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15 MIGRATION, HEALTH AND CITIES

Policy brief from CIDOB and ISGlobal, based on a joint conference held on November 30th 2017 at CIDOB in Barcelona

Introduction

Health risks and services have emerged as an important aspect of the current migration challenge. In the countries of origin and transit preventive care and emergency assistance are needed. Along the migration routes the risk of pandemics is real; preventive and effective mitigation measures are required. As healthcare is seen as an individual right by many, its provision along the migration routes is also an ethical and legal imperative.

In the destination countries, on the other hand, migrants and refugees need to be integrated into national healthcare systems. In Europe this happens with varying degrees of success from country to country. The associated costs tend to even out over time and turn into benefits when integrated migrants and their offspring contribute to the social security systems.

As major destinations, European cities play a crucial role in addressing the need for specific health services on a local level. The individual healthcare needs of migrants vary and need to be addressed (e.g. reproductive health, gender issues, healthcare for children, trauma treatment).

Against this backdrop CIDOB, the Barcelona Centre for International Affairs, and ISGlobal, the Barcelona Institute for Global Health, organised a seminar on November 30th 2017 about Migration, Health and Cities. The seminar gathered experts, practitioners, healthcare professionals, politicians and NGO activists to discuss related issues in the EU context, which we document in this policy brief.

Health and migration in countries of origin and transit

Migration flows in the EU only constitute a fraction of global mobility and pale in magnitude compared to global migration movements. This applies particularly to migration flows from Africa. Preventive care, emergency assistance and pandemics are major healthcare challenges along the migration routes to Europe. Forcibly displaced people fleeing in search of refuge merit special attention because of their specific healthcare needs, particularly those relating to mental health. The right to healthcare access, or “right to health”, is enshrined in several **international human rights instruments**, from the Universal Declaration of Human Rights (Art. 25)¹ to the EU Charter of Fundamental Rights (Art. 35).² All migrants, regardless of status, are entitled to full protection of their right to health. The portability of this right is a major challenge. For example, in Morocco the right to access the healthcare system exists, but questions remain over the extent to which migrants can really benefit from this right and what other aspects beyond legal barriers hamper the access to healthcare. The World Health Organization advocates for full access of migrants to high-quality healthcare and stresses the need to ensure that national health systems are adequately prepared, from origin to destination countries.

1. Office of the UNHCHR. *The Right to Health*. <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

2. European Union Agency for Fundamental Rights <http://fra.europa.eu/en/charterpedia/article/35-health-care>

Countries of origin face several challenges when providing healthcare as a basic public need to all citizens. They have insufficient resources and funds to cover the health issues affecting their populations. **Migrants tend to be in relatively good health when the journey begins**, but the lack of access to health services, such as the routine immunisation of children, compromises their medical condition once the journey is underway.

Most of the health threats to migrants occur in transit countries (e.g. Libya, Egypt, Sudan). Migrants face hazardous conditions due to the complexity of the migratory journey: long routes, bad conditions of travel, physical and psychological abuses and absent or inadequate access to healthcare. Dangerous sea crossings, deserts and other unsafe travel routes in harsh terrain are common. This phase of the migration route is associated with high risks of death and injuries from accidents, systematic violence and harassment. As a consequence, many migrants experience poor physical condition and suffer traumatic experiences that affect their mental health. Insufficient sanitary facilities and limited access to safe food and water resources constitute major health risks too.

In the case of maritime migration routes the first stage of ensuring the safety and health of irregular migrants is through **boat interventions**. They consist of quick medical checkups of recently rescued people. Once settled in camps and reception facilities, the main challenges for assistance are overcrowded infrastructure and the lack of sanitary facilities. **Most migrants also have no medical and vaccination records with them.** This can make the correct assessment of their conditions a difficult task, alongside language barriers. A multitude of cultural backgrounds also feeds into diverging social needs and sensitivities. **These can go unnoticed by medical personnel in the absence of cultural interpreters and intermediaries.** Bureaucratic procedures and border controls can be difficult to understand, drawn-out and can entail harsh treatment. Together with the constant fear of being deported, this can critically affect the mental health of migrants and their access to healthcare.

For this reason, **ISGlobal is working with other public and private partners to establish a Mediterranean Observatory**, a regional hub to foster evidence-based analysis and a regional network to work on migrants, demographic and epidemiologic transitions, regional health security and environmental impacts on health to bring together public and private efforts ranging from the government to academia in order to understand regional transnational health challenges. This would also include global health challenges related to the Sustainable Development Goals (SDGs), such as strengthening health systems, universal health coverage and improvement of reproductive and maternal healthcare for mothers and new-borns. Many challenges to an eventual integration of migrants in destination countries could be tackled by interventions in countries of origin and transit. The **Union for the Mediterranean (UfM)**, which is based in Barcelona, seeks to address this in fields such as youth employability, job creation, education and women's empowerment.

