IOM UN MIGRATION

Migration Health Research Bulletin

A bi-monthly update on migration health research from IOM programs globally

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IN THIS EDITION

We profile articles looking at (1) the public health issues around migrant populations and their interactions with the host populations; and (2) the infectious disease testing of refugees going to the United Kingdom. Other articles included in this issue zeroes in on the Migrant Integration Policy Index (MIPEX) health strand in 38 European countries; health status of migrants in a post-conflict district in Sri Lanka; psychosocial support given to Syrian refugees in Turkey; migration's impact on the mental health of migrants; dissecting the phrase "illegal migrants"; and the practice of female genital mutilation in Sri Lanka.

RESEARC MIGRATION HEALTH

Articles

❶ Mohamed Abbas, Tammam Aloudat, Javier Bartolomei, Manuel Carballo, Sophie Durieux-Paillard, Laure Gabus, Alexandra Jablonka, Yves Jackson, Kanokporn Kaojaroen, Daniel Koch, Esperanza Martinez, Marc Mendelson, Roumyana Petrova-Benedict, Sotirios Tsiodras, Derek Christie, Mirko Saam, Sally Hargreaves, and Didier Pittet. *"Migrant and refugee populations: a public health and policy perspective on a continuing global crisis."* Antimicrobial Resistance & Infection Control, 2018, 7(113).

❷ Alison F. Crawshaw, Manish Pareek, John Were, Steffen Schillinger, Olga Gorbacheva, Kolitha P. Wickramage, Sema Mandal, Valerie Delpech, Noel Gill, Hilary Kirkbride, and Dominik Zenner. *"Infectious disease testing of UK-bound refugees: a population-based, cross-sectional study."* BMC Medicine, 2018, 16:143.

❸ David Ingleby, Roumyana Petrova-Benedict, Thomas Huddleston, and Elena Sanchez. *"The MIPEX Health strand: a longitudinal, mixed-methods survey of policies on migrant health in 38 countries."* European Journal of Public Health, 2018, cky233.

❹ Rachel Burns, Kolitha Wickramage, Anwar Musah, Chesmal Siriwardhana, and Francesco Checchi. *"Health status of returning refugees, internally displaced persons, and the host community in a post-conflict district in northern Sri Lanka: a cross-sectional survey."* Conflict and Health, 2018 12(41).

❺ Guglielmo Schinina and Marian Tankink. *"Introduction to Special Section on: Psychosocial support, conflict transformation and creative approaches in response to the needs of Syrian refugees in Turkey."* Intervention, 2018, 16(2): 161-163.

❻ Guglielmo Schininá and Thomas Eliyahu Zanghellini. *"Internal and International Migration and its Impact on the Mental Health of Migrants."* In: Moussaoui D., Bhugra D., Ventriglio A. (eds) Mental Health and Illness in Migration. 2018.

❼ David Ingleby, Allan Krasnik, and Roumyana Petrova-Benedict. *"Why we shouldn't use the term "illegal migrant"."* BMJ, 2018, 363:k4885.

❽ K. Wickramage, L. Senanayake, N. Mapitigama, J. Karunasinghe, and E. Teagal. *"The need for an evidence-informed, multi-sectoral and community participatory action framework to address the practice of female genital mutilation in Sri Lanka."* Ceylon Medical Journal, 2018, 63(2): 53-57.

Featured Article

Migrant and refugee populations: a public health and policy perspective on a continuing global crisis

Mohamed Abbas, Tammam Aloudat, Javier Bartolomei, Manuel Carballo, Sophie Durieux-Paillard, Laure Gabus, Alexandra Jablonka, Yves Jackson, Kanokporn Kaojaroen, Daniel Koch, Esperanza Martinez, Marc Mendelson, Roumyana Petrova-Benedict, Sotirios Tsiodras, Derek Christie, Mirko Saam, Sally Hargreaves, and Didier Pittet

Antimicrobial Resistance & Infection Control, 2018, 7(113)

