

# Health of refugees and migrants

Regional situation analysis, practices,  
experiences, lessons learned and  
ways forward

**WHO Region of Americas**  
2018





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# WHO Region of the Americas

## I. INTRODUCTION

### Background

To achieve the vision of the 2030 Agenda for Sustainable Development– to leave no one behind – it is imperative that the health needs of refugees and migrants be adequately addressed. In the 140th session of the World Health Organization (WHO) Executive Board in January 2017, the Board requested that its Secretariat develop a framework of priorities and guiding principles to promote the health of refugees and migrants.<sup>1</sup> In May 2017, the 70th World Health Assembly (WHA) endorsed Resolution WHA70.15 on “Promoting the health of refugees and migrants,” urging Member States to strengthen international cooperation on the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants and to consider providing the necessary health-related assistance through bilateral and international cooperation to countries hosting and receiving large refugee and migrant populations, as well as using the framework of priorities and guiding principles at all levels. In addition, the Resolution requests the Director-General to conduct a situation analysis and identify practices, experiences, and lessons learned in order to contribute to the development of a draft global action plan to be considered for adoption by the 72nd WHA in 2019 (16).

Pursuant to this Resolution, WHO issued an online global call for contributions on evidence-based information, practices, experiences, and lessons learned in addressing the health needs of refugees and migrants. In response to this call, in effect from August 2017 to January 2018, 12 Member States in the Region of the Americas, as well as partners such as the International Organization for Migration (IOM) and the International Labour Organization (ILO) submitted valuable information on the current refugee and migrant situation, health challenges associated with migration and forced displacement, more than 21 past and ongoing practices addressing the health needs of this population, legal frameworks in place, lessons learned, and recommendations for the future.

### Scope of the report and evidence synthesis

This report<sup>2</sup>, as well as its accompanying document on practices addressing the health needs of refugees and migrants in the Region of the Americas, is intended to contribute to the development of a draft global action plan on the health of refugees and migrants and to provide Member States and partners in the Region with information on past and ongoing public health interventions and practices to address refugee and migrant health, including health care access and outcomes. This report discusses current migration trends in the Region, key regional policy frameworks and legal instruments, and health challenges faced by migrants and their host communities, emphasizing the special challenges faced by refugees, irregular and regular migrants who, because of their situation, are in conditions of high vulnerability (1-3), while examining health determinants, conditions of migration, and health issues associated with migration. This report also presents a path forward, considering current strategic lines of action at the national and supranational levels. In addition, the report’s accompanying document

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<sup>1</sup> Decision EB140(9). To access the framework of priorities and guiding principles to promote the health of refugees and migrants: [http://www.who.int/migrants/about/framework\\_refugees-migrants.pdf](http://www.who.int/migrants/about/framework_refugees-migrants.pdf)

<sup>2</sup> This report is an adapted version of the chapter on national and international migration presented in PAHO’s 2017 Health in the Americas.

highlights practices in the Region that include efforts to address the health needs of refugees and migrants. The information received from Member States and partners in response to the aforementioned WHO global call for contributions was examined and compiled in the accompanying document – practices in addressing the health of refugees and migrants in the Region of Americas.

## Methodology and type of evidence

A rapid scoping review of available technical reports and peer-reviewed and gray literature in English and Spanish, as well as Member States' and partners' contributions in response to the global call for contributions between August 2017 and January 2018.

## Synthesis questions

The objective of the review is to answer the following questions:

- What are the current migration and displacement trends in the Region?
- What are the relevant global and regional legal frameworks for addressing the health needs of refugees and migrants in the Region?
- What are the current health challenges and outcomes associated with migration in the Region?
- What are the current policies, interventions, practices, experiences, and lessons learned in the Region?
- What are the ways forward in and recommendations for addressing the health needs of refugees and migrants in the Region?

## II. CURRENT SITUATION

### Regional migration trends and demographic distribution

Migration in the Americas exhibits four trends: a steady flow of returnees due to economic crises and inhospitable social settings in high-income countries; the receipt of remittances from migrants living in high-income countries as an important source of income for several Latin American and the Caribbean (LAC) countries; human trafficking and the smuggling of migrants; and the contribution of LAC communities in the United States, Canada, and Europe to the development of cultural, economic, and social ties with their countries and communities of origin (4).

In the Americas, the number of people migrating across international borders in the Region has surged by 36% in the past 15 years, reaching 63.7 million in 2015; of these migrants, 808,000 were defined as refugees<sup>3</sup> (see Figure 1). LAC hosted the fifth largest number of international migrants (10 million), and of the 258 million international migrants reported worldwide in 2017, LAC was the region of birth of the third largest number (38 million) (6). About 15.2% of the population in North America and 1.5% of the population in LAC are international migrants. Approximately 39% of this population in LAC and 26% in

<sup>3</sup> According to IOM, a refugee is a person who "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" (Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A(2), 1951 as modified by the 1967 Protocol). In addition to the refugee definition in the 1951 Refugee Convention, Art 1(2), the 1969 Organization of African Unity (OAU) Convention defines a refugee as any person compelled to leave his or her country "owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country or origin or nationality." Similarly, the 1984 Cartagena Declaration states that refugees also include persons who flee their country "because their lives, security or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violations of human rights or other circumstances which have seriously disturbed public order" (5).

North America are 29 years old or younger, and about 51% are female (see population pyramids in Figure 2). Forced migrants within country borders account for an estimated 7.1 million people, 6.9 million of whom are in Colombia (7, 8). Most LAC members are primary sources of emigration to northern high-income countries in the Americas and Europe. Despite these flows from lower- to higher-income countries, migration between low- and middle-income countries and from higher- to lower-income countries has recently increased (9). In addition, LAC has been experiencing a significant increase in extraregional irregular migrants. For example, according to IOM, Costa Rica experienced an influx of over 5,600 irregular migrants between April and August 2016, primarily from Haiti and African and Asian countries (10).

