Migration Health – Research & Epidemiologic Methods

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Assisting a World on the Move for 60 Years

Migration for the Benefit of All

Presentation Outline

I. Introduction
II. Methods & Studies
III. Ethics
IV. Information dissemination
V. Way Forward

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PART I

INTRODUCTION

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INTRODUCTION
Outline

1. Migration Health Framework
2. Learning Objectives
3. Key Terms
4. Need for Research

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Migration Health Framework

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Health & Migration process

INBOUND immigration	OUTBOUND emigration	INTERNAL migration

Pre-departure → Travel → At destination → Return

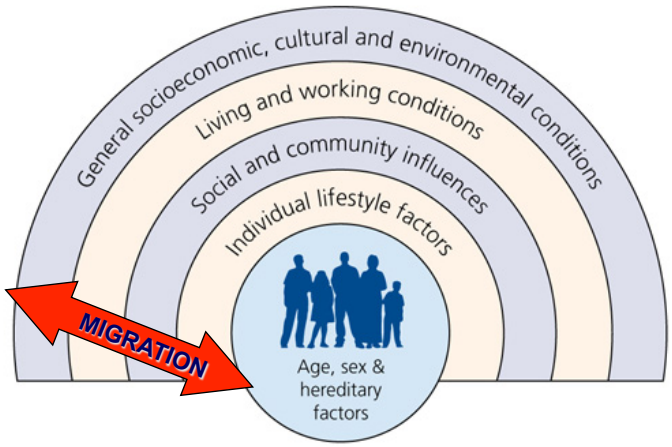
- Monitoring Migrant Health
- Policy and Legal Framework
- Migrant Sensitive Health Systems
- Partnerships Networks Multi-country Frameworks

Cross Cutting

Human rights, Multi-sectoral Action,

Public Health, Financing Health of Migrants

Migration as a Social Determinant of Health



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Migration – Health - Migration

1. A more interconnected and interdependent world resulting in a large global population cohort of migrants
2. Large proportions of migrant and foreign-born cohorts within national populations
3. Wide range of collective health needs and implications

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Objectives

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At the end of this lecture, we should be able to:

1. Recognize importance of research and information dissemination as a key strategy in the international migration health framework

2. Identify critical themes for investigation in migration health – around health status and health determinants thereof

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At the end of this lecture, we should be able to:

3. Consider research questions and design for specific migration health contexts to generate evidence for action

4. Obtain an overview of selected migration health studies conducted by IOM & partners

At the end of this lecture, we should be able to:

5. Discuss challenges in migration health research, including methodological issues and ethical concerns

6. Understand strategies for effective information dissemination and note future priorities for international migration health research

Key Terms

Key Terms

1. **Epidemiology** : The study of the distribution and determinants of health-related states or events in defined populations

2. **Research** : The organized quest for new knowledge. May consist of systematic empirical observation or hypothesis testing, and the use of a pre-planned research design such as an experiment

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Key Terms

3. **Research design** : The procedures and methods, predetermined by an investigator, to be adhered to in conducting a research project

4. **Situation analysis** : Study of a situation that may need improvement

Key Terms

5. **Surveillance** : An ongoing systematic collection, analysis and interpretation of health-related data essential to the planning, implementation and evaluation of public health practice

6. **Survey** : An investigation in which information is systematically collected but in which the experimental method is not used

Key Terms

7. **Monitoring** : The performance and analysis of routine measurements aimed at detecting changes in the environment or health status of populations

8. **Health services research** : The integration of epidemiologic, sociological, economic and other analytic sciences in the study of health services

Need for Migration Health Research

Context

- Lack of global and regional integrated scope in migrant health information
- Need for cohesive and collaborative assessments of migrants' health status and trends, and better monitoring and analysis of health information

Context

- Restricted traditional focus of research and monitoring – communicable disease-based
- Limited expansion to study health needs of migrant populations, especially in the West
- Moving ahead – need for in-depth studies on differential morbidity and mortality, interface with social determinants of health

Knowledge Gaps

- Distribution of health characteristics, indicators, outcomes and needs of migrants
- Distribution & Etiology of health and disease risks across different social, economic and epidemiological environments
- State of availability of, access to and use of appropriate health and medical services

Knowledge Gaps - Examples

- What are the workplace and occupational health challenges faced by migrant workers, particularly those in irregular situations?
- What are the health risks encountered by trafficked persons?
- What are the socioeconomic factors influencing reproductive health outcomes among migrant women?

Knowledge gaps – Health of labour migrants

- What is the magnitude and mechanism of relation between migrant health outcomes and employment conditions?
- How do health outcomes differ by host country's labour regulations and policies?
- How do socio-economic conditions impact health inequality for legal & illegal migrant day labourers?

Key variables for study

I) Pre-departure stage

- Prevalence of endemic diseases
- Level of socio-economic development
- Access to care
- Availability of care
- Awareness and use of health services

  (preventive, promotional, diagnostic, therapeutic)

Key variables for study

II) During transit/travel

- Trauma (physical-psychosocial)
- Deprivation
- Violence
- Exposure
- Injury

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Key variables for study

III) Upon/after arrival at destination

- Administrative/legal status
- Poverty
- Language
- Cultural factors
- Occupational risks

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Key variables for study

IV) Upon return

- Change in health systems at origin
- Change in epidemiological factors of migrants/ origin communities
- Loss of social support
- Improvements or declines in financial status/ healthcare spending capacity

Study of migration health variables

Two common approaches -

- At time of migration, comparison with origin or receiving population.
- Evolution over time, comparison with non-migrating cohort at place of origin

Challenges in migration health research

- Diversity in source data (definitions and denominators)
- Restricted access to some populations / communities
- Evolving population dynamics such as circular, temporary & return migration and integration of previously migrant communities

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PART II

STUDIES & METHODS

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STUDIES & METHODS
Outline

1. Migrant typology
2. Examples of migrant health research studies
3. Methods challenges
   - Bias in migration health studies
   - Estimation of irregular/undocumented migrants
   - Representativeness of samples of trafficked persons

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Migrant typology

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Migrant typology

1. International migrants – individuals who remain outside their usual country of residence for at least one year

   Estimates: At mid-year 213,948,812

   Females 49%, Males 51%

2. Internal migrants – individuals who move within the borders of a country, usually measured across regional, district, or municipal boundaries, resulting in a change of usual place of residence

   Estimates: ~ 740 million

Migrant typology

3. Irregular (or undocumented/illegal) – individuals who enter a country, often in search of employment, without the required documents or permits, or who overstay the authorized length of stay in the country

   Estimates: ~ 20 to 30 million (10-15% of the world' s immigrant stock)

5. Trafficked persons – who are coerced, tricked, or forced into situations in which their bodies or labor are exploited, which may occur across international borders or within their own country

   Estimates: unreliable

Migrant typology

5. International labor migrants (flow) – engaged in a remunerated activity in a state of which he or she is not a national, including persons legally admitted as a migrant for employment

Estimates: Total 27,390,884
Total among countries with sex-disaggregated data 3,037,335
Females 45%, Males 55%

Migrant typology

6. Internally displaced persons (IDPs) – who have been forced 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 man-made disasters, and who have not crossed an international border

Estimates: Total protected/assisted by UNHCR, including people in IDP-like situations 15,628,057

Migrant typology

7. Refugees – individuals, who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, are outside the country of their nationality, and are unable to, or owing to such fear, are unwilling to avail themselves of the protection of that country or return because of fear of persecution
   - Estimates: As a percentage of international migrants, 7.6%
   - Total in refugee-like situations 10,396,540 (Females 47%, Males 53%)

Migrant typology

8. Asylum-seekers – individuals who have sought international protection and whose claims for refugee status have not yet been determined
   - Estimates: Applications made 912,749

Migrant typology

9. Stateless persons – not considered as citizens of any state under national law. Covers *de jure* and *de facto* stateless persons, including persons who are unable to establish their nationality. Stateless persons may or may not be migrants.

   Estimates: Total assisted by UNHCR 208,869

Migrant typology

10. Tourists – traveling to and staying in places outside their usual environment for not more than one consecutive year and whose main purpose of visit is other than work

    Estimates: 808 million (world)

Migrant Typology

11. International students – admitted by a country other than their own, usually under special permits or visas, for the specific purpose of following a particular course of study in an accredited institution of the receiving country

Estimates: Total 2,348,704

Total among countries with sex-disaggregated data 1,359,660 (Females 45%, Males 55%)

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Examples of Migration Health Research Studies

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(I) Migrant Health Research Study

Title: Exploring TB-related knowledge, attitude, practice, behaviour and access to services among migrant workers in Tajikistan
Survey report

Year: 2009

Agencies: International Organization for Migration, Geneva, Switzerland. World Health Organization, Regional Office for Europe, Copenhagen, Denmark. WHO Country Office, Dushanbe, Tajikistan.

