MIGRATION AND HEALTH

A BACKGROUNDER

ABSTRACT

This backgrounder provides a glimpse of the necessity of more attention required towards health care of migrant population especially the Nepali labour migrants working in difficult conditions abroad compromising their health and risking their lives. The document also provides evidences of various studies conducted about health vulnerabilities of migrants. Some praiseworthy interventions are carried out by IOM but there more serious attention is required from the government level for sustainability of such efforts.

HERD

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Introduction

There are an estimated 1 billion migrants in the world today. The collective health needs and implications of this large population are substantial. Migration flows comprise a wide range of populations, such as workers, refugees, students, undocumented migrants and others, with different health determinants, needs and levels of vulnerability. In a globalized world defined by profound disparities, skill shortages, demographic imbalances, climate change as well as economic and political crises, natural as well as man-made disasters, migration is inevitable. Migration is also essential for some societies to compensate for demographic trends and skill shortages and to assist home communities with remittances.

The health of migrants and health matters associated with migration are crucial public health challenges faced by governments and societies. As international borders become less rigid and population movement increase, cross-border mobility has grown to become a normal part of life for millions worldwide. With an estimated 245 million people on the move internationally, and three quarters of a billion people migrating within their own country, population mobility is increasingly acknowledged as a major determinant influencing the well-being of individuals and populations, including their health status.

Migration and Health

The relationships between disease, travel and migration have historical roots that continue to influence modern medical activities. Traditional medical approaches dealing with migrant health have focused on the recognition, identification and management of specific diseases, illnesses or health concerns in mobile populations at the time and place of their arrival. These activities have often been based on the principles of protecting the recipient population through policies of exclusion directed at the migrant or arriving traveler. Derived from the historical practices of quarantine, similar processes continue in a modern context through immigration medical screening and border control practices intended to reduce threats to public health or to mitigate potential impacts on healthcare services.

The epidemiological analysis of illnesses and disease in migrants is most commonly approached in one of two ways in receiving countries. The first is to consider the health issue of concern in terms of the status at the time of migration, while the second is to study the evolution of the health characteristic over time. The reference population for the first analytical approach is normally the host or receiving population, while the reference group for the second approach can be either the host population or a comparison cohort at the migrants' place of origin.

The quarantine-associated historical basis of migration health practices has ensured that much of the interest in health and migration has been directed towards communicable diseases. Commonly, migrant medical screening focuses on conditions differentially prevalent between the migrant and host population, such as tuberculosis, leprosy, or syphilis. Medical screening has been used to quantify and document aspects of health and disease in migrant cohorts, most often in relation to national public health statistics. Over time, these studies have described some of the immediate and long-term impacts of population movement in individual migrant receiving nations.

Recently, the growing international importance of migration has stimulated new interest in other aspects of migrant health. In addition to communicable diseases, attention is now focused on pre-existing non-infectious diseases and other health domains, including behaviour, morality and genetic or ethnic profiles in migrant populations. Epidemiological studies now involve chronic illnesses such as malignancies, renal failure and severe cardiac disease, as well as mental and psychosocial health and maternal and child health. Lifestyle-associated health issues, including tobacco use, alcohol consumption and substance abuse, are also being examined in relation to the process of migration in some migrant receiving countries.

The dynamics of health disparities

Some diseases or illnesses are sustained by differences that are purely geographic or environmental in origin. In other situations, differences in health outcomes, and the factors that determine or influence health outcomes, result from more complex interactions. The environment, socio-economics, genetics and biology, and behavioral factors influence population measurements of disease prevalence individually and in combination.

Examples of environmentally-limited diseases include vector-borne conditions, for which environmental factors determine the distribution of disease transmission, as observed in the global epidemiology of malaria, Chagas' disease, yellow fever and West Nile Virus. Environmentally-related non-communicable disease epidemiological disparities include micronutrient deficiencies and geographically-defined exposure risks, such as health outcomes related to extreme weather or altitude. Movement of the population out of the risk environment or establishment of disease transmission outside of the usual environmental constraints will impact on the epidemiology of the condition in the receiving region and on the local population health outcomes.

