Briefing

Development Research Centre on Migration, Globalisation & Poverty

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Migration and the Millennium Development Goals for Health

Summary of Key Issues

Migration and health are inter-related in a number of ways. Most obviously, the movement of human populations can promote the spread of diseases, and place migrants in positions where their health suffers. However, migration may be a form of livelihood diversification and so ill health may deny some individuals the opportunity to migrate. For example, remittances generated by migration may be critical in promoting access to essential treatment and drugs. This may also promote health-seeking behaviour and the spread of knowledge of health and technology.

There is a considerable and growing body of literature on the relationship between migration and health, although little to date that has focused specifically on the potential impacts of migration for achievement of the Millennium Development Goals on Health. This briefing summarises some of the available evidence in this field, and highlights ongoing work being carried out by the Migration Development Research Centre at the University of Sussex.

Migration and Ill Health

- Ill health can exclude individuals from the opportunity to migrate, and affect households' overall health status, through its impact on loss of income, the cost of accessing health care, time spent caring for the sick, and associated restrictions on carers' mobility.

The MDGs for Health

- **Halting and reversing the spread of HIV/ AIDS**
- **Reduction of child mortality by two thirds**
- **Reduction of maternal mortality by three quarters**
- **Consideration of health issues specifically for forced migrants**
- **Consideration of the impact of mobility of health professionals on health systems expected to deliver MDGs by 2015**

- Illness is extremely costly to migrants in terms of time spent not working, and cost of treatment. Some studies have documented the impact of migration on psychological well-being, especially in detention centres and refugee camps. For poorer households, time spent caring for the sick is costly, whilst loss of wages can be catastrophic.

- Migrant health might be compromised during the process of migration, something especially true for poorer, undocumented and/or forced migrants. At their destination, migrant workers and displaced people may receive food of poor quality leading to malnutrition; moving across ecological conditions may expose movers to new diseases and promote disease transmission; migrants may be excluded from public provision of food or other services as they are not 'locals' or citizens; whilst poor living and working conditions can promote ill-health.

- Much of the literature that explicitly examines the relationship between migration and health focuses on the spread of communicable diseases (e.g. HIV/AIDs). There is a need for more attention to be paid to the kind of non-communicable diseases that affect the poor disproportionately when compared with other income groups, which may develop as a result of unhealthy working and living conditions (e.g. Repetitive Strain Injury, rheumatism, arthritis, and various respiratory conditions that result from work with toxic substances).

Migration and Well Being

- Although migration may be negative for the health of migrants and their families, there is also the possibility of migration promoting well-being. In particular, remittances can help to shore up incomes and so allow access to drugs. It may also build social relations, enabling better

care of the sick. This may include investment in health insurance and other forms of health protection by migrants.

- Migrants may move to healthier environments, where they can earn higher incomes and achieve higher levels of life expectancy. Such changes may impact not only the achievement of health MDGs, but also MDGs on income, education and environmental sustainability.

The relationship between migration and health can be both positive and negative, and a growing literature provides evidence from a wide range of geographical and demographic contexts. However, the impact of migration on achieving the millennium development goals is less clear.

Migration and HIV/AIDS, Malaria and Other Diseases

Fear that migrants and travellers carry communicable diseases is not new and, since at least twelfth-century Venice, has led to isolation and quarantine, and restrictions on movement, both within and between countries (Garenne 2003). Such fears are still very much in evidence today, and may not be unreasonable: the SARS epidemic of 2003 spread to some 28 countries in all continents within six months, infecting over 4,000 people and taking nearly 300 lives. There is little doubt that migration (and human movements more generally) contribute to the spread of communicable diseases.

- Studies in Africa and elsewhere, suggest that mobility has been a key factor in the spread of HIV/AIDS, and related sexually transmitted diseases.

- Human migration has been identified as contributing to the re-emergence of malaria in areas of the world where malaria eradication campaigns had been effective in the 1950s and 1960s.

- A decade ago, a Task Force of the International Union Against Tuberculosis and Lung Disease warned that TB amongst foreign migrants to Europe represented an increasing and important proportion of all notified cases.

There are a number of reasons why migration is a matter of concern in relation to the MDGs for HIV/AIDS, malaria and other major diseases. In the case of malaria, for example, migration may increase exposure to the disease, transport mosquitoes to new areas and/or create habitats that are favourable to mosquitoes. Migration may also help the spread of resistance to drugs. In the case of HIV/AIDS, mobility is important both because population movements allow the virus to disseminate, and because of the possible risky behaviours of those who are mobile.

Yet it is not easy to quantify the impact of migration on the spread of these diseases, nor is it simple to isolate the overall effect of migration on the likelihood of reducing disease incidence. Migrants not only transmit and/or suffer from disease, but may also move into areas or economic or cultural circumstances in which it is easier to combat disease. Migrants' health-seeking behaviour may be different to that of non-migrants.

