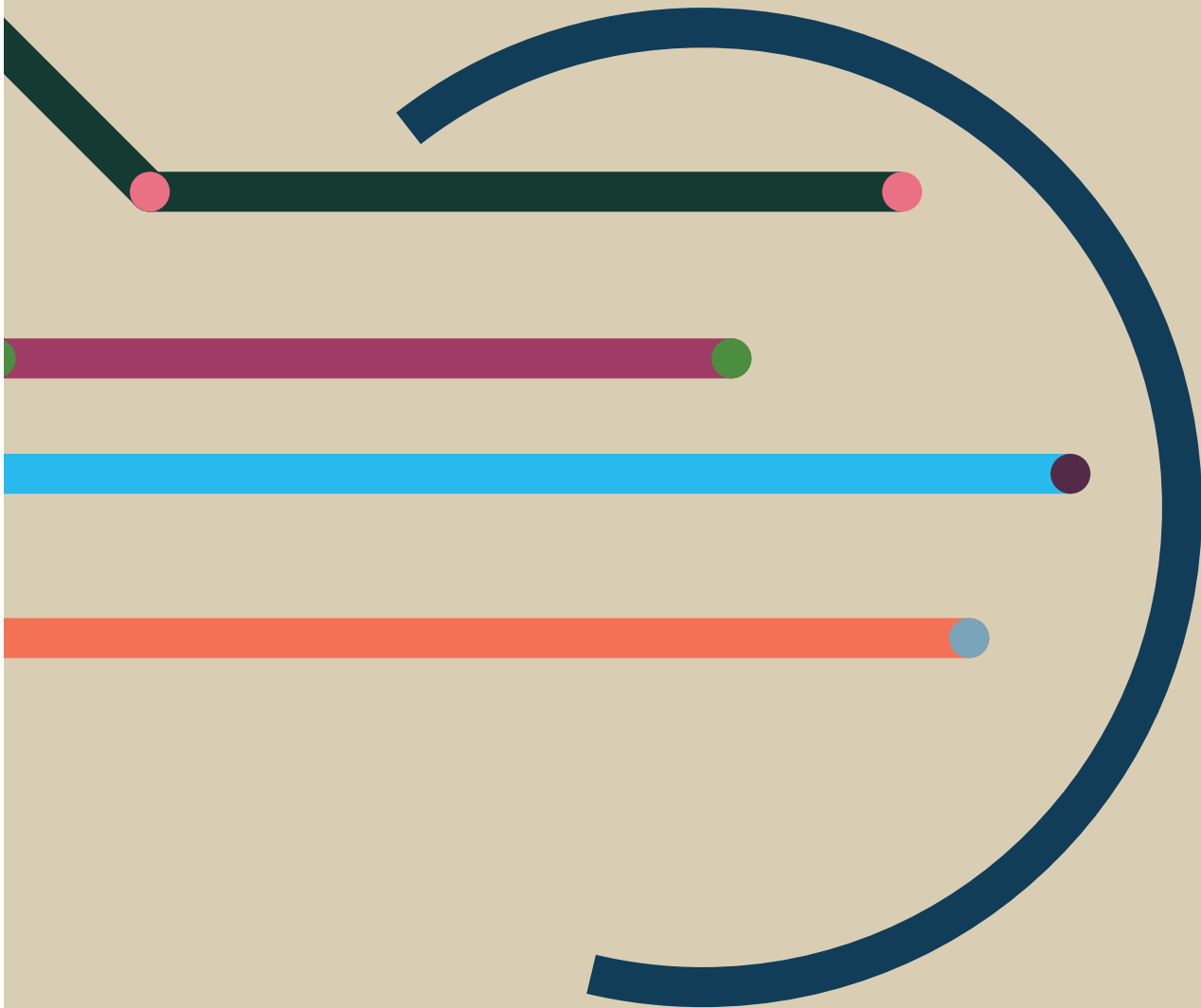




World Health
Organization

Common health needs of refugees and migrants: literature review



WHO Health and Migration Programme

The WHO Health and Migration Programme brings together WHO's technical departments, regional and country offices, as well as partners, to secure the health rights of refugees and migrants and achieve universal health coverage. To this end, the Programme has five core functions: to provide global leadership, high-level advocacy, coordination and policy on health and migration; to set norms and standards to support decision-making; to monitor trends, strengthen health information systems and promote tools and strategies; to provide specialized technical assistance, response and capacity-building support to address public health challenges associated with human mobility; and to promote global multilateral action and collaboration.



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ISBN 978-92-4-003310-8 (electronic version)

ISBN 978-92-4-003311-5 (print version)

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Foreword

Refugees and migrants have the fundamental human right to the enjoyment of the highest attainable standard of health. Yet they may also have specific health needs and vulnerabilities, including the impact of a hazardous migration journey, and require culturally sensitive and effective care that recognizes and responds to their physical and mental health needs. These needs are often expressed, yet in practice are all too often not met. Many come from societies affected by war, conflict and economic crisis and lead tough and insecure lives on the fringes of society, facing discrimination, poverty and poor housing, education and employment. Refugees and migrants may experience exclusion, stigma and discrimination, as well as serious challenges for obtaining health care, including language and cultural differences and restricted access to health services.

Over recent years, WHO has developed agreed policies and interventions to promote and secure the health rights of refugees and migrants in the context of the human right to health and universal health coverage for all populations, including refugees and migrants. The 2019 WHO Global Action Plan: Promoting the Health of Refugees and Migrants is aligned with the United Nations 2030 Agenda for Sustainable Development, WHO's Thirteenth Global Programme of Work and the global compacts on refugees and on

safe, orderly and regular migration. It was developed in close collaboration with the International Organization for Migration and the United Nations High Commissioner for Refugees.

All countries need robust and resilient health services of good quality that can respond to the needs of all in their population, including those who may be vulnerable such as refugees and migrants. National health policies, and supporting legislative and financial frameworks, should promote migrants' right to health, embracing health as an integrating force in society. Strengthening the capacity and reach of health systems is a global priority, particularly in the light of the COVID-19 pandemic. For refugees and migrants, systems must be responsive to their languages and their health problems across the life course, including noncommunicable and communicable diseases, and trauma from injuries and violence. Women and girls are at risk of sexual and other forms of gender-based violence, abuse and trafficking and should have access to sexual and reproductive health-care services and rights. Unaccompanied children are particularly vulnerable and need special consideration.

This literature review draws on peer-reviewed research to identify key findings on the common health needs of refugees and migrants and the responses relevant to their health

across different contexts and clinical settings. The report looks specifically at the barriers and challenges that may prevent refugees and migrants from accessing health care and is intended to support countries in building health system capacity and resilience to provide quality people-centred health services for all, including for refugees and migrants.

Throughout the review, migration is recognized as a key determinant of health, one that shapes access

to health care and interactions with the health workforce. It is hoped that this review will show the complexity of the health needs of refugees and migrants throughout the life course and help countries to provide health services for them that are safe, effective and culturally sensitive.



A handwritten signature in black ink, appearing to read 'D. Jakab'.

Dr Zsuzsanna Jakab
Deputy Director-General
World Health Organization



Preface

Refugees and migrants are often among the most vulnerable members of a society. Access to mainstream health services and interactions with the health workforce may be hampered by issues such as high costs of care, difficulties navigating health facilities and health insurance systems, language and cultural differences, discrimination and exclusion. In addition, some may have made hazardous migration journeys. Migration is considered to be a key determinant of health and well-being.