Social and economic influences can be significant factors in the creation and maintenance of differences in health and disease outcomes between populations. Poverty, education, housing and nutrition are directly related to disease prevalence and illness outcomes. The capacities and capabilities of medical and health sectors can affect health through the availability, accessibility and affordability of health promotion, disease prevention and treatment services. Additional factors that influence health risks and outcomes include language skills, behavioral and cultural practices, such as the use of tobacco, dietary practices and population norms for body mass and physical exercise.

IOM Initiatives

IOM has been involved in the prevention, recognition and response to outbreaks of communicable infections, such as **measles, varicella (chickenpox) and polio** and in the management of infectious diseases, such **as drug-resistant tuberculosis (TB)** in both refugee and displaced person populations. Managing those outbreaks and conditions often includes medical holds, isolation and occasionally confinement of exposed individuals or contacts.

Additionally, IOM operations, systems and practices are identical to many of the surveillance and contact tracing components, as well as community communication and mobilization strategies

required to respond to public health emergencies of international concern, such as the EVD outbreak in West Africa, and lend themselves to future integrated strategies for regional and cross-border prevention and detection of new or emerging threats.

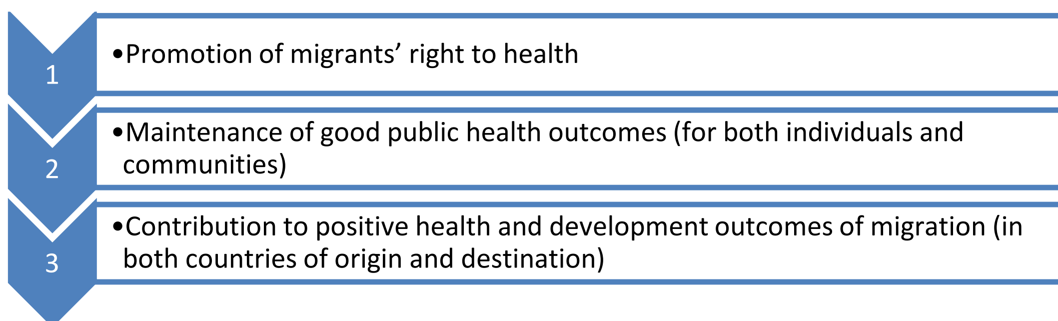
Furthermore IOM has provided global training in Psychosocial Interventions in Migration, Displacement and Emergency. IOM has worked to contribute to a global paradigm shift in the migration and health discourse, moving from an exclusionary approach based on principles of disease control and protection of receiving communities, to a more inclusive approach founded on multi-country and multisector cooperation and meant to reduce health disparities and address social and health protection.

IOM has attempted to incorporate global public health values and approaches into the provision of Migration Health Assessments through a variety of means. For IOM, pre-departure health assessments offer an opportunity to promote the health of assisted migrants in providing an occasion to initiate preventive and curative interventions for conditions that, if left untreated, could have a negative impact on the migrants' health status or the public health of host communities.