Abstract

Background

The 2015–2017 global migratory crisis saw unprecedented numbers of people on the move and tremendous diversity in terms of age, gender and medical requirements. This article focuses on key emerging public health issues around migrant populations and their interactions with host populations. Basic needs and rights of migrants and refugees are not always respected in regard to article 25 of the Universal Declaration of Human Rights and article 23 of the Refugee Convention. These are populations with varying degrees of vulnerability and needs in terms of protection, security, rights, and access to healthcare. Their health status, initially conditioned by the situation at the point of origin, is often jeopardized by adverse conditions along migratory paths and in intermediate and final destination countries. Due to their condition, forcibly displaced migrants and refugees face a triple burden of non-communicable diseases, infectious diseases, and mental health issues. There are specific challenges regarding chronic infectious and neglected tropical diseases, for which awareness in host countries is imperative. Health risks in terms of susceptibility to, and dissemination of, infectious diseases are not unidirectional. The response, including the humanitarian effort, whose aim is to guarantee access to basic needs (food, water and sanitation, healthcare), is gripped with numerous challenges. Evaluation of current policy shows insufficiency regarding the provision of basic needs to migrant populations, even in the countries that do the most. Governments around the world need to rise to the occasion and adopt policies that guarantee universal health coverage, for migrants and refugees, as well as host populations, in accordance with the UN Sustainable Development Goals. An expert consultation was carried out in the form of a pre-conference workshop during the 4th International Conference on Prevention and Infection Control (ICPIC) in Geneva, Switzerland, on 20 June 2017, the United Nations World Refugee Day.

Table 1
Key steps and health determinants of migrants' health – medical footprint

Step	Main problems/issues	Shortages
1. Pre-migration health experience	Local epidemiological situation and poverty, conflict and war	Diagnosis, vaccination, healthcare, clean water, adequate housing, personal safety
2. Transit health experience	Long in time and space, often worse than in country of origin	Water, nutrition, hygiene, sanitation, housing (overcrowding), social and sexual protection (hostility of resident populations, exploitation by criminal gangs). Exposure to new pathogens for which they have no immunity
3. Destination experience	Unfavourable and unhealthy. Lasting situations governed by the will to survive. Adverse weather conditions outdoors, or if indoors overcrowded conditions and risk of transmission of infectious diseases among migrants	Lack of appropriate clothes, shoes and personal belongings (often abandoned, lost or stolen before or during sea crossings), lack of psychosocial support
4, Healthcare access/use experience	Fear of the law, suspicion of giving out personal data and the general feeling of not being appreciated may affect the evaluation by migrants of their right to access healthcare and other services	Trained healthcare personnel
5. New transit experience	There are often several transit experiences, for instance through North Africa and Southern Europe; through Turkey and the Balkans; or through Central America and Mexico	Water, nutrition, hygiene, sanitation, housing (overcrowding), social and sexual protection (hostility of resident populations, exploitation by criminal gangs). Exposure to new pathogens for which they have no immunity
6. Final destination experience	If and when a migrant finds a job, it is often dirty, dangerous and degrading ("3 Ds"). It may also be illegal, with no insurance coverage and limited access to healthcare. These informal jobs are vitally important for the economies of high-income countries	Lack of appropriate clothes, shoes and personal belongings (often abandoned, lost or stolen before or during sea crossings), lack of psychosocial support

Medical footprint and burden of disease

The medical footprint is a useful framework to understand each migrant's personal health capital and its evolution. Whenever a person decides to move, they bring with them a social, cultural and economic capital, which is liable to change during the trajectory of the individual through time and space. Each migrant also has a personal health capital, which will also evolve during their journey from their home country to an eventual destination. It is important to take into account migrants' health capital, and its evolution, the latter being impacted by social determinants of health, and advocate for enabling polices to maintain and develop it. This is important for health equity – universal coverage cannot be realized if certain populations are left aside – but also because there are interactions between migrant and host populations.

Conclusion

Humanitarian problems require political solutions, therefore political commitment is sorely needed to try to reduce the number of uprooted people and improve their conditions when they are on the move. There is a need to work in a concerted manner on points of origin, points of transit and final points of destination. Academics also have a responsibility in lending their voice to the cause of bettering the condition of migrants. Conducting research that sheds light on the plight of migrants, or on how policy can negatively affect their existence is valuable. Health equity and early access to healthcare appear as critical responses to the migratory crisis. The principles of public health equity mean that medicine must be used to assist human populations in distress. This commitment at a global level must be followed by concerted actions in the field, where migrants need assistance and protection. Too often, they are denied healthcare or health insurance. If universal health coverage is to be achieved, it cannot be conditioned upon the status of any person

