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.

Articles


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.
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:

IOM Contributor:
- Roumyana Petrova-Benedict (Brussels)
**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

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**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 8,506–9,759). 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.
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:

IOM Contributors:
- Steffen Schillinger (Manila)
- Olga Gorbacheva (Geneva)
- Kolitha Wickramage (Manila)
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:

IOM Contributor:
• Roumyana Petrova-Benedict (Brussels)
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:

IOM Contributor:
• Kolitha Wickramage (Manila)
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

IOM Contributor:
• Guglielmo Schinina (Brussels)
Internal and International Migration and its Impact on the Mental Health of Migrants
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

IOM Contributor:
• Guglielmo Schinina (Brussels)
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:
• Roumyana Petrova-Benedict (Brussels)
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.
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

IOM Contributor:
- Kolitha Wickramage (Manila)
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:

Comments or Questions

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