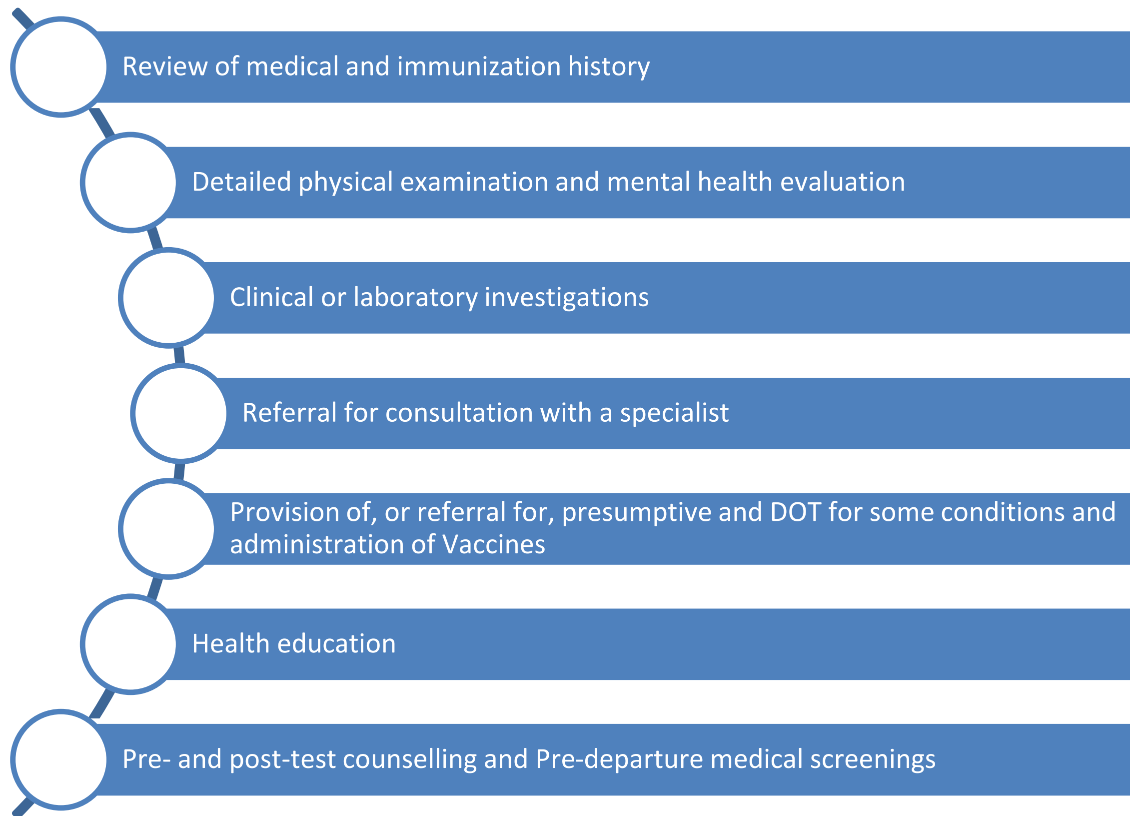
Value of Migration Health Assessment (MHA)

The primary scope of MHAs is to prevent or limit the introduction of infectious diseases. Though its historical function has been to exclude individuals with infectious or "prohibited" conditions, it is increasingly recognized that MHAs have the potential to become an integral component of public health promotion and prevention in migrant-receiving countries and could serve to facilitate migrants' integration into health systems at destination. MHAs overlap with national obligations towards International Health Regulations, especially with regard to health measures on "arrival and departure", as well as on "treatment of travelers". Increasing collaboration between migrant-receiving countries on public health topics has also helped to make MHAs more relevant and better understood in the context of global public health.

The Migration Health Division's vision of "Healthy Migrants in Healthy Communities" is centered on three key principles and approaches, namely:



MHAs may include some or all of the following components:



Lessons learned from IOM experiences

1. Recognition of importance of medical screening programmes in providing service to migrants, while simultaneously meeting governmental requirements and supporting international public health goals
2. Recognition of importance to bridge pre-departure and post-arrival services to facilitate the integration process, which includes connecting with the health-care system, gaining cultural familiarity and adapting to a foreign environment
3. The development and use of data systems is increasingly vital. With increased data and better data management comes enhanced knowledge. Health assessments should be considered within the overall framework of national and international public health measures. Similarly, detection and treatment of infectious diseases such as TB should be closely linked with national and regional TB control programmes.
4. Need to use MHAs as a means for health promotion and health education on a larger scale. Need for MHAs to adapt to changing epidemiological landscapes and migration patterns