See full article:
https://aricjournal.biomedcentral.com/articles/10.1186/s13756-018-0403-4

IOM Contributor:

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Featured Article

Infectious disease testing of UK-bound refugees: a population-based, cross-sectional study

Alison F. Crawshaw, Manish Pareek, John Were, Steffen Schillinger, Olga Gorbacheva, Kolitha P. Wickramage, Sema Mandal, Valerie Delpech, Noel Gill, Hilary Kirkbride, and Dominik Zenner

BMC Medicine, 2018, 16:143

Abstract

Background

The UK, like a number of other countries, has a refugee resettlement programme. External factors, such as higher prevalence of infectious diseases in the country of origin and circumstances of travel, are likely to increase the infectious disease risk of refugees, but published data is scarce. The International Organization for Migration carries out and collates data on standardized pre-entry health assessments (HA), including testing for infectious diseases, on all UK refugee applicants as part of the resettlement programme. From this data, we report the yield of selected infectious diseases (tuberculosis (TB), HIV, syphilis, hepatitis B and hepatitis C) and key risk factors with the aim of informing public health policy.

Methods

We examined a large cohort of refugees (n = 18,418) who underwent a comprehensive pre-entry HA between March 2013 and August 2017. We calculated yields of infectious diseases stratified by nationality and compared these with published (mostly WHO) estimates. We assessed factors associated with case positivity in univariable and multivariable logistic regression analysis.

Results

The number of refugees included in the analysis varied by disease (range 8506–9759). Overall yields were notably high for hepatitis B (188 cases; 2.04%, 95% CI 1.77–2.35%), while yields were below 1% for active TB (9 cases; 92 per 100,000, 48–177), HIV (31 cases; 0.4%, 0.3–0.5%), syphilis (23 cases; 0.24%, 0.15–0.36%) and hepatitis C (38 cases; 0.41%, 0.30–0.57%), and varied widely by nationality. In multivariable analysis, sub-Saharan African nationality was a risk factor for several infections (HIV: OR 51.72, 20.67–129.39; syphilis: OR 4.24, 1.21–24.82; hepatitis B: OR 4.37, 2.91–6.41). Hepatitis B (OR 2.23, 1.05–4.76) and hepatitis C (OR 5.19, 1.70–15.88) were associated with history of blood transfusion. Syphilis (OR 3.27, 1.07–9.95) was associated with history of torture, whereas HIV (OR 1521.54, 342.76–6754.23) and hepatitis B (OR 7.65, 2.33–25.18) were associated with sexually transmitted infection. Syphilis was associated with HIV (OR 10.27, 1.30–81.40).

This is the first study which reports on, and compares findings of, medical HAs for infectious diseases among a UK-bound refugee population. We found higher diagnostic yields than expected for a number of diseases, including hepatitis B. For TB, testing yields broadly mirror WHO-estimated prevalence figures.

Infectious disease yield and exposure factors identified

Table 2
Active tuberculosis (TB) yield per 100,000 population among tested applicants compared to WHO country TB prevalence estimates per 100,000 population (reference year 2014), by country of nationality

Country of nationality	Number screened (n)	Number of cases detected (%)	TB yield per 100,000 among tested applicants (95% CI)[a]	WHO country prevalence per 100,000 (95% CI), 2014 reference year [22]
Afghanistan	63	0	0	340 (178–555)
Democratic Republic of Congo	570	3 (0.53)	526 (170–1621)	532 (282–859)
Eritrea	59	0	0	123 (63–203)
Ethiopia	290	1 (0.34)	345 (48–2414)	200 (161–243)
Iran	15	0	0	33 (17–55)
Iraq	540	0	0	67 (35–111)
Palestine	28	0	0	N/A
Somalia	562	2 (0.36)	356 (89–1413)	491 (254–805)
South Sudan	40	0	0	319 (139–572)
Sudan	369	0	0	151 (67–267)
Syria	7195	3 (0.04)	41 (13–129)	19 (6.2–39)
Uganda	2	0	0	159 (87–253)
Other AFR[b]	8	0	0	
Other EMR[c]	9	0	0	
Other EUR[d]	5	0	0	
Other[e]	4	0	0	
Total	9759	9 (0.09)	92 (48–177)	