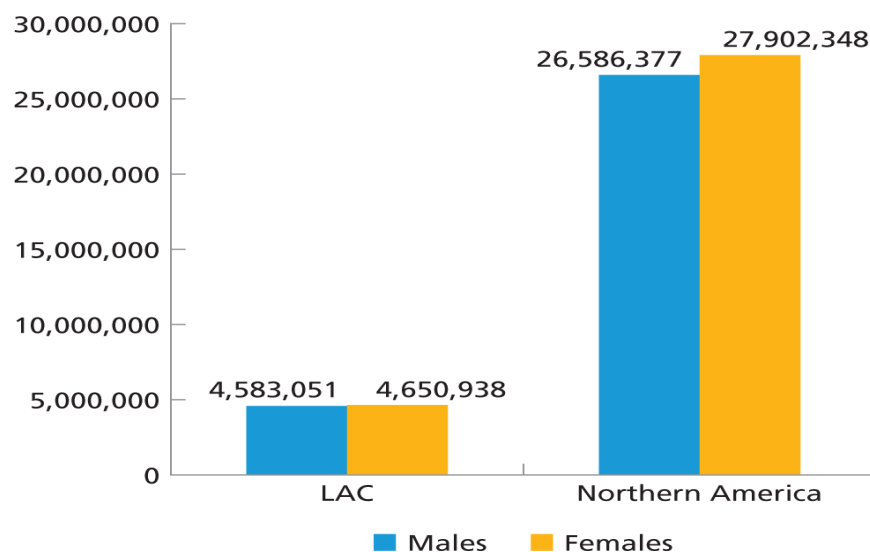


Figure 1: Total male and female international migrant stock in LAC and Northern America in 2015 (7)

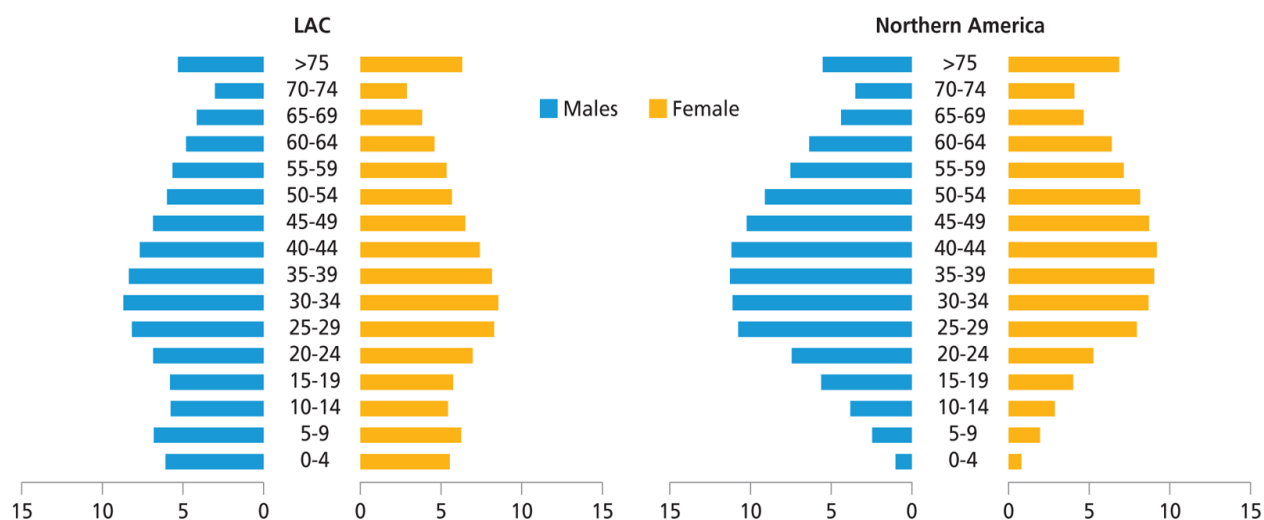


Figure 2: International migrant stock by age and sex in LAC and Northern America in 2015 (7)

### III. KEY REGIONAL FRAMEWORKS AND LEGAL INSTRUMENTS

At the Third Summit of the Americas, held in April 2001 (11), Heads of State in the Americas agreed to establish an inter-American program within the Organization of American States (OAS) for promoting and protecting the human rights of all migrants, regardless of their immigration status. The OAS recognizes that, given the scope, prevalence, and significance of the current migration phenomenon, virtually every state in the Americas has become a country of origin, transit, destination, or return for migrants, and as a direct result of this, migration has become a priority in the Region (12).

Specifically in health, the new WHO International Health Regulations of 2005 (13) were adopted "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade." As of 2016, the status of all core capacities established in the International Health Regulations across PAHO Member States continues to be heterogeneous, with the lowest scores consistently recorded in the Caribbean (14). In September 2016, the Directing Council of PAHO adopted Resolution CD55.R13 "Health of Migrants," urging PAHO Member States to generate health policies and programs to address health inequities that affect migrants; improve regulatory and legal frameworks in order to address the specific health needs of migrants; ensure access to the same level of financial protection and health services that other people living in the same territory enjoy; and coordinate programs and policies on the health of migrants in the border areas between countries (15).

At the 53rd Directing Council of PAHO in 2014 (17), the Member States approved the Strategy for Universal Access to Health and Universal Health Coverage (18) as the overarching framework for health system action to protect the health and well-being of migrants. Moreover, in April 2017, the ministers of health and health authorities of the Mesoamerican countries signed the Ministerial Declaration on Migration and Health in Mesoamerica, which recognizes the commitment to improve the health of migrants (19). Among other provisions, the Declaration outlines agreements to work jointly to share experiences and good practices to improve information systems, promote changes and improvements in regulatory frameworks to meet the health needs of migrants, strengthen interagency and intersectoral work capacities, establish mechanisms for multilateral cooperation, and strengthen health surveillance systems for the in-transit population.

