services are routinely provided to those in emergency situations (201). The initiative began in 2006 as a five-year project to enable partner agencies the opportunity to develop expertise and to provide comprehensive services, to set longer-term objectives and monitor results, and to strengthen linkages between relief and development partners.

The five main areas of focus for the RAISE initiative are: basic and comprehensive emergency obstetric care, including post-abortion care; all family planning methods and emergency contraception; sexually transmitted infection prevention and treatment; HIV prevention, including voluntary counselling and

testing, prevention of mother-to-child transmission and referral, and medical response and referral for gender-based violence. Since 2011, the RAISE initiative has had a more intensive focus on contraceptive services and abortion-related services in humanitarian settings as there have been significant gaps in services for these crucial areas relative to other components of SRH (202).

Culturally responsive family planning policies and programmes

UK policy initiatives such as the Inequalities in Health Report (published 1998 and now archived); Race Relations Amendment Act (2000) and Race Equality Scheme 2005-2008, although not maternity specific, all underscore the importance of creating health and social care services responsive to ethnic diversity, proactively setting out a high-level vision for reducing health inequalities and promoting equity (188).

Rwandan refugees in the Democratic Republic of Congo during the mid-1990s voiced a demand for family planning services; some sought to have contraceptive implants removed, while others wanted contraceptives so that they would not have another child to carry on their return journey. Access to family planning services in these camps was established, however, soon after the services were established, the refugees had to flee ongoing conflict (192).

In Southern Sudan, the American Refugee Committee started reproductive health programming, beginning with several meetings to raise community awareness and sessions to train health workers about reproductive health. The organization offered family planning services bringing oral and injectable contraceptives to a war-ravaged people who live under difficult circumstances and who had not had access to modern methods (192).

The Mae Tao Clinic near the Thai-Burma border provides reproductive health services to tens of thousands of Burmese refugees (192). The Reproductive Health Programme established in 1989 aims to keep mothers strong and give all children a healthy start. Inpatient and outpatient departments provide comprehensive women's services including family planning, gynaecology, normal and complicated labour and delivery, neonatal care, and post-abortion care. The antenatal care programme offers screening for malaria, HIV, sexually transmitted infections and anaemia (203).

Community participation in developing sexual and reproductive health programmes

Participatory approaches, whereby sexual and reproductive health programmes are designed in consultation and collaboration with women, ensure programmes are based on sound knowledge of cultural beliefs and practices (204). The inclusion of men, adolescents and those not of reproductive age is advised (204). Programmes are best developed with staff who are knowledgeable in caring for women and children in complex humanitarian settings, yet flexible enough to provide integrated, comprehensive and culturally appropriate information to meet the diversity of regions, populations and communities (194). These approaches work best when they emphasise essential services, including a mix of preventative and treatment strategies such as curative interventions for STIs and breastfeeding education and they are not heavily reliant on advanced technologies (194).

For example, in Switzerland mobile health services were developed with local government, community and medical institutions. Irregular migrants attended the mobile community service primarily due to the clinic employment of bi-cultural staff and that the facility was outside public institutions (198).

Education and Health Promotion

Reframing the way sexual and reproductive health care is discussed with migrant and refugee women enables more culturally appropriate education which may help to overcome resistance to family

planning. For example, discussing and promoting the use of contraceptives as a means for birth spacing and its usefulness in protecting women's health is more acceptable to many migrant women, rather than discussing contraceptive use as a means to reduce the number of children only (195). In addition, traditional media (TV, radio), and social media are acceptable platforms for culturally competent sexual and reproductive health promotion ensuring a socio-ecological approach is taken (193).

Implications

SRH should not be viewed as only within the medical domain. Instead it should be incorporated into population-based policies and programmes (204).

Improving Access to Maternity Care

Structural, organisational and societal factors should provide refugees, asylum seekers and migrant women the same opportunity as general citizens, that is to be equally in control of their sexual health and sexuality (193). Achieving this is possible when policy and programmes are developed with collaborative arrangement between global policy organisations, NGOs and importantly consultation with women and their communities (204-206).

Service packages

Reducing barriers to sexual and reproductive health service access is important to improve health care for women. Achieving this can occur by addressing the prevention and management of sexual violence, reducing HIV transmission, preventing maternal and newborn death and illness, and planning for comprehensive sexual and reproductive health care that is integrated into primary health care (191). Furthermore, better data collection and evaluation that aims to improve service package planning, implementation and sustainability is required (188, 191) as well as improved funding and co-ordination across sectors (191).

Culturally responsive services

Developing policy that addresses more than maternal health care and HIV/AIDS is required if refugee and migrant women are to experience a holistic approach to sexual and reproductive health care (207). Women should also have access to sexual education, the freedoms to decide on choice of partner and when to become sexually active, the ability to be able to pursue a satisfying sexual life, family planning that includes effective contraception choices (207) and safe abortion care (192). Focussing on women of all ages rather than only those in the reproductive years ensures all migrant women have access to screening programmes and gynaecological health care (207).

Culturally competent health care is imperative to improve access to sexual and reproductive health services for migrant and refugee women. Services must ensure access to appropriate interpreting services (188). Multi-sectoral and multi-disciplinary services provide co-ordinated service delivery in complex health systems and appropriate referral pathways (196). Professional development opportunities for health professionals in best practice SRH education (193) and increased awareness and knowledge of cultural and religious beliefs ensures health professionals are providing person-centered care (189).

Limitations

This section reflects many of the issues refugee and migrant women face when accessing sexual and reproductive health care and implications for policy and programmes, however, limitations exist. A comprehensive, systematic review process has not been undertaken and this has limited the quantity of evidence in this rapid review. Gaps in the published literature concerning the subtopics of migrant women were present. Most papers described interventions and approaches to sexual and reproductive health for refugee and migrant women, however, did not evaluate their impact. (See Section 5, Limitations of the literature).

4.8. Promoting continuity of care

What is the evidence on policies and interventions that improve continuity of care for refugees and migrants with disabilities, HIV, TB, mental health care and other chronic health conditions?

Context

Migration presents challenges to the provision of continuous, high quality and long-term health care. Poor quality and disrupted care, due to poverty and inequity of access, can act as both a driver for displacement, and heighten the vulnerability of migrants and forcibly displaced persons (208). However, the protracted nature of modern displacement, and migrants with chronic conditions such as cardiovascular disease, diabetes, chronic lung disease, cancer, mental illness and others, has rendered continuity of care for migrants an increasingly relevant issue for host countries (209).

Continuity of care is often interrupted for migrants during their period of transit, due to a range of factors, including, but not limited to insufficient sustainability of health services for migrants, language barriers, administrative obstacles, discrimination, poverty, social exclusion, poor understanding of entitlements, mistrust of authorities and an underutilisation of health services (64, 210). Policy variations can also affect continuity of care. With limited congruency in policies across nations, even within the same region, there is a risk that migrants with chronic conditions may experience disruptions to their continuity of care during migration (44, 211).

As such, chronic conditions such as HIV and TB among others, are often inadequately addressed or followed-up (209). For TB, poor continuity of care, particularly across borders, can lead to issues such as delayed diagnoses, interrupted or substandard treatment, lack of appropriate medications at certain points during migration, and even forced deportation of migrants with TB (64, 212). This is of concern as it raises the risk of the emergence of multi-drug resistant TB (212). For patients with HIV, migration may result in unstable housing, psychological stress, and poor health coverage, all of which can challenge the delivery of optimal HIV management, particularly when there is a need for facility-based health care (209). These conditions highlight the challenges faced in providing continuity of care across other chronic conditions for migrants and forcibly displaced persons. The fracture of continuity created in these circumstances can exacerbate the existing burden of chronic disease in these populations by leading to increased severity of disease and mortality, increased cost of care, the potential spread of communicable diseases, and poorer settlement and integration (67, 209). Unfortunately, the global systems in place to provide migrants with health care are not targeted towards the health needs of migrants with chronic disease.

Ensuring that ongoing quality health care and continuity of care is available for mobile and migrant populations is different to providing emergency aid and requires further planning and long-term funding. However, the development of a sustainable, migrant-sensitive health system can ensure both the delivery of equitable, high quality care to all persons, including migrants, whilst remaining fiscally feasible for host countries (210).

Findings: policies and interventions to improve continuity of care

International coordination

The literature indicates that collaboration is a key factor for the provision of continuity of care to mobile populations. Collaboration between countries experiencing migration, in addition to cooperation between NGOs, governments and other stakeholders is necessary for patient data to be shared, and for migrants-in-transit to receive minimal interruption to their health care (213).

The high degree of variability in migrant health policies may create confusion, and it is important for countries that host migrants and mobile populations to collaborate with each other to coordinate care and reduce migrant mortality and morbidity. This kind of coordination may involve cross-border referral systems, with contact tracing, shared patient information, and harmonisation of treatment protocols and the coordination of pre-entry screening and assessment of migrants with appropriate and relevant care through TB services in the host country (212, 214).

Maintaining continuity of care across borders requires communication between health professionals, interventions to reduce the risk of transmission of communicable diseases and screening pre-entry, at entry and after entry (215). Such cross-country collaboration policies have been introduced in Australia, Italy, Norway, Netherlands, UK and US, and impact on the continuity of care in TB management for migrants to these countries. In high income countries, continuity of care in the management of TB can be improved with the use of portable records, toll-free numbers for referrals, use of interpreting to break down language barriers, and the creation of informed databases (216).

Other aspects of collaboration and coordination are discussed further in this report (see Section 4.11, Strengthening partnerships, coordination and collaboration).

Coordination of care in low income countries

The co-ordination of care for migrants across lower income countries may be supported by aid organisations and non-government organisations. For example, in Southern Africa, there is a high prevalence of HIV and TB, significant mobile populations, and restrictive migration policies that limit inter-country collaboration and thus continuity of care (217). Chronic conditions such as HIV and TB require adherence to treatment and ongoing follow-up and care, however national systems in the region struggle to coordinate cross border referrals, leading to poor continuity of care for the patient. In this context, aid organisations have a major role in supporting the continuity of care of migrants-in-transit. For example, on the Zimbabwean-South African border, Medecins Sans Frontieres offer primary health care services to migrants as they transit, preventing interruption of treatment of their chronic health conditions (217). Another example is the Great Lakes Initiative on HIV/AIDS, which, funded by the World Bank, supports the development of regional networks to improve cross-border referrals, particularly in migration corridors, and to facilitate the sharing of health information across various initiatives in the region (217). While the effectiveness of this initiative is unclear, the concept shows promise in its ability to address the fractured continuity of care for HIV patients amongst mobile populations. In situations where resource poor host countries require support from NGOs, the UNHCR may be required to coordinate these groups to ensure service gaps are addressed and the needs of refugees and other migrants are met to optimise continuity of care for migrants, there is a need for bilateral agreements between countries of migration, making use of both local and regional arrangements to create a sustainable cross-border health system (213).

Integrating migrant and refugee health care

The literature indicates that countries that improve their own infrastructure and health care systems and enable them to cater to migrants in an integrated way, rather than relying on parallel health

systems and services, tend to improve the continuity of care received by these migrants. Countries that utilise an integrated health care system are also better able to provide sustainable and quality care without placing a high burden on NGOs or relying on unpredictable humanitarian funding (149). It is rare for primary health care services to be the main entry point into the health care system for migrants, particularly for irregular migrants. Not all countries are equipped with an integrated health system that can fully address the needs of both migrants as well as the general population, and therefore rely heavily on expensive parallel health systems that are, at times, funded by scarce humanitarian aid. These migrants may initially receive care instead from NGOs or other private providers. This arrangement may be due to the preference of migrants to access these services from organisations they trust, rather than from government-funded services, which they may believe have links with immigration authorities (149, 218, 219).

While private providers and non-state actors have an important role in the immediate and emergency care of migrants, the long-term management of refugees and migrant health care is best assured when integrated into existing national policies, with provisions to facilitate the enrolment of migrants into the public health care system (220). This may be conducted solely through the national budget and by the government of the host country, or, more often, through the funding of local health systems by external donors, or with the assistance of donor-funded NGOs. (221)

In Europe, several countries, including Spain and England, offer an integrated system to address the health care needs of refugees and other migrants. These systems involve identifying specific challenges faced by their respective migrant populations and reinforcing their existing health systems to address these challenges and improve the capability of these health systems to serve the needs of migrants. (222) Examples of changes made to existing health policies include the creation of working groups and early detection programmes in England, introduction of culturally acceptable and language-appropriate health programmes and treatment services in Italy, and the creation of immigrant health support networks and portable health records for mobile residents in Spain. These actions worked to improve the way that immigrants were able to access and interact with the existing health systems in these countries, and to address specific health concerns faced by these populations, including the prevalence of long-term illnesses such as TB, HIV and mental illness. (222) Although evaluation of these immigrant health policies in these countries is inadequate, it is hoped that these policies reduce interruptions to the continuity of care of migrants. (222)

Developing health infrastructure

An example of the development of local health infrastructure is apparent in the work of the Pan-American Health Organisation (PAHO), which has responded to local and migrant needs by re-organising and improving health care services in general, creating integrated health services delivery networks that are centred on primary health care services. In addition, member countries are increasing the capacity of their first line of care to address the needs of the community, and reforming hospital organisational structures to improve the sustainability of the system (223).

In Africa, in the early nineties, Ethiopia underwent significant regional health system development to address the large refugee population it was facing. Although this was deemed to produce good outcomes, very little data was produced to allow the formal evaluation of this work. Uganda also underwent significant redevelopment to address the large refugee population. Integrated health care services were set up throughout the West Nile region with the assistance of international, regional, and local NGOs and other stakeholders (221, 224). Although there is more data from this integration process, there were significant challenges, and insufficient baseline information to adequately assess the impact of these changes (225).

Delivering quality health care

To maintain continuity of care and ensure sufficient long-term management of chronic conditions in migrants, host countries need to ensure that the care offered to these populations is of high quality at every stage of the health care journey. The quality of care provided to migrants may impact the continuity of treatment they receive for chronic illnesses (220).

Culturally sensitive care is an indicator of good quality of care for migrants. In Australia and many other nations, emphasis is placed, particularly in the primary care setting, on improving cultural competence, communication and interpreter use, and the provision of information regarding entitlements and available services (67, 222). In England, policies have created minor changes to health service delivery to consider different cultural and religious practices, including changes to hospital menus and the offering of choice in the gender of health professionals. England and Spain also include cultural diversity training for medical professionals to improve their interactions with migrants (222). It is beneficial to have migrants involved in the training of staff in inter-cultural communication and around specific risks in migrant populations.

There are currently few universally accepted indicators of quality care for migrants, and there is a need to define standardised and evidence-based indicators of quality to allow the assessment of policies and health systems (44, 220). Measures of quality may need to address barriers to continuity of health care such as language differences, administrative hurdles, lack of information about entitlements, and discrimination (218, 220). Although policies are being developed to improve the quality of care offered to migrants, further research is required to scale up the evaluation of the quality of health interventions for migrants and other displaced persons (41).

Implications

A number of policies and practices are recommended to improve continuity of care for refugees and migrants. Given the increasing burden of chronic disease in migrant populations, these may serve to improve the continuity of care and reduce the burden of disease experienced by migrants, refugees and asylum seekers.

International coordination of care

To improve the continuity of care provided to migrants, countries involved in the transit of these persons should co-ordinate their efforts to facilitate collaboration between their health care systems (217) (see Section 4.11, Strengthening partnerships, coordination and collaboration). This may require broad, as well as more local regional frameworks that are universally agreed upon, so that patient information may be shared and treatment regimens harmonised. The WHO may be responsible for organising the co-ordination of member states in order to facilitate this collaboration process (217). In addition, for resource-poor countries that require support to adequately participate in cross-border health care delivery, there is an important role for NGOs and international aid organisations to co-ordinate this care, particularly for refugees and asylum seekers. In these situations, assistance should be provided to co-ordinate these services by the UNHCR (217).

To prevent over-reliance upon aid organisations to care for migrants and displaced persons, and to prevent the formation of parallel health systems for these populations, countries that host migrants must plan ahead to create long-term solutions to meet the needs of these groups (219). This requires resource allocation, not merely for the provision of immediate and short-term care, but for the development of a sustainable health care system that is able to meet the needs of a culturally diverse and vulnerable migrant population (219).

Integrating migrant and refugee care in national health systems

For better sustainability, countries with migrant and refugee populations should invest in the development of integrated health systems that are able to cater to migrants, refugees and the general population (149). Where possible, countries should avoid relying on humanitarian aid, NGOs or other private providers, as in the long-term this results in the creation of expensive parallel health systems. (149) (219).

Developing health infrastructure

Governments have the responsibility to develop health infrastructure and national policies that are culturally appropriate, able to identify and integrate migrants into the public health care system, and financially sustainable. This can be achieved by prioritising primary health care services with the capability to address the first-line needs of a range of migrant communities. (223) Training should be provided to assist in understanding the specific challenges faced by migrant populations in host countries and equipping primary health care services with the resources to meet these challenges, as well as improving their cultural sensitivity to these migrant communities (222).