This literature review explores the physical and mental health needs of refugees and migrants, including the impact of migration. It considers how effective and responsive care can be provided to refugees and migrants in a culturally and linguistically sensitive way, with the avoidance of exclusion, stigma and discrimination. The review draws on peer-reviewed research to identify key findings on needs and responses relevant to refugee and migrant health across different contexts and clinical settings. It looks specifically at the barriers and challenges that may prevent refugees and migrants from accessing health care over the whole life course. It also considers how an adaptable, well-trained and culturally competent health workforce can be trained.

The review supports the implementation of the 2019 WHO Global Action Plan: Promoting the Health of Refugees and Migrants, which calls for the building of health-care capacity for service provision; for affordable and nondiscriminatory access to health with reduced communication barriers; and for training the health-care workforce in culturally sensitive service delivery for refugees and migrants, particularly those with disabilities. The WHO Health and Migration Programme is committed to support the Global Action Plan by providing global leadership and advocacy; setting norms and standards on health and migration, including development of tools and strategies on health and migration and strengthening the health workforce; and promoting an information and research agenda to support evidence-informed decision-making.

The Programme also aims to promote multilateral action and intercountry, interregional and global collaboration for continuity of care and coherent and integrated actions to accelerate progress for migration health by working across the United Nations system, including the United Nations Network on Migration and other intergovernmental and nongovernmental mechanisms.

It is hoped that this review will help to achieve the goal of promoting universal health coverage and ensure that refugees and migrants are included in this, thus helping countries to provide safe, effective and responsive health services to refugees and migrants.



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Acknowledgements

This review was developed by the WHO Health and Migration Programme (PHM) under the strategic lead and supervision of Santino Severoni. It was produced in collaboration with the WHO Health Workforce Department directed by James Campbell and the Migrant and Refugee Health Partnership (Migration Council Australia), through Christine Phillips (Australian National University), Gulnara Abbasova and Amanda Lee.

Kanokporn Kaojaroen (PHM) was responsible for the coordination and execution of the review with the support of Ibadat Dhillon and Siobhan Fitzpatrick from the WHO Health Workforce Department.

Thanks are owed to Veronica Cornacchione, Mohammad Darwish, Cetin Dogan Dikmen, and Rifat Hossain from the PHM team for support in the production and dissemination of the review. Deep appreciation is expressed to the teams from the WHO Department of Sexual, Reproductive Health and Research, led by Ian Askew, the Department of Mental Health and Substance Use, led by Devora Kestel, and the Department of Global HIV, Hepatitis and STIs Programmes, led by Meg Doherty, for their valuable inputs and support.

WHO would like to thank the members of the Strategic Working Group for their valuable contribution: Aula

Abbara (Imperial College London, United Kingdom of Great Britain and Northern Ireland), Jill Benson (University of Adelaide, Australia) Fouad M. Fouad (American University of Beirut, Lebanon), Indika Karunathilake (University of Colombo, Sri Lanka), Elsie Kiguli-Malwadde (African Centre for Global Health and Social Transformation, Uganda), Allan Krasnik (University of Copenhagen, Denmark), Paul Spiegel (Johns Hopkins University, United States of America), István Szilárd (University of Pécs, Hungary), Jo Vearey (University of the Witwatersrand, South Africa) and Cynthia Whitehead (University of Toronto, Canada).

This document (Common health needs of refugees and migrants: literature review) with the multicountry review (Mapping health systems' responsiveness to refugee and migrant health needs) inform the development of the refugee and migrant health Global Competency Standards for health workers, which will set a benchmark for the health workforce in providing culturally sensitive care to refugees and migrants.

PHM also greatly appreciates and values the in-kind contribution by the Migration Council Australia as well as the financial support by the German Federal Ministry of Health and the Universal Health Coverage Partnership, which made the production of this report possible.

Executive summary

Refugees and migrants may have health needs that differ from those of the host population, requiring effective and culturally responsive care that recognizes the impact of migration on physical and mental health. Refugee and migrant populations may also face a number of challenges to accessing health care that can shape their interactions with the host country's health system and health workforce, including language and cultural differences, low levels of health literacy, discrimination and restricted access to mainstream health services.

Communication is recognized as critical in the provision of culturally responsive care to refugees and migrants. However, inadequate use of interpreting services in various countries undermines access to and quality of health care for these populations. Notwithstanding communication barriers, health professionals can play an important role in educating refugees and migrants on the health system of the host country, thereby increasing their health literacy and engagement with health services.

This literature review explores the common health needs of refugee and migrant populations across the life course and is designed to complement the development of the Global Competency Standards for the effective provision of health services to refugees and migrants. Health professionals providing care to refugees

and migrants should be aware of how the migration experience – which can involve poor transit conditions, restrictive entry and integration policies, exclusion and acculturation stress – influences the health status of individuals and their health needs.

For example, refugee and migrant children may have worse health outcomes related to infectious diseases and chronic diseases, as well as mental health, compared with local children in high-income host countries. Traumatic or stressful experiences in their country of origin, during migration process or while settling in their host country can lead to the poorer mental health outcomes experienced by refugees and migrants. Screening for sexually transmitted infections is essential for refugees and migrants, particularly for women who have come from environments that carry a high risk for sexual violence. While access to contraception is critical, knowledge of contraceptive methods, including emergency contraception, within some migrant groups may be quite limited. Unwanted fertility is a key concern for refugee and migrant women, who may experience higher rates of unwanted pregnancy as well as increased risks of adverse pregnancy outcomes.

Communicable diseases are another serious health concern for refugee and migrant populations. Refugees and migrants are more likely to be

susceptible to childhood vaccine-preventable diseases, in particular rubella, tetanus and diphtheria, due to under-immunization. The process of migrating can also expose individuals to significantly greater risks of contracting infectious diseases such as HIV and tuberculosis, and now SARS-CoV-2 (COVID-19), through issues such as overcrowding, poor living conditions and inadequate hygiene services.

A number of gaps in the literature were also identified, emphasizing the need for more data and research on specific health needs of refugee and migrant populations. In particular, further research is needed to strengthen the evidence base for provision of care for mental, oral, hearing and vision health, and for older refugees and migrants and those with disabilities.



Introduction

Refugees and migrants are a heterogeneous group and have a variety of health-care needs. Some migrant populations may enjoy better health upon arrival than host populations, in what is known as the healthy migrant effect; however, over time, their morbidity and mortality reach similar levels to those of the host population (1). Other groups, including refugees, asylum seekers and irregular migrants, may be at a higher risk of poor health outcomes (2). The migration experience, which may involve poor transit conditions, restrictive entry and integration policies, exclusion and acculturation stress, can increase the vulnerability of refugees and migrants to both chronic and infectious diseases (2). Migration is recognized as a key determinant of health: one that shapes access to health care and the interactions with the health workforce.

There is a substantial body of literature on the barriers to health-care access experienced by refugees and migrants. Key barriers include language and cultural differences, lack of culturally responsive services, low levels of health literacy, inadequate use of interpreting services and policies that grant or deny access to services (2). Further, unfamiliarity with the health system of the host country can lead to low usage of primary care services by

refugee and migrants and increased their presentations at emergency care (3). Policy and legal frameworks in host countries can also create barriers for refugee and migrant populations accessing health care.