In November 2017, representatives of South American governments met at the 17th South American Conference on Migration (SACM), a regional consultative forum on migration that, since its creation in 1999, has promoted and developed international migration policies and initiatives in the South American context (20). With the theme "inclusion and integration of migrants beyond territorial borders," the Conference focused on areas that included the human rights of migrants and the strengthening of migration governance (21). The SACM highlighted the importance of inclusive public policies on migration that consider migrants to be "under the same conditions as nationals in the host country regardless of their origin, nationality, or immigration status" (20). Also in November 2017, representatives from countries in the Americas met at the Regional Conference on Migration (RCM), a multilateral regional forum on international migration, created in 1996. The topics discussed at the meeting included strengthening institutional capacities for comprehensive assistance to migrants and forging partnerships to benefit the migrant population (22).

## Migrants' right to health and other related human rights in the Americas

The Universal Declaration of Human Rights proclaims that “all human beings are born free and equal in dignity and rights,” that every person is entitled to all human rights and fundamental freedoms, and that all persons “have the right to freedom of movement and residence within the borders of each State [and] the right to leave any country, including his own, and to return to his country” (23). The Constitution of the World Health Organization (WHO) also clearly supports the right to health: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (24). This right applies to all persons, wherever they are and regardless of their migration status.

There are 27 international legal instruments relevant to migration and human rights (25). In particular, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families of 1990 (3) has increasingly been recognized and prominently reflected in the international agenda. As States Parties to the Convention, 18 governments in the Americas have acknowledged the need to integrate health needs and the vulnerability of migrant workers into their national plans, policies, and strategies. Accordingly, these governments have demonstrated a heightened appreciation for the development of health programs and policies that address health inequities and improve access to health facilities, goods, and services. It is important to note that migrant destination countries such as Brazil, the Dominican Republic, Canada, and the United States have yet to take action on the Convention.

In the Americas, the 59th Session of the Executive Committee of PAHO, held in 1968, began discussing the relationship between health and international human rights instruments in the context of the technical cooperation that PAHO provides to its Member States (26). In 2007, ministers and secretaries of health of the Americas underscored their commitment to the aforementioned international principle in the Health Agenda for the Americas (2008–2017). In so doing, they placed human rights among this instrument's principles and values and reconfirmed the importance of ensuring the highest attainable standard of health by stating, “In order to make this right a reality, the countries should work toward achieving universality, access, integrity, quality and inclusion in health systems that are available for individuals, families, and communities” (27). In 2010, the 50th Directing Council of PAHO agreed to work to improve access to health care for groups in conditions of vulnerability, including migrants, by promoting and monitoring compliance with international human rights treaties and standards (28).

## IV. HEALTH CHALLENGES AND AREAS OF CONCERN IN THE REGION

At the national level, there are wide differences in the extent to which countries in the Americas have considered and implemented national migrant policies that include the health dimension. They range from free access to health services in the formal public system for all people in precarious economic conditions, including migrants, as in Argentina (29), Brazil (30), and El Salvador (184), to ensuring health insurance coverage or health services in the public system only to migrants with legal residence status, as in the United States (31) and Canada (32). The overall political climate in a country is an important factor that can help or hinder health systems in becoming more responsive to the needs of migrants (33). The range of areas to be addressed by migrant-sensitive health policies should go beyond improving health services to include action to address the social exclusion of migrants and their employment, education, and housing conditions.



Migrants, especially irregular and forced migrants, often have limited access to appropriate health services and financial protection in health. Factors associated with health policies and the organization of health systems can constitute formal barriers to health service access. These include legal restrictions on entitlements to health services and financial barriers to irregular and forced migrants. In several countries in the Americas, only emergency and limited private health services run by charities are available to these migrants. For example, exclusionary policies and treatment resulted in limited access to health services for male Latino migrant workers in North Carolina, U.S.A. (34). User fees can also be considered a formal barrier, creating inequality in access due to migrants' limited financial means.

Low levels of health literacy, language differences, sociocultural factors, stigma, and perceptions of the health system may constitute informal health service access barriers (35-37). The health beliefs and health-seeking behavior of migrant groups may differ from those of host communities because of their needs and the differences in social norms, culture, and structure of the health systems in their communities of origin. For example, a study of a shelter in Monterrey, Mexico, housing migrants primarily from Central America shows that migrants avoided public health services due to their need to work in order to survive and the constant fear of being traced (38). In these situations, health education is often regarded as a solution that can improve health literacy and help migrants acquire the skills they need to navigate their new health system. Health education programs for migrant groups need to be properly targeted to reach them more effectively (39). Limited proficiency in the host community's language can also pose a major obstacle to health service access. For example, an analysis of 2003 and 2005 data from the U.S. Behavioral Risk Factor Surveillance System showed that Spanish-speaking Hispanics reported far worse access to care than did English-speaking Hispanics (40). Migrants may also be reluctant to make use of services because of stigma or anxiety about reactions within their own community. Mental health disorders, for instance, are often stigmatized in migrant communities. For example, the discrimination and humiliation experienced by Haitian migrants in the Dominican Republic have contributed to poor mental health and limited access to health services in this group (41). Reproductive health, sexuality, pregnancy, and childbirth are sensitive topics that people may find difficult to discuss with a stranger. Often, one of the elements that helps overcome informal barriers to health service access is trust.

## **Social determinants of health of migrants**

Migration is regarded as a social determinant of health, since the health of migrants is determined primarily by conditions along the migration path. The health of migrants can vary with personal characteristics, individual and relational factors, social and community influences, living conditions, and general socioeconomic, cultural, and environmental conditions (30). In particular, irregular and forced migrants may travel to destination communities under perilous conditions. For example, many irregular migrants from Central America ride atop moving cargo trains colloquially known as *La Bestia*, or the beast, on their journey across Mexico to the United States. Along the way they face physical perils including amputation and death. They are also subject to extortion and violence at the hands of gangs and groups affiliated with organized crime (42).