A Migration and Health Study carried out by HERD and IOM

A project was carried out, '*Strengthening Government's Capacity of Selected South Asian Countries to address the Health of Migrants through a Multi-sectoral Approach*' in Bangladesh, Nepal and Pakistan from 2013 to 2015. This study aimed to understand the health vulnerabilities of departing and returnee migrants in Nepal in order to inform policy and program development regarding the health of migrants in South Asia. The objective of this study was to contribute to the general understanding of the health vulnerabilities of departing and returnee migrants in Nepal to inform the development of evidence, policies, services and programs that respond to migration related health challenges.

This study had interviewed 411 Nepali migrants for the quantitative study, consisting of 201 departing and 210 returnee migrants, 386 male and 25 female. The study revealed that condom use within migrant populations was particularly low with spouses; **condoms were used regularly by 9% of respondents, and never used by 65% of respondents**. Reported condom use was significantly higher with other partners, most notably with sex workers, with condoms always used by 83% of those migrants who self-identified themselves as clients of sex workers.

A wide range of health care services were available in the community, mainly general medical check-ups (91% of respondents) and medical treatment (87%). Both preventive and curative health-care services were mostly provided by community government centers, with private facilities mentioned by about a half of respondents for both men and women.

From 2013 to 2014 a total of approximately **521,878 labor permits were issued**, largely to Malaysia, Saudi Arabia, Qatar and the United Arab Emirates and Kuwait according to the Department of Foreign Employment (2014). In addition, a high number of undocumented migrants traveled to India. Of the total number of Nepali migrants, between 3.4 % and 10% are estimated to be women, many of whom are trafficked through irregular channels. It is estimated that **5,000-15,000 Nepali women are victims of human trafficking each year**, primarily to India and the Middle East.

On average, **67% of all migrants surveyed had completed a mandatory health examination prior to departure**; 93 % of returnees and 40 % of departing migrants. Private providers were the most popular venues for the mandatory health examination, followed by employers/ agencies (31%) and NGOs (17%). About 70 % of migrants reported that health providers asked for consent prior to conducting a medical test during the mandatory health examination.

Television, radio, educational institutions, and health facilities were important sources of health information among all respondents. Health information in general appeared less accessible to women compared to men, particularly those media requiring literacy, such as newspapers and billboards. **About 65% of migrants received health-related communication materials** from health providers in Nepal, and 91 % of them found the contents understandable or easily understandable. While abroad, 43 % of returnees had received health communication materials.

Current lack of sound health system infrastructure illustrates the country's limited capacity to handle migrant populations and places migrant populations at a particular disadvantage,

especially if they are seeking mandatory health examination prior to departure or returnee health services for illnesses incurred during a period of migration. Key health vulnerabilities of migrants include HIV, Tuberculosis (TB), Maternal Neonatal and Child Health (MNCH) and mental health issues. The **HIV prevalence among the adult population in Nepal is 0.5%.** The HIV epidemic in Nepal, however, is concentrated among key populations (working age) and of all HIV positive cases in Nepal, **27% are among male labor migrants**.

Given the likelihood that migration trends will continue to increase in Nepal, improved knowledge of the migration and health related challenges that Nepal faces is needed in order for the key government ministries to understand the importance of supporting migrants, in order to reduce health disparities and ensure better health outcomes for all categories of migrants.

Nepal has a large TB burden, with an **incidence rate of 163 per 100,000**. Multi-drug resistant TB (MDR-TB), extensively drug-resistant TB (XDR-TB), and TB/HIV co-infection represent growing concerns and challenges for TB control in Nepal. Migrants are particularly vulnerable to TB due to their lower socio-economic status and poor working and living conditions.