Communication is key to the effective provision of care to refugee and migrant populations, creating the foundation for trusting relationships between health-care providers and patients. Continuity of care is also critical, although the mobility of these populations can mean that service providers often do not have a full picture of their patient's health history. Together, the barriers and challenges experienced by refugees and migrants in accessing health care reinforce the need for effective, culturally responsive service delivery. Access to health services that meet the needs of diverse populations is essential to ensure that refugees and migrants are supported in achieving good physical health and mental health.

This review adopts a life-course approach, exploring the needs of refugee and migrants in relation to child health, sexual health, reproductive health, mental health, preventive health, chronic diseases, communicable diseases, oral health, and care for older people and those with disabilities.

Limitations

This review draws on grey literature and peer-reviewed research available in English, with over 90 studies examined as part of the development process. It is not intended to be an exhaustive systematic review of refugee and migrant health. Rather, it focuses on key areas of health where refugees and migrants may have needs that differ from those of host populations, identifying key findings across different contexts and clinical settings as well as common barriers and challenges that may prevent refugees and migrants from accessing health care.

This review uses the term refugees and migrants to capture the diversity of populations who have migrated, noting that the term refugee is defined in the

1951 Convention relating to the Status of Refugees and its 1967 Protocol but the term migrant has no universally accepted definition. This is reflected in the varied terminology adopted in the literature, with the terms immigrant, migrant, refugee and asylum seeker, and other related terms, being defined and applied in differing ways depending on the context and author. However, it should be noted that refugees, asylum seekers, internally displaced people, skilled migrants and other migrant populations may have different health-care needs and challenges. The findings of this review apply generally to refugees and migrants but the specific experiences in accessing health care for subgroups, such as asylum seekers and internally displaced people, may diverge.

Health literacy and health system literacy

Health literacy refers to a person's knowledge, skills and confidence when using information to achieve and maintain good health through a change in lifestyle and living conditions (4). Health literacy is particularly important for refugees and migrants, who may have specific communication needs that must be appropriately addressed in order to provide them with information to promote and maintain good health (5). In addition to general health literacy, education and training regarding the host country's health system are crucial (3).

There is research to suggest that poorer health outcomes among some populations, including refugees and migrants, can be partly attributed to lower levels of health literacy in the host environment (2). It is important to note, however, that other factors, such as different cultural beliefs, attitudes and behaviours, also have a significant influence on health. Nevertheless, low health literacy has been found to correlate with a higher prevalence of health risk factors and comorbidities, lower engagement in prevention activities and increased hospital and emergency admissions (2). Studies

suggest that there is also a strong link between migrant health literacy and chronic disease management, namely the relationship between low health literacy, poor treatment adherence and worse patient outcomes (6). Thabit et al. in 2009 highlighted that low health literacy affects the ability of individuals to read medication labels and understand educational material, which adversely impacts self-management of disease (7).

A systematic review of 147 studies in 2019 highlighted some of the challenges experienced by refugees resettled in Australia, exacerbated by low levels of health literacy in the host environment (8). While refugees

valued the availability of appropriate health information, some also felt overwhelmed by information during their settlement process. On the whole, the provision of culturally appropriate and easily understood health information was associated with an increase in confidence, autonomy and agency. In the absence of such information, refugees and migrants tended to rely upon family members, friends, interpreters, support workers, past experiences and their own cultural knowledge to bridge the gap in health care. In some cases, reliance on family and friends, and cultural knowledge, further disempowered them and led to poorer health outcomes (8).

Health needs of refugees and migrants

Barriers to health-care access

Refugees and migrants experience both formal and informal barriers to accessing health care. Formal barriers include, but are not limited to, legal frameworks and policies denying access to services, inadequate use of interpreting services and high user

fees. Informal barriers include low levels of health literacy among some refugee and migrant populations, low levels of cultural competency among health providers, stigma and language differences. Some of these barriers are discussed below.

Systemic barriers

There is significant variation in health-care provision for refugees and migrants across different countries. Policy settings and national legal frameworks can exclude certain migrant populations from accessing mainstream health services in their country of destination. In some countries, refugees and migrants may only be able to access emergency care or private health services provided by charities and international organizations. Further, policies that deny access to migrant-friendly health and social services may also have a detrimental impact on the health of refugees and migrants (2). A systematic review and meta-analysis of 46 articles highlighted the impact of non-health-targeted public policies

on migrant health in high-income countries (9). The study found that entry policies such as temporary protection, detention and restricted asylum reception led to negative effects on the mental health of migrants affected by these policies. Health inequalities between host/local residents and migrants affected by policies upon entry were also identified, with the latter experiencing poorer self-rated health and higher mortality rates (9). Settings with strict documentation requirements also led to poor mental health for migrants, whereas settings with more generous documentation policies showed positive impacts on migrants' mental health (9).

Inadequate use of interpreting services

Interpreting services play a critical role in language-discordant consultations. Patients who have access to interpreting

services are more likely to be satisfied and have more trust in the health system (10). Further, patients are more

likely to receive a lasting solution to their condition when they receive care in their preferred language (10). However, the availability of interpreting services is limited in some countries, linked to a lack of government policies and subsidies (11). In addition to a paucity of easily accessible interpreters, studies have reported that health-care providers experience communication difficulties while working with interpreters because they have not been trained on how to use interpreting services effectively (12). In the absence of accessible interpreting services, health-care providers tend to rely on family members or bilingual health-care workers, which can create challenges in communication and quality of care. Patients may feel more comfortable in some situations

Language and cultural differences

In addition to the inadequate use of interpreting services, cultural and language differences may also pose challenges in communication, which can affect access to and quality of health care. Numerous studies have highlighted how language and cultural divergence can create hurdles in the provision of culturally responsive care to refugee and migrant populations. A 2015 systematic review gave one

with family members facilitating communication, but this poses the risk of miscommunication, depending on the person's language skills, and may lead to patient frustration in cases of misdiagnosis, error and poor care (12). The engagement of bilingual health-care workers is also questionable since bilingualism does not equate to effective interpreting skills and may not be sufficient for quality and safe care. The use of machine-automated translation is likely to increase in the future, although one systematic review in Australia noted that current artificial intelligence is generally ineffective when translating nuanced and complex information, which is often the case in health and legal settings (13).

example of female nurses perceiving a lack of respect from some patients from migrant backgrounds, highlighting how patriarchal norms and other cultural beliefs may create difficulties in effective communication between providers and patients (14). Further, a lack of diversity in the ethnic backgrounds of health-care providers was found to be another barrier to providing cross-cultural care.

Interactions with the health workforce

Health workforce interactions capture personal engagement and relationships between health professionals and

patients during the delivery of health-care services. As discussed above, refugees and migrants face a number

of barriers to accessing health care in host countries, and interactions with health-care professionals in particular have a significant influence on future help-seeking behaviours (15). A scoping review of 26 studies (predominantly from Australia, Canada, the United Kingdom and the United States of America) identified the need for culturally appropriate health-care improvements, with a proportion of refugees reporting experiences of discrimination from health professionals due to their race, accent or low proficiency in the native language of the host country (15).

Further, the failure of health professionals to adopt a trauma-informed approach that is sensitive to previous experiences of human rights violations and other traumatic incidents has also been found to impede the delivery of effective care to refugees (16).

Communication is recognized as especially critical in the provision of effective and culturally responsive care to refugees and migrants. There is a significant body of research on the communication barriers experienced by health professionals and patients alike from migrant backgrounds. A number of strategies to improve communication are identified in the literature. For example, in the Australian context, the 2016 Recommendations for Comprehensive Post-arrival Health Assessment for People from Refugee-like Backgrounds (17) suggest adopting people-centred care principles using the acronym ASK.

