Migration and health

While there is a long history of research on migration and health, it has generally been narrow focusing on disease, especially communicable disease. Moreover, dominance of the ‘healthy migrant’ model whereby migrant populations are considered to be healthier than non-migrant populations because of the selectivity of the migration process has masked the complexity of the relationship between migration and health. However, the 2008 World Health Assembly (WHA) and the 2010 Global Consultation on Migrant Health (Fortier 2010) have directed the attention of States towards a more holistic consideration of the diversity of migrants’ vulnerability to health problems and the need for developing more migrant-sensitive health systems. This chapter focuses on the key migration health concerns and issues faced by migrants and health providers in South and South-West Asia and then considers the availability of, and accessibility to, health-care services among migrant groups.

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2 The sixty-first session of the World Health Assembly was held from 19 to 24 May 2008 in Geneva. During this session, which had 2,704 participants from 190 countries, a number of public health issues were discussed and several resolutions were adopted. One of the points dealt with was public health challenges faced by governments and societies on the health of migrants and health matters associated with migration. Thus, it was in this session that the Member States requested WHO to assess health aspects in migrant environments and to explore options to improve the health of migrants and from this basis, a resolution on the health of migrants was formed.
Migrants have an influence on the health of populations in both places of origin and places of destination because their health tends to differ from those of the non-migrant population at both locations. However, the relationship is more complex than this because migrants can be more vulnerable to health problems than non-migrants and they also can introduce new diseases into populations. It is this latter aspect that has disproportionately engaged the interest of researchers, especially in recent years in relation to the spread of HIV and AIDS (Herdt 1997, Haour-Knipe and Rector 1996).

Health factors alone can be the motivation for migration. In addition, migration can have significant implications for health services in destination contexts. Are migrants at greater risk of ill health because of their lack of immunity to local disease? Is their migrant status a barrier to accessing health services? In this context, the migration of health workers can also be of significance in shaping the availability of health services in places of destination as well as places of origin. These dimensions of the health-migration inter-relationship will be addressed here in the context of the South and South-West Asia subregion.

There has been a significant shift in thinking about the migration and health relationship in recent years as pointed out in the report from the Global Consultation on Migrant Health (Fortier 2010):

“Traditional approaches are often based on the principle of exclusion of migrants with certain health conditions, with the interests of the nation at the centre, using security and disease control as the primary rationales. The modern approach is based on inclusion, and focuses on reduction of inequalities and social protection in health in the context of a multi-country and multi-sectoral approach”

Source: WHO and others (2010, p.10).

In the past there has been a dominance of the healthy migrant approach which recognizes that there is strong selectivity in the migration process, which often is exacerbated by countries of destination imposing health testing as one of the barriers to entry. However, this detracts attention away from the fact that migrant health is often compromised during the migration process and, especially, with time at the destination. Moreover, an overwhelming focus on migrants as ‘spreaders of disease’ has directed attention away from other, often more significant, health-migration relationships.
Demographic changes

The reduction in the fertility rate throughout South and South-West Asia has led to a 'demographic dividend' whereby the number of young people entering adulthood who were born during a time of higher fertility outnumbers the number of children being born, increasing the proportion of the population in the most productive (and mobile) ages of youth and young adults. Table 1 shows that the young adult population (ages 20–34) is growing more rapidly than the total population. It offers the opportunity for a demographic dividend because of the increasing proportion of the total population in the most productive age groups, but it also results in greater overall mobility because these ages are also the years of greatest personal mobility.

Table 1.
Growth of the population aged 20–34, 1990–2030

<table>
<thead>
<tr>
<th>YEAR</th>
<th>POPULATION AGED 20–34</th>
<th>TOTAL POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NUMBER</td>
<td>%</td>
</tr>
<tr>
<td>1990</td>
<td>299 492</td>
<td>23.9</td>
</tr>
<tr>
<td>2000</td>
<td>375 694</td>
<td>24.5</td>
</tr>
<tr>
<td>2010</td>
<td>462 875</td>
<td>25.9</td>
</tr>
<tr>
<td>2020</td>
<td>516 954</td>
<td>25.3</td>
</tr>
<tr>
<td>2030</td>
<td>531 755</td>
<td>23.6</td>
</tr>
</tbody>
</table>

Source: UN DESA (2010).

Rural-urban migration

There has been a marked redistribution of population in the subregion from rural to urban areas as both a cause and consequence of rapid social and economic change. This is evident in table 2, which shows that growth in the urban population is expected to be nine times that of the rural population between 2010 and 2030.

International migration and globalization

The globalization and internationalization of labour markets has led to an unprecedented number of international migrants from South and South-West Asia. While people from the region have been involved in an array of types of international mobility, such as skilled migration to Organisation for Economic
<table>
<thead>
<tr>
<th>Country</th>
<th>Urban Population</th>
<th>Rural Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% Change</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2,277</td>
<td>6,581</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>22,908</td>
<td>46,149</td>
</tr>
<tr>
<td>Bhutan</td>
<td>90</td>
<td>246</td>
</tr>
<tr>
<td>India</td>
<td>220,280</td>
<td>364,459</td>
</tr>
<tr>
<td>Iran (Islamic Republic of)</td>
<td>31,958</td>
<td>53,120</td>
</tr>
<tr>
<td>Maldives</td>
<td>56</td>
<td>126</td>
</tr>
<tr>
<td>Nepal</td>
<td>1,892</td>
<td>5,559</td>
</tr>
<tr>
<td>Pakistan</td>
<td>35,400</td>
<td>66,318</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>3,217</td>
<td>2,921</td>
</tr>
<tr>
<td>Turkey</td>
<td>33,204</td>
<td>52,728</td>
</tr>
<tr>
<td>Total South and South-West Asia</td>
<td>351,061</td>
<td>598,207</td>
</tr>
</tbody>
</table>