Child and Maternal Mortality: Does Migration Make a Difference?

In relation to both child and maternal mortality, available evidence suggests that, for rural-urban migrants at least, migration is associated with improvements in health outcomes, not least because of an increased utilisation of services in urban relative to rural areas. For example, recent work on rural-urban migration in Ghana suggests that infant mortality is lower amongst rural-urban migrants compared to rural non-migrants, and that this applies after controlling for socio-economic characteristics. However, the health status of rural-urban migrants still often falls short of that of urban residents.

One way of considering whether migration impacts levels of child and maternal mortality overall is to look at the policy interventions that aim at reducing child and infant mortality in line with the MDGs, and whether migration helps or hinders such interventions. Key interventions to reduce child mortality include immunisation against childhood diseases, action to reduce malnutrition, oral rehydration therapy, HIV/AIDS interventions, female education and family planning. Attempts to improve maternal mortality have focused on institutional delivery and the potential for pre-natal care to highlight risky deliveries.

From this perspective, there is some evidence that migration is positively associated with the spread of female education and family planning. The use of medical services in general by migrants also appears to increase. However, a key question is whether migrants are already pre-disposed to seek health services, or whether the act of migration makes them more likely to do so. Here, although some studies of health-seeking behaviour by migrants are available, they do not provide conclusive evidence one way or another. For example, a recent study of rural-urban migrants in Mumbai, India, found migrant women more likely to take up opportunities for pre-natal care, but making the same choices regarding place as rural non-migrants.

Forced Migration, Mortality and Morbidity

Whilst poor migrants in general may be vulnerable to disease, where migration is forced, the impact on health can be much more severe. This is particularly true where refugees are contained in camps or detention centres. For example, Physicians for Human Rights have recently raised concerns about how asylum-seekers are treated when they arrive and are detained in industrialised countries. Their findings indicate that the experience is often extremely stressful, and can

contribute to ill health. There has also been an impassioned debate (see ID21) on the 'prison-like' conditions in refugee camps in the south, and their impact on health.

However, it is not always the case that refugee flight and settlement leads to negative outcomes for health. For example, monitoring of the health status of Malian refugees in Mauritania during the 1990s shows an improvement in health outcomes as a result of the provision of health care to a previously nomadic population beyond the reach of modern medicine.

Migration and the Health Brain Drain

Perhaps the key to achieving the MDGs for health is the provision of adequate and timely health interventions, yet this may be compromised by the high levels of emigration of health professionals in some countries. A survey of African countries in 1998 revealed vacancy levels of over 70 percent for medical specialists in Ghana, and over 50 percent for nurses in Malawi. A number of countries around the world are affected by shortages of medical personnel as a result of overseas recruitment.

However, such high rates of emigration are not universal. Indeed, emigration of health professionals may represent as much a symptom as a cause of poor health systems in many developing countries. Codes of conduct to address 'poaching' of health professionals from developing countries have been developed by, amongst others, the UK's National Health Service and the Commonwealth, but these are not always entirely effective. It is also important to allow for the professional development of health professionals, in which a period spent abroad may be highly valuable. As a result, some migrant health workers may return better equipped and more experienced to augment the provision of health services. This opportunity is being exploited by some developing countries who are recruiting from the diaspora.

New Research

There remain a number of areas concerning the relationship between migration and the MDGs for health. The Development Research Centre on Migration, Globalisation and Poverty is seeking to improve existing knowledge on these areas through funding research. For example:

- There is potential to explore the causes of change in health-seeking behaviour by migrants, particularly in relation to childbirth and child mortality. This would help to inform policies that seek to engage with migrants to improve their health outcomes, rather than treating migrants as a health risk.

- There is some evidence of investment in health protection for families and communities back home by migrants, but the extent of this investment remains unquantified. The factors which promote health investment – and positive health outcomes – are also relatively unexplored.

- Studies of the 'brain drain' of health professionals have tended to confine themselves to analysis of the numbers leaving individual countries, rather than exploring the range of dynamic effects – on training and labour markets, for example – that might result from such emigration. Ways to encourage the sustainable return of developing country health professionals also deserves closer scrutiny.

Further Reading

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Waddington, C. (2003) 'Livelihood Outcomes of Migration for Poor People'. Development Research Centre on Migration, Globalisation and Poverty Working Paper T1, University of Sussex, Brighton. Online at: http://www.migrationdrc.org/publications/working_papers/WP-T1.pdf

Development Research Centre on Migration, Globalisation and Poverty

The Migration DRC aims to promote new policy approaches that will help to maximize the potential benefits of migration for poor people, whilst minimising its risks and costs. It is undertaking a programme of research, capacity-building, training and promotion of dialogue to provide the strong evidential and conceptual base needed for such new policy approaches. This knowledge base will also be shared with poor migrants, contributing both directly and indirectly to the elimination of poverty.

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