- **A**sk the client: discuss the person's country of origin, preferred language, occupation, interpreter preference, current stressors and priorities for health.
- **S**creen for medical and psychosocial issues: ensure informed consent and understanding of health assessments.
- **K**indness: coordinate care with the person's network, if appropriate, and ensure sensitivity as well as a "universal precautions approach" to a potential pre-migration history of violence or trauma.

In addition to communication, continuity of care may be more challenging for refugees and migrants because of the low health literacy and high mobility of these populations. Factors influencing continuity of care include the availability of information and education on the health system of the host country, collaboration of different institutions to support information exchange and ease of access to health facilities (3). In particular, knowledge of the host country's health system is considered critical to facilitate continuity of care, as otherwise patients are more likely to present directly at emergency departments through lack of familiarity with the role of primary care practitioners in the host country (3). Health professionals can play an important role in educating refugees and migrants on the health system of the host country, thereby increasing their health literacy and engagement with health services.

Child health

Children form a significant proportion of the refugee and migrant population globally. According to estimates from the United Nations High Commissioner for Refugees, at the end of 2019 children below the age of 18 years accounted for between 30 million and 34 million (38–43%) of forcibly displaced people globally (18). A similar number (33 million) were classified by the United Nations Children's Fund as migrant children in 2019 (19). Children are considered more vulnerable to certain diseases, particularly in the absence of adequate nutrition and care. Refugee and migrant children have been shown to have worse health outcomes in a number of areas, including infectious diseases, chronic diseases and mental health, compared with local children in high-income host countries.

Refugee and migrant children, however, are not a homogeneous cohort; their health needs and outcomes vary significantly based on a multitude of factors, including country of origin, socioeconomic status, migration and asylum-seeking experiences, and the health-care system in their host countries. A regional WHO report found greater differences in health status between children from different migrant groups compared with the host countries' children in the WHO European Region (20). Overall, refugee and asylum-seeking children are reported to have worse health outcomes than other migrant children, particularly if they are unaccompanied (21). This is

often a result of the conditions under which they fled their home countries, such as unfavourable journeys to reach destination countries, including crowded and unhygienic transit spaces, limited nutritional options and restrictive asylum-seeking processes (20). Among migrant children, those who are considered irregular or without documents are at much higher risk of poor health outcomes than other migrant children.

Generally, refugee and migrant children are reported to have higher rates of infectious diseases such as influenza, hepatitis B and C, tuberculosis, and intestinal and skin infections (22). They also may have a high prevalence of anaemia, haemoglobinopathies, vitamin D deficiency and nutritional problems ranging from wasting and stunting to obesity (22). Higher rates of communicable diseases are often the result of lack of availability or inaccessibility of vaccination programmes through disruption in their home countries or during their migration journeys. Dental problems are also one of the most common health issues faced by refugee and migrant children (20).

Despite higher prevalence of many serious diseases and health issues, refugee and migrant children are less likely to access health-care services in host countries than local children. Their usage of preventive services, primary and dental care, and other

specialized health services may also be lower because of language and culture barriers. They are, however, more likely to use emergency and hospital services than the local populations, which suggests that there are delays in seeking care for their health concerns (23).

Mental health is one of the most studied aspects of the health of refugee and migrant children (24,25). While psychological well-being is of concern for migrant child populations more broadly (24), refugee and asylum-seeking children are at higher risk of experiencing mental health conditions such as depression and post-traumatic stress disorder (24). Experiences of, or exposure to, violence is one of the major risk factors contributing to poor mental health outcomes (25). Unaccompanied refugee children are a particularly vulnerable group as they are more likely

to experience traumatic events and stressful situations – such as exploitation or abuse - that can have longer-lasting impacts on their mental health and well-being. They are also more likely to develop behavioural problems (21). There is research to suggest that children of refugees who had experienced traumatic events are also likely to have higher rates of post-traumatic stress disorder and depression (26). Refugee parents or caregivers who are facing different stressors or struggling with mental health conditions may have more difficulty in providing a sense of security and support to their children and in engaging in positive caregiving and parenting practices (20). However, it has been shown that reliable settlement and social support improves the mental health of refugee and migrant children (27).

Sexual health

Sexual health refers to the ability of individuals to enjoy a safe and satisfying sex life, which is underpinned by physical, mental, emotional and social well-being in relation to sexuality (28). Sexual health is particularly important for refugee and migrant women and girls because of the risks of gender-based violence, sexual trafficking and sexual violence in conflict zones and refugee camps, as well as their limited access to sexual health education, contraception and sexual health commodities for prevention and care (29).

Sexual health may be a sensitive topic for refugees and migrants to discuss with health-care providers, and this discussion may be further complicated by low levels of health literacy and limited language proficiency (17). People from refugee and refugee-like backgrounds may also be unwilling to disclose experiences of sexual assault or gender-based violence when discussing their sexual history with service providers, particularly if family members or friends are present (17). It is also important to consider gender preferences for interpreters and having

partners or family members present or not present for such discussions (e.g. a male partner may request to be present) as the women's choice should be ascertained and facilitated when initiating sensitive discussions around sexual health.

Screening for sexually transmitted infections is essential for refugees and migrants, particularly for women who have come from an environment with a high risk for sexual violence (17). Sexually transmitted infections, if left undetected, can have serious effects on the person's health and future fertility and can lead to further transmission in the community. Research on the burden of sexually transmitted infections among refugees is limited but findings from a global systematic review suggest that overall prevalence levels are comparable to the general population (30).

Reproductive health

Reproductive health refers to the ability and freedom of individuals to reproduce when they wish to do so (33). It is an important component of overall health and well-being. For refugee and migrant women in particular, reproductive health is heavily influenced by their circumstances and living environment. The fertility rates of refugee women may increase as they decide to rebuild families, but the desire to prevent pregnancy may rise in response to instability and uncertainty with migration (34). Unwanted fertility is a key concern for refugee and migrant

women, who may experience higher rates of unwanted pregnancy (35). In particular, refugee women living in conflict situations face increased risks of unintended pregnancies, adverse pregnancy outcomes and poor birth spacing (36). Safe abortion care is a proven and life-saving intervention to prevent maternal death and morbidity and to manage the consequences of sexual violence in emergencies. Evidence suggests that there is demand for safe abortion care in humanitarian settings as a result of the disrupted health systems, decreased access to

contraception, increased numbers of unintended pregnancies and increased incidence of sexual violence. Despite this, women and girls who become pregnant during emergencies often lack access to safe abortion care, leaving many to undergo risky procedures (37,38).

Contraception is an important health service need among refugee and migrant populations, but knowledge regarding contraceptive methods within some groups may be quite limited. Attitudes to contraception are shaped by a range of factors, including culture, religion and partner influence (34). One study in Australia found that refugee and migrant women reported having low or less knowledge about sexual reproductive health compared with Australian-born women (39).

The most common contraceptive methods also differ between regions. The intrauterine device and the male condom are most commonly used in eastern and south-eastern Asia, while female sterilization is the dominant method in central and southern Asia (40). For Europe and North America, the oral contraceptive pill and male condom are the most commonly used methods (40). In Latin America and the Caribbean, female sterilization and the oral contraceptive pill are most commonly used and in Oceania, it is the oral contraceptive pill (40). The oral contraceptive pill and the intrauterine device are the leading contraceptive methods in northern and western Africa, with injectables the most

commonly used method in sub-Saharan Africa (40). Additionally, it is noted in the literature that many women from refugee and migrant backgrounds may not be aware of emergency contraception options (40).