Ensuring service eligibility

In addition to developing a more viable, long-term health care system, host countries must also ensure that the health system is equitable. Therefore, health systems should be tailored to ensure that all migrants are eligible for the full range of health care services, rather than merely screening and emergency care (211, 220). Migrants should also be supported to understand their entitlements and to access local health services (67). (See Section 4.2, Promoting access to health services).

Further discussion of access to and continuity of services relating to communicable and non-communicable diseases is provided elsewhere in this report (see Section 4.6, Reducing morbidity and mortality through public health interventions).

Ensuring service quality

Host countries should ensure that health care provided to migrants and displaced populations is of high quality and is appropriate to address the health needs of this population at every stage of their health care journey. This requires the health care system to provide not only equitable care, but also health care that is culturally sensitive and targeted for migrant and refugee needs, with culturally competent and gender-appropriate health care staff, adequate and appropriate interpreting services to address language barriers, and information and support to facilitate access to care (220, 222).

Limitations

Due to the rapid review nature of this report, the findings outlined may not be fully comprehensive or be able to assess the many interventions utilised internationally in the provision of continuity of care for refugees and migrants. Furthermore, some of the papers included in this report provided only general summaries and descriptions of interventions without detailing their processes or evaluation. Whilst this report provides a general overview about continuity of care for refugees and migrants, for further detail, a systematic review is recommended. (See Section 5, Limitations of the literature).

4.9. Promoting gender equality and empowering women and girls

What is evidence on policies and interventions that reduce gender inequality and empower refugee and migrant women and girls?

Context

Given that nearly half of the “approximately 244 million migrants worldwide” are women, the gender dimensions of migration must be considered (226).

As defined by the UNHCR, gender equality is, “the equal rights, responsibilities and opportunities of women and men and girls and boys...[it] implies that the interests, needs and priorities of both women and men are taken into consideration” (227). The UNHCR highlights that gender equality is a systematic issue. Gender equality is not a “women’s issue” or the fight for women to be the same as men, rather it is the proposition that men and women should be provided the same level of opportunity and responsibility (227).

It is evident however that this desired state of equality is far from realised. Extensive research indicates that a gendered divide exists for equal opportunity in many societies globally. Whilst discrimination affects all women, a disproportionate effect is evident for those further marginalised by refugee or migrant status (228). Informed by age, religion, race, ethnicity, disability, displaced women and children are at higher risk of sexual and gender-based violence (SGBV) and harassment and humiliation. Migration can challenge traditional gender-roles and compromise accessibility to services (227, 229).

Impacts of displacement

Gender inequality exacerbates uncertainty and insecurity for refugee and migrant women. The UNHCR in their “Handbook for the Protection of Women and Girls”, list several significant impacts of forced displacement on women of refugee and migrant background (UNHCR, 2008) As families are separated, the support and security of the family unit is changed exposing women to uncertainty. Furthermore, family members may have to assume different roles and women and girls may become sole providers for their children or siblings.

Refugee and migrant women seeking work in a new country are often paid extremely low wages, are unable to afford decent housing accommodation, or they might have to travel extensive distances for work, putting further strain on limited resources and reducing accessibility to civil and health services. Women’s lack of access to the labour market leads to lower paying and less regulated jobs, including domestic work. This may expose women to exploitation and human trafficking. Housing is a potential area of disadvantage and inequality for women, especially where women are seeking refuge from a violent partner. Women, unable to find work, may be at greater risk of physical or sexual exploitation, causing inequalities to become further entrenched (226, 230, 231).

As families experience forced displacement or seek refuge or asylum in a country with different socio-cultural values, traditional cultural norms and hierarchies may be challenged. In this context, men's unemployment may break down traditional structures and can lead to frustration or a sense of demasculinisation. Men's unemployment has been linked to a high prevalence of domestic violence (232).

Limitations to accessible and appropriate health care

Despite significant government reforms to improve the quality of health care, many refugee and migrant women continue to face significant barriers in accessing culturally appropriate, affordable, accessible and quality health care. In some countries, tradition suggests that men control the economics and decision making of the household (228), limiting the opportunity for women to access health services independently and as required. Further, where women must be accompanied by a male relative in order to access medical or travel permission, women's freedom of movement is greatly minimised (227). (See section 4.2, Promoting access to health services).

Findings: evidence on promoting gender equality

International policies and legal standards to promote gender equality

The UN system-wide policy on gender equality and the empowerment of women and a strategy on gender mainstreaming (233) is a policy enforced by the UN that includes a holistic set of recommendations:

- Strengthen accountability processes and mechanisms for gender mainstreaming and strengthen results-based management system for gender equality.
- Monitor, evaluate, audit and report mechanisms for enhanced oversight.
- Allocate adequate human and financial resources to implement gender mainstreaming.
- Develop training and development for all staff members to increase their capacity and competency in gender analysis, including that of senior management, to ensure that a gender perspective is reflected in their work at all times.
- Reinforce coherence, coordination and knowledge and information management to ensure common goals and consistent working methods in promoting gender equality and the empowerment of women, especially at the country level.

The New York Declaration of the UN General Assembly contains commitments to address gender equity for migrant and refugee populations. It says, for example:

"We will ensure that our responses to large movements of refugees and migrants mainstream a gender perspective, promote gender equality and the empowerment of all women and girls and fully respect and protect the human rights of women and girls. We will combat sexual and gender-based violence to the greatest extent possible" (234).

The strengthened application of international legal standards to promote gender equality and empower women and girls is underpinned by several key tenants. These include the recognition that women's and girls' rights are human rights (see Section 4.1, Promoting the right to health). Further, gender equality and the empowerment of women and girls are essential preconditions for development, peace, and security (235). It is also noted that violence against women and girls, whether in private or public life, is a grievous violation of human rights and a serious impediment to enjoyment of other rights. Further to this, rape and other forms of violence against women and girls can constitute war crimes and crimes against humanity. Finally, women's and girls' enjoyment of specific rights, such as their rights

to education, health or land and housing, require targeted action to ensure their realization on an equal basis to men and boys (227).

The UNHCR states that in order to achieve gender equality “targeted actions are required to empower women and girls and other groups of different ages and backgrounds who face discrimination” (227). This is within the broader setting of the UNHCR Age, Gender and Diversity Policy (see Annex 5) (236). They recommend a process of empowerment for women and girls that includes the following four stages. First, their situation needs to be analysed from an age, gender and diversity perspective. Next is the requirement to be able to access information on their rights and to define their own priorities. Finally, action can be taken to address the inequalities found. Women will then be in a position to realize their full capacities and skills, so that they can attain a level of control over their own environment and livelihood (227).

More specifically for refugee women, UNHCR adopted Guidelines on the Protection of Refugee Women (237). These guidelines call for “integrating the resources and needs of refugee women into all aspects of programming”, reviewing the legal protections that women refugees may require and the steps that should be taken. The Women’s Commission for Refugee Women and Children evaluated the guidelines and argue that UNHCR staff need to be aware of the specific needs of women in these circumstances. Implementation of the guidelines was “found to be uneven and incomplete.” (238). The Women’s Commission further states that positive actions were found to be “sporadic, and they are often insufficient to provide refugee women with equitable protection.” Two specific limitations were found. First, there was a lack of access and resources that impeded efforts on behalf of all refugees regardless of gender or age. Secondly, the guidelines need to be worked into standard operating procedures and used for planning and evaluation at each step of programming.

One programme, A Gender Approach to the Work with Refugees, Returnee and Displaced Women (FoReFem) was employed in Central America using the guideline to inform activities to address human rights protection, legislation, assistance and development issues related to women at project, programme and policy levels (239). Key lessons include the need to consider women refugee’s needs and highlight the role that UNHCR can play. It was also found that activities should “Increase the visibility of refugee women by obliging project staff to consider the gender implications of their work.” With clearly defined implementation plans, projects should also “keep national government involved in drafting gender blueprints for action.”

Legal standards go some way toward promoting gender equality but there is diversity between individual states in how their national policies address these issues.

National policies and legal standards to promote gender equality

Several countries (Argentina, Dominican Republic, Ecuador, Jamaica, Jordan, Mozambique, Nepal, Russian Federation, Togo) have provisions within their constitutional framework or national legislation to provide a legal platform for gender equality. In some cases, gender equality legislation is linked to immigration laws, providing protection for migrant and refugee women. These linkages take different forms in different countries. For example, “in Jamaica, Jordan and Mozambique these laws cover all persons working or living within their territories regardless of nationality. Bosnia and Herzegovina has a national law on gender equality which forbids discrimination on the grounds of gender, and harmonized both the Law on Foreigners and the Law on Asylum with the Law on Gender Equality” (226).

Other countries have additional commitments, including national action plans with a gendered focus, that intend to protect women migrant workers specifically (Argentina, Burkina Faso, Cambodia, Dominican Republic, Indonesia, Jamaica, Sri Lanka, Turkey). “Indonesia is currently drafting an

amendment to the Law on the Placement and the Protection of Indonesian Migrant Workers to harmonize it with the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Improved access to justice for women migrant workers has been reported by Costa Rica, Ecuador, Indonesia and Nepal, with Costa Rica and Ecuador highlighting the need for improvements for women with irregular migration status. In Ecuador, the Judicial Council developed policies to combat gender-based violence, maltreatment and sexual exploitation of women regardless of their migration status and to help overcome institutional barriers” (226).

Women’s equality is a human right and the rights of migrants and refugees can be better protected through the promotion of gender equality. The Malaysian women’s advocacy group EMPOWER calls for Malaysia to sign up to the various UN conventions pertaining to refugees and stateless persons, and to “integrate a gender sensitive approach throughout the process of granting asylum/refugee status, in close cooperation with appropriate international agencies” (240).

Strengthening participation and leadership of women and girls

The UN General Assembly, seventy-second session reports that many countries, in particular Australia, Costa Rica, Mexico and the Philippines are investing in capacity-building programmes for women migrant workers. These programmes include information on employment rights and standard working conditions, and training on violence and legal protections (226). Such capacity building programmes for migrant workers are found in Indonesia, Nepal and the Philippines which conducts government-mandated “pre-departure training programmes” free of charge. Each workshop or briefing runs for one day and covers an array of modules including language classes, stress management and modules on employment contracts and financial literacy (241). Whilst pre-departure interventions are necessary to protect the rights of migrants, current programmes have been found insufficient. There are three recommendations for improvement: 1) seek the cooperation of receiving countries; 2) leverage learnings from other programmes; and 3) develop community relations to build ties between migrant workers and destination country government and institutions (241).

In 2016, UN Women released “Recommendations for addressing women’s human rights in the global compact for safe, orderly and regular migration” (242). These recommendations are grounded in international human rights law, in particular: the Convention on the Elimination of All Forms of Discrimination against Women, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, International Convention on the Elimination of Racial Discrimination, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). The recommendations acknowledge the importance of women’s contributions throughout the migration process and that women’s “expanding contribution to global value and care chains” are “vital to ensuring economic growth and human development”. Further, the recommendations “acknowledge that development cannot be truly sustainable and inclusive until it encompasses and fosters the full economic, social and political empowerment and the leadership of women and girls at all stages of migration.”

UNHCR advises that in order to empower women and girls’ their full participation in all decisions affecting their lives, and in the planning, implementation, evaluation, and monitoring of programmes is required. Globally, different programmes have explored strategies for increasing women’s participation (237).

Two programmes, the General Initiative Fund for Women (GIFW) (243) and the Cambodian Female Condom Programme in Svay Pak (244), employed women’s specific workshops to promote their participation in decision making. The GIFW used workshops to engage women asylum seekers to establish gender and asylum sensitive procedures for promoting gender equality in programming (243). Similarly, the Svay Pak condom programme generated a safe environment for women to build agency

over their sexual health by participating in information sharing. Programme evaluation found that having completed the workshop, women felt a greater sense of empowerment in negotiations with sexual partners, developed a sense of community with other attendees, and were more likely to use condoms to initiate safe sex (244).

Programmes which increase women's involvement and promote women's status within the community are more likely to improve women's security, protection and voice on specific needs and concerns (245). Research in two of the largest camps of North Darfur, and in the community of Shangil Tobai, found examples of successful programmes which enhanced women's active participation. These include the establishment of women's groups and community elected sheikas (community health nurses) to represent women's issues and concerns, including security and threat of violence (245). Women's active participation within each of the two programmes granted women a safe space to discuss community issues that are of importance to women and a sense of value, responsibility and recognition within their community. Evidence of success of such programmes can be seen in Sudan (246).

A Malaysian women's organisation, EMPOWER (240), is involved in a range of programmes focused on women's political participation. Some of these schemes involve working with established political parties seeking to field more women candidates in state and national elections, but the programme also incorporates grassroots-level training, often with groups of women workers employed in the informal sector. The term "political participation" is thus interpreted broadly and includes educating women about their employment rights and the importance of gender equality and seeking to encourage women from poor and marginalised communities to stand for election, for example to neighbourhood associations (240).

There are few accepted tools to evaluate levels of empowerment. The Longwe Women's Empowerment Framework (247) is a tool which could be used to assess the situation of displaced women and to measure the empowerment process. The framework identifies five dimensions of women's empowerment which focus on the ability of women to access resources, exercise self-awareness with respect to their rights, mobilize around their rights, control their environment with a facility equal to that of men, and the gender-equality of results within institutions.

Navigating complex gender norms and stereotypes

Humanitarian aid organisations have an important role to play in promoting female leaders and gender equality in general. Organisational policies are in fact thought to be "essential tools for tackling gender discrimination in the community" One study found however, that policies must be underpinned by staff commitment and strong managerial support. Gender equality is a concern for the communities that aid organisations operate in but there is also evidence that within the organisations there is work to do in developing more equitable relationships and attitudes for gender equality. "It is these staff who shape, steer and implement strategies and direct programme interventions. In so doing, they make visible and bring the messages on gender equality to communities, as well as serving as potential role models for promoting change" (245).

While women's participation in programmes may be empowering, some have argued that women's participation in and of itself is not the goal, rather that gender equality is the ultimate endpoint at which all work should be aimed. The Age, Gender and Diversity Mainstreaming (AGDM) strategy of the UNHCR runs consultations where women are described as "key sources of information" (237). It has been argued that humanitarian policy discourse which represents women's participation as "a means of programme implementation" and "best practice" rather than as a means of building gender equality, justice, access to decision-making power, agency or improving the human rights of refugee women is misguided (248). Furthermore, when women's participation is promoted through gendered assumptions about women's nature or gender-specific qualities, such as women being "the secret

weapon to beat hunger’ or as ‘key actors in influencing the public health of the household’, such “participatory programs” may actually exemplify women’s disempowerment and limit the ways in which women can act (248).

One study examines the work 58 UN humanitarian aid workers for Burmese refugees in Bangladesh (248). For example, a UN humanitarian programme aimed at addressing child malnutrition, enrolled mothers into a series of educational programmes which included: cooking demonstrations, nutrition education workshops, health and hygiene promotion sessions, kitchen gardening programmes and group counselling. Despite the “active participation” of women, these programmes were found to reinforce harmful gender roles of women as the “main caretaker of children” and as “natural child caregivers” and enhance unequal gender relations placing the onus solely on the mother to care for the children and to learn to do it better. This type of programme is particularly inequitable for refugee women who may have limited access to resources, space and agency to shift complex problems. For example, placing the responsibility on mothers to obtain a sustained source of nutritional food in displacement camps or amidst humanitarian crises. There is a call for international agencies to also promote men’s role within the private space. Where little attention is given to transforming gender roles and stereotypes, the position and leadership of women remains stuck and the division of household, community and economic labour inequalities enhanced (245).

One case-study where a gender-transformational approach was successfully employed is that of the Centre for Investigation and Actions for Latin American Women (CAIM) and Mama Maquin in Mexico (238). In selected refugee camps in Mexico, social change was promoted for women within family and social structures by training women in their rights and addressing gender discrimination. The work was found to transform gender relations for the refugee women who reported enhanced literacy and social connectedness and increased opportunity for paid employment, as well as more confidence in asserting their rights, questioning gender roles (with greater understanding of options outside of being a wife and/or mother) and challenging contentious issues (238). Key lessons from the programme included a recognition that institutional policy should drive the work of empowering refugee women. It was also found that women’s organisations should be strengthened through capacity building and a recognition that women refugees have the capacity to self-organise. Finally, it was found that gender awareness and human rights training should be provided for both men and women.

Gender mainstreaming

The UN Policy on Gender Mainstreaming states that “all programmes, policies and operations are required to mainstream a gender perspective (237). This perspective recognizes that “gender equality is not simply a female issue and that supporting women’s and girls’ empowerment needs to be complemented by a wider strategy. By focusing also on men and boys, as well as institutions, policies, and programmes, it holds great potential for societal change. It clearly recognizes that gender equality can only be achieved through partnership between women and men” (237). Supplementing this policy is the UNHCR’s Age and Gender and Diversity Mainstreaming (AGDM) strategy (236).