Migrants work in some of the riskiest industries in their destination communities, including agriculture, forestry, fishing, and construction. These types of work have higher injury and fatality rates than other sectors. Migrant farmworkers are also more exposed to pesticides and their associated health risks. Moreover, their housing tends to be characterized by unsafe drinking water; crowding; substandard and unsafe heating, cooking, and electrical systems; poor sanitation; dilapidated structures; and food insecurity. For example, it is estimated that more than half of the migrant farmworker households in the

United States suffer from food insecurity due to their limited access to transportation, food storage, and cooking facilities (43).

Migration can also affect the health and well-being of relatives who remain in the communities of origin through remittances and “brain drain” (that is, the migration of educated workers to higher-paying countries). On the one hand, remittances can improve the economic conditions of remittance-receiving households in communities of origin and can have a positive effect on their health and well-being. Households that receive remittances have better human development outcomes, including greater access to health services, less crime, and better education. A study in Nicaragua, for example, showed that about 48% of remittances are used to pay for health services, 27% for home improvements, 15% for education, and 10% for savings (44). In 2014, there was a US\$ 63.6 billion inflow of remittances to LAC countries, with the top remittance recipients being Haiti (22.7% of gross domestic product, or GDP), Honduras (17.4% of GDP), El Salvador (16.8% of GDP), and Jamaica (16.3% of GDP). On the other hand, family separation may have a negative impact on health and well-being, including psychological trauma, material hardship, residential instability, and family dissolution. Remittances may also create tensions and inequalities between households that receive them and those that do not (45, 46). In addition, communities of origin may find themselves at risk of a talent “brain drain,” depriving them of trained workers in key sectors of their economy (47).

## Health along international borders

The nature of existing cross-border political cooperation can influence the health situation of the border population and at the same time determine how the countries and their respective border populations organize for a joint response to their health needs. For border areas in which the relationship is one of mere coexistence or even confrontation between countries, tackling health issues may foster understanding between them. For example, in 2012, Paraguay was politically suspended from regional country integration systems but continued participating in health projects. This shows that joint work in health activities can overcome political barriers, bringing neighboring nations together (48). For border areas in which the relationship is one of interdependence between countries, there is mutual interest in improving health conditions. However, in several cases, that interdependence may be asymmetrical. For example, there has been financial asymmetry in environmental health collaboration between the United States and Mexico along the border. Most of the funds available for border programs have been provided by the U.S. Environmental Protection Agency, giving this agency more control over the program agenda (49). For borders where relationships are more integrated, countries and border communities make maximum use of existing resources (50); examples include portable health insurance for communities at the border between Uruguay and Brazil (51-56), health services shared by Ecuador and Peru (57), and the joint delivery of emergency health services by Chile and Argentina (58, 59).

Defining health priorities and designing structures and mechanisms to address border health issues may be official or unofficial. For the former, the predominant actors are national and subnational governments, including local governments, in the countries that share the border (60, 61). Generally, the higher the level of participation by public institutions, the better organized the structures or mechanisms and the longer-term their objectives (62, 63, 64–68). However, they may also be more political, slower to act, less sensitive to the perceived needs and assets of border communities and have more problems addressing issues on which the countries do not agree (69, 70). The opposite is the case when unofficial structures and mechanisms such as academic, private, or community-based institutions play the central role (71, 71–75). They are often more technical and have a more limited sphere of work and a shorter-term vision. They also tend to be transient or have limited sustainability. Many border areas address health issues through both mechanisms. For example, health issues in the U.S.–Mexico

border area are addressed by formal national and state-level structures through the United States–Mexico Border Health Commission or more informal structures through binational health councils that are part of sister city arrangements (76).

Depending on their objectives, the structures and mechanisms can be temporary or permanent. Countries in the Americas have developed structures and mechanisms to address border health issues that include the types mentioned, from specific short-term projects to medium-term programs to permanent binational commissions (77, 78), the latter of which have been developed primarily for cases in which the needs of border communities have been made a national priority and placed at the highest level of the political agenda.

## Humanitarian health assistance

In the Americas, estimates by the Inter-Agency Standing Committee (IASC) (79) indicate that Haiti, Colombia, and Guatemala have the highest risks for humanitarian crises and disasters. This is illustrated by the five-fold increase in asylum-seekers, primarily unaccompanied children, from Guatemala, El Salvador, and Honduras from 2012 through 2015 (UNHCR) (80). Moreover, as it strives to resolve decades of conflict, Colombia reported about 6.9 million internally displaced persons.<sup>4</sup>

In 2016, PAHO reported giving critical support to several Member States that have experienced unexpected migrant flows, including Colombia with 171,000 Venezuelan migrants between October 2015 and May 2016; Central America, where over 5,000 Cuban nationals were stranded in late 2015, after traveling through Ecuador with the apparent intention of continuing northward to the United States; and Haiti, with approximately 100,000 nationals repatriated in 2015 after living in the Dominican Republic (81).

A special concern during humanitarian crises is the need for adequate basic health services and sanitation in shelters and settlements. For example, in Colombia, even though 75% of the internally displaced persons were affiliated with the national social security program in 2014, only 32% had access to health services. (Of those, 38% were male and 62% were female.) Barriers to health services include limited infrastructure, technology, and human resources in rural areas (82). The low vaccination rate among Venezuelan migrants in Colombia also raised concerns about a potential change in the host population's health profile. Another major health concern was the increased risk of cholera outbreaks among deported migrants in the Haiti–Dominican Republic border area (83).

Finally, the impact of climate change—primarily on Small Island Developing States such as the ones in the Caribbean and on indigenous communities—have led to discussions about decision-making regarding the potential need to migrate (84, 85). Climate-induced migration may represent forced displacement from rural to urban areas and from one country to another. The range and extent of health risks associated with future climate-related population movements cannot be clearly foreseen. However, the evidence of population movements due to similar situations indicates that health risks will predominate over health benefits (86).