While there are significant differences within populations of refugee and migrant women, on the whole they demonstrate poorer reproductive health than women in host countries. There are some exceptions; for example, a study of African refugee women in the United States found a healthy migrant effect in relation to their reproductive health outcomes. The study reported that African refugee women had fewer pre-pregnancy health risks, fewer preterm births, fewer low-birth-weight infants and higher rates of vaginal deliveries (41). Nevertheless, an overwhelming amount of research points to poorer reproductive health outcomes experienced by refugee and migrant women overall, as well as inadequate quality of and access to the needed health services.

Negative trends in the reproductive health of refugee and migrant women include higher rates of maternal death and morbidity; higher risks for mental health conditions, such as postpartum depression; increased number of preterm births; higher morbidity and mortality during and after pregnancy (including stillbirth); and increase in congenital abnormalities (35). Studies of asylum-seeking and refugee women have shown a higher occurrence of obstetric complications,

offspring mortality and unwanted pregnancies within this subgroup (42). One systematic review of maternal and perinatal outcomes for asylum seekers and irregular migrants in European countries found that the legal status of asylum seekers and irregular migrants was a critical factor in determining potential risk to their maternal and perinatal outcomes (43). For example, maternal and perinatal outcomes for asylum seekers are impacted by their short length of residence, low socioeconomic status and language barriers. For irregular migrants, poor housing conditions, fear of deportation and limited opportunities of employment are significant factors contributing to their risk (43).

Risk factors for poor reproductive health in refugee and migrant women more broadly include pre-existing genetic and biological factors, including consanguinity and thalassaemia in some regions; higher rates of diseases such as HIV in their countries of origin and/or transit; and social factors such as lower socioeconomic status, lower levels of education and lack of social support (35).

Additionally, there are challenges such as the financial accessibility of health care, language and communication barriers, real or perceived discrimination, lack of health information and shame in accessing reproductive health services; these all contribute to poorer outcomes for refugee and migrant women (44). A qualitative study of refugee and migrant women living in

Australia and Canada found cultural taboos around menstruation and sexuality to be of significant impact in women's ability to access reproductive health information and services (45). Another study found that the experiences of refugee and migrant women with health systems in their countries of origin and the prevalence of gender roles within their families (particularly with regard to decision-making on women's reproductive rights) were factors contributing to negative health outcomes (39). The role of cultural experiences and beliefs in shaping migrant women's pregnancy preparation and preconception health is also highlighted by an Australian study, which emphasized the importance of preconception care for women from refugee and migrant backgrounds (46).

Some studies have called for a shift away from a focus on individual and cultural characteristics towards a better understanding of structural and systemic barriers that impede access to reproductive health care for refugee and migrant women (47). With regard to systemic barriers, health systems in host countries are reported to have issues concerning resourcing, funding and cost of services, and time constraints can limit health-care providers' ability to deliver adequate and equitable reproductive health services to refugee and migrant women (39). Limited availability of interpreting services and lack of access to social security systems in host countries can also contribute to adverse reproductive health outcomes (35). Finally, a lack of culturally sensitive

services and experiences of racism, prejudice and stereotyping within health-care systems can also prevent and discourage women from accessing reproductive health services (42,48).

Most of the literature on refugee and migrant reproductive health tends to be focused on the experiences of women, in particular pregnancy- and childbirth-related health concerns. There is limited research on reproductive health in relation to adolescent and male refugees and migrants, nor for lesbian, gay, bisexual, transgender and gender non-binary individuals. However, one study of the fertility of male migrants in western European countries highlighted the disrupting effect of migration

on men's fertility potential, as male migrants tend to postpone having children until they have paid off most of the costs associated with migration and their partners have joined them in the country of destination (49).

There are also specific barriers faced by migrants in accessing care for infertility services. Infertility rates are highest globally in south Asia, sub-Saharan Africa, north Africa/Middle East, central/eastern Europe and central Asia (50). A growing body of literature indicates significant disparities in access for assisted reproduction care for refugees and migrants in high-resource host countries (51).

Mental health

The mental health of refugees, migrants and asylum seekers is a serious health concern. Traumatic, stressful or difficult experiences in their country of origin, during the process of migrating, when seeking asylum or while settling in their host country can lead to poorer mental health outcomes compared with those of the general population (52). Asylum seekers particularly have been found to have worse mental health outcomes than other subgroups of migrants (53). Studies have emphasized that long-term, ongoing mental health care, extending beyond the period of resettlement, has significant value in promoting the health of both the individual and their community, and continuing support from mental health

professionals is encouraged (54).

The mental health of refugees and migrants can be seriously affected by the stressful experiences they may be exposed to before, during and after migration (52). Research indicates that asylum seekers and refugees have a greater likelihood of suffering from post-traumatic stress disorder than the general population of the host country (54). The increased prevalence of this and other mental health conditions associated with stress has also been found to persist for more years in refugee and migrant populations (54). Refugees and migrants also have increased rates of depression, suicidal ideation, more severe anxiety and

increased somatic symptoms (55). Moreover, leaving one's home country and settling in another creates unique personal and social stresses, including adapting to a new environment, language and culture and being faced with economic stressors and limited social support networks. These can increase the risk of developing mental health conditions (52).

Pre-migration traumatic and stressful experiences that increase the risk of developing mental health conditions include physical violence and torture, war and other conflicts, sexual violence, violations of human rights and separation from family (17). Some research has found that up to 21% of adult refugees have experienced torture before settlement (56). Post-migration factors can also significantly contribute to the poor mental health outcomes of refugees, migrants and asylum seekers (52,54). These factors include limited economic opportunities, poor social support in new communities and uncertainties about bureaucratic processes related to visa approvals and applications for asylum (52).

People seeking asylum in their country of destination have an increased risk of developing mental health conditions compared with other refugees and migrants in that country (53). They face uncertainty about their applications for asylum and their future; they may be held in detention and can encounter significant barriers to accessing mainstream health care (including mental health care) and employment

opportunities (57). Asylum seekers often spend at least a year in the asylum system, possibly including time in detention, while their applications are processed (53). People in detention have been found to have poorer mental health than both refugees outside of detention and the general population, with longer periods of detention linked to worse outcomes (55).

Refugee and migrant women are also at particular risk of developing mental health conditions. One review of 26 studies on mental health conditions in refugees and asylum seekers found that, while the levels of post-traumatic stress disorder in refugees and asylum seekers already exceeded that of the general population, the levels were higher still for refugee women (54). The increased prevalence in women is consistent with studies finding a sex difference in the general population, but this review also proposed that the increased likelihood of sexual violence, the risks of trafficking and exploitation and stressors relating to childcare all contribute to a higher risk of developing post-traumatic stress disorder in refugee women and women seeking asylum (54).

Research indicates that most refugees and migrants with mental health issues do not require interventions that are substantially different from those for the general population (52). However, the existing tools and approaches to assessment, diagnosis and treatment typically have to be adapted to the specific needs and barriers to accessing care faced by refugees and migrants.

Mental health services and supports may have reduced applicability to refugees and migrants because of cultural differences around mental health, language differences, concerns about sharing personal or distressing details through an interpreter and potential financial or legal barriers to accessing care (17,52).