KAP survey among migrant workers, Tajikistan, 2009

Research questions

- What are the TB related knowledge, attitudes, practice and behaviour among migrant labour workers in Tajikistan?
- What are the obstacles experienced by migrant labour workers to accessing heath services in labour destination regions?
- What are the obstacles experienced by migrant labour workers to accessing heath services in home country?

KAP survey among migrant workers, Tajikistan, 2009

Purpose of the study

- To determine TB related knowledge, attitudes, practice and behaviour among migrant labour workers in Tajikistan
- To determine obstacles experienced by labour migrants in accessing health services both in the destination countries and Tajikistan

KAP survey among migrant workers, Tajikistan, 2009

Study site

- Labour migrant communities in Khationoblast and Rasht Valley – most emigration affected regions in Tajikistan

Methods

- Quantitative knowledge-attitude-practice-behaviour (KAP) survey among migrant labour workers
- Qualitative in-depth interviews

KAP survey among migrant workers, Tajikistan, 2009

KAP Survey

- n=509 respondents in 36 district clusters (14 persons/cluster)
- Face to face interview
- Sample size

  S = Z2 (P(1-P))/D2
- The correction factor to adjust S to a finite population and obtain the final estimate of sample size was calculated using

  Sample Size = S/(1+(S/population)

KAP survey among migrant workers, Tajikistan, 2009

KAP Survey

- In this study, 95 per cent CI = Z = 1.96; P = 50%; D = 5%;
- Population size: 3,400 households.
- Sample size was calculated as 95 per cent CI = 345. (99% CI= 555).

KAP survey among migrant workers, Tajikistan, 2009

Sampling

- Research Center SHARQ' s database on migrant households
- 2-stage cluster sampling – villages>>households
- Systematic sampling with a random selection of the households
- 10 households in each standby cluster were selected to replace a household in case of refusal to participate in the KAP interview or in case the migrant was absent.

KAP survey among migrant workers, Tajikistan, 2009

Labour migrant

- Defined as member of the household over 15 years old
- Lived and/or worked abroad during 2007-2008

Questionnaire

- Pilot interviews
- Russian and Tajik languages
- Validation check on respondents, 10% by telephone survey
- A total of 509 interviews conducted from 36 sampling points; 18 (3.5%) persons refused to participate

KAP survey among migrant workers, Tajikistan, 2009

In-depth interviews

- To determine any barriers encountered in obtaining a diagnosis and treatment for TB
- Inclusion criteria: migrants who lived and worked outside Tajikistan within the previous 2 years
- Ten one-hour interviews among TB patients
- Informed consent from all participants

KAP survey among migrant workers, Tajikistan, 2009

Data analysis

- Use of SPSS statistical software
- Identifying themes in the in-depth interview: lack of money to pay for private consultation, the economic need to keep working, the lack of knowledge that TB could be cured, or fear of community stigma and being socially ostracized

KAP survey among migrant workers, Tajikistan, 2009

Limitations

- Perceived insincerity from some respondents
- Reluctance to answer questions about their health and diseases
- Difficulty of some respondents in answering or obviously concealing history of TB

KAP survey among migrant workers, Tajikistan, 2009

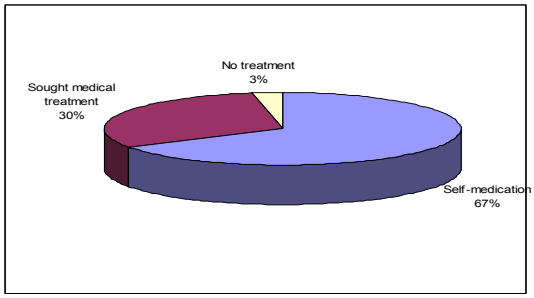
Findings

- Only 238 (46.7%) of the 509 interviewed migrants indicated their employer providing social guarantees or benefits in case of illness
- Of them, 180 (75.6%) declared to have had their employer paying medical services abroad and 58 (24.4%) to have been entitled of paid sick leave

KAP survey among migrant workers, Tajikistan, 2009

Findings

- Almost one half of the migrants surveyed, i.e. 240 migrants, become ill while working abroad and had varied health seeking behaviours



KAP survey among migrant workers, Tajikistan, 2009

Barriers to accessing health services

Barrier	N	%
Cost	217	76.7
Fear of losing job if found to have an infectious disease	24	8.5
Long distance to health care facilities	13	4.6
Language	8	2.8
Fear of medical staff	6	2.1
Cannot get to the clinic or hospital (undefined reasons)	4	1.4
Do not know where to access medical services	11	3.9
Total	283	100.0

KAP survey among migrant workers, Tajikistan, 2009

Key Findings

- The average level of knowledge regarding TB transmission is relatively low.
- Serious misconceptions: TB transmission can occur through shared meals, eating utensils and handshakes.
- Less than half of the migrants interviewed had access to social guarantees or benefits in case of illness
- Majority found the services expensive or very expensive
- In Tajikistan, TB drugs are free, but diagnostic services (sputum tests and chest x-rays) are not

(II) Migrant Health Research Study

Title: HIV & Syphilis Integrated Biological and Behavioural Surveillance (IBBS) Survey among Female Sex Workers in Hargeisa, Somaliland

Year: 2008

Agencies: World Health Organization/Joint United Nations Programme on HIV/AIDS/ International Organization for Migration

HIV & Syphilis Integrated Biological and Behavioural Surveillance (IBBS) Survey among Female Sex Workers in Hargeisa, Somaliland

2008

Background/Research question:

No current data on:

- population sizes of FSWs and clients
- Proportion of sex workers and clients engaging in HIV risk behaviours
- Prevalence of HIV or other STI infections

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Aims:

- Establish baseline epidemiology and behavioural risk correlates of HIV and syphilis infection among FSWs in Hargeisa and Berbera, Somaliland
- Establish and contribute to develop an evidence-informed response to the Somali HIV/AIDS response among MARPs, particularly FSWs

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Objectives:

- Establish baseline information on HIV and syphilis prevalence among FSWs
- Determine baseline HIV and STI knowledge, attitudes, risk behaviours, treatment seeking behaviours, and preferred sources of HIV/STI information

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Eligibility Criteria

1. Female Aged 14+
2. Exchanged sexual intercourse (vaginal and/or anal) for money, a gift, or a favour in the past 3 months in Hargeisa
3. Had not participated in the survey already
4. Was currently living and working in Hargeisa
5. Consented to both behavioural questionnaire and biological components
6. Had a valid coupon to participate in the study
7. Was able to give informed consent.

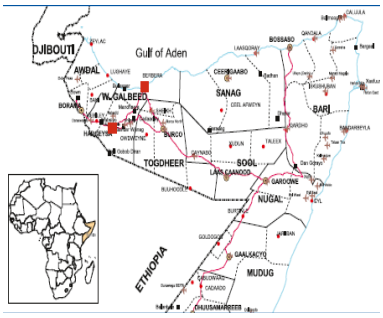
HIV & Syphilis Integrated Biological and Behavioural Surveillance (IBBS) Survey among Female Sex Workers in Hargeisa, Somaliland

2008

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Selection of Sites

- Berbera
- Highest ante-natal clinic HIV prevalence in Somaliland at 2.7% in 2007, while syphilis prevalence was at 1.4%
- Large volume of mobile populations who reported buying sex, particularly truck drivers



- Hargeisa

-Most populous city in Somaliland

-A number of mobile populations reported buying sex

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Respondent-Driven Sampling

Key advantages of using snowballing sampling in this study:

- Avoided the lengthy mapping process necessary for population size estimates
- Avoided "advertising" the study and the target population, and by association identifying participants in a highly stigmatized context

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Sample Size Calculation[5] $N=(z)^2 P(1-P) / W^2$

N	Sample Size
Z	Z Score corresponding to CI
P	Expected proportion of outcome of interest
W	Width of the interval (e.g. margin of error, +/-3% is 0.06)

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

8 Key Indicators and Prevalence estimates for Sample size calculation:

1. % FSWs infected with HIV (UNGASS 23) – estimate 5%
2. % FSWs used a condom at last sex (UNGASS 18) – estimate 10%
3. Less than 5 SCs in the last 7 days – estimate 40%
4. Less than 2 SCs on last day worked – estimate 50%
5. % FSWs ever heard of male condom – estimate 80%
6. % FSWs who received HIV test in past 12 months and know result (UNGASS 8) – estimate 15%
7. % FSWs who correctly identified ways of preventing HIV transmission and rejected major misconceptions (UNGASS 14) – estimate 60%
8. % FSWs listened to the radio in the last seven days – estimate 50%.