The UNHCR ADGM Policy explores six main elements of gender mainstreaming: 1) working in partnership; 2) accountability; 3) results-based management; 4) capacity development; 5) human and financial resourcing; and 6) monitoring, evaluation, audit and reporting. This strategy provides even broader approaches to promote equal rights and opportunity for participation in decision-making (see Annex 5). The AGDM strategy provides a broad approach. However, some believe that the policy merely inserts women’s concerns into the existing male framework without acknowledging the systemic biases that impact on women’s empowerment. In this context, system-wide reform must take place before gender mainstreaming strategies can effectively generate women’s equality. (249, 250). Gender-mainstreaming policies and programmes are found to minimise and over-simplify the full

extent of the gendered, political, racial and religious causes of displacement, and in doing so, exacerbate disempowerment and risk to women seeking asylum (249, 250).

One of the first refugee camps where gender-mainstreaming was implemented was the Kakuma refugee camp, Kenya. The implementation of this strategy, included a set of programmes as recommended by UNHCR bottom-up, community-based policies, such as the “UNHCR Handbook for Protection of Women and Girls” (Annex 6) (250). Programmes included: physical protection services for women and girls through monitoring and the development of “Safe Havens” and “Protection Areas” for women at risk of violence; education and schooling support for girls at risk of domestic abuse, forced marriage or early pregnancy; economic empowerment and leadership through mobilisation, rights and organisational skill training and micro-finance support; and awareness-raising on human rights and gender issues which included public advocacy through billboards targeting GBV and discrimination (250).

Whilst some activities in the gender mainstreaming strategy as employed in Kakuma were found to increase women and girls’ chances, options and access to rights, other components failed to negotiate complex gender relations emphasising stereotypical qualities of “male” and “female” and creating a feminised image of women and girls as “victims” or “survivors” and men as “perpetrators” or “violators.” Instead, gender-mainstreaming strategies need to challenge traditional racial, cultural, political and religious gender norms, creating activities centred around education, awareness-raising, mixed gender sport and cultural activities, workshops and promotions of girls’ participation as leaders – activities evidenced to redress gendered discrimination and role-modelling beyond marriage (250).

In this context, system-wide reform must take place before gender and AGDM mainstreaming strategies can effectively generate women’s equality (249). International gender mainstreaming strategies firstly must recognize that in-country policy already exists and that these need to be reorganised in such a way that enables the “full” integration of complex gender perspectives across “all” phases of implementation and reform, taking into account women’s autonomy and power and actual presence of voice (229, 251).

Prevention of gender-based violence

Steps are also taken toward the prevention of discrimination and violence for women migrant workers. “Prevention strategies, such as educating policy makers and the public, providing capacity-building to migrants and training for public officials, and strengthening labour inspections are all central to eliminating violence against women migrant workers.” Several States (Australia, Costa Rica, Mexico, Philippines, Sri Lanka, Togo) referred to specific measures in place to prevent violence against women migrant workers. In particular Australia, Italy and Sri Lanka are “developing specific training programmes for employers, employment agencies and intermediaries on the rights of women migrant workers...” A new Taskforce has been developed in Australia, the Migrant Workers’ Taskforce, to examine “the labour hiring practices of companies that employ migrant workers to identify persistent cases of exploitation and underpayment, particularly of vulnerable groups or in specific sectors” (226).

Turkey has developed a mainstream awareness-raising campaign called “‘Here I am to end violence against women’, with banners at sports games and advertisements on television.” Japan and Poland provide other kinds of specific support for “organizations working to reduce the exploitation and abuse of women migrant workers” (226).

As above, there is a call in the literature to consider how programmes may unintentionally disempower women and girls. Victimisation of women significantly hinders refugee women and girl’s empowerment and autonomy (251). As evidenced above, current policy discourse around gender-based violence, particularly that around trafficking, calls upon the state to protect refugee and migrant women and

girls, reinforcing the subordinate position of such women in patriarchal hierarchies (251). The United Nations Human Rights Commission warns against international marriages through brokers, with the aim of reducing sex or forced labour trafficking. However, such doctrine leaves little room for manoeuvring around the complexity of women's autonomy and the right of women to partake in sexual commerce or desire to marry for love or economic stability (251).

Implications

Gender dimensions of migration should always be considered. While many countries have provisions within policy and legislation and the UN offers many recommendations to address gender inequality, mechanisms for gender mainstreaming and accountability processes for gender equality should be outlined for all local programmes and implementation processes. Importantly, policy and strategies must account for the multi-dimensional, relational and complex nature of gender inequality and discrimination across "all" phases of implementation, taking into account women's autonomy, power and actual presence of voice (228, 229, 251).

Refugee and migrant women and girls, in particular, encounter intersecting racial, religious, social, economic and political barriers. As such, the UNHCR Good Practices Guide on Gender Equality Mainstreaming Guide states that "initiatives must engage the multiple dimensions shaping the lives of women and girls, including racial and ethnic barriers, and discrimination on the basis of ability, age or sexual orientation" (247).

A strong body of evidence emphasizes using gender-transformative approach in gender-mainstreaming policy and strategy reform and development. This approach challenges traditional gender norms, roles and stereotypes which hinder women and girls progress towards equality and empowerment. Successful gender-transformative activities are education, awareness-raising, mixed gender sport and cultural activities, workshops and promotions of girls' participation as leaders.

Successful strategies for increasing refugee and migrant women's leadership and participation should be adapted and applied for local contexts. Capacity building programmes for women migrants and refugees should be evaluated and where shown to be successful they should be adapted and considered for other contexts. Adopting a rights-based and community-based approach is critical for protecting women and girls (227).

Finally, equality should be the goal of policy and programming, not women's participation. Although programmes that employ women's participation as a means to humanitarian aid may sometimes also contribute to improving women's position and change unequal gender relations, the treatment of equality as a side effect, not a goal in its own right, is nonetheless a source of concern.

Limitations

The literature on the gendered dimensions of migration and women's empowerment is robust, much of it grey literature. However, due to the rapid review methodology, not all the current and relevant literature was consulted. More specifically, there is a bias in the literature reviewed toward refugee women. Effort was made to incorporate the perspective of migrant women more generally. Further, a number of important topics related to the empowerment of women and the promotion of gender equality were not able to be covered in this report. Foremost of these topics is the issue of women trafficking and the implications of violence against migrant women. (See Section 5, Limitations of the literature).

4.10. Improving communication and countering xenophobia

What is the evidence on policies and interventions that improve communication and counter xenophobia to dispel fears and misperceptions among refugee, migrant and host populations?

Context

Negative beliefs about migrants

The increasing number of irregular migrants and refugees globally in recent years has led to debates around migration and its impacts on the political, social, cultural, religious, economic consequences as well as the public health impact of migration in host countries. The debate has entered the public sphere and has played a prominent role in the domestic politics of many receiving countries. At an individual level, this has led to multiple fears about foreigners: personal fear (feeling personally threatened by the arrival of new people), fear of cultural change, fear of identity loss, fear of foreigners' disloyalty and a fear of losing control of the political system (252).

In some cases, stringent anti-immigration policies have been implemented. There has also been a shift in emphasis from human rights aspects of international migration to considerations of state responsibility to focus primarily on the security, safety and welfare needs of its own citizens. The European Commission against Racism and Intolerance identified some worrying trends in its 2015 annual report. Across the EU, there has been an increase in the incidence of violence, harassment, threats and xenophobic speech targeting asylum seekers and migrants. Offenders include people from the general population, members of minority ethnic or religious groups, state authorities, private companies or vigilante groups. Human rights activists and politicians perceived as "pro-refugee" are also targeted and threatened (253).

Human rights and discrimination

The current situation is in stark contrast to the commitment of receiving countries, many of them UN Member States, to uphold and protect basic human rights. Among these is the right to health as indispensable to the realization of other human rights, including the universal right to life, the right to human dignity and the right to freedom of thought, conscience and religion. These rights are enshrined in the European Convention on Human Rights (ECHR), the EU Charter of Fundamental Rights, as well as Article 25 of the Universal Declaration of Human Rights which states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family" (6). (See Section 4.1, Promoting the right to health).

The principles of non-discrimination recognize the "inherent dignity" of every human being, irrespective of nationality, race, colour, sex or other status and requires equal treatment of all. The right to health and the principle of non-discrimination are closely related. Different forms of discrimination create obstacles for the realization of the right to health and other rights of migrants.

Therefore, all states party to the treaties enshrining the right to health, have an obligation to protect and promote these basic rights (254, 255).

The principle of non-discrimination can be found in Article 21 of the Charter (256) and Article 14 of the ECHR (257). The Council framework decision on combating certain forms and expressions of racism and xenophobia requires EU Member States to take measures to punish public incitement to violence or hatred directed against a person or persons belonging to a group defined by reference to race, colour, religion, descent or national or ethnic origin (258). The Victims' Rights Directive (2012/29/EU) provides the EU with a set of rules to protect victims of crime (259).

To effectively address discrimination, changes in government policies and rhetoric as well as changes at the level of the individual offender are required. The latter largely reflect both popular opinion and the political rhetoric of the communities in which they live.

Findings: approaches to addressing xenophobia

The majority of the available literature identified in this rapid review was concerned with xenophobia and discrimination against migrants and asylum seekers in the EU countries. The following section will therefore focus mainly on these countries. Interventions to address xenophobia fell into two categories: the broader social, political and legislative interventions; and micro level interventions aimed at educating the perpetrators and empowering the victims and the potential targets of discrimination and hate crimes.

Legislation and policy

The rapid review of literature identified a number of social level interventions that have been implemented to address discrimination as a barrier to universal health coverage.

The legislative and policy context can be used to ensure non-discrimination, equal protection and opportunity under the law, as well as in national policies. Currently, within the EU there are variations in legislative, policy and service context to meet the above priorities. To address this, the second wave of the European Union Minorities and Discrimination Survey (EU-MIDIS II) was launched in 2015. The aim of the survey was to address issues of discrimination, criminal victimisation, and rights awareness. EU-MIDIS II covered all 28 EU Member States, respondents included members of different ethnic minority and immigrant backgrounds across the EU. The evidence was collected to inform the development of targeted legal and policy responses to racism and hate crime, and to support civil society organisations' advocacy work (253).

Monitoring and reporting

Streamlining methods for monitoring and reporting discrimination and data collection on the incidence of racial crimes and violence and attacks against asylum seekers and migrants allows for greater accountability and redress.

A report examining data collected in 14 EU Member States, found that only Germany, Greece, Finland and the Netherlands monitor and collect data on incidents and hate crime targeting asylum seekers. The situation in Canada and the United States sheds light on some of some of the technical issues that pose a barrier to collecting accurate data on hate crimes. The efforts of the US federal government's commitment to hate crime data collection are constrained by the narrow definition of both the protected groups and the enumerated offences, which excludes many criminal and non-criminal offences (260). EU member states are encouraged to standardize hate crime definitions; standardize official data gathering mechanisms; and/or utilize multiple methodologies to further their understanding of the nature and dynamics of intolerance and bias motivated violence within and across borders (260).

A key impediment to collecting accurate data is that in the EU most hate crimes against minority groups are not reported, rendering the issue invisible and difficult to address. In December 2013, all 28 EU Member States, the European Commission, the Office for Democratic Institutions and Human Rights (ODIHR), the European Commission against Racism and Intolerance (ECRI) and the European Agency for Fundamental Rights (FRA) set up a working party to combat hate crime in the EU, with a two-year mandate. The working party is facilitated by FRA to promote the exchange of good practice and to develop strategies to report hate crimes (253).

Empowering victims

Article 7 of the Victims' Rights Directive states that EU Member States shall ensure that "victims who do not understand or speak the language of the criminal proceedings concerned are provided, upon request, with interpretation in accordance with their role in the relevant criminal justice system in criminal proceedings, free of charge" (259).

Three examples of best practice were identified in the European context. In Spain, The Anti-Rumours Agency was created in collaboration with other organisations, entities and individuals (professionals, citizens, journalists etc.) to provide factual information related to migration, and to challenge rumours, myths and negative stereotypes about asylum seekers and migrants through its "Anti-Rumour Agents" (261). Identifying high risk situations and enhancing the protection of refugees can also empower migrants and others. The Swedish Migration Agency opened "special security accommodations" for persons belonging to ethnic minorities, persons who have been subjected to torture, and LGBT persons with a special need for networks and social contexts, are eligible for this accommodation (261). To empower asylum seekers to report hate crime, an informative brochure on hate crimes in 11 languages was released in October 2016 by the Finnish League for Human Rights, RIKU Victim Support Finland and the Ministry of the Interior (261).

A large body of literature for empowering victims has emerged from South Africa in response to the outbreak of xenophobic violence in 2008 (262). Adult education programmes play an important role in changing attitudes that promote xenophobia. A three-day human rights and counter-xenophobia workshop held near Cape Town by Umoja wa Afrika, a local non-governmental organization, demonstrated how a peer educators' programme with learning materials, course content, training methodology and processes can enable young adults to develop a critical consciousness about human rights and xenophobia (263).

Special provisions for children

Around the world, an estimated 50 million children migrated across borders or were forcibly displaced in 2015. United Nations Children's Fund (UNICEF) calls on world leaders to embrace a six-point Agenda for Action that puts children at the heart of the global compacts for refugees and migration (264). There are many initiatives underway around the world that provide children with assistance as they navigate the complications of integrating into new surroundings, including countering xenophobia.

Two examples of best practice for children were identified. To combat the stigma and link unaccompanied children with services, the New York City Mayor's Office of Immigrant Affairs works with city agencies and a network of local and national NGOs to reach out to unaccompanied and irregular migrant children and connect them to crucial services. The city's interventions include: helping immigrants up to age 21 enrol in classes tailored to their specific learning needs; connecting immigrant children and pregnant mothers to public health insurance; and linking immigrants to legal services to assist with claims related to their immigration status and distribution of information about services (264). To protect children from discrimination and abuse the Italian parliament passed the Legge Zampa (Provision of Protection) law in March 2017 after a two-year advocacy campaign by child

rights organizations. The law includes budgetary provisions and creates a legislative framework to protect refugee and migrant children and is the first comprehensive act for unaccompanied children in Italy (264).

Educating perpetrators

In addressing the problem of discrimination at the level of individual offenders, “humanizing” the victims of hate crime and their communities has proven to be an effective means of responding to incidents of hate crimes as well as an enabler for communication. Key strategies include: educational opportunity for hate crime offenders by teaching the offenders the effects of their actions, and by putting a human face on the victims; offender counselling complemented with anti-bias programmes delivered either through the justice system or through non-profit agencies; victim-offender mediation to allow victims and offenders enter into a dialogue intended to enhance their understanding of the motives of the offender, as well as the effects on the victim; and restorative justice may be a viable option for low-level bias-motivated offences, particularly for juvenile offenders. This model goes beyond mediation, and requires the involvement of the victim, the offender, and the community in the justice process (260).

Implications

While xenophobia is expressed and rationalised differently in each country and in relation to different groups, the findings suggested common approaches that may be adopted to prevent and address xenophobia (265). These include political leadership to reflect a commitment to universal human rights and non-discrimination. Media plays a key role in giving rise, as well as dismantling fears and countering negative stereotypes. There is a role for the media to communicate and affirm the human rights and non-discriminatory aspects of legislation and policies.

Literature emphasised the importance of monitoring, data collection and research on the subject of xenophobia. The quality of data can be enhanced by stratifying it according the target group and whether it was motivated by the victims’ migration status. This will enable more efficient and targeted interventions, and monitoring and evaluation of public health policies and actions to ensure health and social equalities are addressed effectively.

Literature highlighted the need for interventions at the broadest level as well as the micro level. These include Governments’ mandate to create policies, legislations and educational policies to address xenophobia. Innovations at the level of local governments such as local community forums to manage tension as a means of managing xenophobia and increasing safety, and training locals in sustainable activities were also found (266-268). The policy and legislative framework is required to enable the allocation of resources to implement best practice programmes and approaches at the local level, for example employment of social workers to deliver education and counselling for the perpetrators and victims of xenophobia (269).

Limitations

The report is based on the findings of a rapid review of the literature on xenophobia and is therefore not exhaustive. A systematic review of the literature on the topic is needed for a comprehensive mapping of programmes and interventions that have been used to address xenophobia. Further, a comprehensive review of evaluation outcomes of existing programmes is needed to identify best practice approaches to counter xenophobia. (See Section 5, Limitations of the literature).

4.II. Strengthening partnerships, coordination and collaboration

What are the intersectoral, intercountry, and interagency mechanisms that increase partnership, coordination and collaboration amongst countries, regions and at the global level to promote the health of refugees and migrants?

Context

Increasingly, governments, national and international agencies are working in partnership to improve health and well-being of migrant populations. Partnerships are usually designed to bring together relevant actors who share a common goal, agree on how to achieve this goal and are able to contribute resources to its achievement.

To be successful, partnerships must overcome several challenges. Firstly, bringing multiple agencies together with government is a difficult task, particularly if these agencies have a history of competing for funding or have vastly differing approaches to addressing the same problem. Secondly, agencies rarely enjoy equal decision-making rights within a partnership, and the goals of the partnership may not align with the expectations of all stakeholders. Where funding is concerned, this misalignment may lead to the withdrawal of contributions (270).