Assessing and treating a person's mental health often requires in-depth personal communication, which can be difficult when the person and the health-care professional cannot speak the same language or they have differences in proficiency in a shared language (52). Expecting family or community members to provide interpretation can also lead to problems regarding disclosure of personal information and confidentiality. Some studies have indicated that the engagement of an interpreter may give rise to concerns about confidentiality, particularly in smaller migrant communities where an interpreter may be a member of the patient's social group (52). Therefore, confidentiality and patient trust must be prioritized to effectively gain benefits associated with the use of interpreting services. Engaging professional interpreters has been found to help to create better therapeutic relationships, better patient experiences and improved outcomes of treatment (57). A review of available research on the mental health of refugees and migrants found that post-traumatic stress disorder and depression were more commonly diagnosed in studies where diagnostic

approaches included the assistance of an interpreter (54).

Cultural differences may also pose a barrier to effective diagnosis and treatment of mental health conditions in refugees and migrants. Research indicates that expression of psychological distress can differ between cultures (57). It may be that individuals from refugee and migrant backgrounds focus on physical complaints associated with mental health conditions when presenting to health-care providers or have supernatural explanations for mental health symptoms, which may lead them to seek help from religious leaders or cultural healers. This can make assessment and diagnosis more complex but also underlines the importance of training health-care providers in frontline assessment, management and referral for mental health conditions (58) and of facilitating links to community and religious leaders for referral (52). In addition, cultural-responsiveness training and the development of positive patient relationships can help to bridge the gap between cultural understandings.

Any assessment of the mental health of a refugee or migrant should include consideration of both pre-arrival experiences and post-arrival factors, including social and cultural integration, access to employment, vocational or education opportunities and any isolation from family and friends (52,54). It is generally not recommended that health-care professionals ask individuals

to provide details about their potentially traumatic past experiences (17). However, it is important that health-care providers and other frontline workers (e.g. social care workers) are able to provide basic psychological support such as listening and facilitating access to basic needs (59). Significant risks, such as suicidal ideation, should be assessed and appropriately managed by trained and supervised health workers or specialized mental health professionals when apparent or suspected, particularly if the individual is or has been in detention where the risks for suicidal ideation exist (17,55,58).

Research indicates that a lack of awareness or understanding about the availability of entitlements to care and the ways to access this care may reduce the help-seeking behaviour of refugees and migrants. It is important that health-care professionals themselves are aware of specific mental health

services and supports that are available for refugees and migrants in order to make any referrals that may be required and help them to access treatment (52). Engaging in community outreach, working with cultural mediators, strengthening referral links (e.g. with health and social services, educational institutions, community leaders) and addressing barriers to accessing mental health care where needed (e.g. knowledge, trust, transport or costs) are equally important. Better mental health outcomes for refugee and migrant populations can be supported by adapting clinical guidelines for mental health conditions to specific contexts, training and supervising general health workers in their use (58) and engaging professional interpreters when needed to assist in the assessment, diagnosis and treatment of mental health conditions (52,57).

Preventive health services

Immunization, nutrition and physical activity are important aspects of preventive health, which aims to minimize the burden of disease and associated risk factors (60).

A significant proportion of refugees and migrants are likely to be more susceptible to vaccine-preventable childhood diseases, in particular measles, rubella, tetanus and diphtheria, because of insufficient immunization (34). While routine

childhood vaccination began in the mid-1970s, vaccines for mumps and rubella are not routinely administered in many developing countries, with the global vaccine coverage ranging anywhere from 50% to 90% (34). Further, although some refugees may have received vaccinations in their country of origin, the vast majority do not have documentation of immunization and, consequently, catch-up immunization is recommended in the absence of written documentation (17).

Nutrition is an important indicator of health. Refugees and migrants undergo changes in their diet as a result of migration, which can impact their health in the short and long term. Research from the United States suggests that the majority of migrants from low-income countries settling in high-income countries will eventually adopt obesogenic behaviours and gain weight as their immersion into the host culture increases (61). This is partly attributed to the typical diet of many high-income countries that some migrants adopt as part of the acculturation process, which generally features higher amounts of unhealthy fats, meat, snacks and fast foods than their traditional diet (62).

While obesity is a health concern for some migrant populations living in high-income countries, nutritional deficiency is a key risk for refugees from countries where food insecurity persists. Refugees and migrants from regions with limited access to foods rich in

iron and with higher rates of infectious disease are at risk of iron deficiency, with iron-deficiency anaemia being the most common nutritional disorder in the world (34). Iron-deficiency anaemia is associated with poor pregnancy outcomes as well as impaired physical and cognitive development in children (34).

Like adequate nutrition, regular physical activity is important for maintaining good health (63). A systematic review found that refugees and migrants have limited participation in physical activity, which can exacerbate the risk of chronic disease, although the authors noted that there is limited research assessing the flow-on impacts of acculturation on sport and physical activity participation (63). It is acknowledged, however, that a diverse array of factors can contribute to participation in physical activity including time, past exercise habits, social support, culture and family obligations (63).

Noncommunicable/chronic diseases

Research on chronic diseases in refugees and migrants is limited, and some studies have come to conflicting conclusions (17). Some research suggests that refugees and migrants may experience a higher likelihood of noncommunicable diseases such as diabetes mellitus and hypertension (64). This particularly applies to refugees and migrants from low- and middle-income countries, which are more likely to have

poor dietary patterns, comparatively minimal physical activity and higher rates of tobacco use, which contribute to the development of many chronic health conditions (65,66). Other studies, however, show reduced frequency of noncommunicable diseases in refugees and migrants compared with the general population of their host country (67).

Poor nutrition and low rates of physical activity can lead to obesity, which contributes to the development of noncommunicable diseases, including diabetes and cardiovascular diseases. Research indicates that refugees and migrants are not inherently more likely to be obese or overweight, but negative lifestyle factors may develop as they acculturate to the host country and host culture, which may lead to a less-healthy lifestyle (61). Other studies suggest that refugees and migrants may in fact be healthier than the general population of the host country (67). However, this healthy migrant effect tends to dissipate over time, and their morbidity and mortality alters to reach similar levels to that of the host population (7).

A systematic review of eight studies on the prevalence and treatment of noncommunicable diseases in refugees and migrants settled in urban areas found that these diseases were fairly common in this group, with cardiovascular diseases, diabetes and musculoskeletal disease being among the most common (64). However, the review noted that this may not be reflective of general refugee and migrant populations globally. This review also found that urban refugees originating from middle-income countries were more likely to have a chronic disease than those from low-income countries (64). In addition, the review found that urban refugees' access to primary health care in host countries was adequate but access to secondary and tertiary health care, which is often required for treatment

of chronic diseases, was not sufficient. Financial barriers to accessing health care was identified as the primary reason for this (64).

Noncommunicable diseases are managed in a variety of ways, including lifestyle changes, medication and surgery. Reviews of countries where a reduced level of noncommunicable diseases has been reported have found that improvements in lifestyle, nutrition and physical activity had the most significant reducing impact (65). However, preventive measures have been found to be challenging for refugee and migrant populations because of their limited resources and difficulties in accessing early intervention before the chronic condition develops (64).