Policies related to Migration in Nepal

Nepal has approved various human rights conventions and International Labor Organization conventions related to migration. Some of them are listed below:

POLICIES	
	International Covenant on Economics, Social and Cultural Rights (1966)
	Indigenous and Tribal Peoples Convention (1989)
	International Covenant on Civil and Political Rights (1966)
	Convention on the Elimination of Racial Discrimination
	Discrimination against Women (1979)
	Convention on the Rights of the Child (1989)
	Right to Organize and Collective Bargaining Convention (1979)
	Forced Labor Convention (1930)
	Minimum Age Convention (1973)
	Worst Forms of Child Labor Convention (1999)
	Equal Remuneration Convention (1951)
	Discrimination (Employment and Remuneration) Convention (1958)
	Weekly Rest (Industry) Convention (1921)
	Minimum Wage Fixing Convention (1970)
	Tripartite Consultation (ILS) Convention (1976)

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However, Nepal has not ratified two major conventions related to migration: Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, and UN Protocol to Prevent, Suppress and Punish Trafficking in Persons. Furthermore, there are no policies or guidelines for the reintegration of Nepali migrants, including those deemed unfit and deported by their receiving country.

Migration and Nutrition in Nepal

According to a Nutrition Surveillance Report by IOM published in 2013 related to child malnutrition, in Nepal, a study with a sample size of 962 refugee children (mostly from Bhutan) showed that approximately **3.7% prevalence of wasting** in the children existed and 1**8.9% were found to be stunting** and about **9.1% were found to be underweight**. Further, overweight was found in around 3 % of the children.

In the case of Nepal, guardians of refugee children with moderate to severe malnutrition are advised to consult the nutrition unit in the camps. Nutrition interventions include supplementary feeding of undernourished children, and pregnant and lactating women, whereas children in need of therapeutic feeding programmes are referred to the nutrition rehabilitation centers in government referral hospitals in the district. The report recommends that routine nutrition surveillance, prompt referrals and further investigation at selected sites can reduce excess mortality and morbidity caused by malnutrition among refugee children.

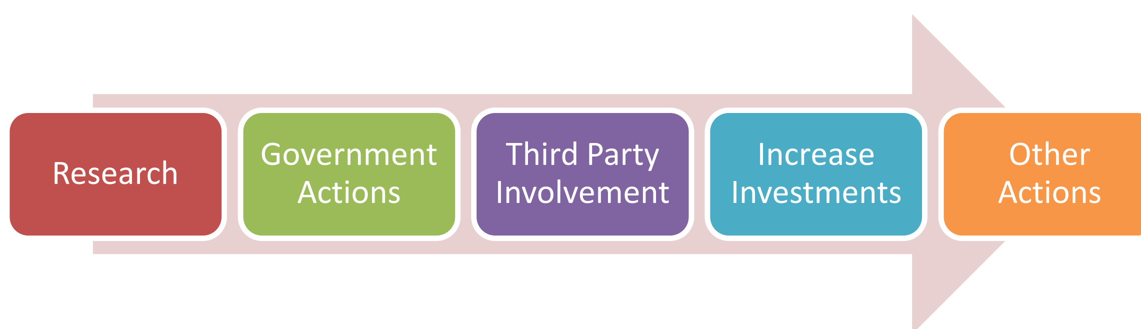
Health and Occupational Hazards faced by Nepali workers abroad

There are an **estimated 2.2 million Nepali migrant workers**, many of whom work in India, however, a large number work in the Middle Eastern oil industry. There are several serious cases of the situation of Nepalese migrants working in unauthorized countries without any legal or social protection by the host countries, for example, the massacre of twelve Nepalese workers by an Iraqi extremist group in 2004. Moreover, more than five hundred Nepali migrant workers have died in the Gulf region owing to workplace-related accidents and mental illness (including suicide), poor labour conditions (e.g., a lack of safety standards and formal labor relations). These may have contributed to higher mortality rates for Nepalese migrants in this region. More recently, Nepalese workers died in Qatar in a five week period due to cardiac arrests, respiratory diseases, kidney failure, heart attack, road accidents and committed suicide. Media coverage about migrant workers in **Qatar has included the death of 12 Nepalese and 11 Indian cleaners.**