Findings: mechanisms that increase coordination and collaboration

While there are many examples of coordination on the national and international scale to improve the health and well-being of migrant and refugee populations, few of these are well-documented in the literature. Much of the existing literature on coordination is limited to narrative accounts without a detailed description of contextual, organisational or interpersonal factors influencing the nature of the partnership and its overall success in attaining stated programme objectives (271). This section presents a series of published case studies, with lessons learned, where this analysis has been undertaken.

The United Nations system provides support of migration and human rights through standard setting and normative oversight, provision of a forum for human rights-based dialogue and cooperation, service provision and technical assistance, and building up the knowledge base on migration and human rights (12). The UN created the interagency Global Migration Group in 2006 to coordinate the work of the international system on migration to “promote the wider application of all relevant international and regional instruments and norms relating to migration, and to encourage the adoption of more coherent, comprehensive and better coordinated approaches to the issue of international migration” (12).

One example of government level collaboration can be found in The Global Forum on Migration and Development (GFMD). GFMD is an “initiative of the United Nations Member States to address the

migration and development interconnections in practical and action-oriented ways.” This informal, non-binding, voluntary, government-led process had its first meeting in 2007 and “marks the culmination of more than a decade of international dialogue on the growing importance of the linkages between migration and development.” The Forum takes a global perspective and recognizes the importance of an intergovernmental framework. To date the Forum has inspired over one thousand policies by 182 governments (272).

Formal agreements and clear governance

Large, multi-country collaborations illustrate the importance of clearly defined roles and governance and well-defined mechanisms for information sharing. The EpiSouth project is a collaboration between countries in the southern Mediterranean region for communicable disease surveillance and training. The collaboration brings together 26 countries and several international agencies including the European Commission (EC), the European Centre for Disease Prevention and Control (ECDC), the Italian Ministry of Work, Health and Social Policies and the WHO. The Italian national public health institute has responsibility for overall coordination. A steering committee with broad stakeholder representation is responsible for identifying priorities and guiding the overall project coordinating mechanisms. The national institutes of France, Bulgaria and Greece oversee three work packages in the areas of epidemic intelligence, vaccine preventable diseases and migrants, and, emerging zoonoses. The EpiSouth project is credited with promoting mutual trust and understanding between the countries involved as well as putting in place a mechanism for rapid information sharing and collaboration in the event of a public health emergency (273).

There is value in having formal arrangements for collaborative, cross border information sharing. A multi-national initiative to better manage the diagnosis and care of migrants with TB as they cross international barriers advocates for an electronic data sharing platform modelled on TBNNet (USA) and the TB Consilium (WHO, European region). A web-based, open access system where information is freely available in multiple regional languages could improve overall management of TB cases by individual clinicians, as well as facilitating data sharing between such clinicians who are responsible for managing people with the disease as they travel across national and international boundaries. Challenges that will need to be overcome if such a system is to be broadly implemented include ensuring patient privacy and confidentiality, aligning local protocols to fit with internationally accepted, evidence-based approaches, and, encouraging clinicians to systematically report relevant clinical information on TB cases (215).

Central coordination and leadership

Other programmes and collaborations require the identification of a central, lead agency. A programme to deliver long-lasting insecticide treated bed nets for improved malaria control in South Sudan identified weak collaboration between partners as a challenge to the effectiveness of the programme. This challenge was addressed by nominating a single agency (Malaria Technical Working Group) to be responsible for overall technical oversight and implementation at the national level, with complementary coordination at the state and county levels. The Malaria Technical Working Group was responsible for developing guidelines for distribution at the county level and for defining the roles of implementation partners in a micro plan. The study concluded that the campaign benefited from central coordination and use of evidence-based guidelines (274).

Collaborative decision making

Having mechanisms for collaborative decision making, as well as the ability to draw on expertise as required are both valuable elements to a successful partnership. A partnership between HelpAge, Medecins du Monde, Amel Association International, Young Men’s Christian Association Lebanon and

the American University of Beirut to improve hypertension and diabetes management among Syrian refugees living in Lebanon concluded: inclusion of all partners in decision-making on project activities and leveraging the expertise of each partner agency in the design and implementation of the project was the basis for effective partnership (275).

Collaboration and partnerships have been shown to succeed where shared values, goals and mutual respect are present. A capacity building intervention for operating theatre nurses in five Palestine Red Crescent hospitals in Lebanon concluded that the success of their interagency partnership stemmed from stakeholders' shared aspirations and mutual respect, as evidenced by their willingness to listen to and understand the perspectives of others in the design and implementation of a quality improvement intervention (276).

Examples of cross-border cooperation and collaboration on migrant health and health service access are described in the Greater Mekong Subregion (122). 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. Several initiatives illustrate the role of multilateral partners in supporting collaboration between Thailand and neighbouring countries to improve migrant health: 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 TB 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 (64).

Community engagement and ownership

True community partnership draws on local capacity and shared decision making to build trust and equitable distribution. A multi-level partnership to provide essential health services to internally displaced people in Myanmar identified the following elements as critical to the success of the partnership: building technical capacity of local providers and facilitating their involvement in decision-making so as to promote local ownership and autonomy; leveraging grass-roots health workers as the primary conduit for health service delivery for better access to vulnerable populations; ensuring multi-ethnic representation so that relief efforts can be equitably distributed communities of different ethnic and religious backgrounds (277).

Stakeholder engagement

Collaboration can also be achieved when stakeholders are able to benefit in a variety of ways, such as capacity building and data sharing. An effort to address gaps in human resourcing for health in Sudan led to the creation of the national Human Resources for Health (HRH) Observatory by the Global Health Workforce Alliance. This observatory was tasked with overall coordination across HRH stakeholders. Stakeholders included the Federal Ministry of Health, other ministries and government institutions, health worker registration councils, professional associations, NGOs and international non-governmental organisation. Buy in was achieved by acknowledging institutional interests, offering capacity building opportunities, providing free and timely access to data, and, increasing the visibility of stakeholder agencies. In time, the role of the observatory was handed over to the Government of Sudan, and the work prioritized within the public sector through political endorsement (278).

Partnerships with faith-based organisations

Development partnerships between UN agencies or governments and faith-based organisations (FBOs) and faith communities are considered mutually beneficial because they increase understanding and collaboration.

Five principles were proposed for coordination between public sector agencies and FBOs. The first principle advocated for a three-way dialogue between the UN agency or government and FBOs and faith communities so that all stakeholders could understand each other's perspectives. The second principle related to the need for UN agency and government representatives to understand religious structure, culture and beliefs within each community. UN agencies and governments were encouraged to propose partnerships on initiatives that were aligned to FBOs and faith communities' values. The third principle involves governments entering into both financial and non-financial partnerships with FBOs. Mutually beneficial, government funding has the potential to enhance the scope and scale of an FBO lead initiative and the FBOs ability to mobilise faith communities could expand the vision and capacity of any government funded initiative. The fourth principle involves the creation of learning partnerships which brings government representatives, FBOs, faith communities together with researchers, health service providers and local policy makers. Here, evidence can be generated on effective partnership models for this context. The final principle advocated broader engagement with FBOs and allowing these agencies to provide services according to their values. A similar approach in Germany, where citizens able to choose a culturally appropriate service provider were more likely to seek out the service, thus leading to more equitable service delivery overall, was cited as successful example (279, 280).

National frameworks and tools

A number of multi-level frameworks have been developed to improve partnerships and coordination for refugee health. A systematic review of national and international literature, complemented with key informant interviews and consultation processes, was carried out to determine the characteristics of a best practice framework for the coordinated delivery of primary health care to refugees in Australia. This study developed nine recommendations to enhance coordination at the service, interagency, intersectoral, network and national system levels (281) (Annex 7).

Partnership tools have also been developed through a refugee youth programme. In the evaluation of the "UCan2 program" to provide education, welfare, advocacy and counselling for refugee youth, the VicHealth Foundation's Partnership Checklist (282) and the Partnership Continuum (283) were used. The analysis conceptualised the partnership as operating on two levels – programme development and programme delivery. The following factors were identified as influencing the partnership: 1) shared commitment and goals and mutual respect for the expertise of individual agencies, 2) established professional relationships, which improved communication and collaboration between the agencies, 3) programme delivery staff were not involved in decision-making and there was poor communication. Changes to the programme which improved verbal and written communication helped. Researchers recommended 1) allowing adequate time for partners to negotiate shared outcomes in the early stages of programme development, 2) engaging programme delivery staff in decision-making (where applicable) and implementing robust communication pathways between programme development and programme delivery sectors, 3) promoting understanding and appreciation for the skills/expertise of each agency, 4) identifying staff with strong interpersonal skills to be involved in collaborative projects and offering staff opportunities to further enhance these skills (283).

Implications

Evidence suggests that partnerships are more successful for addressing the health needs of migrants and refugees when agencies reach consensus on common strategies for addressing challenges based on a shared understanding of the underlying problems.

Partnership, coordination and collaboration can be promoted through formal agreements and clear governance arrangements for migrant and refugee addressing issues; strong leadership and central coordination functions; stakeholder and community engagement; clear communication, respectful dialogue and trust building; collaborative decision making; and regional coordination, cross-border collaboration and information sharing.

Limitations

Several limitations were identified. The principal of these is that many papers did not provide sufficient detail on the contextual, organisational or interpersonal factors influencing partnerships and the attainment of stated programme objectives. Papers that detailed partnership descriptions that were included in the review were generally associated with “successful” partnerships (publication bias). Furthermore, none of the partnerships described in this section were evaluated using established frameworks for high quality partnerships. As a result, further work is needed if the information presented in this section is able to be applied to the development of partnerships in addressing the health needs of refugees and migrants in general. (See Section 5, Limitations of the literature).

5. Limitations of the literature

This rapid review has identified key findings for addressing the health needs of refugees and migrants across a broad range of priority topics. The rapid review methodology has captured key peer-reviewed literature and reports (with an emphasis on the former), however is by no means fully comprehensive.

The focus on English language literature in this review has identified papers and reports predominantly from European, North American and other high-income countries where English is spoken. There was little English language literature available from non-English speaking regions and low-income countries. The implications are that the findings may not be directly generalizable for all countries and may require significant adaptation for local contexts.

The research questions used were designed to focus on key aspects of the priority topics of the WHO framework of priorities and guiding principles to promote the health of refugees and migrants (10). There are many other aspects of these priority topics that have not been covered such as the health of migrant workers, the needs of children and adolescents, gender violence, human trafficking, health system leadership and governance, health workforce development, access to medicines and regional migration frameworks.

A more comprehensive understanding of these issues could be achieved by conducting a series of systematic literature reviews including papers, reports and broader literature in English and languages other than English. Using literature databases beyond those directly associated with health may also provide richer perspectives.

While many papers and reports described policies, interventions and practices implemented by Member States, very few evaluated their actual impact on the health outcomes of populations and individuals. Further research is required to evaluate the impact of these approaches to determine their effectiveness.

6. Conclusions

Addressing the health needs of refugees and migrants is a complex task requiring multiple, intersecting approaches. It requires a commitment to human rights and equality, consistently applied health access policies, culturally responsive health programmes and services, integrated prevention and treatment approaches, strategies for addressing the social determinants of health, health information systems for monitoring migrant population needs, and strong collaboration between Member States.

The findings of this rapid review of English language literature and reports can be used to inform policies, interventions and practices for addressing the health needs of refugees and migrants, including the development of the Global Compact on Refugees, the Global Compact for Safe, Orderly and Regular Migration, and the Draft Global Action Plan to Promote the Health of Refugees and Migrants. It should be supplemented by additional systematic reviews of literature and reports, and by consultations with migrant and refugee communities, technical experts, stakeholder organizations, Member States, WHO region offices, WHO departments and UN agencies.

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Annexes

Annex I: International legal instruments relevant to migration and human rights

Overview of international legal instruments relevant to migration and human rights (12)

Universal Declaration of Human Rights (1948)

Core international human rights treaties:

- International Covenant on Civil and Political Rights (1966)
- International Covenant on Economic, Social and Cultural Rights (1966)
- International Convention on the Elimination of All Forms of Racial Discrimination (1965)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
- Convention on the Rights of the Child (1989)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)
- Convention on the Rights of Persons with Disabilities (2006)
- International Convention for the Protection of All Persons from Enforced Disappearance (2006)

Relevant ILO conventions:

- Forced Labour Convention, 1930 (No. 29)
- Labour Inspection Convention, 1947 (No. 81)
- Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)
- Right to Organise and Collective Bargaining Convention, 1949 (No. 98)
- Equal Remuneration Convention, 1951 (No. 100)
- Abolition of Forced Labour Convention, 1957 (No. 105)
- Discrimination (Employment and Occupation) Convention, 1958 (No. 111)
- Minimum Age Convention, 1973 (No. 138)
- Private Employment Agencies Convention, 1997 (No. 181)
- Worst Forms of Child Labour Convention, 1999 (No. 182)
- Domestic Workers Convention, 2011 (No. 189)
- Migration for Employment Convention (Revised), 1949 (No. 97)
- Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers, 1975 (No. 143)

Convention relating to the Status of Refugees (1951) and the Protocol relating to the Status of Refugees (1967)

Convention relating to the Status of Stateless Persons (1954)

Convention on the Reduction of Statelessness (1961)

Convention against Transnational Organized Crime (2000); Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children; Protocol against the Smuggling of Migrants by Land, Sea and Air


Instruments of general relevance to migration:

- International humanitarian law: Geneva Conventions (1949)
- Convention on Consular Relations (1963)
- International Convention for the Safety of Life at Sea (1974); International Convention on Maritime Search and Rescue (1979)
- Convention on the Law of the Sea (1982)
- Rome Statute of the International Criminal Court (1998)

Annex 2: Principles and guidelines on the protection of the human rights of migrants

Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations (14)

- Principle 1:** Ensure that human rights are at the centre of efforts to address migration in all its phases, including responses to large and mixed movements.
- Principle 2:** Counter all forms of discrimination against migrants.
- Principle 3:** Ensure that migrants have access to justice.
- Principle 4:** Protect the lives and safety of migrants and ensure that all migrants facing risks to life or safety are rescued and offered immediate assistance.
- Principle 5:** Ensure that all border governance measures protect human rights.
- Principle 6:** Ensure that all returns fully respect the human rights of migrants and comply with international law.
- Principle 7:** Protect migrants from torture and all forms of violence and exploitation, whether inflicted by State or private actors.
- Principle 8:** Uphold the right of migrants to liberty and protect them from all forms of arbitrary detention. Make targeted efforts to end unlawful or arbitrary immigration detention of migrants. Never detain children because of their migration status or that of their parents.
- Principle 9:** Ensure the widest protection of the family unity of migrants; facilitate family reunification; prevent arbitrary or unlawful interference in the right of migrants to enjoy private and family life.
- Principle 10:** Guarantee the human rights of all children in the context of migration and ensure that migrant children are treated as children first and foremost.
- Principle 11:** Protect the human rights of migrant women and girls.
- Principle 12:** Ensure that all migrants enjoy the highest attainable standard of physical and mental health.
- Principle 13:** Safeguard the right of migrants to an adequate standard of living.
- Principle 14:** Guarantee the right of migrants to work, in just and favourable conditions.
- Principle 15:** Protect the right of migrants to education.
- Principle 16:** Uphold migrants' right to information.
- Principle 17:** Ensure that all responses to migration, including large or mixed movements, are monitored and accountable.



Principle 18: Respect and support the activities of human rights defenders who promote and protect the human rights of migrants.

Principle 19: Improve the collection of disaggregated data on the human rights situation of migrants while protecting personal data and their right to privacy.

Principle 20: Ensure human rights-based and gender-responsive migration governance.

Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations (14)

- Principle 1:** Ensure that human rights are at the centre of efforts to address migration in all its phases, including responses to large and mixed movements.
- Principle 2:** Counter all forms of discrimination against migrants.
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- Principle 18:** Respect and support the activities of human rights defenders who promote and protect the human rights of migrants.
- Principle 19:** Improve the collection of disaggregated data on the human rights situation of migrants while protecting personal data and their right to privacy.
- Principle 20:** Ensure human rights-based and gender-responsive migration governance.

Annex 3: ETHEALTH recommendations for addressing health inequalities among migrants and ethnic minorities

The 46 recommendations of the ETHEALTH group designed to address health inequalities among migrants and ethnic minorities in Belgium (37).