Co-operation and Development (OECD) countries, marriage migration and student migration, the increasing flows of labour migrations are of particular significance. Not only are the numbers large and increasing, but it is the form that this mobility takes which is significant from a health perspective. This is because the migrant is usually an individual migrant worker that leaves his/her family behind for a period of two years and often lives under marginal conditions in the host country. Moreover, much of the movement takes place through informal and irregular channels. Migrants with an irregular status are estimated to comprise 15 per cent of the migrant population, and can be very vulnerable to negative impacts to their well-being and health, in particular. In cases of countries where demand for workers is high and no legal migrations systems are in place, migrants

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3 Migrants in an irregular situation are people who, owing to illegal entry or the expiry of his or her visa, lack legal status in a transit or host country. The term applies to migrants who infringe a country’s admission rules and any other person not authorized to remain in the host country (IOM 2004).
experience high levels of risks and exploitation. Smuggling, trafficking, bonded
labour and lack of respect for human and worker rights are the fate of millions of
migrants, most of them from poorer countries (GFMD 2011). Having an irregular
migration status amplifies the potential for abuse and exploitation because these
types of migrants do not have access to judicial channels of possible relief and
redress in fear of imprisonment or deportation. In addition, lack of coverage for
health services can lead to excessive costs for migrants many of whom have to
cover their health costs out of their own pocket. This deters many of them from
accessing services, which exacerbates health conditions that could have been
prevented, often at reduced costs, if services had been available.

Patterns of disease

The nature of the burden of disease in terms of daily disability-adjusted life
years (DALYs) has been shifting rapidly, with the proportion of communicable
diseases, maternal and child health and nutrition problems decreasing and non-
communicable diseases (NCDs) increasing. Figure 1 shows that in South Asia,
NCDs and injuries account for 55 per cent of the disease burden. Nevertheless,
it must be noted that communicable diseases still account for 46 per cent of the
burden, which is higher than the global average. Hence, South Asia has a distinct
health profile in that both communicable and non-communicable diseases each
make up a sizeable portion of the sub-region’s disease burden.

Poverty

Disease patterns are influenced by, and influence, the broader human
development profile of the region. Figure 1 shows that among the low- and
middle-income sub-regions, South Asia has relatively low economic indicators
and that its population has the lowest life expectancy with the exception of Sub-
Saharan Africa. Moreover, the sub-region’s expenditure on health as a percentage
of GDP and the amount spent per capita is the lowest among the world’s sub-
regions. Hence, the availability of health services and access to health services in
the total population, let alone among migrants, is low.

Humanitarian crises

The high incidence of crises related to natural disasters and political conflict
prevalent among many counties in South and South-West Asia influences the
migration and health relationship. A survey published online by The Disaster
Center shows that of the 100 natural disasters that killed the most people during
the twentieth century, approximately one-third occurred in South and South-
West Asia, most notably in Bangladesh and India. Natural disasters not only
cause massive loss of life but they often displace huge numbers of people on
both a permanent and temporary basis and this displacement can expose those
moving to a number of health risks (Disaster Center no date). Particularly in
South Asia, disasters often destroy houses and livelihoods, forcing the survivors
into overcrowded and often unhealthy camps where there is a high risk of the
spread of infectious disease.
Figure 1.
Burden of disease as a proportion of total forgone disability-adjusted life years (DALYs) by cause, selected regions, 2004

### Table 3.
Demographic, economic and health profiles for low- and middle-income regions

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>INDICATOR</th>
<th>YEAR</th>
<th>SOUTH ASIA</th>
<th>SUB-SAHARAN AFRICA</th>
<th>EAST ASIA AND PACIFIC</th>
<th>EUROPE AND CENTRAL ASIA</th>
<th>LATIN AMERICA &amp; CARIBBEAN</th>
<th>WEST ASIA &amp; NORTH AFRICA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total (millions)</td>
<td>2010</td>
<td>1,590,678,804</td>
<td>862,324,301</td>
<td>1,956,907,667</td>
<td>408,234,264</td>
<td>578,010,198</td>
<td>816,770,232</td>
</tr>
<tr>
<td></td>
<td>Rural (%)</td>
<td>2009</td>
<td>70.2</td>
<td>63.1</td>
<td>55.0</td>
<td>35.6</td>
<td>21.0</td>
<td>42.4</td>
</tr>
<tr>
<td></td>
<td>Over 65 years (%)</td>
<td>2009</td>
<td>4.6</td>
<td>3.1</td>
<td>7.4</td>
<td>10.9</td>
<td>6.7</td>
<td>4.40</td>
</tr>
<tr>
<td></td>
<td>Dependency ratio (% of working-age-population)</td>
<td>2009</td>
<td>58.5</td>
<td>84.9</td>
<td>42.9</td>
<td>43.8</td>
<td>53.9</td>
<td>56.5</td>
</tr>
<tr>
<td></td>
<td>Young</td>
<td>2009</td>
<td>50.9</td>
<td>78.4</td>
<td>32.1</td>
<td>27.9</td>
<td>43.3</td>
<td>48.4</td>
</tr>
<tr>
<td></td>
<td>Old</td>
<td>2009</td>
<td>7.3</td>
<td>5.8</td>
<td>10.5</td>
<td>15.7</td>
<td>10.3</td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td>Gross national income per capita</td>
<td>2010</td>
<td>1,213</td>
<td>1,176</td>
<td>3,692</td>
<td>7,214</td>
<td>7,802</td>
<td>510</td>
</tr>
<tr>
<td></td>
<td>Gross national income per capita, purchasing power parity</td>
<td>2010</td>
<td>3,208</td>
<td>2,126</td>
<td>6,624</td>
<td>13,200</td>
<td>10,951</td>
<td>1,247</td>
</tr>
<tr>
<td></td>
<td>Annual GDP growth (%)</td>
<td>2010</td>
<td>8.8</td>
<td>4.8</td>
<td>9.6</td>
<td>5.6</td>
<td>6.2</td>
<td>5.9</td>
</tr>
<tr>
<td></td>
<td>Labour force participation rate</td>
<td>2009</td>
<td>58.9</td>
<td>70.7</td>
<td>72.5</td>
<td>59.0</td>
<td>65.5</td>
<td>50.6</td>
</tr>
<tr>
<td></td>
<td>% male 15 years and older</td>
<td>2009</td>
<td>61.6</td>
<td>80.8</td>
<td>80.3</td>
<td>68.5</td>
<td>79.9</td>
<td>75.1</td>
</tr>
<tr>
<td></td>
<td>% female 15 years and older</td>
<td>2009</td>
<td>35.1</td>
<td>60.9</td>
<td>64.4</td>
<td>50.5</td>
<td>51.8</td>
<td>26.0</td>
</tr>
<tr>
<td></td>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>2009</td>
<td>54.6</td>
<td>80.8</td>
<td>21.4</td>
<td>18.9</td>
<td>18.9</td>
<td>27.4</td>
</tr>
<tr>
<td></td>
<td>Maternal mortality ratio (per 100,000 live births, modelled estimates)</td>
<td>2008</td>
<td>290.0</td>
<td>640.0</td>
<td>88.7</td>
<td>33.5</td>
<td>85.5</td>
<td>87.5</td>
</tr>
<tr>
<td></td>
<td>Crude death rate (per 1,000 people)</td>
<td>2009</td>
<td>7.35</td>
<td>13.5</td>
<td>7.1</td>
<td>11.1</td>
<td>6.0</td>
<td>5.6</td>
</tr>
<tr>
<td></td>
<td>Life expectancy at birth</td>
<td>2009</td>
<td>64.4</td>
<td>52.5</td>
<td>72.4</td>
<td>70.1</td>
<td>73.6</td>
<td>70.8</td>
</tr>
<tr>
<td></td>
<td>Total expenditure (% GDP)</td>
<td>2009</td>
<td>1.32</td>
<td>2.9</td>
<td>2.2</td>
<td>4.0</td>
<td>3.9</td>
<td>2.7</td>
</tr>
<tr>
<td></td>
<td>Public share of total health expenditure (%)</td>
<td>2009</td>
<td>32.9</td>
<td>44.2</td>
<td>50.4</td>
<td>66.0</td>
<td>51.7</td>
<td>50.7</td>
</tr>
<tr>
<td></td>
<td>Total health expenditure per capita (current US$)</td>
<td>2009</td>
<td>40.00</td>
<td>75.97</td>
<td>148.28</td>
<td>388.23</td>
<td>543.21</td>
<td>182.06</td>
</tr>
</tbody>
</table>