[a]TB yield was calculated on adults aged > 15 for ethical reasons and consistency

[b]Other AFR included Burundi, Congo, Rwanda, Cameroon, Nigeria

[c]Other EMR included Jordan, Lebanon, Djibouti, Yemen, Pakistan

[d]Other EUR included UK, St Helena, Switzerland, Turkey

[e]Other included Solomon Islands, China, Taiwan or applicants with no nationality specified

CI confidence interval

Table 5
Hepatitis B yield (%) in tested applicants compared to estimated prevalence of chronic HBV infection (reference years 1965–2013), by country of nationality

Country of nationality	Number screened (n)	Number of cases detected	Yield in tested cohort, % (95% CI)[a]	Estimated prevalence of chronic HBV infection (HBsAg seroprevalence), 1965–2013, % (95% CI) [21]
Afghanistan	57	1	1.75 (0.24–11.61)	1.62 (1.29–2.03)
Democratic Republic of Congo	499	29	5.81 (4.07–8.24)	5.99 (5.68–6.31)
Eritrea	54	0	0.0	2.49 (2.32–2.67)
Ethiopia	251	12	4.78 (2.73–8.24)	6.03 (5.77–6.31)
Iran	14	0	0.0	0.96 (0.95–0.96)
Iraq	514	3	0.58 (0.19–1.79)	0.67 (0.65–0.70)
Palestine	28	0	0.0	1.80 (1.07–3.02)
Somalia	384	13	3.39 (1.97–5.75)	14.77 (13.77–15.84)
South Sudan	40	5	12.50 (5.24–26.96)	22.38 (20.10–24.84)
Sudan	361	21	5.82 (3.82–8.76)	9.76 (9.03–10.54)
Syria	6996	102	1.46 (1.20–1.77)	2.62 (2.17–3.17)
Uganda	2	0	0.0	9.19 (8.65–9.77)
Other AFR[b]	8	1	12.50 (1.50–57.31)	8.83 (8.82–8.83)
Other EMR[c]	9	0	0.0	3.01 (3.01–3.01)
Other EUR[d]	5	1	20.00 (2.11–74.35)	2.06 (2.06–2.06)
Other WPR[e]	3	0		5.26 (5.26–5.26)
Total	9228	188	2.04 (1.77–2.35)	

[a]Yield was calculated on adults aged 15 years and older, for ethical reasons and consistency

[b]Other AFR included Burundi, Congo, Rwanda, Cameroon, Nigeria

[c]Other EMR included Jordan, Lebanon, Djibouti, Yemen, Pakistan

[d]Other EUR included UK, St Helena, Switzerland, Turkey

[e]Other WPR included Solomon Islands, China, Taiwan or applicants with no nationality specified

CI confidence interval

Conclusions

Testing refugees in an overseas setting through a systematic HA identified patients with a range of infectious diseases. Our results reflect similar patterns found in other programmes and indicate that the yields for infectious diseases vary by region and nationality. This information may help in designing a more targeted approach to testing, which has already started in the UK programme. Further work is needed to refine how best to identify infections in refugees, taking these factors into account.

See full article:
https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-1125-4

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Article

The MIPEX Health strand: a longitudinal, mixed-methods survey of policies on migrant health in 38 countries

David Ingleby, Roumyana Petrova-Benedict, Thomas Huddleston, and Elena Sanchez

European Journal of Public Health, 2018, cky233

Abstract

Background

Within health systems, equity between migrants and native-born citizens is still a long way from being achieved. Benchmarking the equitability of policies on migrant health is essential for monitoring progress and identifying positive and negative aspects of national policies. For this purpose, the 2015 round of the Migrant Integration Policy Index (MIPEX) was expanded to include a strand on health, in a collaborative project carried out between 2013 and 2017 in 38 countries.

Methods

Indicators of policies to promote equity were derived from the 2011 Recommendations of the Council of Europe on 'mobility, migration and access to health care' and used to construct a questionnaire compatible with MIPEX methodology. This yielded scores for Entitlement, Accessibility, Responsiveness and Measures to achieve change.