European health integration policies: Health and migration in destination countries

Once in Europe, the health situation of migrants is far from perfect, with many differences depending on destination countries. As the **European-funded Sophie project** points out, the countries of the European Union have different integration policy models that depend on healthcare systems, the services provided and the accessibility for migrants.³ The three major categories identified are: **inclusive/multicultural** (e.g. Sweden, Finland, Norway, Belgium, the Netherlands, Spain, Portugal, Italy), **political integration/assimilationist** (e.g. France, Germany, Switzerland) and **exclusionist** (e.g. Denmark, Austria, eastern Europe). Migrants' health tends to be worse in countries with less inclusive policies.⁴ They suffer poorer physical and mental health and die earlier. Apart from health policies, it is important to improve the migrants' overall health by implementing integration policies at a national level that tackle the economic discrimination that exists between migrants and natives. The health gap between natives and migrants is always present, no matter whether the health regime is inclusive or exclusionist, although it is wider in countries with exclusionist policies.

In the same vein, the **MIPEX project**, which compares migrant integration policies in the EU, shows that health integration policies matter.⁵ Immigrants generally face greater obstacles in **emerging destination countries** with small numbers of immigrants where targeted health policies to address their needs are few (e.g. the **Balkan countries**, which are not only transit countries). At the same time, they tend to benefit from more equal rights and opportunities in **wealthier, older and larger countries of immigration** (for example, countries in **western Europe**), which have a stronger commitment to equal rights and opportunities for immigrants in a broad sense.

Migration does not in itself constitute a risk to health. However, migrants have special health needs depending on their country of origin that might be different from the native population. Therefore they are not identified in the health action plans. They have habits and lifestyles that are different and that can be modified in the process of adaptation during the migration process.

As countries become more diverse, health services are slow to adapt to immigrants' specific needs. Few of the staff are appropriately trained, properly equipped or required to respond. Migrants' basic access to health services directly depends on their legal status. Only a few countries have offered a more personalised and targeted support for immigrants' needs that can reach a larger number of them. The following features are crucial for more inclusive healthcare systems: organisational flexibility in terms of time resources, good interpreting services, cooperation with families and social services, staff cultural awareness, educational information material for migrants, positive and stable relationships with

3. Evaluating the Impact of Structural Policies on Health Inequalities, <http://www.sophie-project.eu>
4. <https://create.piktochart.com/output/2875518-immigrants-health-europe>
5. Migrant Integration Policy Index, <http://www.mipex.eu>

staff and clear guidelines on the care entitlements of different migrant groups.

Finally, **research plays a very important role in identifying the health needs** of immigrants and in adapting and improving health systems so that they can consider these needs in their health strategies. In this way, the evaluation of specific health interventions for the immigrant population in terms of effectiveness, feasibility and cost-effectiveness can help in the decision-making process of the political actors responsible for the implementation of the health policies for this population. In this vein, the collection of systematic data and access to them is a fundamental premise in order to analyse the health status and to meet the particular needs of each migrant and actor involved.

Cities and the management of health and migration: Attending to the diversity of needs

Effective implementation of integration policies is highly dependent on the way local policies are applied. **Migrant integration mainly occurs in urban areas. The role of cities in migration processes and their response to migrant arrival is key, as is proper coordination with central governments.**

Barcelona has a long historical record of receiving migration from the rest of Spain, Europe and third countries. Most recently, there was a strong inflow during the economic boom of the early and mid-2000s. According to Barcelona's municipal authority, **most third-country nationals arrive in the city with irregular status and are regularised after a few years. The foreign population currently stands at 266,000 (2016), which is equivalent to 16.3% of the total population.** Italians, Pakistanis, Chinese, French, Moroccans, Bolivians and Ecuadorians constitute the largest migrant contingents.

The first immigrant integration policies were promoted 30 years ago. Many of the principles of that time remain unchanged today. However, as migration changes, these policies also need to change in close cooperation with civil society, its diversity and intercultural realities. A consensus in Barcelona is that welcoming policies need to be in place as soon as possible for all those arriving in the city, **regardless of their legal status. The criteria used for access to services is residence, not nationality.** By giving (or encouraging)⁶ migrants' access to basic public services such as health, education, social services, culture or sports, Barcelona minimises the negative effects of social exclusion and origin-based segregation.