Topics	Recommendations
Level 1: Content and socio-economic position	
(1) Data on MEM (Migrants and Ethnic Minority Groups)	1.1. Identification of migrants and ethnic minorities in systematic health care register.
	1.2. Improvement of the statistical power of the National Health Interview Survey for MEM.
	1.3. Encouragement of research into MEM health status and health care.
(2) Coordinating efforts to develop a global and coherent strategy between the different levels of governance	1.4. Improvement of coordination between federal, regional, Community, and municipal levels of governance.
	1.5. Encouraging public health authorities to join international networks active in intercultural health care, such as the Migrant-friendly Hospitals network.
(3) Training and licensing culturally competent health professionals	1.6. Making cultural competences training a licensing criterion for health professionals.
	1.7. Encouragement of the orientation of MEM towards the health professions, to add to the diversity of health care teams.
Level 2: Differential Exposures (risk factors)	
(1) Reduction of socio-economic inequalities	2.1. Combating labor market discrimination and application of existing legislation in companies.
	2.2. Taking into account the specific needs of MEM, especially first-generation, in education, but preventing the creation of

Topics	Recommendations
	educational ghettos and discouraging the systematic orientation of MEM to specialized schools.
	2.3. Taking initiatives in several areas to allow the participation of MEM in decisions that concern them.
(2) Culturally competent health prevention, health promotion, and health education, including strengthening community health	2.4. Increasing the awareness of health professionals in primary care services of the specific risks experienced by MEM and the higher risk of developing certain diseases, such as tuberculosis, while preventing “ethnification” or “racialization” of these diseases.
	2.5. Structural integration of preventive activities into the existing health care services.
	2.6. Adopting proactive initiatives to provide comprehensible and adapted information on the health care system for MEM, with strengthening the role played by the sickness insurance funds in informing clients.
	2.7. Considering community health as a main activity of the primary health care services.
	2.8. Taking into account, as far as possible, the context of the client in the delivery of health care facilities, especially in chronic treatment and in residential treatment, to avoid dropping out.
	2.9. Improvements to the curriculum of community health nurses, in nursing school as well as in the field, and including community health in the agreed standards for primary care services.
Level 3: Differential vulnerability (at-risk groups)	
(1) Irregular migrants and migrants with a precarious legal status, including asylum-seekers	3.1. Clarifying the application of the legislation on Urgent Medical Aid and ensuring a clear framework of reimbursement for health care for migrants with a precarious legal status.
	3.2. Entrusting the Public Centres of Social Action with the social inquiry to decrease the burden on social services in hospitals.

Topics	Recommendations
	3.3. Delivering to all irregular migrants a voucher entitling them to request assistance from different social and medical institutions.
	3.4. Extending the use of the “medical card” to all irregular migrants, entitling them to urgent health care.
	3.5. Diversification of the health professionals and health services available to treat MEM with a precarious legal status or in irregular situations, so as to prevent the formation of “health ghettos”.
	3.6. Provision of a temporary residence permit for irregular migrants with contagious diseases such as tuberculosis, in order to create confidence and ensure MEM follow a full course of treatment.
	3.7. Requiring better support from the Federal Agency for the Reception of Refugees and Asylum Seekers (FEDASIL) for the provision of specific training for these health professionals.
	3.8. Ensuring decent reception conditions, that respect human dignity, for all asylum-seekers, to avoid situations where their place of residence may increase mental and physical health problems.
	3.9. Ensuring access to all health care services for all asylum-seekers, whatever their conditions of reception/detention.
(2) Migrants and ethnic minorities with mental health problems	3.10. Developing and providing culturally competent preventive actions in mental health care, developed in partnership with the target population.
	3.11. Developing and providing culturally competent mental health services, especially in urban centres in all the regions of Belgium.
	3.12. Developing interpreting facilities and intercultural mediation within mental health care services.
	3.13. Improving access to specific training in mental health for health professionals.

Topics	Recommendations
	3.14. Improving collaborative links and referral between mental health services and associations that assist MEM, whatever their legal status.
	3.15. Increasing awareness of mental health problems and adequate referral of clients within the primary care services.
(3) Women	3.16. Improving management of MEM women in maternity units, accident and emergency departments, and gynecological services, with due consideration for cultural, financial, linguistic, or social obstacles.
	3.17. Developing diversified responses to the struggle against genital mutilation and sexual violence.
	3.18. Improving prevention in relation to sexual and reproductive health for MEM women by improved information on their rights (including abortion, contraception, and protection against conjugal violence).
	3.19. Promoting access to prenatal care and screening services for breast or cervical cancer.
Level 4: Differential health outcomes	
(1) Reinforcing the accessibility and quality of health services	4.1. Reinforcing the accessibility and organization of primary care services, especially where needs for intercultural care are more predominant.
	4.2. Ensuring free access to health care services and basic drugs for all clients between 0 and 18 years.
	4.3. Stimulating a stable relationship with the general practitioner and the creation of a global medical file.
	4.4. Stimulating the creation of frontline primary health care centres, working in interdisciplinary teams with integration of social, community, and mental aspects into health care facilities.
	4.5. Stimulating the creation of efficient networks involving primary-care services, specialized health care services, support structures in other sectors (labor or housing), and

Topics	Recommendations
	representatives of MEM, in order to ensure the transmission of information and the adequate orientation of clients.
	4.6. Providing adequate information to MEM about health and preventive/curative health care services.

Topics	Recommendations
(2) Promoting culturally competent health care services	4.7. Increasing the accessibility of, and encouraging collaboration with, interpreters and intercultural mediators in all health services.
	4.8. Increasing awareness of culturally specific components in health care delivery, with a view to improving the accessibility and quality of health care for MEM (e.g. adaptation of meals to religious precepts or religious facilities inside the institution).
	4.9. Stimulating the openness and awareness of health professionals to diagnosis and management of MEM.
	4.10. Promoting collaborative work with diversified health care teams (gender, age, culture, or educational level).
	4.11. Encouraging each health professional and each health service to develop action plans and to mobilize resources to meet the needs of MEM.

Annex 4: Health Information Assessment Tool on Asylum Seekers

Dimensions, sub-scales and items of HIATUS (108)

Table 1. Dimensions, sub-scales and items of HIATUS (version 1.0).

D1—Data Sources & Availability
D1.1—Population based records
Are asylum seekers represented and identifiable in: the population registry? population census or demographic data obtained by census-like approaches? the death registry? Can a distinction be made by cause of death? nationally representative health interview surveys?
D1.2—Health records
Are asylum seekers represented and identifiable in: claims data or other service utilisation data based on (routine or specific) registries in the health system? any disease registers for specific non-communicable diseases? notification-systems for infectious diseases? Is it possible to obtain information on denominator data to calculate incidence or prevalence rates?
D1.3—Sub-group specific records
Are there records that allow assessing the health status of or access to health care for: victims of torture or violence? unaccompanied minors? pregnant women? accompanied children/ minors?
D1.4—Resource records
Are data available on: the volume of health facilities and key health services specifically provided to asylum seekers (e.g., number, size, distribution)? human resources for health specifically concerned with asylum seekers (e.g., density, composition and distribution)? financing and expenditure for health services specifically provided to asylum seekers?
D1.5—Microdata
Are microdata (i.e., individual level data) practically available for researchers or policy makers (e.g., upon request) from: population registry? death registry? population surveys, e.g., health interview surveys? claims data or other routine data of the health care system? disease registers? infectious disease notification systems? records on resources and health services inputs?
D2—HIS Resources & Capacity
D2.1 Coordination, Planning and Policies
Is there a: written plan in active use to comprehensively monitor the health status or health care access of asylum seekers? functioning national organisation responsible for coordination, planning and implementation of HIS for asylum seekers?
D3—Published Indicators and Reports
D3.1—Self-reported health
Are there any published indicators, statistics or reports of studies covering self-reported health indicators in the last 10 years such as: self-rated general health (from poor to very good)? self-reported access to health care services? self-reported impairments of disabilities? self-reported longstanding chronic illnesses?
D3.2—Non-communicable diseases
Are there any published indicators, statistics or reports of studies covering non-communicable diseases in the last 10 years such as: cardiovascular diseases (e.g., stroke, ischemic diseases, myocardial infarction, angina pectoris or heart failure)? diabetes? obesity/overweight or under-nutrition? cancer types? musculoskeletal diseases? accidents and injuries (excluding suicidal behaviour)?

Table 1. *Cont.*

D3.3—Infectious diseases
Are there any published indicators, statistics or reports of studies covering infectious diseases in the last 10 years such as: tuberculosis? HIV/AIDS? hepatitis B or C? vaccine preventable diseases?
D3.4—Mental health
Are there any published indicators, statistics or reports of studies covering mental health conditions in the last 10 years such as: depression (including depressive symptoms)? anxiety disorders? post-traumatic stress disorder (PTSD)? suicidal behaviour including death from suicide?
D3.5—Socio-economic status
Are there any published statistics or reports covering any indicators of socio-economic status in the last 10 years such as: level of educational achievement of adult asylum seekers? employment and type of occupation among asylum seekers? income, welfare transfers or poverty among asylum seekers?
D3.6—Health behaviour
Are there any published indicators, statistics or reports covering health-related behaviours in the last 10 years such as: alcohol intake (amount, frequency)? smoking (current status, amount)? physical activity (type of activity, amount)? unsafe sex?

2.2. Dimensions and Sub-Scales of the Tool

HIATUS assesses HIS performance across three dimensions of country HIS:

- (D1) Data sources and data availability: measures the *availability* of data related to asylum seekers across HIS data sources as well as the *extent of details available* across five subscales.
- (D2) Resources and capacity: measures *HIS resources* and (*monitoring*) *capacity* focusing on the areas of coordination, planning and policies related to health monitoring in asylum seekers.
- (D3) Published indicators and reports: measures the *general coverage* and *timeliness* of published information on selected key indicators across six sub-scales (self-reported health indicators, non-communicable diseases, infectious diseases, mental health, socio-economic position, and health-related behaviours) in the last 10 years.

HIATUS comprises 50 items, each rated on an ordinal scale (yes/limited/no) including a residual category (don't know) to assess data availability across relevant data sources, HIS resources and capacity, as well as coverage and timely publication on key indicators (Table 1). For each item, we formulated specific criteria to define a rating as 'limited'. HIATUS is meant to be primarily applied at national levels, but it might be applied to assess the HIS at subnational levels following the same procedure.

Annex 5: The UNHCR Age and Gender and Diversity Policy

UNHCR Age, Gender and Diversity Policy (236)

I. Objective

1. Through the systematic application of an Age, Gender and Diversity (AGD) approach in its operations worldwide, UNHCR seeks to ensure that all persons of concern enjoy their rights on an equal footing and are able to participate fully in the decisions that affect their lives and the lives of their family members and communities.

II. Rationale

2. Each person is unique. The differences between people, whether actual or perceived, can be defining characteristics that play a central role in determining an individual's opportunities, capacities, needs and vulnerability.

3. AGE refers to the different stages in one's life cycle. It is important to be aware of where people are in their life cycle as their capacities and needs change over time. Age influences, and can enhance or diminish, a person's capacity to exercise his or her rights.

4. GENDER refers to the socially constructed roles for women and men, which are often central to the way in which people define themselves and are defined by others. Gender roles are learned, changeable over time, and variable within and between cultures. Gender often defines the duties, responsibilities, constraints, opportunities and privileges of women and men in any context. Gender equality refers to the equal enjoyment of rights, responsibilities and opportunities of women, men, girls and boys. Gender equality implies that the interests, needs and priorities of each gender are respected.

5. DIVERSITY refers to different values, attitudes, cultural perspectives, beliefs, ethnic background, nationality, sexual orientation, gender identity, ability, health, social status, skill and other specific personal characteristics. While the age and gender dimensions are present in everyone, other characteristics vary from person to person. These differences must be recognized, understood and valued by UNHCR in each specific context and operation in order to ensure protection for all people.

6. By analyzing the AGD dimensions as interlinked personal characteristics, we are able to better understand the multifaceted protection risks and capacities of individuals and communities, and to address and support these more effectively. By promoting respect for differences as an enriching element of any community, we promote progress toward a situation of full equality. Equality means respect for all. It includes the promotion of equal opportunities for people with different needs and abilities and direct, measurable actions to combat inequality and discrimination.

III. Core Commitments

7. UNHCR acknowledges and reaffirms that the complete realization of gender equality is an inalienable and indivisible feature of all human rights and fundamental freedoms. The systematic promotion of this principle in measurable results is essential to ensuring protection and durable solutions for women and men of all ages and backgrounds served by the Organisation.

8. UNHCR is deeply committed to ensuring that refugees, stateless and displaced people have equal access to their rights, protection, services and resources, and are able to participate as active partners in the decisions that affect them. To this end, UNHCR has committed to mainstreaming an Age, Gender and Diversity (AGD) approach. AGD is a human-rights and community-based approach. Mainstreaming AGD means to plan, programme, implement, monitor and evaluate operations, keeping in mind equality and full participation as guiding principles.

9. Working in partnership with people of concern and other stakeholders, UNHCR is committed to ensuring that safeguards are in place to prevent any action from inadvertently increasing marginalization, vulnerability, exclusion and stigmatization that may put some people/groups at further risk.

10. UNHCR is also committed to advocating for the implementation of an AGD approach by other intergovernmental, governmental and non-governmental entities working with refugees, stateless and displaced persons.

IV. Main elements for mainstreaming an Age, Gender and Diversity approach

11. Working in partnership with persons of concern: Working to ensure equality, putting people at the centre of decision making as well as supporting their capacities and efforts to have their rights recognized and accessible, together serve to promote the role of women and men of all ages and backgrounds as agents of positive social change in their own families and communities.

12. Accountability: All staff are expected to understand and integrate age, gender and diversity sensitive work practices. Senior managers ensure that this policy is translated into action in all phases of UNHCR's operation cycle. They are accountable to the High Commissioner for successful integration of age, gender and diversity considerations into their work and the work of their teams.

13. Results based management: Targeted actions to advance gender equality and support individual and community capacities to address protection risks and gaps need to be visible, appropriately resourced and measurable in all Country Operation Plans. UNHCR's results-based management tool, Focus, provides timely information to senior managers in respect of the AGD-sensitivity of operations enabling them to make strategic decisions. This ensures that the emphasis remains on results as opposed to processes alone.

14. Capacity development: Developing and strengthening staff capacity and competency in age, gender and diversity analysis is essential. UNHCR is committed to addressing gaps in this regard on a continuous basis through the provision of additional guidance and the development of new learning opportunities for staff at all levels.

15. Human and financial resources: Adequate human and financial resources are allocated to the implementation of age, gender and diversity mainstreaming to achieve desired outcomes. This entails better utilization of current resources, the assignment of additional resources where required and the alignment of resources with expected outcomes.

16. Oversight through monitoring, evaluation, audit and reporting: Enhancing oversight is critical to ensuring accountability of all UNHCR staff for their performance in age, gender and diversity mainstreaming. UNHCR's accountability framework has been developed for this

purpose. The Annual Programme Review (APR) will also provide an opportunity to assess the AGD policy compliance of operations globally.

V. Defining Diversity: One Community, Many People

17. Women and girls frequently take on important roles in their families and communities. But they often have fewer opportunities and resources, lower socio-economic status, less power and influence and face multiple layers of discrimination. These factors are sharply amplified by displacement, leading to exposure to numerous protection risks, including exploitation, enslavement, rape and other forms of abuse and Sexual and Gender Based Violence (SGBV). Women suffering from discrimination and violence face enormous challenges providing for their families and themselves. Their engagement in improving their own situation has a direct and positive impact on the well-being, livelihood and protection of their families and communities.

18. The roles of men and boys often change in displacement. This can create protection risks that need to be detected and addressed. Boys, in particular, can be at high risk of trafficking, forced recruitment and sexual and other forms of violence and abuse in situations of displacement. Promoting and supporting the positive engagement of men and boys in the many issues related to their community, including in the prevention and response to the scourge of SGBV, is a fundamental step towards ensuring access to protection and equality for all.

19. Children, including adolescents, enjoy comprehensive rights under international law, yet they are often deprived of the most basic ones. Forced displacement exacerbates children's exposure to neglect, exploitation, and sexual and other forms of violence and abuse. Children are at particular risk and require special attention due to their dependence on adults to survive, their vulnerability to physical and psychological trauma, and their needs that must be met to ensure normal growth and development. Participating in education in a safe environment provides children and young people with invaluable opportunities to attain normalcy in their lives. It is also a powerful vehicle for raising awareness of gender equality and teaching children and young people to respect one another and diversity within their communities. Children can often bring unique and valuable perspectives and solutions to the problems confronting them and their communities. Their participation in decisions affecting them, as well as their best interests and a strong focus on their protection and wellbeing, are essential.

20. People who are lesbian, gay, bisexual, transsexual or intersex (LGBTI) are often exposed to discrimination and abuse linked to their sexual orientation and gender identity. These risk factors are often severely compounded in situations of displacement, where the nature of the discrimination they encounter can be particularly virulent, their isolation from family and community profound, and the harm inflicted on them severe. Their participation in decisions affecting them is central to maximizing their protection, access to rights and the positive contribution they can make to community life.

21. Older women and men have the same basic needs as others, but may suffer increasing vulnerability due to the aging process. Aging factors alone, or in combination with other individual characteristics, can place older persons in situations of forced displacement at heightened risk of marginalization, exploitation and other forms of abuse. While they may be severely challenged during displacement, older persons should not be seen only as passive, dependent recipients of assistance. Older people often serve as community leaders and transmitters of knowledge, culture, skills and crafts. They can give guidance and advice, and

contribute to peace and reconciliation measures, thus contributing greatly to the well-being of their families and communities.