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<sup>4</sup> According to IOM, internally displaced persons are “persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border” (Guiding Principles on Internal Displacement, UN Doc E/CN.4/1998/53/Add.2).

## Health of migrant workers

According to the ILO (87), in 2013 there were 150.3 million migrant workers worldwide (55.7% male and 44.3% female), representing 4.4% of the global workforce. The majority of international migrant workers were in high-income countries, about 24.7% in North America and only 2.9% in LAC, accounting for 20.2% and 1.4% of the workforce in North America and LAC, respectively. These workers were concentrated in certain economic sectors, primarily services (71.1%), industries that included manufacturing and construction (17.8%), and agriculture (11.1%). Domestic service migrant workers represented 7.7% of all international migrant workers (with 73.4% of domestic service migrant workers being female) and were concentrated in high-income countries.

The ILO estimates that in 2015, migrant workers sent US\$ 601 billion in remittances to their home countries, evidence that their work is a driver of economic development in the countries of origin. At the same time, migrant workers fill labor gaps in countries of destination. Nonetheless, unequal distribution of the types of work, income, benefits, and job opportunities has raised questions of social justice, sustainable development, and health equity (88).

Based on the impetus created by the adoption of the 2030 Agenda for Sustainable Development, the ILO has developed several instruments for addressing migrant workers' health rights and equity. For example, the GEM (gender equality in labor migration law, policy, and management) tool kit (89) was created to support fair immigration and respect for the fundamental rights of women migrant workers, seeking to offer them real opportunities for decent and healthy work.

## Disease burden

### Communicable diseases

In the Americas, the spectrum of communicable diseases among migrants may range from diseases that require acute recognition and management (such as malaria) to chronic illnesses with significant public health concerns (such as tuberculosis and HIV/AIDS). The recognition and management of infectious diseases in migrants requires knowledge of the geographic context, modes of transmission, and clinical presentation of a wide variety of infectious agents. Health care providers in destination communities may be unfamiliar with many of these infections.

### *Malaria*

In South America, small-scale gold mining draws people from different countries to the Guiana Shield, an area comprising Guyana, Suriname, French Guiana, and parts of Colombia, Brazil, and Venezuela. In 2014, miners in this region, known in Brazil as *garimpeiros*, accounted for at least 13% of all malaria cases in the Americas. The number is very likely even higher due to underreporting, since many miners live solitary lives and tend to avoid health facilities. Mining also prompts related movements within country borders, leading to malaria outbreaks. For example, malaria cases in the Sifontes municipality of Bolivar State in Venezuela soared from around 21,000 cases in 2010 to over 52,000 in 2014 due to the growth of the mining population from other parts of the country (90).

The importation of cases is a major factor that can hinder progress in outbreak control and defer elimination of the disease. For example, the district of Candelaria in Campeche State, Mexico, near the Guatemalan border, reported an outbreak of malaria in 2014, even though it had had no cases in previous years. A change in migration patterns was suggested as a possible reason for this outbreak.

Similarly, malaria in Dajabon, in the northwest corner of the Dominican Republic, has been attributed to mobility across the international border between the Dominican Republic and Haiti. This location is known for its binational market, which attracts residents from both countries. Since 2005, approximately 2,000 Haitians have entered the Dominican Republic twice weekly to buy and sell their goods. The number of malaria cases subsequently reported increased from approximately 100 in 2005 to about 1,000 in 2007. This number has decreased in recent years (17 cases in 2014) due to focused interventions (91).

### *Tuberculosis*

In the Americas, migrant groups are associated with an increase in TB prevalence in low-risk countries. For example, the increase in TB incidence in Costa Rica between 2009 and 2011 was associated, *inter alia*, with the influx of Nicaraguan migrants. The increase in TB incidence in Chile was also associated with migrants from endemic countries (92).

At the national level, migration has also influenced the incidence of TB in destination countries outside the Americas. For example, Spain has one of the highest TB incidence rates in Europe, with approximately 20 cases annually per 100,000 population, primarily among international migrants. In Barcelona in particular, the percentage of foreigners with TB increased from 5% to 32%, with an incidence rate of more than 100 cases per 100,000 population per year between 1999 and 2000 (93). Studies conducted between 1998 and 2013 revealed that multidrug-resistant TB was 2.5 to 4.0 times more frequent in immigrant populations from Latin America, Eastern Europe, Africa, and Asia than in the native Spanish population. Multidrug-resistant TB was diagnosed in 7.8% of immigrant population cases but in only 3.8% of native-born cases (94, 95). Moreover, studies using Spanish national surveillance data between 2004 and 2009 reported that TB was often diagnosed in later stages in migrant populations due to their limited access to quality migrant-sensitive health services (96). About 60% of TB cases in migrants were diagnosed in hospitals rather than primary health care facilities.

### *HIV/AIDS*

Migration can disrupt migrants' access to HIV services. Barriers include lower and late access to testing and treatment and fear of discrimination and deportation (97). For example, there are documented cases of Central American migrants having their HIV services disrupted when they travel through Mexico to the United States (98). According to a cross-sectional study by Leyva-Flores et al. (99), HIV prevalence among Central American migrants traveling through Mexico was 0.71% between 2009 and 2013, peaking at 3.45% in the transvestite, transgender, and transsexual community, a reflection of the concentrated epidemic in the countries of origin. In addition, there appears to be a modest positive association between population mobility, measured by the net migration rate, and HIV prevalence in Central America and Mexico when socioeconomic cofactors are included by country (education, health, and income) (100). Moreover, male migrants who stayed in border areas were more likely to have engaged in sex, and to have had unprotected sex, with female sex workers during their recent stay on the border compared with those in other contexts (101).