IBBS

HIV & Syphilis Integrated Biological and Behavioural Surveillance (IBBS) Survey among Female Sex Workers in Hargeisa, Somaliland

2008

Sex Worker Sample Size Calculation Based on Eight Key Indicators

	Indicators Considered (P)	Somaliland (Estimation)	N	With Design Effect (*2)	
1	% FSW infected with HIV (UNGASS 23)	0.05	72.99	145.98	N=146
2	% FSWs used condom at last sex (UNGASS 18)	0.10	138.30	276.60	
3	% FSWs had less than five SCs in last seven days (>5)	0.4	368.79	737.59	
4	% FSWs has less than two SCs on last day worked	0.5	384.16	768.32	
5	% FSWs ever heard of male condom	0.8	245.86	491.72	
6	% FSWs who received HIV test in past 12 months and know result (UNGASS 8)	0.15	195.92	391.84	
7	% FSWs who correctly identified ways of preventing HIV transmission and rejected major misconceptions (UNGASS 14)	0.6	368.79	737.59	
8	% FSWs listened to radio in the last seven days	0.5	384.16	768.32	

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Data Analysis:

- Behavioural data entered through computer assisted device interviewing
- Biological test results recorded in Excel format
- Bio-behavioural merged data analysed using RDSAT

IBBS

HIV & Syphilis Integrated Biological and Behavioural Surveillance (IBBS) Survey among Female Sex Workers in Hargeisa, Somaliland

2008

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Results :

- None (n=0) of the FSWs had HIV test in the past 12 months
- Majority had poor or incomplete knowledge of HIV prevention
- Only 6.9% (n=13) answered correctly the HIV prevention knowledge indicator for most-at-risk populations of HIV/AIDS UNGASS

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Media & Intervention Programme Exposure among Female Sex Workers

Indicator	RDS population estimates (%)	95% CI	n/N
Media and HIV intervention exposure			
Received condoms from clinic, outreach, etc. in past 12 months	0.0	-.-.-	0/57
Source of HIV & AIDS information in past 12 months			
Don't remember	70.1	64.9-76.4	148/219
Radio (not Somaliland)	14.0	8.6-21.1	24/219
Radio (Somaliland)	11.5	7.7-15.4	29/219
TV (Somaliland)	0.9	0.0-3.1	2/219
Friend –Sex Worker	1.9	0.6-2.5	6/219
Friend – Not Sex Worker	1.9	0.0-2.1	2/219

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Limitations:

- Not possible to estimate the FSW population size and location
- Sample size of 219 not enough for disaggregated analysis of indicators by sub-groups
- Representativeness of sample – non-FSWs may have been sampled, some FSWs could be earning more and so differ in HIV status/knowledge/ behaviour,unclear "other" migrant status, sample was heavily weighted to respondents from Ethiopia

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Conclusions:

- The prevalence of HIV among FSWs in Hargeisa was considerably higher than recent data
- Risk characteristics of the Somaliland FSW population:
  - ☒ Low and inconsistent condom use
  - ☒ Multiple concurrent sexual partners (both transactional and non-transactional)

HIV & syphilis IBBS survey among female sex workers, Somaliland, 2008

Recommendations:

Initiate networking with FSWs to –

- Establish entry point for engagement, services, increasing knowledge & behaviour change and improving access to health services, referrals, and condom provision
- Do surveillance (complete baseline, second round, future rounds) for monitoring impact

(III) Migrant Health Research Study

Title: Situational Assessment on the Health of Cambodian Irregular Migrants

Year: 2011

Agency: International Organization for Migration, Cambodia

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Overall objective:

- To gain an in-depth understanding of the health issues faced by Cambodian irregular migrant and host communities in cross-border areas

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Study objectives:

- Assess and document the socio-economic and migration patterns of returned migrants and host communities in the two target border provinces
- Assess and document the current health status and access to health services of returned migrants and the host communities, including their health seeking behavior

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Study objectives cont.:

- Promote better understanding of migrant health concerns, including barriers to accessing health services among the health workforce, relevant Government Ministries, partner organizations and other stakeholders
- Develop and prioritize follow up interventions and key recommendations for policy development

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Overall Assessment Questions:

- What are the factors or circumstances that lead to irregular migration and impacts on the health of irregular migrants in the two targeted border provinces?
- How do irregular migrants perceive their own health risks and health problems? How do they seek health care while abroad compare to at home?

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Overall Assessment Questions:

- Do irregular migrants have specific health needs not being met by current public health services? Are there health disparities between irregular migrants and host communities? What are the specific health disparities and how can they be addressed?

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Sample:

- A total of n=438 adults, 220 migrants and 218 non-migrants for comparison
- Random selection from migrants list; for non-migrants, household selection using a sampling interval calculated by dividing the number of village households by the desired village sample
- Non-migrant villages selected were close to the borders
- Health service delivery assessed through interviews with 100 health care workers, community health volunteers, and peer educators

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Selection of Sites:

- Identified during multi-stakeholder consultations in two operational provinces: Svay Rieng and Banteay Meanchey
- These major border crossings receive deported and repatriated Cambodian irregular migrants from Thailand and Vietnam, including trafficked persons
- Non-migrant sites were selected from villages geographically and socio-economically similar with the migrant sites

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Sample of migrants and non-migrants:

	Migrants	Non-Migrants
Svay Rieng (Kampong Ro & Chantrea Districts)	**102**	**99**
Banteay Meanchey (Poipet & Nimit Communes, Ou Chrov District)	**118**	**119**
Total	**220**	**218**

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Data Collection Methods:

- Structured questionnaires for migrants and non-migrants
- 7 Sections: General demographics, Socio-economic background, Migration and mobility, Health risks, Health issues and health seeking behavior, Health knowledge and awareness, Sources of health information

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Data Collection Methods cont.:

- Questionnaire for government and community health workers
- Interviewers: Provincial and district health and social workers, NGO staff regularly providing health care/case management/family support

Sample questions from survey

Health Knowledge & Awareness	

What are the most common diseases you have heard?
(Tick those mentioned- Don't Read out)

□ HIV/AIDS (1)
□ Sexually Transmitted Infections (2)
□ Influenza (3)
□ Typhoid (4)
□ Diarrhea/Cholera (5)
□ Tuberculosis (6)
□ Malaria/Dengue Fever (7)
□ Depression/Stress/Trauma (8)
□ Hepatitis C (9)
□ Other (99) _____

Did you have any close contact with a person with one of these diseases/illnesses?
□ Yes (1)-> Who? _____ □ No (2)

Sample questions from survey

1.Have you ever had any of the following symptoms while abroad?
(Read list out for interviewee to choose)

□ Cough longer than 2 weeks (1)
□ Coughing up blood (2)
□ Severe headache & neck stiffness (3)
□ Nausea, abdominal cramps, & vomiting (4)
□ Chest pain (5)
□ Weight loss (6)
□ Ongoing fatigue (7)
□ Frequent fevers and sweats (8)
□ Skin diseases (9)
□ Mouth, genital, or anal sores (herpes) (10)
□ Seizures and lack of coordination (11)
□ Difficult or painful swallowing (12)
□ Mental symptoms such as confusion and forgetfulness (13)
□ Severe and persistent diarrhea (14)
□ Vision loss (15)
□ Genital discharges, rashes, pain, ulcers in/around genitals etc. (16)
□ Other (99) _____
□ Do not remember (100)

Sample questions from survey

1.How does TB spread from one person to another?
(Please tick all that are mentioned.)
□ Through shaking hand (1)
□ Through the air when a person with TB coughs or sneezes (2)
□ Sharing utensils and food from the same plate (3)
□ Through touching items in public places (doorknobs, handles in transportation, etc.) (4)
□ Do not know (100)
□ Other (99) _____

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Study Data

- Series of technical meetings with Ministry of Health focal points
- Preliminary findings were identified for further exploration
- Detailed quantitative data analysis using STATA statistical software

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Limitations :

- Representativeness of sample
- Certainty in ensuring that the impact of migration on entire communities was captured
- Comparison of migration experiences

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Findings :

- Final sample (n=438) consisted of 50.23% migrants and 49.77% non-migrants
- Males and females roughly equal in both groups
- Most common age range of 20 – 29 years
- Socio-economic status of migrants generally lower than non-migrants
- Migrants were more likely to have lost home/land ownership and acquired debts

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Findings cont.

- A larger proportion (85.45%) of the migrant sample reported experiencing illness while working abroad.
- Knowledge of Tuberculosis (TB) transmission and prevention was slightly higher among non-migrants compared to migrants.
- Knowledge about where to go for testing in Cambodia was good, however only 33.33 per cent of the total sample had had health testing in the past 12 months. Fear of arrest and cost were obstacles for those migrants who did not have health testing done while working abroad.