22. Disability may affect every aspect of an individual's life and that of his or her family. People with disabilities may face heightened protection risks in displacement, such as exposure to violence and sexual abuse, exploitation, and exclusion from humanitarian assistance, education, livelihoods and health care. The participation of people with disabilities from a range of backgrounds is essential to identifying and developing appropriate solutions to disability challenges during and because of forced displacement. The inclusion of children with disabilities in education is a dynamic process that is central to a wider strategy to promote an inclusive society. People with disabilities, like all people, have skills and capacities to offer to their communities. These are to be valued and promoted.

23. Women and men belonging to national or ethnic, religious and linguistic minorities or indigenous groups often experience discrimination and marginalization, factors that are compounded in forced displacement situations. Age, gender and other specific factors may expose them to additional protection risks and discrimination. Working closely with minority and indigenous groups to identify the risks they face as well as strategies to mitigate them, is of fundamental importance. As individuals and groups, their active participation in community life is an enriching ingredient to be promoted.

Annex 6: A rights- and community-based approach for protecting migrant women and girls

UNHCR Handbook for the Protection of Women and Girls (227)

Element	Actions to realise a right-based and community-based approach
Focus on rights rather than needs	<ul style="list-style-type: none"> • Ensure all UNHCR's programmes, policies, and operations, including in the inter-agency context, further the realization of the equal rights of women, men, girls, and boys of concern of diverse backgrounds, as set out in international law. • Use international legal instruments and standards as the framework for UNHCR's protection strategies and programme assessments, analyses, planning, design (including setting goals, objectives, and strategies), implementation, monitoring, and evaluation. • Base programme planning on protection objectives.
Ensure community participation	<ul style="list-style-type: none"> • Work in partnership with persons of concern of all ages and diverse backgrounds in order to understand the community's priorities, capacities, and resources and to build on them in order to ensure that all members of the community are protected. • Work with women, men, girls, and boys as partners in implementing, monitoring and evaluating protection and programming activities. • Work closely with individual community members and different groups within the community, in order to identify, prevent and eliminate cultural or religious practices that violate the rights of women and girls.
Duty bearers and rights holders	<ul style="list-style-type: none"> • Help develop the capacity of States and their agents, as duty-bearers, to meet their obligations. • Treat women, men, girls, and boys of concern as rights holders, not "beneficiaries", and support them to strengthen their own capacity to claim their rights. • Support participatory processes that bring together government and civil society to discuss, establish common ground and agree solutions to challenges. • Do not tolerate or overlook practices within a community, including traditional, cultural or religious practices, that violate the rights of women and girls, but rather engage communities on these issues as outlined above.

Element	Actions to realise a right-based and community-based approach
Empowerment	<ul style="list-style-type: none"> • Build the capacities and skills of the members of the community and ensure programmes are designed in partnership with them and reinforce their dignity and self-esteem. • Ensure targeted action to support the empowerment of those who might be excluded so that they can claim their rights and participate meaningfully in the community. • Help empower the community as a whole and individuals within the community, particularly women and girls, to access and enjoy their rights.

Annex 7: Coordinated primary health care for refugees: a best practice framework for Australia

Coordinated primary health care for refugees: a best practice framework for Australia. Policy options (281)

Our evidence-based review suggests recommendations for an enhanced model of primary health care for refugees:

- Recommendation 1:** Commonwealth, state and territory governments support the provision of generalist, refugee focused health services in all regions of significant refugee settlement.
- Recommendation 2:** Generalist refugee focused health services provide initial primary health care to refugees during the first 6 months of settlement, offer continuing care for selected refugee clients with complex needs, and actively assist in the transition of clients to mainstream health services for ongoing care.
- Recommendation 3:** Mainstream primary health care services lead the provision of continuing health care for refugees.
- Recommendation 4:** Humanitarian Settlement Services actively collaborate with refugee focused and mainstream health services, and seek partnerships with Medicare Locals in coordinating refugee primary health care needs during settlement.
- Recommendation 5:** Access to fee-free interpreter services in primary health care settings:
- a) is supported by the Department of Health and Ageing, the Department of Immigration and Citizenship, and state and territory governments,
 - b) is broadened to include MBS-funded allied health and psychology services, and Commonwealth-funded dental services.

We argue that this model of care is best delivered within a framework of coordination and integration across sectors, whereby:

- Recommendation 6:** Generalist refugee focused health services help provide health case management across sectors for recently arrived refugees with complex needs.
- Recommendation 7:** Generalist refugee focused health services develop clear protocols for the successful transition of refugee clients and their health information from refugee focused to mainstream health services.
- Recommendation 8:** Medicare Locals and local health authorities work to integrate refugee focused primary health care in all local areas of refugee settlement.

We see this model and framework being enhanced by a networked approach to care, in which:

Recommendation 9: The Department of Health and Ageing helps support the formation and ongoing operation of a National Refugee Health Network to provide a strategic and integrated approach to the primary health care needs of permanently resettled refugees living in Australia.

Recommendation 10: All state and territory governments support state and territory refugee health networks to improve the integrated delivery of primary health care services and programs to refugees.

Broad system wide approaches to care are required, whereby:

Recommendation 11: All health services and programs provide access to care at low or no-cost for refugee clients of low socioeconomic status.

Recommendation 12: Organisations involved in health professional education prepare graduates to be part of a refugee responsive primary health care workforce.

Recommendation 13: All stakeholder organisations have a responsibility to address the health and health system literacy needs of local refugee communities.

Recommendation 14: The National Refugee Health Network contributes to the agenda for improved monitoring, evaluation and research in:

- a) Primary health care workforce capacity to address the needs of refugees,
- b) The effectiveness of primary health care delivery to refugees,
- c) The cost effectiveness of refugee focussed primary health care interventions.”

Annex 8: UN websites reviewed

UN websites reviewed as appropriate

WHO: World Health Organization

<http://www.who.int/migrants/en>

<http://www.who.int/migrants/en>

IOM: International Organization for Migration

<https://www.iom.int>

OHCHR: Office of the High Commissioner for Human Rights

<http://www.ohchr.org/EN/pages/home.aspx>

UNICEF: United Nations Children's Fund

<https://www.unicef.org>

UNDESA: United Nations Department of Economic and Social Affairs

<https://www.un.org/development/desa/en>

UNDP: United Nations Development Programme

<http://www.undp.org/content/undp/en/home.html>

UNESCO: United Nations Educational, Scientific and Cultural Organization

<https://en.unesco.org>

UN Women: United Nations Entity for Gender Equality and the Empowerment of Women

<http://www.unwomen.org/en>

UNHCR: United Nations High Commissioner for Refugees

<http://www.unhcr.org>

UNFPA: United Nations Population Fund

<https://www.unfpa.org>

Annex 9: Literature database key words and search strategies

Promoting the right to health

Key words

Ovid Medline: (emigrants and immigrants OR transients and migrants OR refugees OR asylum seek) AND (right AND health) AND (policy OR health planning OR national health programs)

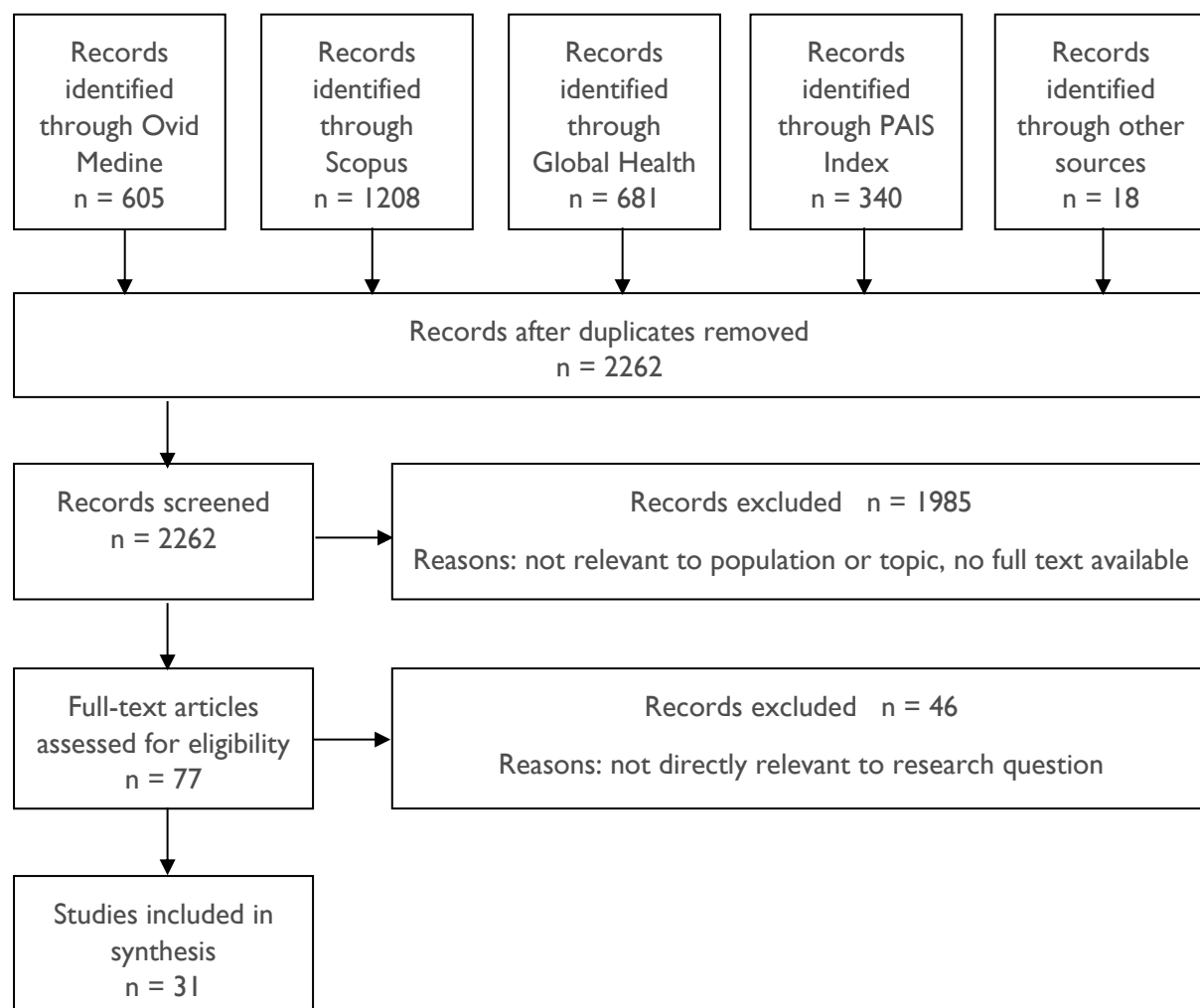
Scopus: (migrant OR refugee OR asylum seek) AND (right AND health) AND (policy OR plan)

Global Health: (migrant OR refugee OR asylum seek) AND (right AND health) AND (policy OR plan OR national)

PAIS Index: (migrant OR refugee OR asylum seek) AND (right AND health) AND (policy OR plan)

Google: migrant AND right to health

Literature identification



Promoting health service access

Key words

Ovid Medline: (migrant OR immigrant OR refugees OR asylum seeker) AND (health) AND (health policy OR health care reform OR health plan implementation OR health planning guidelines OR regulation OR legal protection)

Scopus: (migrant OR refugee OR asylum seek) AND (health policy OR health system)

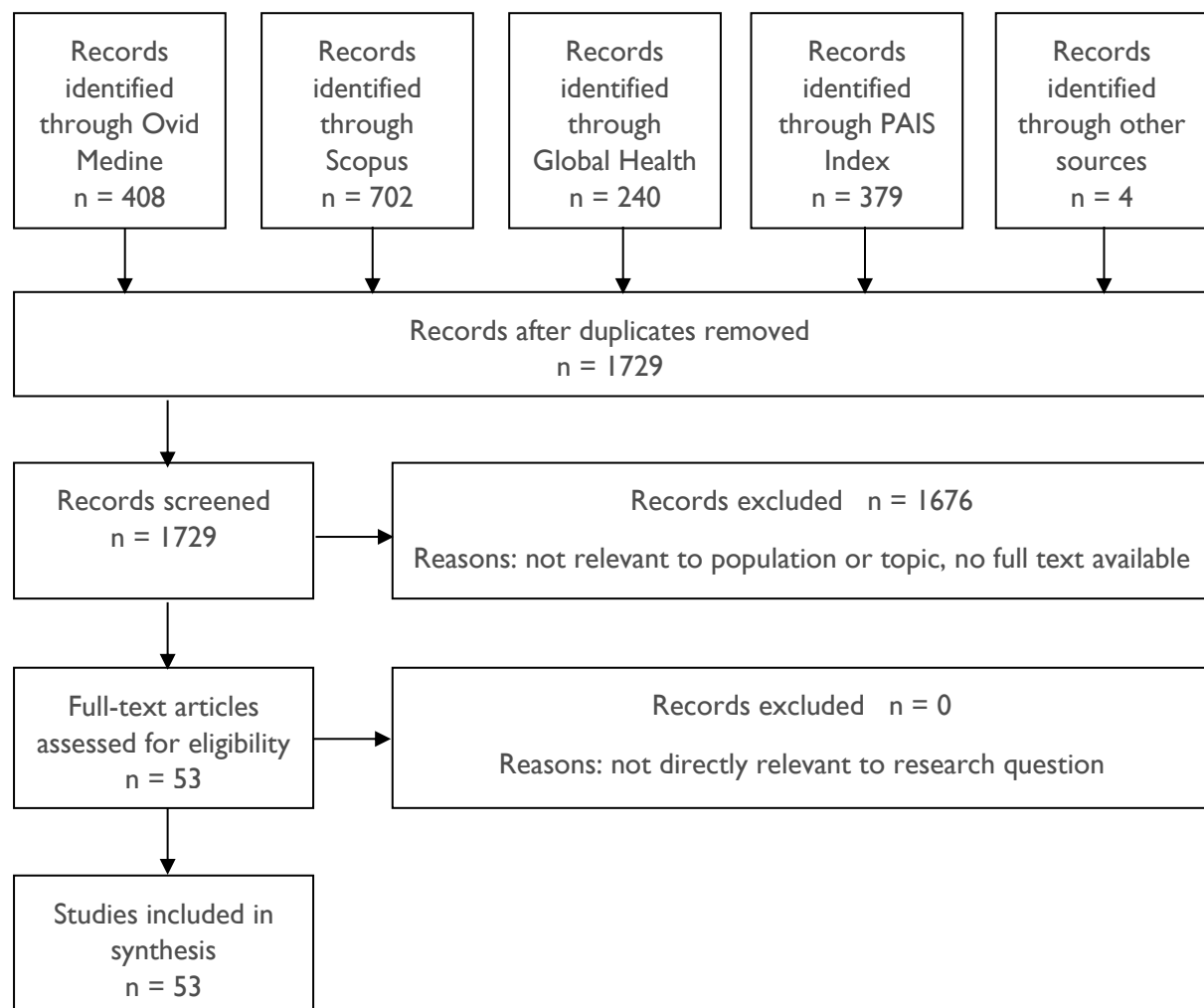
Global Health: (migrant OR refugee OR asylum seek) AND (health policy)

PAIS Index: (migrant OR refugee OR asylum seek) AND (health policy OR (health care reform))

Google: (migrant OR refugee OR asylum seek) AND (health policy)

Due to the large number of papers available on this topic, papers published between 2007 and 2017 only were included.