### **Noncommunicable diseases**

A number of studies have shown differences in the risk for noncommunicable diseases among different population groups of recent LAC migrants to the United States and between recent international migrants and populations born in the United States. For example, recent migrants from South America

to the United States have a lower prevalence of diabetes and overweight than the average U.S.-born population and a lower prevalence than recent migrants from Mexico, Central America, and the Caribbean, as well. Moreover, there appears to be a higher morbidity and mortality burden among Latinos born in the United States versus Latinos born elsewhere. The decline in health status of subsequent generations of Latinos can be attributed to negative acculturation and to the adoption of unhealthy behaviors (poor diet, smoking, alcohol consumption, substance abuse, and physical inactivity) that are more prevalent in the receiving communities to which the migrants moved (102, 103). Furthermore, conditions related to communities of origin appear to have a protective effect on cancers but not on obesity and diabetes. Over time, however, the rates of most cancers tend to converge towards the rates seen in locally born residents (104).

Rural-to-urban mobility in low- and middle-income countries, such as the Andean countries, can also be detrimental to the health of migrants due to changes in dietary and physical activity patterns, heightening the risks, such as hypertension and obesity, for cardiovascular disease (105). However, it appears that the impact of rural-to-urban migration on the cardiovascular risk profile is not uniform across different risk factors and can be further influenced by the age at which migration occurs (106). Moreover, rural-to-urban migrants may have better access to health services than the populations who stay in rural areas (107).

Many studies have reported that the migration process can lead to a whole spectrum of mental health disorders – for example, psychoses (108), posttraumatic stress disorder (109, 110), depression (111, 112), and suicidal acts (113). Multiple factors and complex interactions will determine post-migration adjustment and the outcome of migration. The evidence of mental health disorders among populations who migrate between or within LAC countries is limited. Only a few studies report an association between natural disasters and mental disorders in the region (114–116). Other studies show an increase in psychological issues in migrant children and adults due to political repression in their countries of origin (117–120). On the other hand, there is significant evidence of mental health disorders in people who migrated from LAC to North America (121, 122).

While the aforementioned elements can have an impact on all migrants, some social groups may be exposed to additional risk factors that must be taken into account when considering possible psychosocial or mental disorders, especially for women; children and adolescents; the elderly; lesbian, gay, bisexual, and transsexual (LGBT) people seeking asylum; indigenous populations; and people with mental disorders prior to migrating (123). Preexisting mental health conditions can be intensified due to the same requirements of adaptation over short periods of time that many migrants without preexisting conditions experience (124).

## Violence

Violence is an increasingly important driver of migration in LAC (125). According to 2012 estimates (the most recent available), 18 of the 20 countries with the world's highest homicide rates were located in LAC (see Figure 3 for the top 10). Also, the Region's rate of 23 homicides per 100,000 population was nearly four times the world average (6.2 per 100,000)—higher than the average for “fragile and conflict-affected” countries, as defined by the UN (126). Preliminary 2015 data suggest that after the end of a gang truce in 2012, El Salvador may have overtaken Honduras as the most dangerous peacetime country in the world (127, 128).

Violence associated with transnational organized crime and gang activity in the Central American “Northern Triangle” (El Salvador, Guatemala, and Honduras) and Mexico has created what the UNHCR calls a “protection crisis,” forcing thousands of men, women, and children to leave their home (125). Applications for asylum by Northern Triangle migrants in Belize, Costa Rica, Mexico, Nicaragua, and



Panama soared by almost 1,200% between 2008 and 2014, and the number of families and unaccompanied minors migrating north from Central America through Mexico toward the United States has risen sharply (129, 130). Meanwhile, civil war in Colombia has created the largest internal forced migration in the world (estimated at 6.9 million) (8), as well as a large diaspora of refugees in neighboring countries such as Ecuador (131).

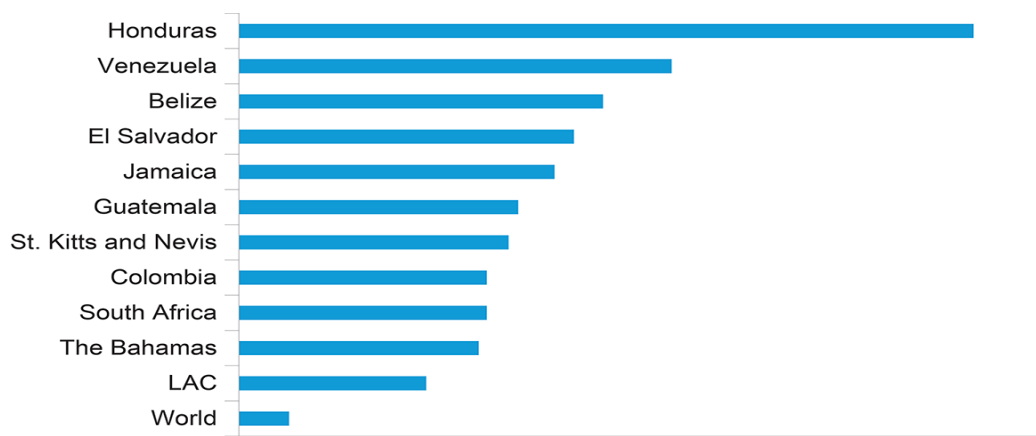


Figure 3: Countries with the highest homicide rates per 100,000, 2012 (135)

Violence plays a particularly important role in female migration. A 2015 UNHCR study found that the majority of women interviewed after migrating north out of Central America and Mexico cited violence, including rape, assault, extortion, and death threats, as a primary motivation for leaving their communities; much of this violence was perpetrated by intimate partners, many of whom were involved in gangs (132). Women often left after local authorities refused or were unable to provide protection. Conflict-related sexual violence has been a persistent feature of the armed conflict in Colombia and an important reason why many women have been forced to leave their communities (133, 134).