The onset of climate change is likely to increase the incidence of some natural disasters and some areas in South and South-West Asia are among the most vulnerable to this global phenomenon. Hugo and others (2009) lists the following as major hot spots:

- Increased flooding in major river valleys such as Pakistan.
- Reduced rainfall across major parts of India.
- Exposure of coastal areas, especially in Bangladesh, to a rise in the sea level and increased storm surge damage.

These changes, which have already been observed in the sub-region, especially in the hot spot areas, will impact migration both as an adaptation to climate change but also due to some displacement of populations. In Bangladesh, for example, table 4 summarizes current and projected environmental hazards and shows the scale of the impact—previous and anticipated.

In addition, some of the countries of the sub-region have been flashpoints of conflicts, which have generated millions of refugees and internally displaced persons (IDPs) in recent decades. The displacement process and the subsequent concentration of refugees and IDPs in camps expose these migrants to significant health risks.

<table>
<thead>
<tr>
<th>Table 4. Current and projected environmental hazards for Bangladesh</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Existing environmental hazards</strong></td>
</tr>
<tr>
<td>Cyclones On average, Bangladesh is prone to 1-3 moderate to severe storms annually, some travel as far as 200 kilometres inland.</td>
</tr>
<tr>
<td>Sea level rise and flood Some 20 per cent of the total land area is inundated annually on average. This figure may increase to more than 36 per cent in cases of severe flooding.</td>
</tr>
<tr>
<td>Drought Increasing occurrence despite the presence of abundant water resources.</td>
</tr>
<tr>
<td>River bank erosion Recurrent in 35 of the country’s highly populated subdistricts.</td>
</tr>
<tr>
<td>The country’s coastal areas are increasingly becoming saline Approximately 1.5 million hectares of coastal and offshore areas affected by salt water intrusion have already lost their agricultural productivity by about 30 per cent.</td>
</tr>
</tbody>
</table>

Of particular concern is the health of women and girls who are displaced by natural or man-made disasters. The limited data available on sex and gender differences with regard to vulnerability to and impact of disasters show that the health of women and girls is at disproportionate risk compared to men. This is due to (sexual) violence, lack of protection and access to reproductive health services, social and cultural beliefs, taboos and norms, particularly those that place women as a subordinate to men in terms of access to resources and decision-making power.

The health of migrants can be considered at various stages of the migration process. Gushulak and MacPherson (2000) and Zimmerman and others (2011) argue that each stage of the migration process—the pre-departure phase, the journey itself, arrival, adjustment at the place of destination and return to the place of origin—is associated with a particular set of health parameters and influences which impinge upon a migrant’s health. These impacts can be both positive and negative. On the positive side, some migrants may have better access to health services at the place of destination than at the place of origin. For example, health services in general are more readily available in urban areas as compared to rural areas. So consequently, migrants to urban areas may be able to access those services more than they could in their origin area. On the other hand, migrants’ journeys can be dangerous and expose them to injury or disease. At the place of destination, they may be exposed to new diseases to which they have no immunity, or they may adopt new behavioural practices, or living and work arrangements that place them at risk. Moreover, marginalization and discrimination at the place of destination may prevent them gaining access to health services. Migrants may also introduce new diseases to their place of origin when they return home.