Literature identification



Addressing the social determinants of health

Key words

Ovid Medline: (migrant OR refugees OR asylum seek) AND social determinants of health

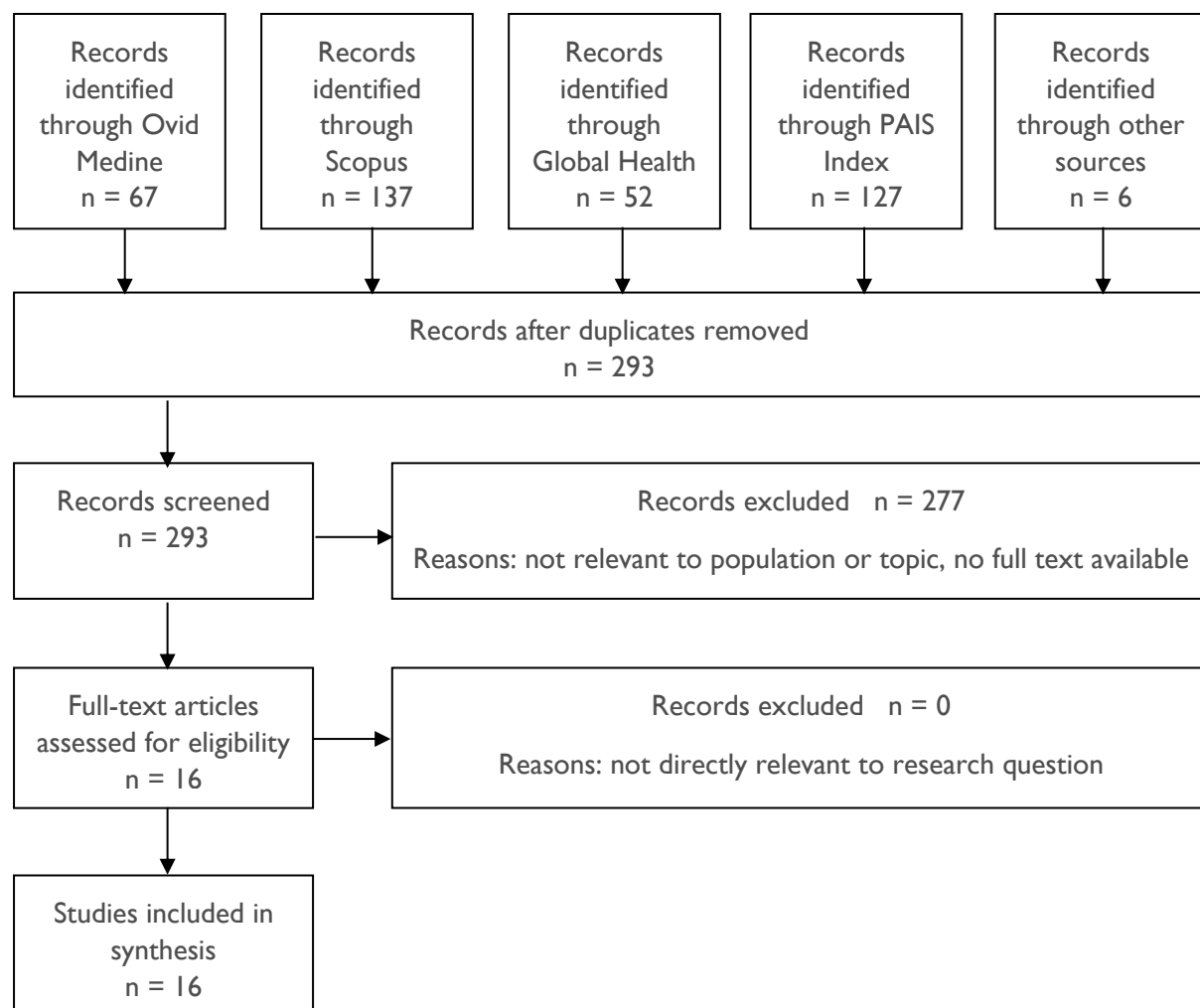
Scopus: (migrant OR refugees OR asylum seek) AND social determinants of health

Global Health: (migrant OR refugees OR asylum seek) AND social determinants of health

PAIS Index: (migrant OR refugees OR asylum seek) AND social determinants of health

Google: (migrant OR refugees OR asylum seek) AND social determinants of health

Literature identification



Strengthening health monitoring and health information systems

Key words

Ovid Medline: (emigrants and immigrants OR transients and migrants OR refugees OR asylum seek) AND (World Health Organization OR health information systems OR health planning OR family practice OR public health OR information systems OR health information systems OR medical records OR health policy) AND (clinical pathway OR clinical protocol OR consensus OR guideline OR position statement OR policy statement OR practice parameter OR best practice OR standard OR path OR pathway OR protocol OR map OR plan)

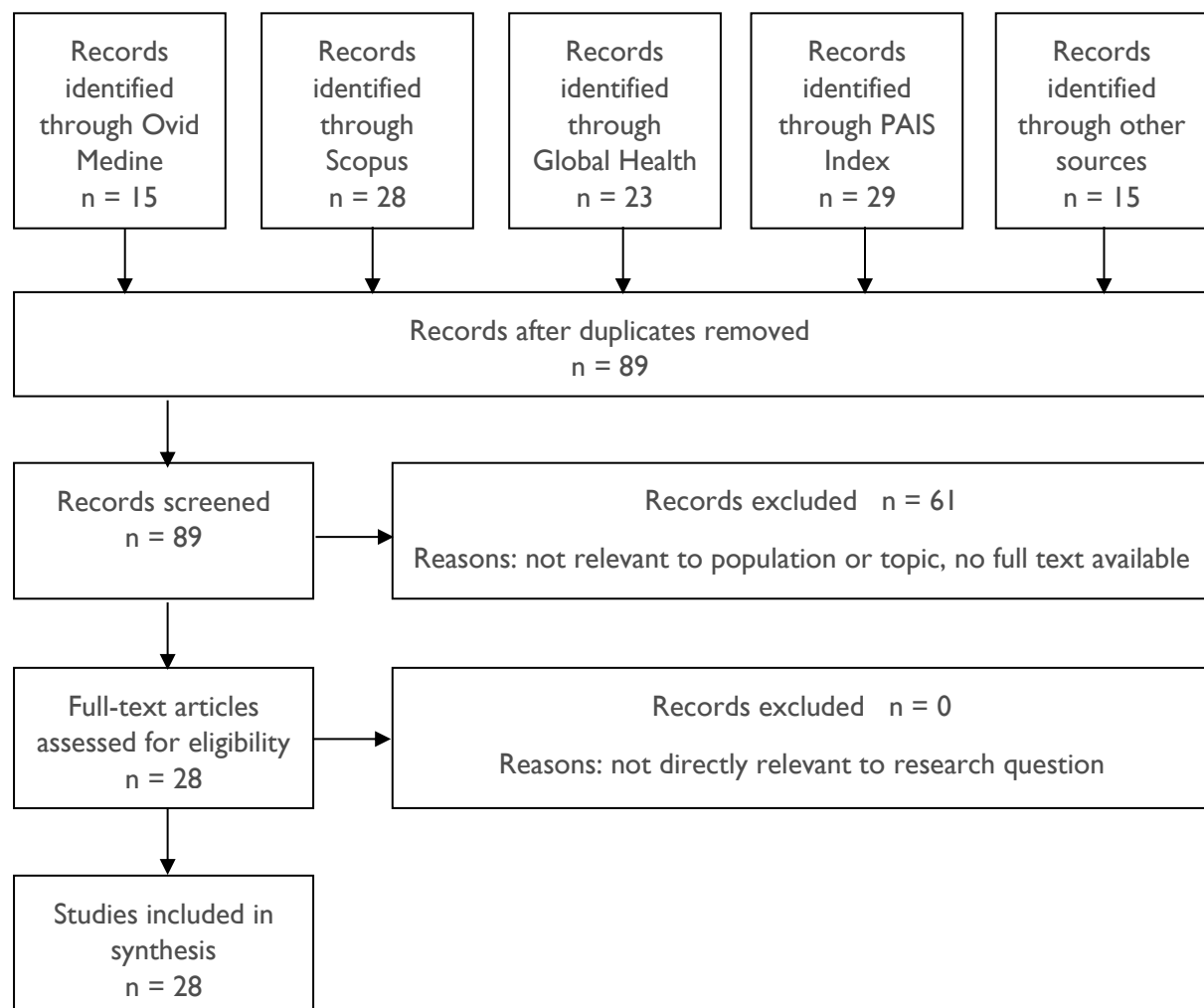
Scopus: (migrant OR refugee OR asylum seek) AND health information system

Global Health: (migrant OR refugee OR asylum seek) AND health information system

PAIS Index: (migrant OR refugee OR asylum seek) AND health information system AND health

Google: (migrant OR refugee OR asylum seek) AND health information system

Literature identification



Promoting Universal Health Coverage

Key words

Ovid Medline: (emigrants and immigrants OR transients and migrants OR refugees OR asylum seek) AND (universal coverage OR health services accessibility OR health insurance OR health equity)

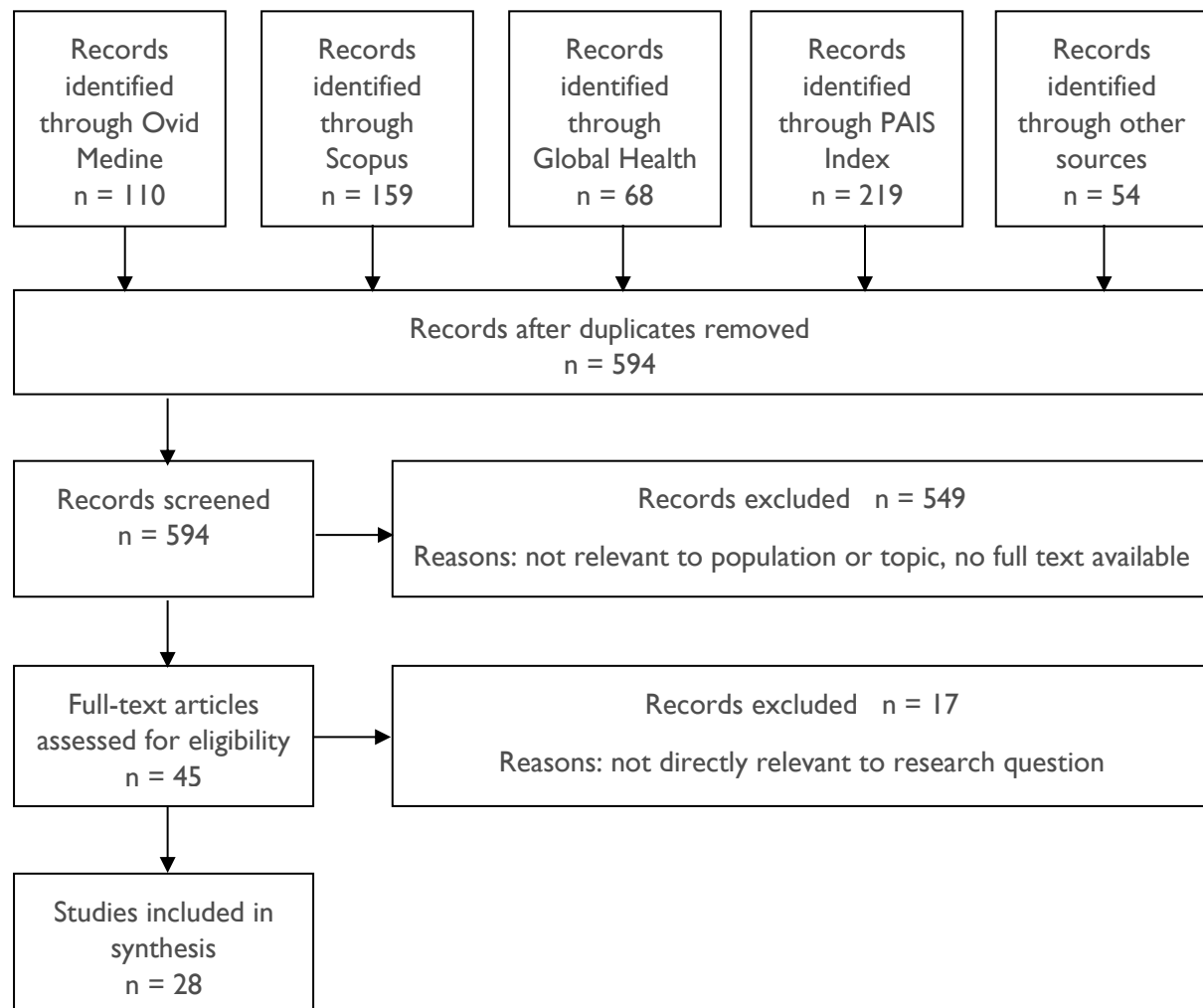
Scopus: (migrant OR refugee OR asylum seek OR immigrant OR transient) AND (universal health cover OR essential health services OR health access OR health equity)

Global Health: (migrant OR refugee OR asylum seek) AND (universal coverage OR access)

PAIS Index: (migrant OR refugee OR asylum seek) AND (universal coverage OR access OR equity) AND (health OR healthcare OR health care OR health services OR medicines OR vaccines)

Google: (migrant OR refugee OR asylum seeker) AND (universal coverage OR healthcare access)

Literature identification



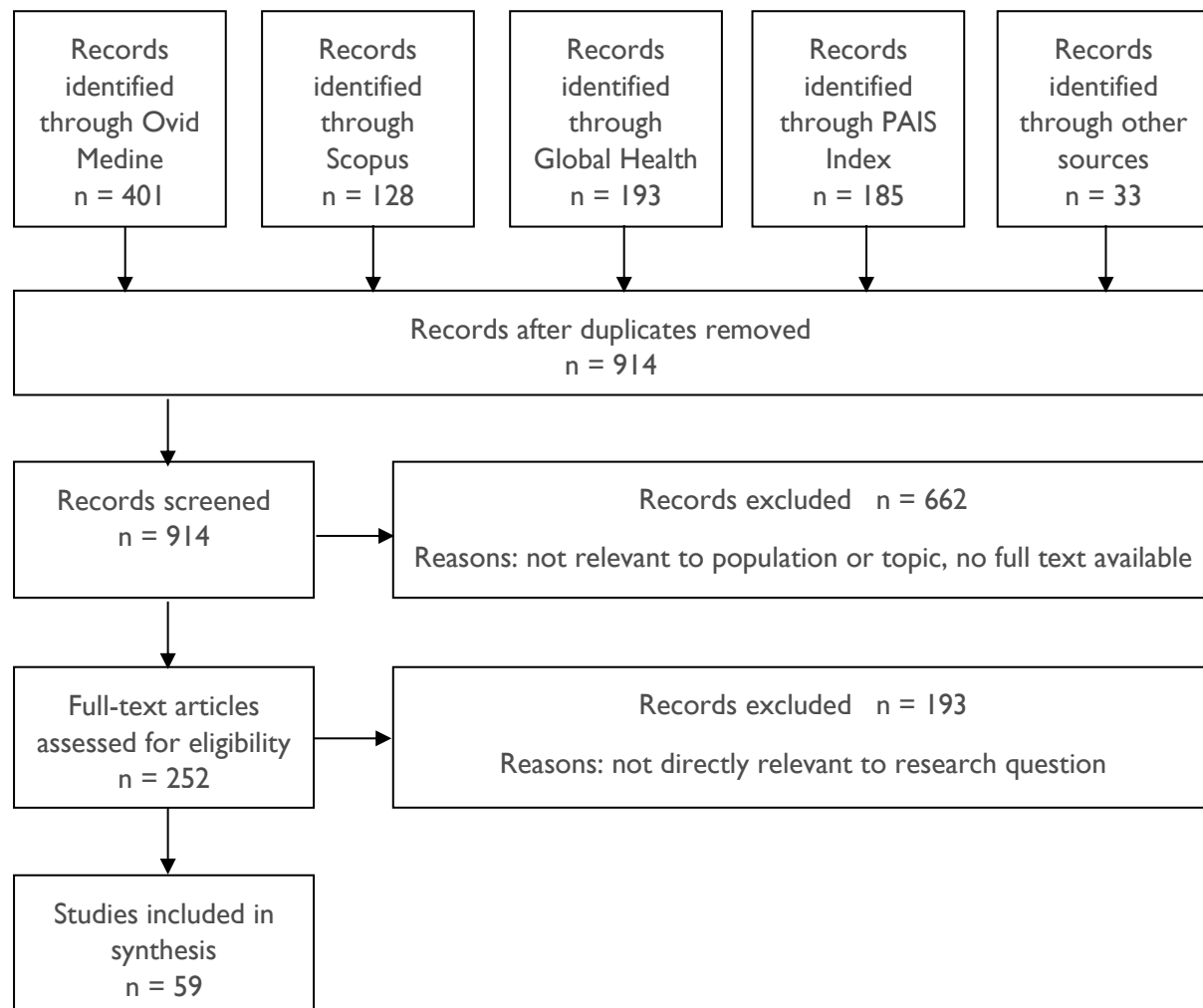
Reducing morbidity and mortality through public health interventions

Key words

Ovid Medline, Scopus, Global Health, PAIS Index and Google:

(migrant OR refugee OR asylum seek) AND (communicable disease OR infectious disease OR noncommunicable disease OR chronic disease OR mental health OR morbidity OR (mortality))