While many migrants leave home to escape violence, they often face a heightened risk of physical and sexual violence during the journey itself and within destination communities. Women and families migrating north from Central America and Mexico report high levels of extortion, kidnapping, rape, death threats, and desertion in life-threatening situations along the migration travel route (135, 136–139). Research in Colombia has documented “pervasive exposure to violence” and vulnerability to physical harm in forced migrant settlements (140). In the United States, migrant populations report high levels of certain types of violence, including sexual harassment and assault among women migrant farm workers (141–143). In sum, violence not only drives much migration in the Region but is an important human rights and public health problem during all stages of migration and displacement, including within communities where migrants and displaced populations settle.

### Children’s, Adolescents’, and Women’s Health

The Americas are home to 6.3 million migrant children, about one-fifth of the global total. Approximately 80% of them reside in three countries: the United States, Mexico, and Canada, with the United States hosting the largest number in the world, an estimated 3.7 million. An alarming concern is the percentage of children who migrate from Central America, where almost half of all migrants are under the age of 18, compared with an estimated 8%, 15%, and 15% from North America, South

America, and the Caribbean, respectively (144). A distinctive pattern in the Region is the number of children who have migrated on their own, primarily from Colombia, El Salvador, Guatemala, Mexico, and Honduras (145, 144, 146), many of them fleeing violence in their homes and communities and wishing to reunite with their families, many of whom are located in the United States (146).

Migrating children and adolescents face access barriers to adequate health services along the migration path (146). Studies have shown that children residing in households with noncitizen parents have trouble accessing health care and thus experience worse health outcomes (147). A study in Argentina reported that migrant women had poor prenatal care and newborns required more medical care than the newborns of native-born mothers (148). Similar challenges have been cited for the children of internal migrants. In a study examining child mortality associated with maternal migration in Haiti, researchers reported that children born to migrants moving from rural to urban areas or vice versa experienced higher mortality (149). Other situations faced by child migrants include being detained at borders, being left behind by migrating parents, and being forcibly returned to their countries of origin (145).

Several countries are trying to improve access to health services for migrant children. For example, Guatemala is working with IOM on capacity building for government officials to assist child migrants in transit, especially those who are unaccompanied or have been separated from their families (150). In Brazil, policies have recently been adopted to ensure equal access to coverage for all migrants, including irregular migrants (151). The growing number of unaccompanied and separated children who have been detained at the southern border of the United States (151) has led to increased cooperation between the United States and several Central American countries—led by El Salvador, Guatemala, and Honduras—in programs to reduce extreme violence and increase economic opportunities in the countries of origin (152). In order to make further improvements to health services for migrant children, it is necessary to better understand their specific health needs by collecting data disaggregated by socioeconomic status, geographic location, and migration status along the entire migration path (151).

Migration can have positive results for adolescents, including greater opportunities for education and income. However, the potential for increased health risks associated with separation from family, peers, school, and community requires careful consideration and response. There is growing evidence that the health and development of adolescents are profoundly affected by their relationships with these social settings. For example, studies in the English-speaking Caribbean countries and territories have documented associations between low levels of connectedness or emotional attachment with parents, peers, school, and community and an increased risk of negative health outcomes and behaviors such as anxiety, depression, suicidal ideation and suicide attempts, unsafe sex, unplanned pregnancy, and substance use (153–155). Studies also document the protective effect of high levels of connectedness on the emotional and physical well-being of adolescents (156, 157). With the interruption of relationships and separation from these social settings that comes with migration, it is critical that programs and services attempt to fill the gap and offer opportunities for adolescents to build meaningful relationships with peers, adults, and social institutions along their migration path.



## V. WAYS FORWARD AND RECOMMENDATIONS

The agreed strategic lines of action defined in WHO Resolution WHA70.15 of 2017 and PAHO Resolution CD55.R13 2016 are well-aligned with the 2030 Agenda for Sustainable Development and comprise the following:

1. **Health services should be inclusive and responsive to the health needs of refugees and migrants.** They should be readily accessible to migrants by eliminating geographical, economic, and cultural barriers. Addressing the specific and differential needs of migrants should be a key component in the context of a country's advancement toward comprehensive, quality, universal, and progressively expanded health services. A comprehensive response to the needs of migrants entails the pursuit of targeted interventions to reduce migrants' health risks and the strengthening of programs and services that are sensitive to their conditions and needs. This effort should include the provision of care that takes cultural, religious, and gender issues into consideration and gives migrants access to health services in the often-complex health system of the country of transit or destination.
2. **Institutional arrangements to provide access to comprehensive, quality, people-centered health services.** In the context of each Member State's commitment to universal access to health and UHC, national health authorities should be at the forefront of the effort to modify or improve the regulatory and legal framework in order to address the specific health needs of migrant individuals, families, and groups to align it with the international human rights instruments related to health. It is of the utmost importance to develop institutional arrangements to provide access to comprehensive, quality, and people- and community-centered services in keeping with applicable international law and human rights instruments related to health. Member States should make adequate institutional arrangements to ensure that these mechanisms are put in place and to educate the population about the rights, needs, and vulnerable conditions of migrants. Countries should work closely together to improve health services in border areas to protect individuals, families, and migrant populations during their transit across borders and collectively monitor migrants' health situation.
3. **Mechanisms to provide financial protection in health.** In the context of each Member State's commitment to equitably and efficiently increase and improve financing for health and to advance toward the elimination of direct payment, which constitutes an access barrier at the point of service, Member States should improve health financing systems so that migrants have the same level of financial protection in health enjoyed by others living in their country, regardless of their immigration status. Migrants, among other groups in vulnerable conditions, especially unaccompanied minors, are the most affected by financial health care access barriers. The Member States should strengthen intersectoral coordination to promote access by migrants in conditions of vulnerability to social protection programs under the same terms as the rest of the population.
4. **Intersectoral action and the development of partnerships, networks, and multicountry frameworks.** Member States should advocate for and exercise leadership to ensure that migrant's specific conditions of vulnerability are considered in the formulation and implementation of policies to address the social determinants of health. Intersectoral action should aim at building individual and community resilience, advocating for migrant-sensitive social policies and programs, and developing partnerships, networks, and multicountry frameworks. This includes advocacy for the adoption of migration policies to promote dignified, orderly, regular, and safe migration to the benefit of all. In particular, intersectoral action is required to promote the same degree of social protection for migrants as for others living in the same country, including access to adequate shelter, sanitation, food, and security in the country of origin, transit, destination, and return.