A review of 24 studies on the efficacy of various culturally responsive interventions to manage chronic diseases in refugees and migrants found that their use of health services tends to be low, despite a relatively high prevalence of chronic health problems (68). Lack of knowledge among health service providers about how to provide culturally appropriate treatment and poor communication and limited understanding on the part of refugee and migrant communities about how health systems operate contributed to the low usage of health services by refugees and migrants. Fear of discrimination or disrespect was found to discourage people from accessing the health system for treatment (68). This review found

that health interventions by bilingual community health professionals and cultural responsiveness training for health professionals led to the greatest improvements in communication

Communicable diseases

Communicable diseases pose a serious, potentially life-threatening health concern for refugees and migrants. The process of migrating can expose individuals to significantly greater risk of contracting infectious diseases, such as respiratory diseases, HIV and tuberculosis, as a result of potential overcrowding, poor living conditions and inadequate hygiene services (17). Additionally, horizontal childhood spread of hepatitis B is the most common means of its transmission globally; this means that many adult migrants with chronic hepatitis B have had it since childhood and are at risk of developing chronic liver disease and hepatocellular carcinoma (69). Social and economic factors experienced by refugees and migrants, such as poverty, separation from family, exploitative working conditions and stress, may also lead to engagement in risk behaviours associated particularly with HIV infection (70).

Refugees and migrants from low- and middle-income countries where HIV/AIDS is prevalent may be more likely to have contracted the virus either while in their country of origin or while migrating to the host country (71). Refugees and migrants are

between health systems and culturally and linguistically diverse patients, and in self-efficacy and self-management of chronic health conditions (68).

considered a high-risk population for HIV and account for 40% of newly diagnosed cases of HIV infection in Europe (72). Adolescent women and young girls in particular have been found to be more vulnerable to poor sexual and reproductive health outcomes, including HIV/AIDS, as a result of forced migration (73). Studies have also indicated that a change in community norms and lifestyle upon migration may increase the presence of risk factors for HIV infection, such as more regular sexual relationships or a greater number of sexual partners and increased drug and alcohol consumption (71). Some refugees and migrants may be already aware of their HIV-positive status but may not have an effective understanding of screening and treatment options available to them in their host country (34).

A review of 24 studies on the link between traumatic migration experiences and HIV risk factors found that there was generally a relationship between trauma, particularly stemming from sexual violence, and HIV risk behaviours among refugees and migrants in low- and middle-income countries (74). This review found that interpersonal trauma, systematic

human rights violations and sexual violence increased the likelihood of individuals engaging in maladaptive coping behaviours, such as inconsistent condom usage, sharing intravenous drug paraphernalia and engagement with multiple sexual partners; all of these can increase the likelihood of HIV transmission (74).

One review of 35 studies on HIV/AIDS-related health-care difficulties for refugees and migrants found that some of the most significant barriers to the efficacy of HIV/AIDS health services were the inadequacy of available services, the inaccessibility of health services to refugees and migrants due to legal status or type of occupation, discrimination and stigmatization, language differences and financial hardship (71). While many of these barriers also exist for non-migrant populations, they were found to have a more significant impact when refugee and migrant populations are involved. Social and cultural stigma surrounding HIV/AIDS presents a significant barrier to testing and treatment of refugees and migrants in their host countries (72). Another critical barrier to effective diagnosis and treatment of HIV/AIDS in refugee and migrant populations is a shortage of dedicated health personnel and a lack of specific training for health personnel regarding HIV/AIDS testing and treatment; this is particularly an issue in low- and middle-income countries (71).

Early diagnosis of HIV is critical to ensuring prompt provision of available

treatment and to prevent further transmission through modification of behaviour. The consequences of late diagnosis can be life threatening (17). Successful management of HIV/AIDS and other communicable diseases requires a holistic approach to lasting health and strict adherence to treatment. Treatment must be managed in context of other cultural, physical and psychological conditions (17).

Approaches to screening and testing for HIV must address the stigma and fear surrounding it. Studies suggest that voluntary rapid testing for at-risk migrant populations may increase the rate of testing and support timely diagnoses and early treatment, which can reduce morbidity (72). Moreover, research indicates that refugee and migrant populations were more likely to be tested for HIV if treatment is available, testing is required for marriage or for legal reasons, confidentiality of results is ensured and support networks are available (72).

Hepatitis B is a major global health challenge, and rates of chronic hepatitis B and hepatocellular carcinoma are rising in North America and Europe, reflecting international immigration from countries of high or intermediate prevalence (75). In contrast to HIV, most host countries do not routinely screen for hepatitis B infection. Most high-resource countries have had several decades of routine childhood vaccination programmes for hepatitis B, but this is not the case for many low-

income countries (76). Health services for refugees and migrants should as a matter of priority screen for hepatitis B infection and consider vaccination for those who are not immune (17).

Tuberculosis and extensively drug-resistant tuberculosis are the subject of national programmes in all WHO Member States (77). Common policies between host countries on pre-migration screening programmes for migrants can help to address the challenge of active tuberculosis in

migrants from high-incidence countries (78), which is a barrier to migration. People from high-incidence countries for tuberculosis are priority candidates for screening and treatment of latent tuberculosis infection after arrival in the host country (17). The risk of developing active tuberculosis is highest in the 12–18 months following exposure, so it is possible that active tuberculosis may develop only after their arrival in the host country (17).

Oral health

Oral health is a key indicator of general health and well-being (79). However, research on the overall burden of oral diseases and their causes for refugee and migrant populations are limited. Some common oral health issues experienced by people from refugee backgrounds include missing teeth, periodontal disease and dental caries (17). In general, migrants from countries where diets are high in sugar and dental care is limited face a higher risk of oral diseases (34).

Country of origin is an important factor in oral health, as the pre-arrival risk of developing tooth decay is influenced by traditional diet, access to dental care and exposure to fluoride, among other factors (80). For example, one study found that refugee children from east African countries have lower rates of dental caries than African-American

children in the United States, which was attributed in part to traditional diets that are low in sugar and to cultural practices such as stick-chewing (81). A number of issues affecting the oral health of refugees and migrants in their country of destination have been identified in the literature, including long waiting lists, high costs associated with dental treatment, competing settlement priorities and the availability of low-cost foods that are rich in sugar (17).

One systematic review of 44 studies (largely drawn from Australia, Canada, Sweden and the United States) found that refugee populations had a high burden of oral disease compared with the least-privileged populations in the host countries (82). Further, professionally assessed and self-perceived oral treatment needs were mostly unmet in this population (82).

Oral health is also a significant unmet health need for migrant workers, in particular farmworkers. Challenges to good oral health experienced by migrant workers may include barriers in access to dental care, such as lack of insurance, high cost of services and

limited clinic hours, as well as limited basic oral health knowledge (83). Moreover, preventive dental care is not considered part of routine health care in some countries, which can influence help-seeking behaviours in relation to oral health (80).

Care for elderly people

Older refugees and migrants generally fall into two groups: people who migrated when they were younger and have aged in their country of destination and recently arrived older refugees and migrants (7). Refugees and migrants aged over 60 years are generally considered as older by the United Nations High Commissioner for Refugees, although there is some variation in the literature regarding the age threshold (84). Further, the age of some older refugees may be considered indeterminate because of inaccurate birth dates on official documentation or the absence of documents of birth (85). Health professionals may be tasked with determining a patient's chronological age, with the best practice for accurate estimation involving a combination of physical examination, life history and corroborating documents (85).

In addition to the usual determinants of health influencing the ageing process, which include sex, ethnicity and socioeconomic background, research has identified migrant-specific risk factors. These may include exposure

to health risks before and during migration, language barriers, low health literacy, cultural factors shaping health-seeking behaviours and psychosocial vulnerability (86). There is limited research on the health behaviours of older migrants (86).

Older refugees and migrants tend to have lower self-rated health, well-being and mental health status compared with host populations, with the long-term effects of trauma being a key concern for older refugees (7). Older refugees are also more likely to have chronic diseases and have higher settlement and recovery needs compared with the general younger refugee population (17). They may also experience complex psychosocial adjustments, as the combination of being both older and a refugee may increase the effects of anxiety, depression, stress and vulnerability. Further, for some older refugees, acquired skills in the language of their host country may be lost as they age, causing them to revert to their native language (17).