Situational Assessment on the Health of Cambodian Irregular Migrants, 2011

Conclusions and Recommendations

- Irregular migrants are a high-risk population for communicable diseases such as TB, STIs and HIV.
- Monitor migrant health – through voluntary health assessments/testing, integrate data collection on existing national/local surveillance systems, feedback from returning migrants
- Migrant-sensitive health systems
- Policy and legal frameworks review and develop basic package of safe migration information
- Partnerships and collaborations with authorities and stakeholders

Methodological challenges in conducting migration health research

I. Migrant health studies – Bias issues

- Bias – deviation of results or inferences from the truth, or processes leading to such deviation. Any trend in the collection, analysis, interpretation, publication, or review of data that can lead to conclusions that are systematically different from the truth.

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Migrant health studies – Bias issues

- Sampling Bias – systematic error due to study of a non-random sample of a population
- Information Bias – a flaw in measuring exposure or outcome data that results in different quality (accuracy) of information between comparison groups
- Selection Bias – Error due to systematic differences in characteristics between those who are selected for study and those who are not

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II. Overview of Irregular Migrant Estimation

Some human rights activists argue that exaggeration is not a major problem, as long as attention ends up being given to whatever abuses are occurring. This seems to be a rather idealistic, not to say naïve approach, which ignores the damage that can be done by misrepresenting the scale of a problem. [.] an inaccurate estimate of the problem is likely to result in a remedy being proposed that is equally inappropriate.

(Source: Tyldum & Brunovski 2005)

Challenges

- "Hidden populations" or "hidden activities" are either difficult to observe or, once observed, are difficult to identify as belonging to that population or as performing such activities
- Knowing more about the size, characteristics and social behaviour of such "hidden populations" is of considerable interest to policymakers

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Challenges

- Generating knowledge on the size and composition of irregular migrants is similar to estimating other "hidden populations".
- A full count of the population of irregular migrants is, by definition, impossible.
  - Not possible to draw a representative sample from the total population (no sampling frame)
  - Difficult to identify whether a particular person is indeed an irregular migrant, even when observed and questioned
  - irregular migrants have incentives to hide from public authorities

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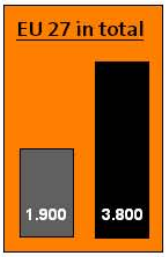
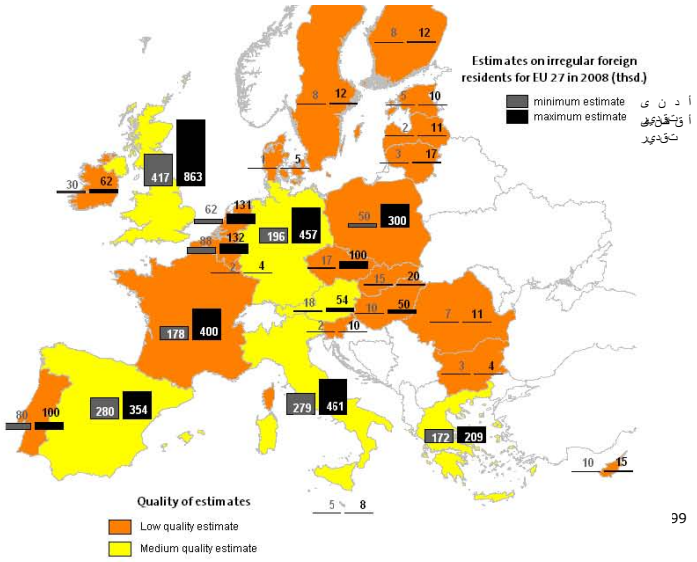
Challenges



Source:
Comparative Policy Brief - Size and development of irregular migration to the EU, CLANDESTINO, October 2009.



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Classification of methods

- Based on United Nations Economic Commission for Europe (UNECE) Working paper 11 (2008) on *"Methodologies for the estimation of stocks of irregular migrants"*
- Direct estimation methods:

  Using data sets that contain (a subset of) irregular migrants: immigration enforcement data (e.g. apprehended illegal residents), administrative records.
- Indirect/residual estimation methods:

  Through comparison between population statistics.

Direct estimation methods

Simple multiplier method

- The total population of legally residing migrants is 100,000. During labour inspections, only 70% of migrants are found to be legally residing.

100,000 / 70 % = 142,857

Total regular migrant population | Multiplier | Total migrant population

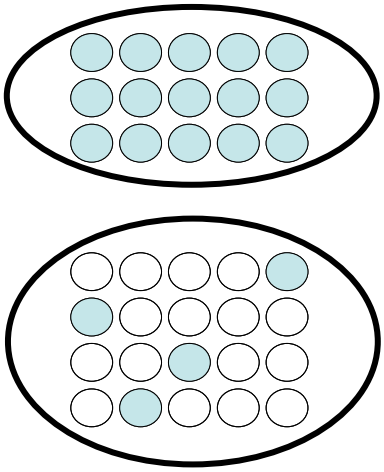
142,857 - 100,000 = **42,857**

Total migrant population | Total regular migrant population | Estimated irregular migrant population

Direct estimation methods

Capture–recapture method

- First, capture 15 fish, mark them, and let them free again.
- Then, capture another group of 20 fish and examine them. If 4 of them are marked (recaptured), you can deduce that the 15 fish marked originally make up 20% (=4/20) of the total population, so there are, presumably, 75 fish in the pond (=15/20%).
- The "pond" could be the files of people apprehended during immigration controls.



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Indirect estimation methods

Comparison of census results

- US example
- Foreign-born population = [L – (M+E)] +T + R
  - L = regular immigrants
  - M = Mortality of regular immigrants
  - E = Emigration of regular immigrants
  - T = Temporary (regular)
  - R = Residual foreign-born (unauthorized migrants)

Total foreign-born = 32.6 million

Survived immigrants = 21.6 million [L – (M + E)]	**Residual foreign-born = 10.2 million**

Temporary migrants = 780,000

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Case study: estimating the number of Sudanese in Egypt

Methodology

- Political statements from Egyptian government officials say that there might be up to **4 million** Sudanese in Egypt (total population 80 million).
- United Nations data: Egypt hosted a total of **245,000** foreign-born in 2010.
- The 2006 Egyptian census recorded **2,662** Sudanese living in Egypt.
- UNHCR registration data: **41,615** Sudanese asylum-seekers, recognized refugees and refugees with closed files believed to be still in Egypt.
- Ministry of Tourism data show that between 2000 and 2008, **30,000** Sudanese that had entered Egypt had not left.

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Case study: estimating the number of Sudanese in Egypt

Methodology – Step one: identifying low and high estimate

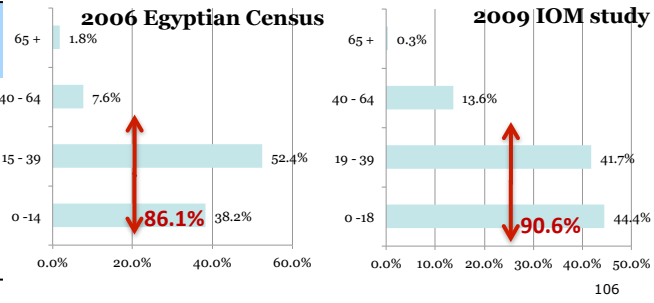
- The low estimate for Sudanese in Egypt is given by the sum of UNHCR registration data: **41,615** people (excluding census data from 2006 because of its limitations).
- The high estimate for Sudanese in Egypt can be obtained from the data from the United Nations Population Division. Sudanese are the second biggest nationality of foreign-born after Palestinians, who number 70,000. If we assume (to be conservative) that no nationalities other than Palestinians and Sudanese are included in the United Nations statistics, we can estimate a maximum of (245,000 – 70,000) = **175,000** Sudanese in Egypt.

Case study: estimating the number of Sudanese in Egypt

Methodology – Step two: refining the estimate

- We used data from the IOM study (2009) to test our estimates. The study surveyed a total of approximately 300 Sudanese households in Cairo, collecting data on approximately 1,050 individuals.

	Percentage of respondents
Recognized refugees	38.6%
Asylum-seekers	40.6%
People with closed UNHCR files	13.3%
Economic migrants	5.8%
Students	1.7%



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Case study: estimating the number of Sudanese in Egypt

Methodology – Step two: refining the estimate

- While the IOM data might not be statistically representative of the Sudanese population in Egypt, the relatively large sample size and the equal distribution of male vs. female highlights the potential of these data to give a good approximation of the breakdown of the Sudanese population beyond UNHCR-registered cases.
- We apply a multiplier method (UNECE, 2008) to estimate possible values of Sudanese in Cairo. Namely, we take **estimates for the total number of Sudanese with different types of residence status and we expand it by the proportion of Sudanese with the same status in the IOM survey**. For this purpose, we assume that the Sudanese counted in the 2006 census were all labour migrants.