In examining the relationship between migration and health it is essential to consider the differences that may exist between a migrant and the population in the host country, including culture and language, age, socio-economic status and financial circumstances. However, determining these differences is very difficult, as many migrant groups are invisible in standard data collections (Gushulak and MacPherson 2000). A key focus area has been on the healthy migrant effect which operates in many international migrations, especially those crossing international boundaries. Migration is invariably selective of young adults and of the healthier among them. Indeed, the international migration regulations of most countries exclude less healthy people and require medical testing of all intending migrants and migrant workers (Asis 2005).

However, once at the destination the ‘healthy migrant effect’ can be quickly compromised due to:

- substandard living conditions;
- low income, poor food;
- exposure to dangerous work situations;
- barriers to accessing health care;
Forced migrants, including refugees, are at particular risk of health problems (Toole and Waldman 1997). Moreover, the circumstances of the migration itself often impinge negatively on the health of the migrants and their concentration in camps immediately after their flight also can lead to deterioration in their health.

The United Nations High Commissioner for Refugees (UNHCR) and other agencies provide medical assistance to some refugees but despite these organizations' efforts, refugees may face greater health risks at the camps than in their country of origin (Adams and others 2007):

“Major causes of mortality in refugee camps include diarrhoeal diseases, measles, acute respiratory tract infections, tuberculosis and malaria.”

Many refugees and IDPs suffer human rights abuses and hardships prior to leaving their place of origin, which can further affect their physical and mental health even after they have settled in a safe destination. Most of the studies on refugee health were conducted in third country settlement destinations, such as Australia and the United States of America. Studies on the health of refugees and IDPs in South and South-West Asia are limited. However, from literature available, it is clear that many refugees suffer poorer health than the non-migrant population (Frisbie and others 2001).

Among the various studies that highlighted the specific health needs of women and adolescents in refugee camps (Norwegian Refugee Council 2005) polymenorrhea (shortened menstrual cycles), dysmenorrhoea (painful menses), and menstrual irregularity were cited as health issues. The violence experienced by this group and the associated psychological and physical stress was the most commonly cited cause for these health issues (International Initiative of Justice 2003). Studies among the refugee population in general also point to a high incidence of mental illness associated with the torture and trauma that many have suffered (Nicholson 1997). Other reported health issues in the camps are skin diseases, nutrition deficiencies, tuberculosis, kidney disease and asthma (Samaddar 2003).
The migration of women in South and South-West Asia lends itself to special attention, from a public health as well as from a human rights perspective. A study conducted in 2004 of 677 migrant women from Bangladesh to India and Western Asia shows that the women tend to be young (under 22 years of age), and often end up engaging in sex work in their destination country, either by choice or as part of “additional duties” forced on them by their employer (Blanchet and others 2004). It highlights that among the returning Bangladeshi women migrants, knowledge of sexually transmitted infections (STIs) and HIV and AIDS is extremely low and condom usage is infrequent, while STI symptoms are high. In addition, it finds that the women rarely seek treatment for their symptoms.

While limited studies have been conducted to document the health problems experienced by these women as a result of their migration, the existing literature shows that STIs, HIV and AIDS, unwanted pregnancy and depression and addiction are some of the most significant health issues (Blanchet and others 2004).

In India, women migrants comprise 48 per cent of the international migrants (Chatterjee 2006). A large number of them are low-skilled and semi-skilled female migrants from neighbouring Bangladesh and Nepal who, as a result of their work status, take jobs mainly in unregulated sectors as domestic helpers, street sweepers and sex workers. These women face unsafe work and living conditions and lack of access to health care can pose a risk to their physical and mental health. A study by Jatrana and Sangwan (2004) examined the health experiences of migrant female workers in the construction industry in North India. It found that the health status of the women had improved after migration but that they had not yet started using modern health services for childbirth or for general health needs.

The reproductive health of female migrants and migrant workers in Asia has been an area of particular concern. Gardner and Blackburn (1996) point out that few reproductive health and family planning programmes have focused on migrants as a specific group.

Gardner and Blackburn (1996) also identify some major areas of concern regarding the reproductive health status of many migrants, refugees and IDPs:

- **Safe motherhood is nearly impossible for refugees and IDPs, especially at times of emergency.**
- **Violence against women is widespread in refugee and IDP movements.**
- **Unsafe abortions are common among refugees and IDPs.**

Studies on migrants in an irregular situation are sparse because of the nature of irregular movements and such migrants tend to prefer to remain unnoticed or are isolated. Despite the lack of statistics and research data, there are ample reports that highlight the significant health risks associated to irregular migration. Migrants working in informal sectors, such as domestic work, are less protected by labour laws and easily end up in an irregular situation which increases their vulnerability to ill-health as a result of substandard living and dangerous working conditions.
conditions, lack of access to health and social services and exploitation and abuse (physical, sexual and emotional). These were part of the findings of a study among Asian migrant workers employed in Arab States (UNDP 2008).

In many countries, irregular migrants are subject to administrative detention over violation of immigration laws. Detention of migrants has been associated with adverse health outcomes, especially for the already vulnerable, such as children. Mental health problems, including self-harm, have been documented, particularly in cases involving prolonged detention (Silove and others 2007).

As previously mentioned, a migrant’s legal status is one of the most significant factors in determining their access to health services in the destination country (Chatterjee 2006). This is particularly true for international migrants. Irregular migrants in host countries are unlikely to be provided with health care or insurance from their employers and are usually only afforded access to emergency medical care under national health care schemes. As a consequence of these two factors, combined with the risk of deportation if their status is discovered (Nygren-Krung 2003), irregular international migrants tend to seek health care or treatment in a destination country only when the disease is significantly advanced or life-threatening (Chatterjee 2006).