Results

As a measuring instrument, the questionnaire has a high degree of internal consistency, while exploratory factor analysis showed a coherent relationship between its statistical structure and the four scales it comprises. Measures to achieve change were strongly associated with Responsiveness, but not at all with Entitlements and only slightly with Accessibility. Examining the results from the sub-sample of 34 'European' countries, wide variations in the equitability of policies were found: these were mainly associated with a country's wealth (GDP), but differences between EU13 and EU15 countries were too extreme to explain completely in such terms.

Conclusions

The MIPEX Health strand is a robust measurement tool that has already yielded a number of important results and is providing a valuable resource for both researchers and policy-makers.

See full article:
https://academic.oup.com/eurpub/advance-article-abstract/doi/10.1093/eurpub/cky233/5163082

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Article

Health status of returning refugees, internally displaced persons, and the host community in a post-conflict district in northern Sri Lanka: a cross-sectional survey

Rachel Burns, Kolitha Wickramage, Anwar Musah, Chesmal Siriwardhana, and Francesco Checchi

Conflict and Health, 2018 12(41)

Abstract

Background

Although the adverse impacts of conflict-driven displacement on health are well-documented, less is known about how health status and associated risk factors differ according to displacement experience. This study quantifies health status and quality of life among returning refugees, internally displaced persons, and the host community in a post-conflict district in Northern Sri Lanka, and explores associated risk factors.

Methods

We analyzed data collected through a household survey (n = 570) in Vavuniya district, Sri Lanka. The effect of displacement status and other risk factors on perceived quality of life as estimated from the 36-item Short Form Questionnaire, mental health status from 9-item Patient Health Questionnaire, and self-reported chronic disease status were examined using univariable analyses and multivariable regressions.

Results

We found strong evidence that perceived quality of life was significantly lower for internally displaced persons than for the host community and returning refugees, after adjusting for covariates. Both mental health status and chronic disease status did not vary remarkably among the groups, suggesting that other risk factors might be more important determinants of these outcomes.

Conclusions

Our study provides important insights into the overall health and well-being of the different displaced sub-populations in a post-conflict setting. Findings reinforce existing evidence on the relationship between displacement and health but also highlight gaps in research on the long-term health effects of prolonged displacement. Understanding the heterogeneity of conflict-affected populations has important implications for effective and equitable humanitarian service delivery in a post-conflict setting.

See full article:
https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-018-0176-7

IOM Contributor:

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Article

Introduction to Special Section on: Psychosocial support, conflict transformation and creative approaches in response to the needs of Syrian refugees in Turkey

Guglielmo Schinina and Marian Tankink

Intervention, 2018, 16(2): 161-163

Abstract

IOM has been involved in psychosocial support activities for migrants, asylum seekers, refugees and crisis-affected communities since the late 1990s. The organization's approach to its psychosocial programmes is systemic, interdisciplinary and community based. One main feature of these programmes has been the organization of executive masters, diploma or certificate courses on psychosocial approaches to population mobility in low-resource or crisis-affected countries and communities. These courses − run from the Balkan peninsula to the Middle East, to South America − have all been adapted to the specific cultural, social and political conditions in the countries, as well as the situations and political landscapes in which they were organized.

The idea of organizing courses looking at the intersections between psychosocial support and conflict transformation in the context of the Syria crisis was informed by different considerations. One was the attempt to step away from a psychosocial approach that is dominated by clinical psychology and public health paradigms, and often forgets the wider inputs that social and psychological sciences (such as community psychology, linguistics, anthropology, ethnography and applied arts) can give to humanitarian action. The aim is to shift the focus away from prevention and the cure of mental disorders to psychologically informed and culturally sensitive social action.

The course in Turkey was organized into three pillars. The first looked at psychosocial support, international standards, the Inter-Agency Standing Committee pyramid of mental health and psychosocial support intervention, counselling skills, assessment skills and systemic approaches to care. The second pillar looked more in depth into the practices of conflict mediation and transformation, pacific coexistence, dialogue and integration at the small community level. The third pillar was dedicated to the use of culture and cultural activities in both other pillars and as a way to link them. The attention to cultural, creative, theatrical and oral history processes and tools was also due to very practical reasons. Within the security situation created by the conflict, counselling and talk therapies were not often welcome by authorities and the clients reluctantly engaged or did not engage due to privacy and security considerations. The use of creative tools and, therefore, of metaphors allowed them to express the unspeakable in safe ways and approach conflict transformation without the imposed sedimentation of a language informed by dominant, polarizing narratives.