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Case study: estimating the number of Sudanese in Egypt

Methodology – Step two: refining the estimate

	Total number (a)	Percentage of total population (b) IOM (2009)	Estimate (a)/ (b)	Source
Recognized UNHCR refugees	10,499	38.6%	27,199	(a): UNHCR (2010)
Asylum-seekers registered with UNHCR	13,005	40.6%	32,032	(a): UNHCR (2010)
People with closed UNHCR files	19,238	13.3%	144,647	(a): UNHCR (e-mail communication)
Economic migrants	2,662	5.8%	45,897	(a): Capmas in IOM (2010)

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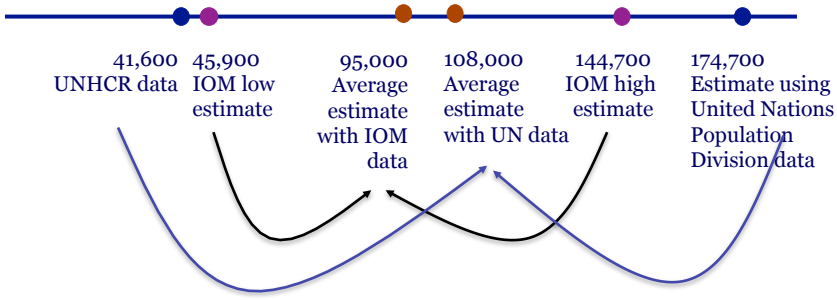
Case study: estimating the number of Sudanese in Egypt

Conclusion



From estimates between **3,000 and 4 million** to **95,000 to 108,000.**

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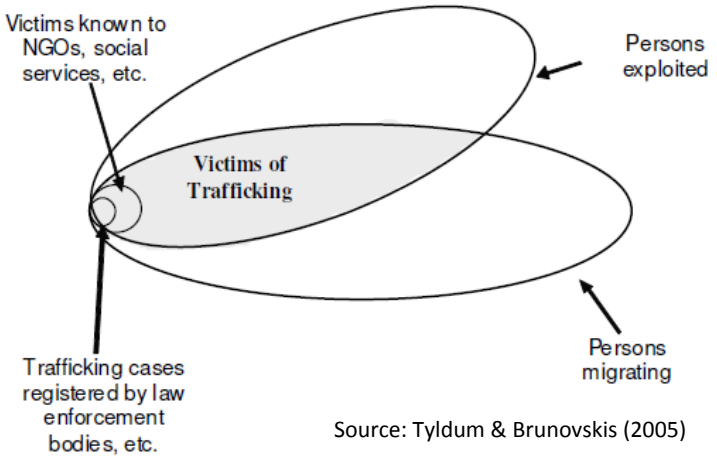
Representativeness of samples of trafficked persons

Are assisted trafficking victims representative?

- Many trafficking victims that are identified are never assisted.
- Many trafficking victims are never identified.
- Assisted victims (those who are willing and able to access assistance) may represent a particular sub-group of trafficking victims who may be systematically different from other trafficking victims.

Sampling of trafficked persons

TARGETING VICTIMS OF TRAFFICKING: SUBPOPULATIONS AND POPULATIONS WHERE VICTIMS OF TRAFFICKING CONSTITUTE SUBPOPULATIONS (relative sizes of populations are hypothetical and likely to vary between regions)



Source: Tyldum & Brunovskis (2005)

Representativeness of samples of trafficked persons

Factors informing who is part of the group of "assisted victims"

- individual characteristics
  > education, age, geographical location, personal experiences and social networks may play a role in their knowledge of and ability/access assistance
- social or cultural norms
- policy or legislative frameworks
- how programmes are designed and funded
- political commitment

Representativeness of samples of trafficked persons

Are assisted trafficking victims representative?

- Many men are reluctant to be labeled "trafficking victims"
- Donors (generally foreign governments) have often influenced who is assisted by dictating what forms of trafficking are considered and funded.
- Information, policies, laws and programmes change over time.

Representativeness of samples of trafficked persons

Is an organization's caseload representative?

- Data may be project or organization based
- Many of the victims, in different ways and at different stages, decided what services and what assistance organizations best suit their situation and needs
- Fluctuations in data may, in some cases, reflect an issue of resources as much as trafficking patterns

Health and trafficking research

- Explain the differences between assisted and all other trafficked persons
- Attend to the selection effects within any one organization's data set
- Make explicit how the methods used in any study or presentation of data inform the extent to which the sample is (or is not) representative

Health and trafficking research

- Make clear the limits of the "sub-sampling" used
- Access alternative sources of data based largely on research
- Identify which victims are going unidentified and unassisted and why this is urgent in terms of trafficking assistance

Migration Health – Research & Epidemiologic Methods

Part III

ETHICS

ETHICS
Outline

A. International standards in health research ethics
B. Special considerations in migrants' research
C. 'Good' ethical practices
D. Case Study
E. Discussion

International standards in health research ethics

Selected Guidelines

- CIOMS (2002) International Ethical Guidelines for Biomedical Research Involving Human Subjects.
- CIOMS (2009) International Ethical Guidelines for Epidemiological Studies.

Selected Guidelines

- National Commission for the Protection of Human Subjects of Biomedical & Behavioural Research (1979). The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.
- Nuffield Council on Bioethics (2002). The Ethics of Research Related to Healthcare in Developing Countries.

Selected Guidelines

- WHO (2001). Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women.
- WHO (2007). WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies.

General Ethical Principles (CIOMS)

1. *Respect for Persons*
   a. respect for autonomy
   b. protection of persons with impaired or diminished autonomy
2. *Beneficence*
3. *Justice*

Special ethical considerations in migrants' research

Ethical questions in migration health research due to -

1. Socioeconomically vulnerability
2. 'Hidden' populations
3. Precarious legal status
4. 'Stigmatized' populations
5. Forced migration contexts
6. Emergencies, Refugee research

'Good' ethical practices in migration health research

Ethical Clearance

- Mandatory in most countries, also required by donors
- National or internationally mandated Ethics Review Committees
- Common requirements –
  1. Research protocol
  2. Informed consent forms

Ethical Clearance (ctd.)

- Common requirements –
  3. Study instruments
  4. Data collection and management forms
  5. Approval or proof of submission to national/ local or donor ethics review committees
  6. Technical review and revisions

Principal ethical issues -

1. What is research?
2. Issues in study design
3. Harm and benefit
4. Voluntary informed consent

Principal ethical issues -

5. Standard of care
6. Obligations to participants and community
7. Privacy and confidentiality
8. Professional ethics

Special concern for migrant groups - Privacy & Confidentiality

- Privacy considerations vary from culture to culture, also between developed & developing countries
- Privacy relates to control over –
  - ✓ who has access to information about someone
  - ✓ who has the right to observe someone when they are not in a public space
  - ✓ specific decisions concerning oneself

Privacy & Confidentiality

- Confidentiality refers to the obligation NOT to disclose private information
- It is essential for research participants to feel confidence that the data they provide to a researcher on private information and details about intimate areas of life, will remain private

Case Study – Health Promotion Survey

Privacy & Confidentiality

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The Case

Health promotion survey research on a commercial farm

Discussion Questions

1. Should the researchers inform farm management of their findings (that many underage girls are working on the farm) and their concerns (that these underage girls are probably exposed to sexually transmitted infections, including HIV)?

Discussion Questions

2. Are the researchers under any ethical obligations to take study participants out of "harm's way" even if they haven't contributed to the risk?

3. If parents knew of the risks to their young daughters and still gave their approval for the work, would it make any difference to what the researchers should do?

Discussion Questions

4. What obligations do you see as part of the researchers' obligations and which ones are not obligations but are morally justifiable?

Implications for Data Protection in Migrant health research

- Has adequate anonymization occurred for all data including samples for future use?
- Are all stakeholders aware of the need for confidentiality and how to maintain it?
- Who has legal rights to the data and for how long? When can data be destroyed?
- How safe are electronic records?

Data Protection & IOM

1. Lawful & fair collection
2. Specified & legitimate purpose
3. Data quality
4. Consent
5. Transfer to third parties
6. Confidentiality
7. Access & transparency

Data Protection & IOM

8. Data security
9. Retention of personal data
10. Application of the principles
11. Ownership of personal data
12. Oversight, compliance and internal remedies
13. Exceptions

Migration Health – Research & Epidemiologic Methods

PART IV

RESEARCH DISSEMINATION

Assisting a World on the Move for 60 Years

Migration for the Benefit of All

RESEARCH DISSEMINATION Outline

- Rationale for information dissemination
- Crafting the messages
- Dissemination
- Application of research to action

Assisting a World on the Move for 60 Years

Migration for the Benefit of All

Rationale for research dissemination

Whether or not the best and most relevant research reaches the person with the problem depends on the efficiency of the communications links. Therefore … the usual prescription for improving the use of research is to improve the means of communication to policy makers.