Very few studies have focused on the health of temporary labour migrants in destination countries and despite frequent newspaper reports of deaths and accidents involving migrant workers, few systematic studies have covered this topic. Kamaladasa and others (1992) reported that the altered lifestyle Sri Lankan migrant workers experience in Western Asia placed them at greater risk of coronary heart disease. It also found a higher incidence of non-insulin dependent diabetes in migrant Sri Lankans in Western Asia while Carballo and Siem (2006) noted that migration studies commonly found a higher incidence of diabetes among migrants than non-migrants. Meanwhile, Alballa and Bambgoye (1993) indicated that road accidents and industrial accidents were a common cause of morbidity and mortality among Sri Lankan migrants in Western Asia.

Human trafficking, especially of women and girls, is a major human rights violation. One report estimated that about 150,000 women and girls across South Asia are trafficked for sex annually (Miko and Park 2002). However, precise estimates of the number of women and girls currently being exploited within and outside of the subregion are not available and are always subject to question especially given the comparative complexity and ease with which international borders on the sub-continent can be crossed (Mehta 2003).

Gushulak and MacPherson (2000) reviewed and summarized health issues associated with trafficking. They demonstrated that despite the paucity of data, the levels of morbidity and mortality among trafficked persons are substantial throughout the migration process due to physical, sexual and psychological abuse, poor living and working conditions, social isolation, forced use of drugs and alcohol and lack of access to health and social services.
The exploitative and abusive nature of the human trafficking process poses health risks for trafficked persons. Among the health-related consequences of trafficking are reproductive health problems, psychological reactions, infectious conditions and physical trauma (IOM and others 2009).

Studies on survivors of human trafficking have documented sex workers’ higher vulnerability to STIs, including HIV, and tuberculosis. Qualitative work in India indicates that the vulnerability of ex-trafficked women and girls to HIV infection is exacerbated by several mechanisms, including forced unprotected sex, mobility restrictions that preclude access to health care and other services, violence upon sex work initiation and limited autonomy (Gupta and others 2009). Sex workers who entered the industry as a result of being trafficked were more likely than other female sex workers to report various increased vulnerabilities to HIV (Jhumka and others 2011). Similarly, studies among repatriated Nepalese sex-trafficked women and girls showed high HIV rates, with those under 15 years at higher risk for infection (Silverman and others 2007).

Regarding psychological risks, studies indicate the significant impact of trafficking for sexual exploitation on general mental health. A 2008 study in Nepal found that victims of sexual exploitation tended to have more anxiety symptoms and prevalence to depression and Post Traumatic Stress Disorder (PTSD) than those subject to labour exploitation (Tsutsumi and others 2008). Female drug users with a lifetime involvement in prostitution had a significantly higher prevalence of lifetime suicidal attempts and depressive ideas than those without (Gilchrist and others 2005). Findings suggested that efforts to assist trafficked populations must pay attention to the work performed during the trafficking process and explicitly focus on mental health and psychosocial support (Tsutsumi and others 2008).

Studies on the relationship between health and migration often focus on migrants and the communities they enter. However, it must be noted that migration can also have health-related impacts on the communities left behind by migrants. One area of particular importance in Asia is the effect on children when one or both of their parents move away to work on a temporary, but long-term, basis. The dominance of temporary international labour migration in Asia means that most migrants leave their spouse and children behind when they move away to work. The disruption of the nuclear family by this migration is a large-scale phenomenon in the region but little research has examined the health effects on those left behind.

In Sri Lanka, women make up more than a half of international labour migrants and as a result, many mothers are separated for long periods from their children (Asis and others 2004). A study of 400 households in Sri Lanka with overseas migrants found that 50 households reported that children who remained at home suffered significant problems due to the absence of their mothers. The problems most commonly cited were mental and physical health problems along with strains associated with loneliness (Hugo and Ukwatta 2010). Children with parents abroad experienced loneliness and had lower levels of school achievement than those with both parents present. In addition, their social development and psychological and emotional well-being were adversely effected. This was especially the case when it was the mother who was away.
Brockerhoff (1994) analysed demographic and health survey data on child mortality to investigate the significance of rural-urban migration and found the following:

- Before migration, children of migrant women had similar or slightly higher mortality risks than children of women who remained in the village.

- In the two-year period following their mother’s migration, children of migrants faced a higher likelihood of mortality than rural and urban non-migrant children. This finding applied to both migrant children who accompanied their mothers and those that stayed behind.

- Children born after migrants had settled in an urban area, gradually experienced much better survival chances than children of rural non-migrants. They also faced lower mortality risks than children of migrants’ born in rural areas before migration.

More recent studies from other sub-regions show that parental migration may also affect the emotional and psychological well-being of a child left behind (Jones and others 2004). In some instances it may also increase the likelihood of drug abuse and teenage pregnancy (AESCO 2007, United Nations General Assembly 2009).

Kuhn (2003) uses data from an ongoing longitudinal survey in Bangladesh to show that international migration of young men from villages has a positive effect on the health and survival of their parents. However, there are also cases where out-migration can have negative effects in places of origin. Roy and Nangia (2005) show in a study in rural areas of the Indian state Bihar that wives left behind by migrant men had higher levels of reproductive mortality than do the wives of non-migrant men.

One of the main concerns regarding migration in the study countries relates to the neglect of human rights of migrants. Among these basic rights, access to health services is significant. The costs of modern health systems in the subregion are also a significant barrier to accessing them for the general population. For migrants, the barriers to accessing health services can be both institutional and financial. Exclusion from the formal health care system can place migrants at greater risk of illness and injury as well as exclude them from the formal medical system. The marginality of migrants means that they are often faced with the double jeopardy situation of being more likely than non-migrants to need health services, but less able to access them.

An area of particular concern with respect to denial of rights and lack of access to health services relates to temporary international labour migrants whose irregular status in the destination society can both expose them to higher risk of illness than residents and deny them access to the health services to deal with them. It has already been demonstrated that spending on health services is lower per capita in this area than any sub-region in the world. Consequently, access to health services is limited for migrant and non-migrants alike but the situation is often exacerbated for the latter.
For temporary labour migration, best practice models have helped to ensure that migrant workers have access to health services before, during, and after the migration process (Hugo 2008). In Sri Lanka, for example, migrant workers leaving under official auspices are required to contribute to a health scheme with employers. In addition, there are special programmes for departing migrants. However, for many migrants who move outside the official system, the cost of obtaining services in the destination location can be prohibitive. Cultural and linguistic barriers can also play an important role and the development of migrant-sensitive health systems is a major priority of a recently implemented World Health Organization (WHO) initiative on migrant health (Fortier 2010).