See full article:
http://www.interventionjournal.org/currentissue.asp?sabs=n

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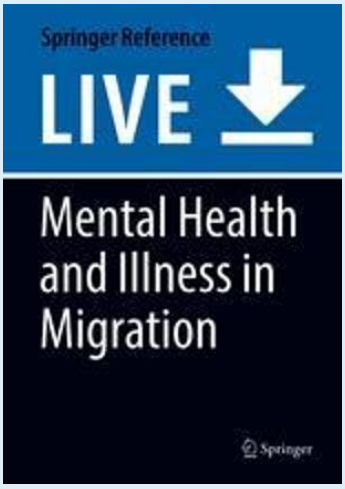
Article



Internal and International Migration and its Impact on the Mental Health of Migrants

Guglielmo Schininá and Thomas Eliyahu Zanghellini. In: Moussaoui D., Bhugra D., Ventriglio A. (eds)

Mental Health and Illness in Migration, 2018

Abstract

This article describes the facts and figures of today's migration patterns and briefly presents the limits and findings of the existing research on the impact of different forms of migration on the mental health of migrants. The article aims at promoting a right-based approach to migrants' access to mental health care, as supported by international legal instruments. Since this right is at times disregarded due to the legal unavailability and factual inaccessibility for migrants of the existing mental health services, the article proposes a series of actions that could facilitate migrants' access to mental health care across health systems and countries.

See full article:
https://link.springer.com/referenceworkentry/10.1007%2F978-981-10-0750-7_3-1

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Article

Why we shouldn't use the term "illegal migrant"
David Ingleby, Allan Krasnik, and Roumyana Petrova-Benedict
BMJ, 2018, 363:k4885

Abstract

Words have consequences, especially in situations where strong emotions, as well as social and political conflicts, are endemic. Raj Bhopal's rapid response in The BMJ, in which he objected to the use of the phrase "illegal migrant" on the grounds that only actions, not persons, can be deemed illegal, merits further reflection and dissection.

Some people think that those who protest against this phrase are taking sides with migrants in conflict with the law, in a futile attempt to cover up what is going on. On the contrary: the very idea that a person can be illegal is incompatible with the rule of law, which is founded on the idea that everyone has the right to due process and is equal in the eyes of the law. Labelling a person as illegal insinuates that their very existence is unlawful.

See full article:
https://www.bmj.com/content/363/bmj.k4885

IOM Contributor:

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Article


THE CEYLON MEDICAL JOURNAL

The need for an evidence-informed, multi-sectoral and community participatory action framework to address the practice of female genital mutilation in Sri Lanka

K. Wickramage, L. Senanayake, N. Mapitigama, J. Karunasinghe, and E. Teagal

Ceylon Medical Journal, 2018, 63(2): 53-57

Abstract

Background

Female genital mutilation or cutting comprises all procedures that involve partial or total removal of the female external genitalia and or injury to the female genital organs. The practice is most common in 30 countries in the Western, Eastern, and North-eastern regions of Africa, and in selected countries the Middle East and Asia. With increased migration from such countries, health professionals in destination countries. are confronted with the challenge of caring for women and girls subjected to it and mounting responses to inhibit its practice. Female genital mutilation is therefore a global concern, with international human rights treaties condemning the practice as a gross violation of fundamental human rights of girls and women.

Methods

In early 2014, a review of research, news articles and other gray literature sources was undertaken to identify any information pertaining to the practice of female genital mutilation in Sri Lanka. Sri Lanka's domestic legal and policy frameworks in reference to female genital mutilation were also looked at. This work was prompted by the personal account of a professional colleague who courageously revealed her experience and that of her daughters of female genital mutilation.

Conclusions

With the paucity of data, a carefully constructed research agenda through a multidisciplinary group of experts (for instance, from backgrounds in anthropology, religious studies, forensic medicine, pediatrics, obstetrics and gynecology) is needed to explore female genital mutilation in Sri Lanka and ways to effectively implement programs encompassing community-based prevention to supporting women living with female genital mutilation. Meaningful engagement with relevant community leaders and religious authorities are essential. An evidence-based and cultural sensitive approach is needed before undertaking any invention or advocacy measures. Evidence from other countries have shown that efforts to curb female genital mutilation relies on the strength of community advocates, legal experts, researchers, clinicians and administrators working at local, regional and national levels. Such collective action is important to catalyze an enabling environment to inhibit the practice.