Source: Weiss 1979

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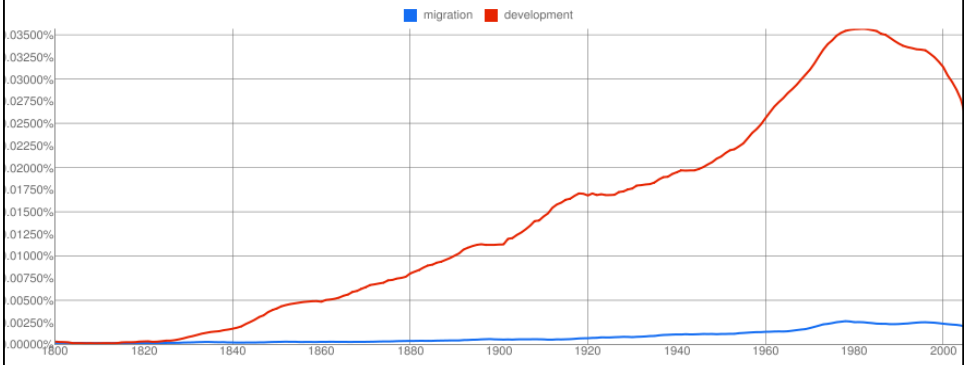
Migration for the Benefit of All

Rationale

If not in public domain, issue not relevant…

Graph these **case-sensitive** comma-separated phrases: migration,development
between 1800 and 2008 from the corpus English with smoothing of 3.
Search lots of books

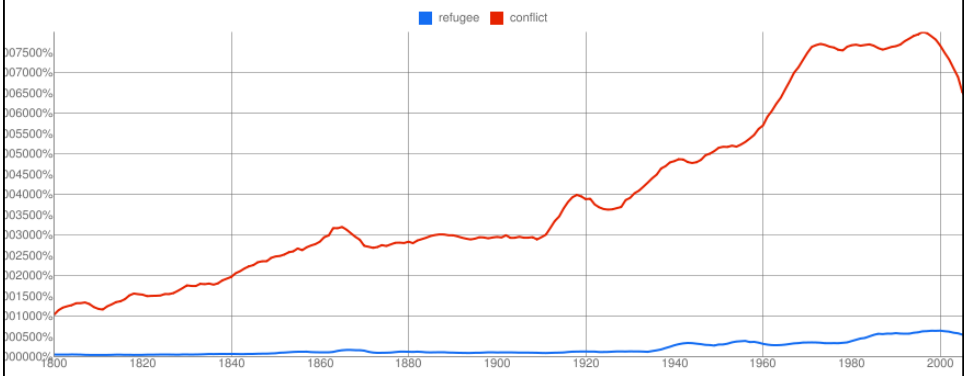


Search in Google Books:

Rationale

If not in public domain, issue not relevant…

Graph these **case-sensitive** comma-separated phrases: refugee,conflict
etween 1800 and 2008 from the corpus English with smoothing of 3.
Search lots of books



earch in Google Books:

Rationale

1. How can we continuously use new data and information to improve the quality of migration health work and inform policy/programme development?

2. Application of research to action important to clarify what is known and understand variations in migrant health status and outcomes

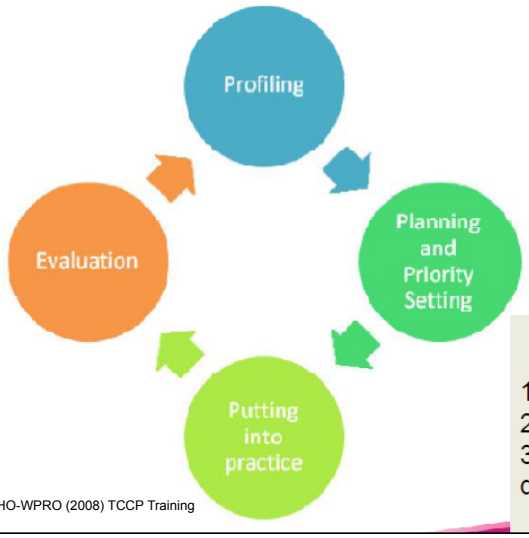
Rationale

3. Researchers and organizations spend a large amount of resources on conducting studies – often, with a limited dissemination to a small group of stakeholders at the launch of a report or paper

4. Lots of 'shelf' materials are often created – without dissemination to policy-makers, advocates, public, other academia, international partners

Rationale

Migration health policies should be constantly informed through research and evaluation



1. People-centred
2. Culturally competent
3. Focused on reducing disparities

Adapted from WHO-WPRO (2008) TCCP Training

Rationale

5. Effective dissemination can bring research findings into the policy debate and stimulate innovative operational approaches and activities

6. Can enable improved consultation between researchers and policy-makers, as well multiple sectors engaged in migration management and health

Crafting the message

Crafting the message

1. While a study might contain a wealth of information, only a specialized audience will read the whole report

2. Fact: Most readers, including policymakers and donors, will read only as far as the executive summary

3. A number of readers will read only the press note and/or listen to a PowerPoint presentation

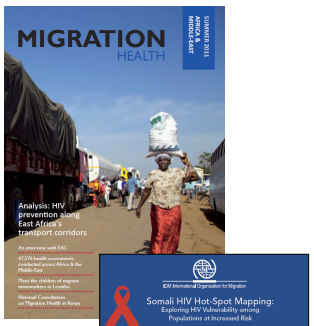
Assisting a World on the Move for 60 Years

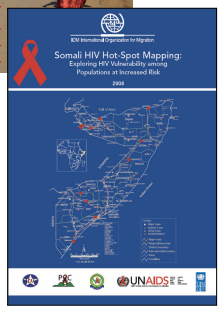
Migration for the Benefit of All

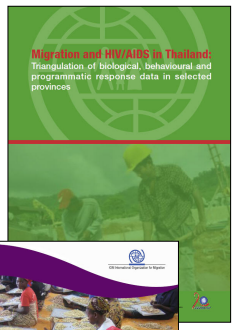
Crafting the message

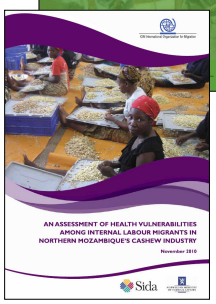
Press release	General public, audience at launch
Executive Summary	Donors, partners
Full report	Technical stakeholders, academia

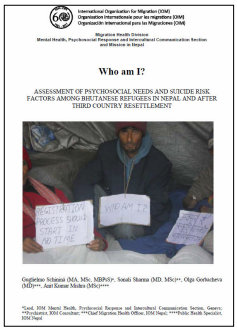
Visibility Materials











Crafting the message

1. It is important to ensure that the right information is contained in the executive summary and visibility materials

- People want simple, impact information:
  - Sometimes numbers and graphs are better than words at conveying ideas. A few figures go a long way
  - Why you should not "dumb down" the message; technicalities and jargon such as "capacity-building" and "migration management" should be avoided, or used as little as possible

Assisting a World on the Move for 60 Years

Migration for the Benefit of All

Dissemination

Assisting a World on the Move for 60 Years

Migration for the Benefit of All

Research dissemination

Going beyond one dissemination workshop

- Make sure full report and visibility materials are readily available on the organization website
- Keep a centralized list of partners/distribution for the Mission so that all stakeholders can be reached with e-mails

Research dissemination

Going beyond one dissemination workshop

- Mail or deliver hard copies of the report to a selected list of top officials at embassies and ministries, with a letter signed from the principal investigator / organization head
- Use the internet

Research dissemination

Simple routine

1. Post the study on your websites with a fact sheet if possible
2. E-mail the link to distribution lists for migration and health maintained by you and partners
3. Re-post on portals like ReliefWeb, Zunia.org, forced migration listserv, and other open access sources
4. Edit the relative entry on websites like Wikipedia

Research dissemination

Research dissemination

Research dissemination

Application of research to action

Why is research application important?

- To promote evidence–based project/programme development
- To foster the development of institutional knowledge (scope and scale of activities, beneficiaries, etc.)
- To identify lessons learned and good practices for future replication

Assisting a World on the Move for 60 Years

Migration for the Benefit of All

Why is research application important?

- To increase visibility of migration health studies in the country and regionally
- To avoid duplications and overlapping of activities
- To move towards an evaluation culture

Participatory research and information dissemination

- Important to move migrant health policy decision-making to the local level and include migrants in the process
- Need for a public sphere for knowledge sharing and establishment of best practices & local policies among researchers, policy-makers and beneficiaries themselves

Migration Health – Research & Epidemiologic Methods

PART V
Way Forward

Assisting a World on the Move for 60 Years

Migration for the Benefit of All

WAY FORWARD
Outline

1. Improved monitoring of migration health & expanded focus of migrant health research
2. Integration of routine migration and health surveillance/information systems

Assisting a World on the Move for 60 Years

Migration for the Benefit of All

Improved migration health monitoring

Rationale

1. Urgent need for evidence for policy development
2. Need for better application of epidemiological tools to gather primary data on health and healthcare utilization, as well as outcomes of national policies on migrant health
3. Methods to be refined through validation and piloting of tools in local context

Assisting a World on the Move for 60 Years

Migration for the Benefit of All

Recommendations for improved monitoring

1. Improved standardization of metrics and indicators
2. Better monitoring of under-represented communities and migrant populations
3. Improved definition of metrics and indicators specifically related to migration vs. those resulting from existing global disparities

Optimal data use for migrant health monitoring

	Population census	Administrative sources	Surveys
Comparability	+	-	+ / -
Costs	-	+	-
Frequency	-	+	-
Policy relevance	+/-	+	+

Optimal data use for migrant health monitoring

Migrants Count: Five Steps Toward Better Migration Data

- Published by the Center for Global Development in Washington DC (May 2009)
- Endorsed by both the GFMD and the GMG
- A simple guide to capacity building in the area of migration data. http://www.cgdev.org

The five steps .....