As previously mentioned, there is increasing concern about migrant women having less access to reproductive health information and services than non-migrants (Gardner and Blackburn 1996, Huntington and Guest 2002). The barriers experienced by migrants and especially refugees and IDPs in accessing these services relate to a lack of knowledge and information about how the services are organized and are able to be accessed as well as to cultural, language and financial issues. Moreover, in some cases, there may be institutional barriers to accessing services. In addition to institutional barriers, low usage of health services by migrants can be attributed to financial constraints, language barriers and not having legal status in the host location as well as cultural factors, such as traditional health beliefs.

A common theme in the studies of health of international labour migrants is the role of high costs and illegal status as barriers to accessing health services. Gaur and Saxena (2004) in a study of Indian workers in Lebanon described their plight as follows:

“Apart from being exploited by employers and agents, most unauthorized workers lived on the edge with the fear of arrest and deportation hanging over their heads. When they fell ill, either they shouldered all the medical costs or just coped with their ailments. With their lower wages and the pressure of having to pay loans, most of them could barely afford to seek health care. They were also afraid to seek medical care because they could be arrested and deported.”

Refugees and IDPs is one group that may have difficulty accessing health services. This is especially true when they are in flight, but may also be the case when they are in camps, which are often overcrowded and under resourced and may not provide adequate health services.
The complex relationship between migration and the spread of infectious disease is well exemplified in the case of HIV and AIDS. While South and South-West Asia has a low HIV prevalence (less than 1 per cent), it is the subregion with the second highest number of people infected with HIV after sub-Saharan Africa (UNDP and ILO 2010). Table 5 shows that India, the Islamic Republic of Iran, Pakistan and Nepal have the highest number of adults living with HIV and AIDS, respectively. However, data collection methods vary greatly between the countries in the subregion and this must be taken into account when making comparisons of HIV prevalence in the region (UNDP and ILO 2010).

Table 5.
Estimated number of people living with HIV, 2007–2008 (in thousands)

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>ADULTS 15 OR OVER LIVING WITH HIV (THOUSANDS)</th>
<th>ADULT HIV PREVALENCE (PERCENTAGE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>12</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Bhutan</td>
<td>&lt;0.5</td>
<td>0.1</td>
</tr>
<tr>
<td>India</td>
<td>2300</td>
<td>0.3</td>
</tr>
<tr>
<td>Iran (Islamic Republic of)</td>
<td>85</td>
<td>0.2</td>
</tr>
<tr>
<td>Maldives</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Nepal</td>
<td>68</td>
<td>0.5</td>
</tr>
<tr>
<td>Pakistan</td>
<td>94</td>
<td>0.1</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Turkey</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: UN DESA (2010a).

A consistent finding across Asia is the strong influence that the type of migration has on risk of HIV infection. In most countries the highest rates of infection are recorded among highly mobile groups, such as truck drivers, fishermen and itinerant workers (Chantavanich and others 2000). In Nepal, seasonal labour migrants to India accounted for 46 per cent of the estimated HIV cases reported in 2005 (UNAIDS 2008).

However, as cautioned in the report, *HIV/AIDS and Mobility in South Asia* (UNDP and ILO 2010), discussions of HIV and migration must take into account the fact that migrant workers are often subject to mandatory or routine HIV testing,
both before their departure and while abroad, and this significantly biases any comparison of HIV prevalence between migrants and the general population who in general are not routinely tested. Despite this reporting bias, the fact that significant numbers of people living with HIV become infected while working abroad clearly demonstrates that there is a gap in current measures to tackle HIV.

An Integrated Biological and Behavioural Surveillance Survey (IBBSS) conducted in 2008 of 360 male migrant workers from the Western and Mid- to Far-Western development regions of Nepal\(^4\) found that they were almost four times more likely to use a female sex worker when they were in India than in Nepal (New ERA and STD/AIDS Counselling and Training Services 2008). While reported awareness of HIV was high among the male migrants, between 20 and 33 per cent had engaged in unprotected sex with a female sex worker while in India. Of further concern is the fact that spouses and female partners of migrant workers account for approximately 20 per cent of adult HIV infection in Nepal (UNAIDS 2008).

India has the highest number of people living with HIV in the region and is also the largest country of origin for migrant workers in Asia (UNAIDS 2009). However, returning migrant workers are not routinely tested for HIV and as such, no data are available for this group. Studies have, however, indicated a higher incidence of the disease among people returning from overseas (www.keralamonitor.com 2009).

There is a complex linkage between migration, the commercial sex industry and infectious disease, as explained in the Monitoring the AIDS Pandemic’s (MAP) 2004 Report on Aids in Asia which makes three crucial points on this relationship:

- “In Asia more people engage in commercial sex than in any other behaviour that carries high risk of HIV infection. Indeed most new infections in the continent are still contracted during paid sex” (MAP Network 2004, p. 4).

- “The women at highest risk are those who migrate specifically to sell sex in large cities where demand is high” (MAP Network 2004, p. 72).

- “Sex workers also move around, since their earnings tend to be better when they are new to an area and drop as they become familiar and no longer satisfy clients’ preference for variety and novelty” (MAP Network, 2004 p. 72).

In addition, Hugo (2010) has pointed out that the commercial sex industry is concentrated in locations where there are large numbers of circular migrants such as cities, border crossing points, construction and mining sites, plantations, tourist destinations and transport corridors. This highlights the important nexus between migration, HIV and the commercial sex industry. Sex workers are often placed in powerless situations in which they cannot use condoms and therefore often have higher prevalence of HIV infection than the general population.