Work-related accidents, deaths and suicides are common in the Gulf countries. It is estimated that **two Asians die per day on the Dubai construction sites and one case of suicide occurs every four days**. There were 67 Indian suicides in Dubai and the northern emirates in 2004 where as in UAE 100 Indians died in a twelve month period between 2005 and 2006. Independent research has found that **880 migrant construction workers died in UAE in 2004**, yet the Dubai Municipality recorded only 34 deaths in the same period. During the same period, the total number of deaths of Nepalese migrants in UAE was 30, but in 2005 just one construction-related death was reported. Again, during 2005, the Embassy of Nepal in UAE reported the deaths (cardiac arrests) of 13 immigrants, seven suicides, seven fatal road accidents and two deaths of unknown causes39.

Subjective evidence has suggested that the reason for the high mortality rates of Nepalese workers is because of excessive intake of homemade alcohol and the risky nature of many jobs. The most recent study about Nepalese migrants in the Middle East has found that many Nepalis have been working in risky occupations (e.g. agricultural and construction work) and about **one in four migrants face accidents and injuries during their work**. Likewise, very few migrants have been provided with safety training and most of them do not have private health insurance. In other words, the rates of accidents, deaths and suicides among migrant workers are high and far too high in the Gulf countries.

Recommendations



Research

Further research on both inbound and outbound migrants in Nepal needs to be done to understand their health-care facilities, accessibility, finance, sexual risk behaviours and vulnerabilities to STIs/HIV. More research is required to understand women's experience of migration, given the male dominated sample in this study and the general shortage of studies targeting female migrants. More comprehensive research of the sexual behaviours of migrants throughout the migration process would be useful to understanding their risks of STIs/HIV and research should be undertaken to consider destination country-specific migrant experiences to enable custom interventions.

Government Actions

The Government of Nepal should approve the major migration related conventions: Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and UN Protocol to Prevent, Suppress and Punish Trafficking in Persons. Health issue of migrants should be an essential and 'non-negotiable' component when Nepal establishes bilateral labor agreements with any labor receiving country. The Government of Nepal should create effective health related foreign policies, especially at the diplomatic level so that all high level diplomats show concern and take necessary action if any Nepali citizen faces any problem related to his/her life and health risks.

Regulate Third Party Involvement

Involvement of a third-party overseeing authority or development of more strict regulations should be applied to minimize contract alteration and ensure agencies or employers adhere to their contractual commitments. Agencies and employers should take on increased responsibility for the wellbeing of migrants they process, particularly with regard to health-care coverage and providing information on the living and working environment.

Increase Investments

The Government of Nepal should continue to invest in improved health infrastructure and health provider capacity, particularly in rural areas. This should cover training and dissemination of guidelines to ensure implementation of informed consent, sharing of test results, and post-test counselling, as well as equitable and ethical treatment of migrants. Integration of migrant health into the health-care system and recognition of migrants as a particular group with their own health risks and needs should be promoted through capacity building sessions as well as regular staff meetings with both medical and migration staff should be carried out to encourage exchange of knowledge and best practices.

Other Actions

The Government of Nepal should take further steps to monitor and regulate the activities of local brokers, recruitment agencies, and health examination facilities. This should include standardizing pre-departure orientations and health examinations, ethical compliance, and policies related to health insurance coverage. Interactions should take place in the form of discussions, meetings and conferences with representations from government, private agencies, NGOs/INGOs and migrants to come up with a comprehensive policy and implementation mechanism relating to addressing the health vulnerabilities of migrants. The Government of Nepal should take initiatives of inter-ministry coordination between stakeholder agencies, especially Ministry of Foreign Affairs, Ministry of Labor and Employment and Ministry of Health to facilitate the foreign employment process.

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