1. Ask basic census questions – country of birth, citizenship, previous residence by age and sex – and tabulate and disseminate the answers
2. Compile and release existing administrative data
3. Centralize labour force surveys
4. Provide access to micro-data
5. Include migration modules on more existing household surveys

Secondary use of migrant health assessment data

- More effective analysis and dissemination of health data gathered through migration health assessments
- Useful tool for monitoring and health profiling of migrant populations
- Additional data collection using quantitative and qualitative surveys can supplement programmatic data to generate migrant health knowledge for planning purposes.

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Results of tuberculosis screening in applicants for migration in Vietnam and Cambodia

Table 1 Age-specific rates of newly diagnosed smear- or culture-confirmed tuberculosis for applicants from Vietnam (n = 5108) according to method of detection

		Initial rate		Final rate	
Age, years	Per cent of sample	Number of cases	Rate per 100 000	Number of cases	Rate per 100 000
<15	12.6	0	0	0	0
15–34	64.5	7	213	13	395
35–54	15.3	0	0	6	768
⩾55	7.6	1	257	6	1542
Total	100.0	8	157	25	489

FROM THE CENTERS FOR DISEASE CONTROL AND PREVENTION

Health of Resettled Iraqi Refugees—San Diego County, California, October 2007–September 2009

MMWR. 2010;59:1614-1618

1 figure, 2 tables omitted

IN RECENT YEARS, IRAQI REFUGEES HAVE been resettling in the United States in large numbers, with approximately 28,000 arrivals during October 2007–September 2009 (federal fiscal years [FYs] 2008 and 2009). All refugees undergo a required medical examination before departure to the United States to with timely collection and review of health data, enables early detection, treatment, and follow-up of conditions, and can help public health agencies develop and set priorities for population-specific health interventions and guidelines.

During FYs 2008 and 2009, California received 24% (6,626) of all U.S.-bound Iraqi refugees, the largest proportion of any state. The California Refugee Health Program provides comprehensive, standardized medical assessments for all refugees within 90 days of arrival. Based on those assessment results, refugees are referred to primary-care providers and, if needed, for specialized care. This initial assessment, based partially on CDC guidelines for arriving refugees,[1] includes a history, physical exam, mental health

International Organization for Migration

Migration Health Division

NEWSLETTER

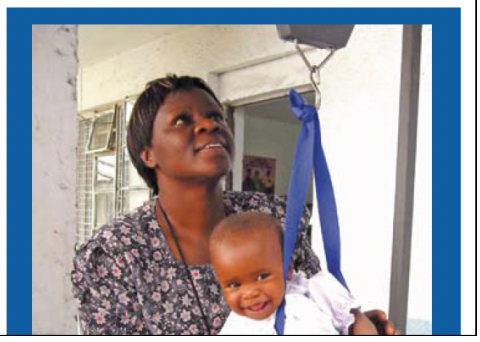
ISSUE NO.1, January–June 2011

Nutritional surveillance reports, January–June 2011

Malnutrition among refugee children aged 6–59 months is a critical public health concern due to the heightened disease vulnerability of this age group and the food insecurity facing refugee populations.[1] As part of refugee health assessments at key locations around the world, the IOM Migration Health Division teams routinely conduct anthropometric measurements for all persons examined. Using this data, IOM provides regular Nutrition Surveillance reports that are disseminated to key partner agencies, including the United Nations High Commissioner for Refugees (UNHCR) and other non-governmental organizations (NGOs). These reports will contribute to refugee health monitoring and aid in the planning of essential nutrition interventions for refugee children.

Child growth and malnutrition indicators

This Report presents the prevalence of two key indicators among refugees aged 6–59 months examined in various countries – overall and at specific sites – is assessed using prevalence ranges recommended by WHO.[2]



Health as part of National Migration Profiles/Situation Assessments

Stage One: Framework Setting

- Step 1: Support and resources
- Step 2: Goals and objectives
- Step 3: Relevance
- Step 3: Stakeholders
- Step 4: Coordination platform
- Step 5: Operational framework
- Step 6: Expert team

Stage Two: Implementation

- Step 7: Existing evidence
- Step 8: New evidence
- Step 9: Verify preliminary progress
- Step 10: Adjust the MP template
- Step 11: Analyze and draft

Stage Three: Report Launch and Follow-Up

- Step 12: Validation of content
- Step 13: Apply findings to policy
- Step 14: Towards evidence-based policy making
- Step 15: Sustainability

Health as part of National Migration Profiles/Situation Assessments

Executive summary	Part A: Migration Trends	Part B: Migration Impact	Part C: Migration Governance	Part D: Recommendations	Annexes
	Immigration	Demographic development	Policies	Migration Policy and Governance	Definitions
	Emigration	Economic development	Legislation	Mainstreaming migration into other policies	Data sources
	Irregular migration	Employment and labour market	Institutions		Enacted legislation
	Internal migration*	Social development	International cooperation	Data	References
		Health			
		Environment			

Dimension	Issue	Possible indicators	Likely relationship
Healthcare system	**Key national health indicators**	**•Under-five mortality rate (MDG 4.1) •Infant mortality rate (MDG 4.2) •Maternal mortality ratio (MDG 5.1) •Access to private and public health care in country (e.g. proportion of uninsured; availability and affordability of specialized healthcare); •Proportion of population with advanced HIV infection with access to antiretroviral drugs (MDG 6.5)**	**Migration (e.g. "brain drain" from state sector overseas and into private sector) may undermine public healthcare provision. Migration may spread health related knowledge and good practices. Need to train to overseas standards may improve standards. Migrants and returnees may introduce new practices.**
	Occupational accidents	**•Occupational accidents by main sectors/ industries, comparing migrant workers with non-migrant workers as affected by occupational accidents.**	
	Health security	**•Implementation of relevant public health measures outlined in International Health Regulations (2005) by border management •Number of entry VISAs denied based on medical grounds. •Training for border staff in public health issues and emergency medical care management. •Proportion of population affected by natural disasters that has access to healthcare services and/or healthcare coverage •WASH indicators (IASC recommendations)**	**Population movement may be accompanied by increased disease transmission.**

Health of immigrants	Immigrants' health status	•Availability of disease prevalence/morbidity and mortality national indicators among migrant sub-groups •Foreigner medically tested for work permits (or other status-related procedures) by results, identified disease, citizenship)	Moving location may expose the migrant to different health risk factors and healthcare availability.
	Immigrants' access to healthcare	•Policy on healthcare coverage for migrants (e.g. is there universal (health) coverage/ comprehensive/non-discriminatory/ equitable access; restricted access for certain categories of migrant populations, such as migrants in an irregular situation; denouncing of health seeking migrants in an irregular situation by health providers)) •Number of regular and irregular migrants accessing public health services. •Proportion of migrants without social protection in health, versus proportion of nationals without social protection in health. •Number of emergency room visits over past year for migrants as compared to nationals. •Presence of health services designed for migrant populations (e.g. linguistically/culturally sensitive services; special outreach programmes; delivery of such services by national programmes, NGOs, IOs, or other).	
	Financing of health services for migrants	•Proportion of health financing for migrants that comes from out of pocket payments. •Special social protection for health schemes for migrants (contributory-, employer- or tax – based.) •Number (proportion) of migrants affiliated with national health insurance system	

Questions to support analysis of the health – migration nexus

- Are migrants more vulnerable to particular diseases than nationals? Does the movement of people contribute to the spread of diseases?
- Does in- and out-migration affect the demand for health services in the country (increase or decrease)?
- Do migrants and their dependents have less (or more) access to healthcare while abroad compared to their access back home?

Questions to support analysis of the health – migration nexus

- Do female migrants find it more difficult or easier than male migrants to access health services, particularly keeping in mind their need for sexual and reproductive health services?
- Do migrant households that stay behind have access to health services (legally and de facto in terms of their resources and available infrastructures) if they are no longer covered by the breadwinner' s health insurance?
- Do return migrants have access to health/social services? Are social security benefits portable?