The fact that many migrants are unaware of AIDS and continue to remain so even after testing HIV positive, indicates a lack of support services and treatment for STIs, including HIV, throughout the migration cycle. The development, implementation and enforcement of a comprehensive migration policy at the

\(^4\) Nepal is divided into five development regions, namely Far-Western, Mid-Western, Western, Central and Eastern.
national and regional level represent a vital first step toward effective protection of South and South-West Asian migrant workers.

As suggested in a report from the Commission on AIDS in Asia, “the future of Asia’s epidemics depends to a considerable extent on what happens to men’s incomes and their mobility outside family settings. Men who have disposable income, and who travel or migrate-to-work opportunities, provide most of the demand for commercial sex. If countries in Asia continue to experience rapid economic growth and men’s incomes continue to rise, the demand for commercial sex in the region is also likely to rise” (Commission on AIDS in Asia 2008, p. 58).

However the report also states that generalizations can be misleading because a significant number of migrants move with their partners, and are less likely to engage in HIV-related risk-taking behaviour. In addition, research from China has shown that conservative social norms survive longer among migrants than is commonly thought, such as the view that paying for sex is seen as unacceptable (Hesketh and others 2006). It is therefore not the case that all migrants are necessarily at higher risk of HIV infection (Commission on AIDS in Asia 2008).

While focus is often placed on HIV and AIDS, discussion of the link between mobility and health is not complete without mention of other infectious diseases. Tuberculosis (TB) is one of the most significant diseases among migrant populations (Hugo 2008). It is traditionally a disease of poverty and is strongly linked to social and environmental factors. Consequently, there is vast disparity in the rates of TB between populations of different social backgrounds, with migrants carrying a disproportionate burden of the disease (Hugo 2008). Conditions of overcrowding and poor nutrition, and low awareness of prevention measures contribute greatly to the transmission of TB, which is both an airborne and highly contagious disease.

TB incidence in South Asia is high—in 2008 there were a total 179 reported cases per 100,000 people (World Bank 2008). Of the 22 highest TB burden countries globally, India is ranked first while Bangladesh and Pakistan are ranked fifth and sixth, respectively (WHO 2010). In India, TB is the largest single cause of adult illness and death from a communicable disease (World Bank 2004).

The combination of trends in increasing human mobility, emerging multi-drug resistant TB and rising rates of co-infection with HIV and AIDS are raising new issues in the prevention and control of TB (Hugo 2008).

Migration and non-communicable diseases (NCDs)

NCDs are increasing globally and can no longer be considered as only diseases of the rich. In South Asia, NCDs now account for 50 per cent of the total disease burden (Engelgau and others 2011). The determinants of NCDs are largely social and environmental, and a growing body of research points to the significant impact of migration, globalization and urbanization as the risk factors for NCDs.

As Davies and other (2011) explain, as part of the acculturation process when they move to new societies, migrants may adopt unhealthy lifestyle habits including poor diet and physical inactivity, which increase their risk for NCDs, such as
cardiovascular disease or diabetes. Indeed, one study of Indian migrants living in the United Kingdom of Great Britain and Northern Ireland has shown that increased fat intake and obesity place them at increased risk of coronary heart disease (CHD) compared to their non-migrant counterparts in India (Patel and others 2006).

Stressful working and living conditions in the destination country may also increase their use of tobacco, or promote alcohol and substance abuse (Davies and others 2011a). In a study of CHD risk factors among Indian, Pakistani and Bangladeshi migrants living in Europe, Indian men were found to be more likely to drink alcohol while abroad and Bangladeshi men were more likely to smoke. Compared to their European counterparts, the overall risk of CHD was higher among all three migrant groups (Bhopal and others 1999).

Given the increased mobility of people in and between societies with differing health and demographic profiles, NCD prevention in South Asia and in destination countries of South Asian migrants should be comprehensive and take into consideration the socio-cultural factors and impact of migration on risk factors for NCDs.

The health sector workforce is large and diverse, and includes several highly trained groups. Health workers are of crucial importance to global health systems, which are under increasing pressure because:

- In less developed contexts, health systems are beginning from a low base and limited health human resources are hindering improvements in mortality and morbidity.

- In more developed contexts, the ageing of populations is creating an exponential demand for health workers which is not being met from internal training systems.

The countries in South and South-West Asia are influenced by both these trends since they have a below global average provision of health services yet they are also suffering a burgeoning outflow of health workers to OECD and other high-income countries. Three countries in this region, namely India, the Islamic Republic of Iran and Pakistan, are among the ten countries that have the largest numbers of doctors working abroad (World Bank 2011). In India, despite having the world’s largest emigrant source of doctors, the doctor-to-population ratio in 2006 was 60:100,000 compared with 548.9:100,000 in the United States of America (Khadria 2009). The country, which is also one of the world’s major sources of emigrant nurses, had had only 79 nurses per 100,000 population in 2006 compared with 782 in the United States of America (Khadria 2009).

There is increasing global concern regarding the ‘brain drain’ of health professionals from this subregion as well as other low-income subregions (OECD and WHO 2010). WHO (2010) has developed a Global Code of Practice on the International Recruitment of Health Personnel and the acceptance and implementation of this is an important priority.
Globally, the emphasis on migrant-inclusive approaches to addressing the health needs of both migrants and their host communities is gaining momentum.
The focus of government approaches to migration and health in the ten countries highlighted in this report has largely been disease-based and frequently centred on screening to detect communicable disease. To date, a general approach to mainstreaming migrant health issues into national health policies has been lacking in the sub-region despite increasing migration flows. Migrants from the subregion to most OECD countries are required to undergo health checks before they are granted a visa, with the detection of TB and HIV being common grounds for exclusion. Similarly, migrant workers seeking to travel through official systems to Western Asia or other destinations in Asia, such as Singapore, are obliged to undergo health checks. In several countries of destination, they also have to take regular health tests and can be repatriated if they are found to have particular conditions. There is some controversy about the compulsory tests, especially those detecting infectious diseases like HIV.