## VI. STRENGTHS AND LIMITATIONS OF THE REPORT

Owing to the limitations of the available evidence, the results of this report should be interpreted with the following caveats:

- Studies assessing refugee and migrant health used inconsistent terminology and methodologies. A shared definition of migrants is lacking at the international level, and it was challenging to stratify data by migrant legal status (documented versus undocumented, and refugees).
- Although migration and forced displacement are on the rise, there is little research in the Region; most of the existing studies were conducted in Western countries, and none used clinical or social outcome metrics for evaluating the impact of defined practices.
- Furthermore, there is relatively little information about the health status of and health policies for refugees and migrants, especially undocumented migrants. Moreover, the information available often fails to distinguish between documented and undocumented migrants.
- Since policy implementation takes place at the local level and involves different actors and ministries (e.g., health, labor, foreign affairs, NGOs), there was no way to ensure that all the existing information had been collected or to claim that the report is complete.
- The findings may also highlight the lack of available research in the Region on the subject. Although there has been some success in addressing refugee and migrant health, more research is needed to support the development of good practice in this area.

## Annex: Number of International Migrants in Destination Countries (6)

Region of the Americas								
Major area, region, or country of destination	Number of international migrants (thousands)		International migrants as a percentage of total population		Females among international migrants (percentage)		Median age of international migrants	
	2000	2017	2000	2017	2000	2017	2000	2017
Anguilla	4	6	36.7	37.4	53	52.6	31.3	36.7
Antigua and Barbuda	23	29	27.6	28.1	55.3	55.4	31.1	42.1
Argentina	1540	2165	4.2	4.9	53.4	54	49.9	42.9
Aruba	30	36	33.1	34.5	55.1	55.5	35.4	41.1
Bahamas	36	62	12.2	15.6	46.7	49.4	37.9	39.3
Barbados	28	35	10.5	12.1	56.4	55.1	37.3	37.9
Belize	36	60	14.8	16	48.9	49.7	30.6	37.8
Bermuda	18	19	27.6	30.9	51.7	51.2	39.3	41.5
Bolivarian Republic of Venezuela	1014	1426	4.1	4.5	49.8	49.9	43.6	40.1
Bolivia	93	149	1.1	1.3	48.6	47.6	26.3	28.4
Brazil	685	736	0.4	0.4	46.5	46	58.3	42.2
British Virgin Islands	13	20	62.8	64	50.7	50.7	35.1	37.7
Canada	5512	7861	17.9	21.5	51.8	52.1	45.5	44.6
Cayman Islands	19	24	46.2	39.6	49.6	48.8	34.8	38.1
Chile	177	489	1.2	2.7	52.2	52.9	29.6	32.3
Colombia	110	142	0.3	0.3	48.7	46.7	21.5	28.8
Costa Rica	311	414	7.9	8.4	49.6	52	28.5	39.9
Cuba	18	13	0.2	0.1	56	55.4	58.1	43.9
Curaçao	0	38	0	23.9	0	58.9	0	40.2
Dominica	4	7	5.3	9.2	47.5	47.5	20.7	25.3
Dominican Republic	356	425	4.2	3.9	39.3	39.4	26.1	29.9
Ecuador	152	399	1.2	2.4	49	48.3	29.4	27
El Salvador	32	42	0.5	0.7	53	52.4	27.1	34.3
French Guinea	77	112	47	39.5	49.3	52.5	33.5	35.6
Grenada	7	7	6.7	6.6	50.4	50.4	24.7	32.7
Guadeloupe	83	99	19.6	22.1	52.2	55.5	32.3	32.3
Guatemala	48	82	0.4	0.5	55.9	52.6	31.2	35.1
Guyana	9	16	1.1	2	46.4	46.5	24.4	32.1
Haiti	26	41	0.3	0.4	43.2	42.4	35.6	35.3
Honduras	28	39	0.4	0.4	48.8	47.5	30.1	34.8
Jamaica	25	23	0.9	0.8	49.9	49.2	33.1	32.6
Martinique	54	62	14.1	16	53.3	56.3	29.4	34.4
Mexico	538	1224	0.5	0.9	49.7	49.3	14.8	13.3
Montserrat	1	1	24.4	26.3	48.6	48.5	31	33.9
Nicaragua	30	41	0.6	0.7	49.2	48.5	17.9	26.6
Panama	83	191	2.8	4.7	49.1	48.7	37.3	37.7
Paraguay	177	161	3.3	2.4	47.9	48	31.5	37
Peru	66	94	0.3	0.3	50.3	49.9	34.7	35.4
Puerto Rico	355	273	9.4	7.5	52.5	53.3	33.2	42.2
Saint Kitts and Nevis	6	8	12.9	13.7	47.7	47.7	29.6	32.6
Saint Lucia	10	13	6.3	7.2	49.8	49.5	32.3	32.3
Saint Vincent and the Grenadines	4	5	4	4.2	51.3	51.1	23.9	27.4
Suriname	28	48	5.8	8.5	45.9	45.4	27.1	28.8
Trinidad and Tobago	42	50	3.3	3.7	53.8	51.2	53.4	40
Turks and Caicos	9	25	47.8	69.2	48.3	48.3	29.6	34
United States of America	34814	49777	12.3	15.3	50.3	51.4	37.5	44.7
Uruguay	89	80	2.7	2.3	53.8	54.8	49.2	40.5
<b>Region of the Americas</b>	<b>46820</b>	<b>67069</b>	<b>5.6</b>	<b>6.1</b>	<b>50.4</b>	<b>51.3</b>	<b>32.7</b>	<b>35.4</b>

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