Table 2. Approaches, enables, stakeholders and processors in developing a national action framework for the abandonment of female genital mutilation in Sri Lanka

Vision: National action framework for the abandonment of FGM in Sri Lanka

Underlying approach and enablers determining effectiveness:

- Evidence-informed approach
- Culturally sensitive
- Rights-based
- Inter-sectoral (whole of government approach)
- Multi-disciplinary (e.g. involving health, law, child protection actors)
- Participatory approaches (engagement from policy makers and community members to those undergone FGM)
- Free and open space for policy engagement which values evidence
- High level political, religious and community leadership
- Sustained Investment in action against FGM
- A conducive legal and regulatory environment

Stakeholders:

- **Community:** Women/girls subjected to FGM; Community leaders (ensuring female leadership); Religious scholars (e.g. Imams); Religious welfare and advocacy organizations (focusing on women led coalitions); Civil society groups; Legal reform groups.
- **Relevant government agencies:** Ministry of Health; National Child Protection Authority; Ministry of Social Service and Social Welfare, Human Rights Commission.
- **Professional bodies:** Sri Lanka Medical Association; Sri Lanka College of: Obstetricians & Gynaecologists; Pediatricians; Community Medicine; Forensic Medicine; Medical Administration; College of Law; Government Medical Officers Association etc.
- **Academia:** Scholars at nexus of sexual and reproductive health; child protection; law reform
- **United Nations agencies:** UNICEF, UNFPA, IOM, WHO
- **NGOs**
- **Media**

Processors and platforms at:

National Level:

Establish at National steering committee (NSC) – comprised of stakeholder representatives, to guide action and evaluate progress with government and partners. The NSC can be administratively supported by a relevant national body such as: the Presidential Secretariat, National Child Protection Authority.

- National Research Commission on FGM – to undertake empirical studies on FGM in Sri Lanka using community participatory methods.
- Reforming/enhancing national legal frameworks (could be a sub-group within the NSC).
- National media strategy on FGM (using media to mobilize public opinion, IEC materials, talk shows).
- Training of health and social welfare professionals on FGM.

Community level:

- Community based steering group at district level to undertake training, community sensitization, media advocacy, religious study circles etc.
- Public interest litigation.

The close tethering of the practice to ethnic and religious communities in Sri Lanka warrants a careful calibration of actors, where evidence-based and community participatory approach is needed. The table presents the broad approaches, enabling factors and possible stakeholders in developing a national action framework for the abandonment of female genital mutilation in Sri Lanka.

See full article:
https://www.ncbi.nlm.nih.gov/pubmed/30056692

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Reflection

Informed Consent in Research

What is informed consent and why is it necessary in research?

Informed consent relates to the obligation of the investigator to inform the subject about personal benefits and risk. Subjects in the study must participate willingly only after consenting based on the information given. It is embedded in the communication to participants, commencing with the subject recruitment material through to undertaking research. It involves informing the subject about his or her rights, the purpose of the study, the procedures to be undertaken, the potential risks and/or benefits of participation and alternative treatments available if any (Nijhawan et al., 2013).

Data subjects have the right to choose when and to whom they wish to reveal their personal data. According to the "IOM Data Protection Manual" (IOM, 2010), informed consent occurs when the data subjects agree to the collection of their personal data after having considered all the relevant facts associated with data collection and data processing including the following:

- ✓ specified and related purposes;
- ✓ access, correction and complaint procedures; and
- ✓ all foreseeable disclosures to third parties (including donors and project partners).

Consent forms are a key part of obtaining consent. They need to be tailored to the research project. The World Health Organization (WHO) Ethics Review Committee (ERC) has developed templates to aid in the design of their informed consent forms. Such templates include:

1. Informed Consent for Clinical Studies
2. Informed Consent for Qualitative Studies
3. Informed Assent for Children/Minors
4. Informed Parental Consent for Research Involving Children (qualitative)
5. Informed Parental Consent for Research Involving Children (clinical)

These forms can be obtained at:
http://www.who.int/rpc/research_ethics/informed_consent/en

To learn more:

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Comments or Questions

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