However, globally, the emphasis on migrant inclusive approaches to addressing the health needs of both migrants and their host communities is gaining momentum. An important development in this regard was the adoption by the 2008 WHA of resolution 61.17 on the Health of Migrants. This resolution, which called for WHO Member States to develop migrant inclusive health policies, promote equitable access to health care, and support social cohesion, provided a global operational framework on how to improve the health of migrants and has received strong support from governments of the sub-region. It is recognized however, that implementing the framework will require high-level commitment and engagement from all stakeholders (WHO 2010).

At the regional level, several migration-specific dialogues have helped to identify recommended approaches to migration health that are specific to Asia and the Pacific. The Regional Dialogue on the Health Challenges of Asian Migrant Workers held in July 2010 in Bangkok, Thailand; the September 2010 Asia-Pacific Regional Preparatory Meeting for the Global Forum on Migration and Development also held in Bangkok; and the Fourth Colombo Process Ministerial Consultation on Overseas Employment and Contractual Labour for Countries of Origin in Asia held in April 2011 in Dhaka, Bangladesh, are recent key examples.

A significant outcome of the Regional Dialogue was the adoption by representatives from ministries of Labour, Health, and Foreign Affairs of a set of Joint Recommendations aimed at improving the health and well-being of migrant workers and their families. The recommendations called for recognition of the feminization of migrant flows and the significant number of migrants working in the informal sector, and of the related health vulnerabilities of these groups emphasized the central place of human rights and the need to address barriers to accessing services. Governments of participating Member States also agreed on the need for data and bilateral approaches in formulating guidelines and minimum standards to assist countries in developing viable interventions that support the health and social protection of migrants. The Joint Recommendations also provided a framework for the roundtable

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6 The Outline for An Operational Framework to implement the principles and priorities expressed in the 2008 WHA Resolution on the Health of Migrants was developed as a main product of the Global Consultation on the Health of Migrants – The Way Forward in Madrid, Spain from March 3-5, 2010. The framework is a synthesis of the inputs received from participants representing governments, non-governmental organizations, international organizations, the Red Cross and Red Crescent Movement, academics and experts, as well as professional and migrant associations from all geographical regions.
discussions on migration and health that defined the health related articles in the Bangkok Statement on Migration and Development of 31 Member States of the UNESCAP Asia-Pacific Region for the Global Forum on Migration and Development 2010 in Puerto Vallarta, Mexico.

Furthermore, the health challenges of migration were discussed as part of broader discussions on ensuring the wellbeing of migrant workers at the 2011 Colombo Process Ministerial Consultations, during which the Joint Recommendation on the Health Challenges of the Asian Migrant Workers were presented. Acknowledging the challenges to promote and protect the rights of migrant workers and their families, and improving the welfare, dignity and well-being of migrant workers, especially those of women, the 11 Member States recommended the implementation of migrant-inclusive policies to ensure equitable access to health care and services as well as occupational safety and health for migrant workers.

Important models to enhance social protection in health have emerged in some countries of origin, mainly in those that rely heavily on remittances. Such models provide pre-departure orientation, coverage for disability and health services at the country of destination through a compulsory insurance package, and examination and referral when returning home. Although such models may be limited in their scope of coverage and not applicable to those who migrate through informal channels, these efforts recognize the important contribution of migrants to development and the need to ensure the health of migrants as a human right and as part of good public health practice.

The complex relationship between migration and health remains poorly understood in South and South-West Asia. This chapter has demonstrated that several of these relationships are of fundamental importance to the eradication of poverty and the achievement of the Millennium Development Goals in the subregion. Mobility continues to increase in South and South-West Asia, making it even more essential that its impact on health is better understood. Monitoring variables related to migrant health is a critical aspect of improving both the health status and utilization of health services by migrants (WHO 2010). Only on the basis of such knowledge Governments can develop sound policies that can maximize not only the benefits of migration but also minimize its costs.

To date, several regional and global initiatives have been implemented that promote understanding, partnerships, programming and advocacy for policies addressing the health of migrants and mobile populations, including their host societies and left-behind families and communities. For South and South-West Asia, investments have been made in fostering partnerships, networks and multi-country frameworks through regional dialogues, meetings and ministerial consultations. Prime examples among them are the Regional Dialogue on the Health Challenges of Asian Migrant Workers, the Global Forum on Migration and Development, and the Colombo Process. Although the focus of these initiatives has largely been within the context of labour migration and economic development, they have provided an important platform to discuss the health challenges of migrant workers. Governments may utilize such approaches as potential venues to extend the discussion on migration health to other forms of migration such as irregular and forced migration. These approaches could also
serve as an effective means to promote and discuss with donors the inclusion of migrant health needs in existing regional and global funding mechanisms.

With the existing mechanisms in place, the challenge now lies in implementing these recommendations, priorities, and actions at the country level. Governments, in partnership with other stakeholders, must consider their national migration and health context and take the lead in translating these recommendations into policies and legal frameworks that spur the development of migrant-sensitive health systems. Ensuring the continuity and quality of care received by migrants throughout the migration cycle is a recognized priority in South and South-West Asia. Another area of importance in the subregion is building capacity of the health and relevant non-health service sector to address the health and social issues associated with migration. Some Governments have moved forward on this issue through the following actions:

- establishing a focal point to facilitate inter-ministerial and inter-agency coordination;
- setting standards and frameworks for development, management, monitoring and delivery of migrant-sensitive and migrant-inclusive services; and
- sensitizing relevant service providers and stakeholders.

With careful evaluation, these initiatives could provide models for other countries to replicate or to adapt in their context. Given the varying forms of migration and its importance to the present situation in South and South-West Asia, approaches to migration health also need to further promote the rights of migrants and recognize the public health principles of disease transmission, its prevention, mitigation and where possible, eradication.
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