Questions to support analysis of the health – migration nexus

- Does immigration of foreign health personnel add to the stock of health professionals available in the country? Does it replace national health professionals who have emigrated?
- Does migration - through the sending of remittances - increase the capacity to invest in health at the household, community and national levels in your country?

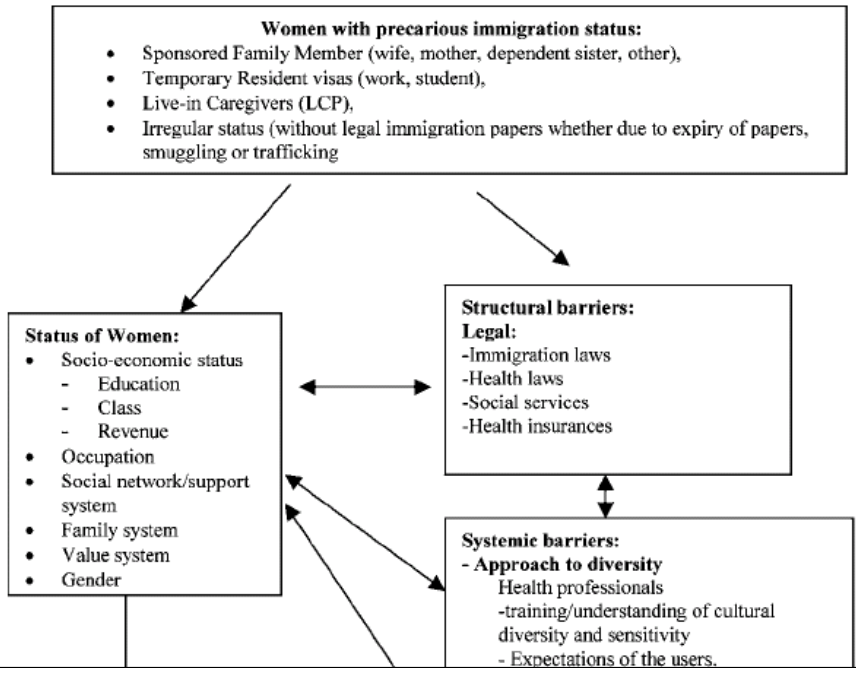
Expanded focus of migrant health research

1. Need to move beyond pure disease-based focus
2. To address migration as a social determinant of health
3. Use of a framework-based approach, based on theoretical models in epidemiological and social science research

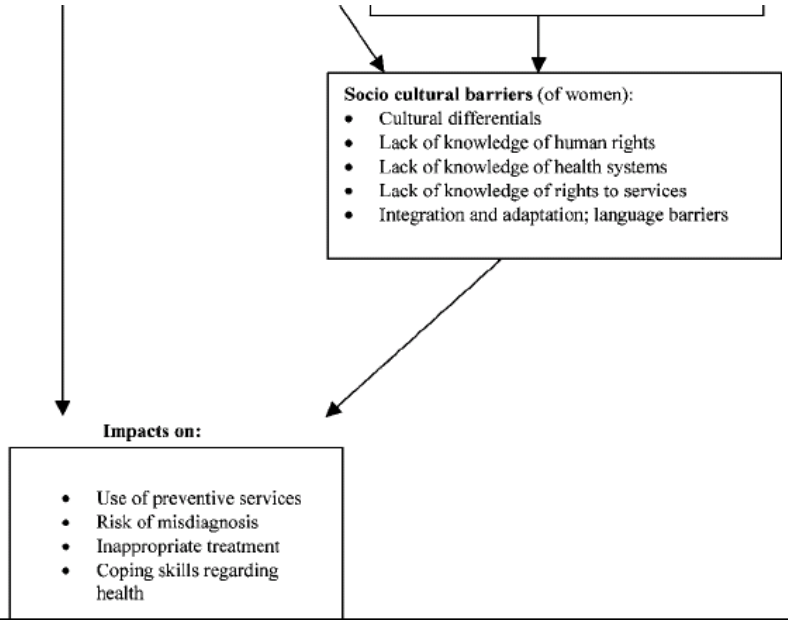
Example – Study of healthcare seeking among undocumented migrants

- Use a behavioral model of health services as a framework to study healthcare seeking behaviours.
- Based on three determinants –
  i. Need
  ii. Enabling factors
  iii. Pre-disposing factors

Example – Health indicators for women migrants



Example – Health indicators for women migrants



Expanded focus of migrant health research

4. Economic evaluations of migrant health interventions

5. Studies on healthcare financing for migrants

Economic evaluations - Rationale

- Appraisal techniques help us monetize the value to society of social policy
- Policy interventions are defined as "efficient" if they abide to the Kaldor–Hicks criterion:

  An outcome is more efficient if those that are made better off could in theory compensate those that are made worse off.

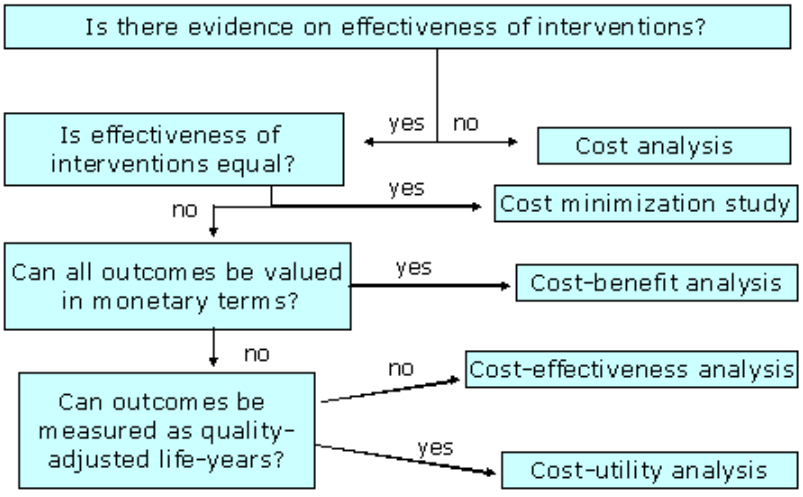
- Imagine a donor funds a health project worth USD 150,000 (of taxpayers money). Is this money going to lead to an improvement in life and health worth at least USD 150,000 to society?

Economic evaluations - Rationale

- To guide decisions about the most appropriate mix of strategies, best way to allocate scarce resources and advocate for new technology
- To provide an overview of the total amount of resources that will be needed to start or expand a project
- To assist managers in deciding on the most appropriate way to deliver a particular health intervention
- To provide evidence-based information to donors and policy makers that funding decisions resulted in cost-effective allocation of resources

Source: http://www.rapid-diagnostics.org/app-cost.htm

Types of economic evaluations



Source: Gray A. Economic Evaluation. In: Dawes, et al.Eds. *Evidence Based Practice: A Primer for Health Care Professionals*. 2001.

Studies on healthcare financing for migrants

- To investigate the existing health care financing options for both regular and irregular migrants
- To gain a better understanding of how each option works, including pros and cons
- To determine the efficacy of cost recovery, health insurance schemes, and other available methods
- To identify alternative options for migrant healthcare financing
- To provide recommendations that will inform future migrant health policy development

Integration of routine migration and health surveillance/information systems

Better linkages among migrant data sources

- Work permits/visa
- Stay permits
- Government-approved contracts

- Census
- Demographic surveys
- Labour force surveys

- Work permits
- Registers of foreigners

Better linkages between migrant data collection systems

- Dept of Overseas Labour / Employment
- Ministry of Commerce
- Foreigners Work permit Dept
- Bureau of Manpower
- Statistical Offices
- Ministry of Manpower
- Dept of Labour
- Ministry of Justice
- Ministry of Health, Labour & Welfare

Integration of migration indicators in health information systems

1. National health surveys
2. Demographic Health Surveys
3. AIDS Indicator Surveys
4. Monitoring of health-related MDG indicators

Integration of migration indicators in health information systems

1. What is your country of birth?
2. What is your current country of nationality?
3. How long have you lived in [country where the survey is being undertaken]?
4. What was the main reason for moving to [country where the survey is being undertaken]?
5. What kind of [an international] migrant do you consider yourself to be?

Integration of migration indicators in health information systems

Advantages -

1. Use of existing national health surveillance systems – efficient resource use
2. Availability of routine health data disaggregated by migration & mobility indicators
3. Sensitization of public health authorities to migration and mobility issues
4. Creating a bridge between traditional health and migrant stakeholders

Way Forward

- Identify gaps –
  1. Are internationally standardized definitions applied?
  2. Is data captured on ALL relevant themes, e.g. economic and health impacts?
  3. Are all possible data sources optimally used, e.g. existing administrative data, other national surveys?

Way Forward

- Identify challenges in setting up and maintaining up-to-date migration information systems – Quality Control?

- Address data sharing –
  1. Intra-national, across multiple sectors
  2. International, regional?

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THANK YOU

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