The situation of refugees in the city is a bit different. **In terms of provision there is a lack of flexibility. The system is excessively centralised and opaque and lacks intra-agency coordination as well as coordination with local administrations.** Municipal social services attend to many refugees who simply "appear" without the social worker having informa-

tion about the situation and journey of the person. **Barcelona tries to address such shortcomings with complementary programmes for refugees** in terms of integration, health, shelter and assistance beyond the 24-month period that government assistance lasts. But the overall problem remains that cities in Spain have to confront the impact of refugees without the necessary information, regulation and funding.

One of the most prominent examples of municipal management of the health issues of migrants is Frankfurt/Main, one of the most international of German cities. **Foreigners constitute 28% of its population and 47% of the population has an immigration background,** meaning that at least one of their parents was born outside of Germany. **Frankfurt currently houses 25,000–40,000 undocumented migrants** out of a total of 200,000–600,000 in Germany.

Frankfurt is part of the region of Hessen, whose public health service law has provisions for vulnerable persons in need of protection. The health department in Frankfurt postulates: It is our business to provide healthcare for any person without health insurance or papers! Its **humanitarian consultation hours started in 2001,** initiated by an African NGO, Masiha e.V. and **originally focussed on African patients.** The latter still make up half of all patients, but since 2007 eastern Europeans from Bulgaria and Romania have made up another 40%.

In partnership with a network of medical specialists, the city council and civil society, **the centre offers individual medical consultations, basic treatment and medication.** This includes paediatric treatment, check-ups, vaccinations, and catering to the specific needs of vulnerable populations such as pregnant women, Roma children or women suffering from genital mutilation. **Among the challenges faced by the centre are** the lack of interpreters, no sufficient psychological treatment and counselling, no care provision for high risk pregnancies, low awareness of a healthy lifestyle on the part of the patients and the transfer of patients "into the system" of regular health assistance, which can be difficult and points to coordination problems between local and federal authorities, not dissimilar to the case of Barcelona described above.

Implications and policy recommendations

1. Institutions must adopt migrants' health and well-being as a goal, inclusively. A range of **collaborative governance mechanisms** need to be developed, with further engagement of both public and private actors for joint action in the health sector. This mechanism can be adopted in the framework of the **Global Compact for Migration**, which will be adopted in December 2018 by UN member states. In general terms, this system requires a **more decentralised approach** regarding access to healthcare by immigrants and refugees.
2. **Increase coordination and collaboration with countries of origin and transit** in order to improve how destination countries address health challenges. **Collection of data** on previous access to medical care, vaccinations and health status can lead to improved treatment and follow-up later on.

6. Some services, such as full health coverage, do not depend upon the local government.

3. **Transit routes are a major health risk for migrants.** Health systems cannot act alone, as the health status of refugees and migrants is directly related to their living conditions and access to basic services. **There is a need for national and international health organisations to coordinate and fund the provision of basic healthcare services and the implementation of sanitation facilities, including referrals across services and individual follow-ups.** It also needs to be assured that enough vehicles for emergency referrals are available and that there is enough capacity to provide first aid en route, including medication and vaccination.
4. Irregular migrants experience **varying exposure to transit conditions. Acquire knowledge of such conditions.** This should include collecting data about migratory trends, the socioeconomic and political situation along the transit routes, means of travel, length of the journey and search and rescue at sea (SAR). Agencies must provide this information for better planning and preparedness, which might ultimately improve the health of the vulnerable population.
5. Destination countries must ensure **that migrants have access to preventive and curative health services on an equitable basis compared to the native population.** Destination countries require knowledge, more regulation and funding to address migrants' health properly. There is an urgent need to bridge the gap between health services and migrant communities. Increased diversity in the health workforce will help patients from minority groups to be more satisfied with professionals of their own ethnic background. That also involves a proper representation of migrant groups in patient platforms and consultative bodies. In order to do that, target health promotion, literacy and education activities that can reach migrant communities effectively.
6. **Strengthen primary care in an international setting** via a Mediterranean Observatory that addresses the major health risks that stem from inequalities and mobility over multiple transit countries. Improve the knowledge of imported diseases with cultural awareness of staff and information materials for migrants. Focus on proper training, updated screening protocols and symposiums on international health in primary care and improving cross-cultural competence among primary care physicians.
7. **Improve coordination between all involved factors and actors,** i.e. the health system, research, the social determinants of health, civil society, education, international health, primary care, social workers, NGOs, social science and innovation.
8. **Forced displaced populations require special attention.** Firstly, healthcare workers face major challenges in attending to these people and their needs. Their physical and mental status is complex and often there are cultural issues. Secondly, special reception should be given to vulnerable groups, such as unaccompanied minors and women, many of who often fall into more than one domain of vulnerability. Thirdly, educational strategies should be implemented to provide full access to and participation in their new context. In sum, healthcare should be understood in the short term and in the long term.