Care for people with disabilities

There are limited data on the number of refugees and migrants living with a disability. However, WHO estimates that some form of disability occurs in around 15% of the global population (87). Some research indicates that migrant workers, particularly those working in potentially dangerous manual labour jobs, may be exposed to a greater risk of acquiring a disability. Refugees fleeing conflict and natural disaster may also have acquired a disability either in their country of origin or while in transit (88).

Refugees and migrants living with disability are likely to have greater unmet health needs and are more at risk of secondary health conditions, comorbidities, age-related conditions and premature death (87). While the health-care needs of refugees and migrants living with disability will differ depending on their age and type of disability, it is important to note that some individuals with disability may not have had a formal diagnosis. Assessment and diagnosis of the disability will be necessary for such people (89).

Refugees with disabilities face higher risks of violence, abuse, exploitation and discrimination than the general population (90). Reliance on family members, friends or other carers makes refugees and migrants particularly vulnerable, and the loss of these caregivers can leave them isolated and without the assistance they require (91). Refugees with disabilities are more likely to be overlooked by humanitarian

assistance when migrating and more likely to be excluded from accessing education, employment and public services in their host country (88).

Undiagnosed vision and hearing problems are of particular concern for refugees and migrants as they may not have received a hearing or vision assessment in their country of origin (17). It is estimated that around 80% of individuals around the world with moderate to profound hearing impairments are from low- and middle-income countries (17). Causes of visual impairment, including glaucoma, cataracts and trachoma, occur at increased rates in the least-developed regions, including sub-Saharan Africa (17). Early detection of these issues is critical.

In addition to cultural and linguistic differences, and other barriers to accessing health services, refugees with disabilities may also require assistance from a caregiver to overcome physical barriers or to assist in communication or administrative tasks in the case of intellectual disability (88). When assessing, diagnosing or treating a migrant or refugee with a disability, it is important to take cultural considerations into account. Some cultural considerations may include an unwillingness to accept outside help that may be offered by the health system and a limited understanding of the support services that may be available (89).



Gaps for further research

To ensure that health systems of host countries are responsive to the specific health needs of refugee and migrant populations, systematic migrant health data collection is needed. As noted by WHO, some data on the health of refugees and migrants are routinely collected by countries but these data tend to be concentrated around infectious diseases (92). Further, some national datasets are not disaggregated by migratory status, with the limited collection and integration of migration health indicators posing a significant barrier to public health planning for refugee and migrant populations (92). Comprehensive and reliable data are critical for informing further research and policies related to refugee and migrant health.

A number of gaps in the literature on refugee and migrant health needs have also been identified over the course of this review. For example, more research is needed on various components of mental health, including ways to scale up accessible and evidence-informed mental health care among different

refugee and migrant populations that are hard to reach (e.g. people on the move) and the use of remote interventions particularly in the context of COVID-19. The maternal and perinatal outcomes for asylum seekers and irregular migrants also requires further exploration. A significant gap has been identified in the literature on non-pregnancy-related reproductive health outcomes among refugee and migrant women.

Oral health for refugees and migrants is not well understood, with limited research on the overall burden of oral diseases and their causes in these groups. More research is also needed on hearing and vision health, and on the experiences of refugees and migrants living with disability more broadly.

Further research on the health and health outcome of older refugees and migrants, both those who aged in their host country and those who arrived at an older age, is also needed to better understand the particular health issues they face.

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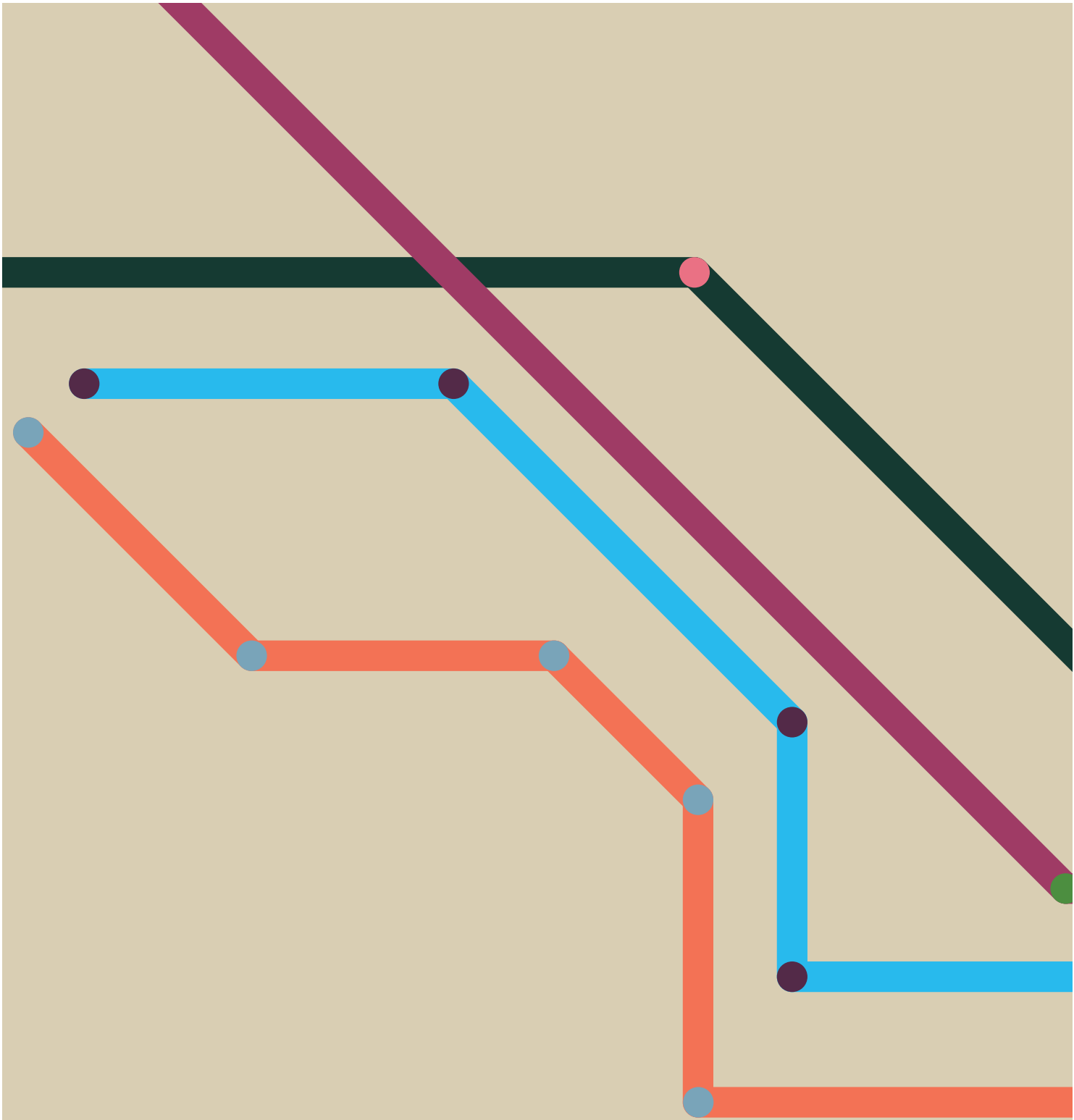
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