Literature identification



Protecting and improving the health and well-being of women and girls

Key words

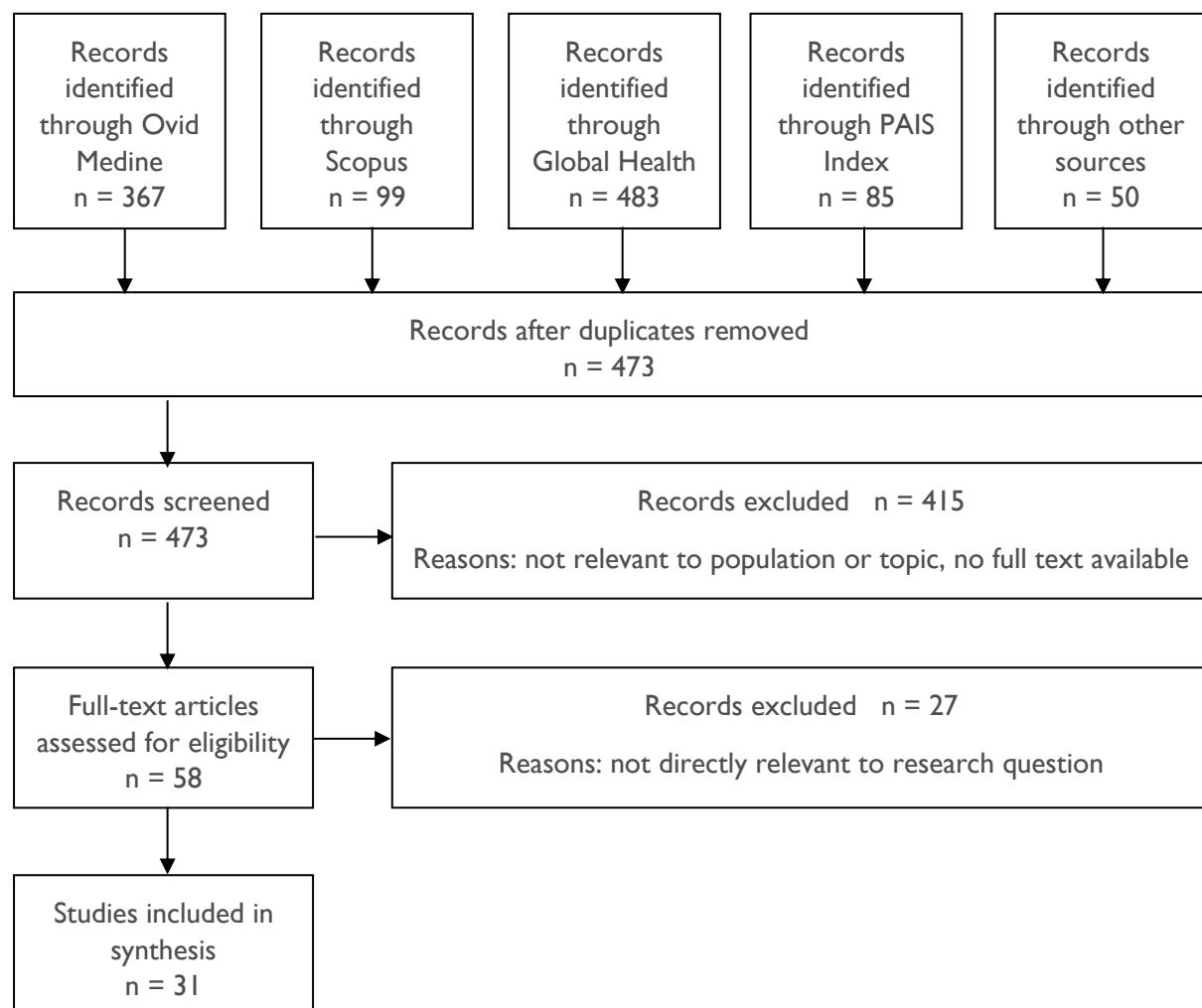
Ovid Medline: (migrants and immigrants OR transients and migrants OR refugees OR asylum seek) AND (reproductive health OR sexual behaviour OR adolescent OR pregnancy in adolescence OR family planning services OR sexual health OR domestic violence OR gender based violence OR maternal health OR emergency obstetric services OR prenatal care OR postnatal care OR sexually transmitted diseases OR child health)

Scopus: (migrant OR refugee OR asylum seek) AND (reproductive health OR gender based violence OR child health OR sexual health OR maternal health OR prenatal care OR postnatal care or sexually transmitted infection OR sexually transmitted disease OR STI OR sexual violence OR child health OR adolescent health OR vaccination)

Global Health, PAIS Index, and Google:

(migrant OR refugee OR asylum seek) AND (reproductive health OR gender based violence OR child health OR adolescent health OR sexual health OR maternal health OR emergency obstetric OR prenatal OR postnatal OR sexually transmitted OR vaccination)

Literature identification



Promoting continuity of care

Key words

Ovid Medline: (migrants and immigrants OR transients and migrants OR refugees OR asylum seek) AND (quality of healthcare OR continuity of patient care)

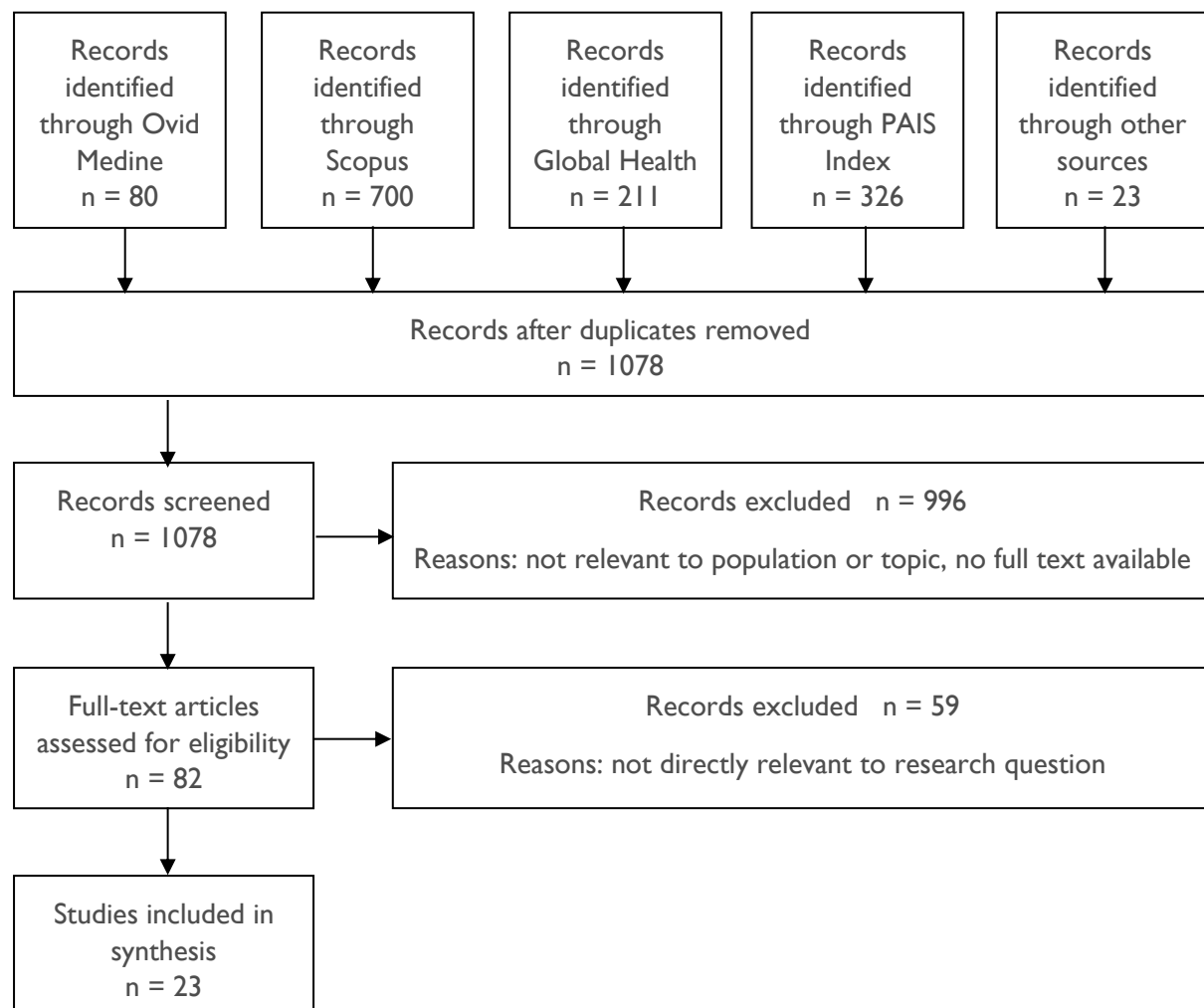
Scopus: (migrant OR refugee OR asylum seek) AND (quality OR continuity) AND (healthcare OR health service)

Global Health: (migrant OR refugee OR asylum seek) AND (quality OR continuity) AND (healthcare OR health service)

PAIS Index: (migrant OR refugee OR asylum seek) AND (quality OR continuity) AND (healthcare OR health service)

Google: (migrant OR refugee OR asylum seek) AND (quality OR continuity) AND (healthcare OR health service)

Literature identification



Promoting gender equality and empowering women and girls

Key words

Ovid Medline: (migrants and immigrants OR transients and migrants OR refugee OR asylum seek)
AND (equal OR empower) AND (gender OR women OR girl)

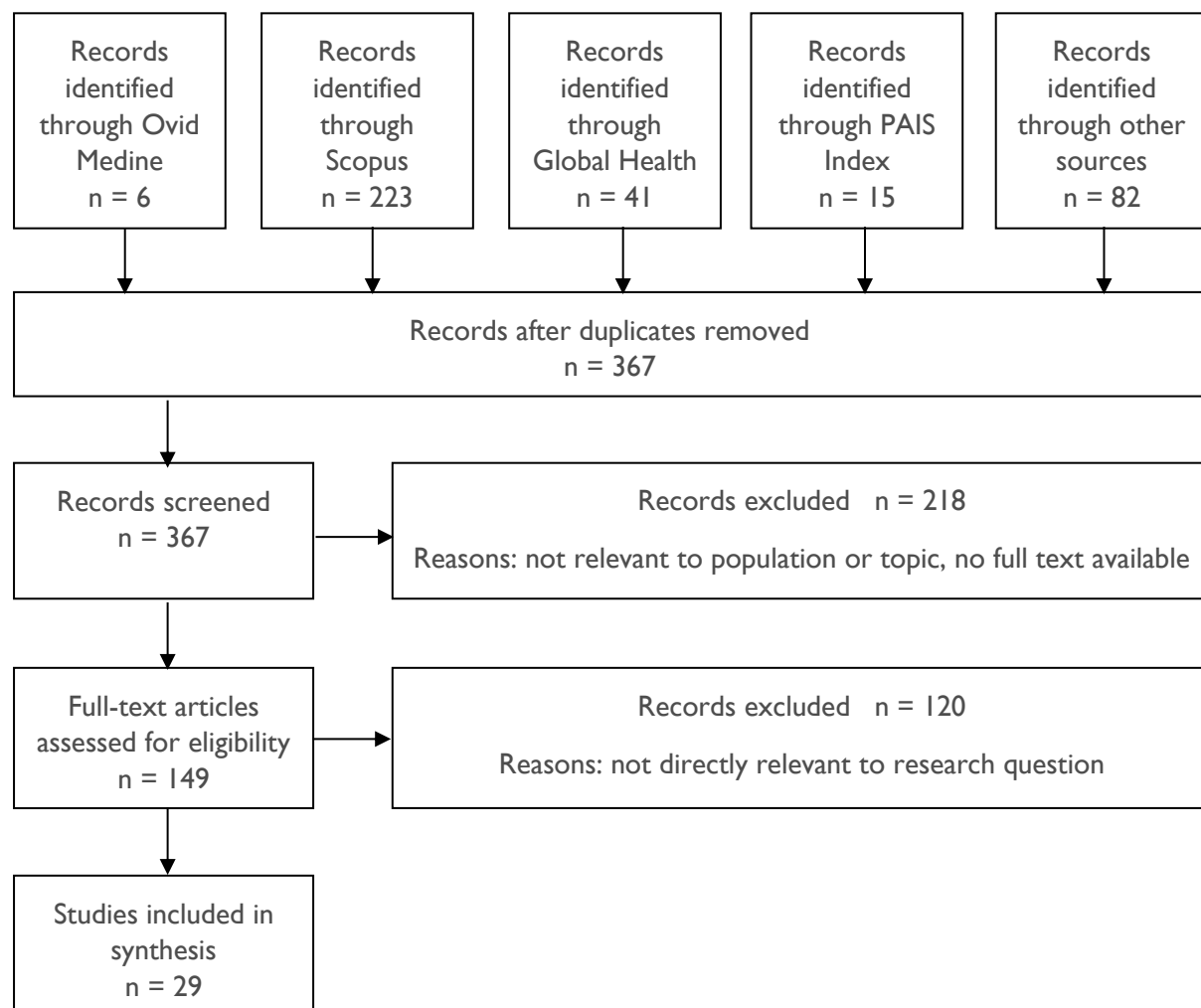
Scopus: (migrants and immigrants OR transients and migrants OR refugee OR asylum seek)
AND (equal OR empower) AND (gender OR women OR girl)

Global Health: (migrants and immigrants OR transients and migrants OR refugee OR asylum seek)
AND (equal OR empower) AND (gender OR women OR girl)

PAIS Index: (migrants and immigrants OR transients and migrants OR refugee OR asylum seek)
AND (equal OR empower) AND (gender OR women OR girl)

Google: (migrant OR refugee OR asylum seeker) AND (empowerment OR equality) AND
(women OR gender OR girls) AND (health) AND (policy OR intervention OR
program OR service OR approach)

Literature identification



Improving communication and countering xenophobia

Key words

Ovid Medline: (emigrants and immigrants OR transients and migrants OR refugees OR asylum seek) AND (xenophobia or communication or discriminat)

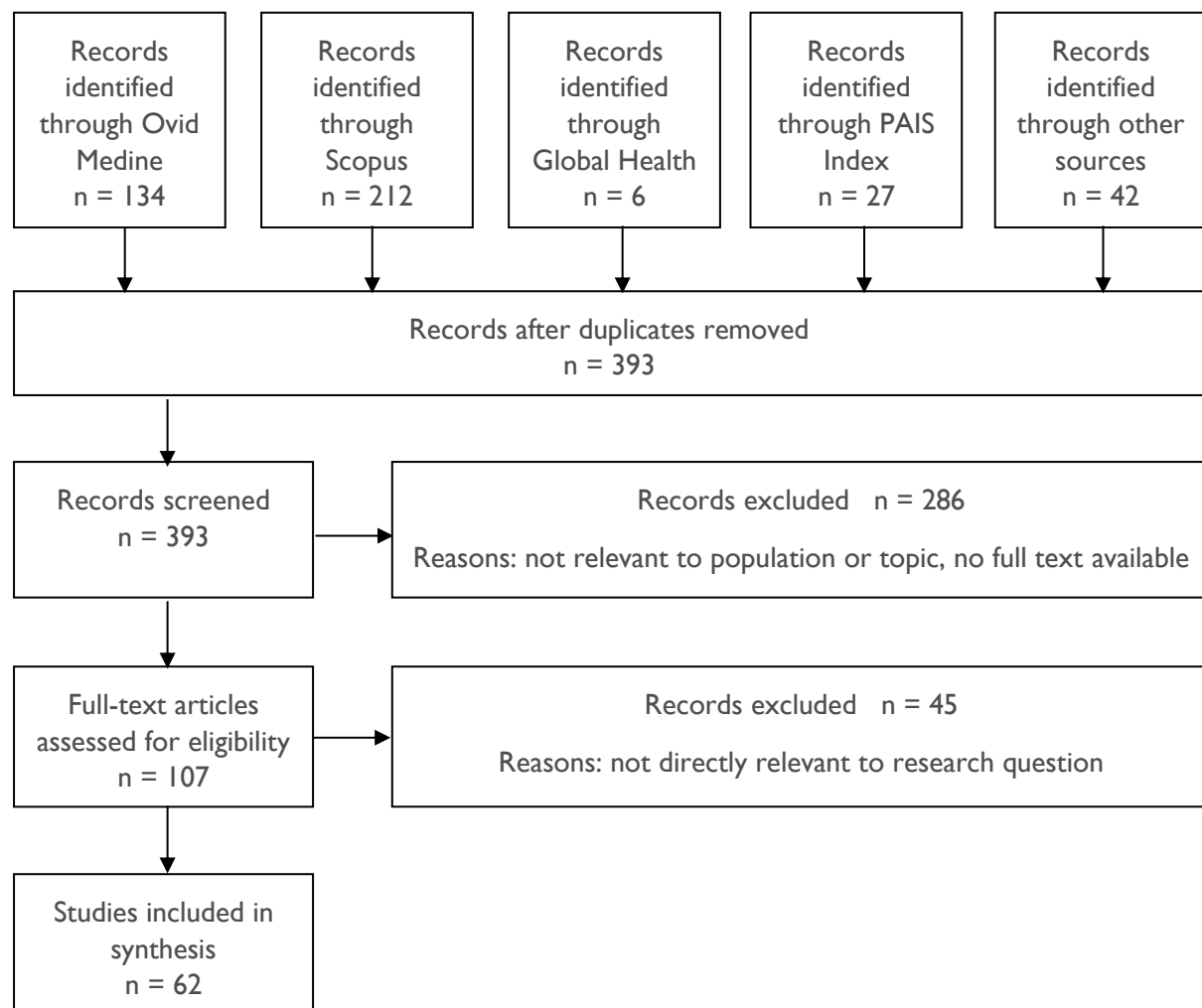
Scopus: (migrant OR refugee OR asylum seek) AND xenophobia

Global Health: (migrant OR refugee OR asylum seek) AND xenophobia

PAIS Index: (migrant OR refugee OR asylum seek) AND xenophobia

Google: migrant AND right to health

Literature identification



Strengthening partnerships, coordination and collaboration

Key words

Ovid Medline: (emigrants and immigrants OR transients and migrants OR refugees OR asylum seek) AND (international cooperation OR interinstitutional relations OR community-Institutional relations OR public-private sector partnerships)

Scopus, Global Health and PAIS Index:

(migrant OR refugee OR asylum seek) AND (international cooperation OR interinstitutional relations OR community-Institutional relations OR public-private sector partnerships)

Google: (migrant OR refugee OR asylum seek) AND (international cooperation OR international partnerships)

Literature identification

