Health system considerations related to voluntary and forced displacement in the Eastern Mediterranean Region: a critical analysis of the available literature

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Abstract

Background: The WHO Region for the Eastern Mediterranean has had a history of complex migration patterns, with high levels of migration to, from and within the Region, overlaid by massive recent forced displacement. Relatively little is known about the health system response to this large-scale mobility.

Aims: To review the literature on the Region critically, identify gaps and suggest areas needing research and policy attention.

Method: A search of the published literature using MEDLINE and POPLINE was conducted on health and migration focusing on the WHO health system building blocks with no date or language limitations.

Results: Out of 4679 retrieved articles published between 1964 and January 2019, 140 met our inclusion criteria; 45 additional articles were included in a December 2020 update. Most publications focused on refugees and on the delivery of services.

Conclusions: Few studies explored the responsiveness of health system to refugees and migrants compared with those for host communities, or assessed the quality of services or refugees'/migrants' perceptions of available health services. Few suggested new approaches to financing health care access for these populations or new governance arrangements.

Keywords: refugees, migrants, health systems, Eastern Mediterranean Region

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Introduction

Background

The World Health Organization (WHO) Region for the Eastern Mediterranean (EMR) has experienced continuous movements of voluntary and forced migration, within the Region and within countries, with forced displacement in particular increasing in recent years. Massive humanitarian crises in many countries of the Region – such as in Afghanistan, Iraq, Libya, Somalia, Sudan, Syrian Arab Republic and Yemen – are overlaid on longstanding and complex migration pathways within, from and into the Region. Intraregional and cross-regional economic disparities and job opportunities, in both the formal and informal sector, lead to large labour migration flows (i.e. both emigration and immigration), involving highly skilled and low skilled migrants. There is a marked vulnerability among the latter, particularly in the domestic and construction sectors and in manual work generally (1). Much of the intra-regional movement has been destined for the high-income countries of the Gulf Cooperation Council, which host disproportionately high numbers of international migrants.

With conflicts increasing in recent years, however, both low- and middle-income countries of the Region in particular are simultaneously hosting migrants and refugees, while sending migrants within the Region and abroad. As of the end of 2018, about 67% of the world's refugees originated from just 5 countries, 3 of which are in the EMR: Syrian Arab Republic (6.7 million), Afghanistan (2.7 million) and Somalia (0.9 million) (2). These same 3 countries, in addition to Iraq (EMR) and South Sudan (AFR), had the highest rates of internal displacement worldwide. Globally by the end of 2018, the majority of returned refugees, internally displaced populations (IDPs) and asylum seekers were within or to Iraq, Pakistan, Sudan and Syrian Arab Republic (2).

These high rates of mobility have increased the need for access and utilization of health care services for and by these populations while on the move and within the countries where they are hosted. While flows of migrants for work purposes in the Region are dominated by men of working-age, those of refugees are predominantly children and young people and women of reproductive age. They also include elderly populations, with a resulting higher burden on the health system, particularly fragile systems (3,4). With a variety of potential health needs among refugees and migrants, health systems need to

be reformed to be able to offer migration-responsive services, and to tailor delivery to different contexts. A critical enabler of such responsiveness, however, is financing, and innovative financing solutions are needed to cover the associated costs (5).

Bozorgmehr et al. have noted that, globally, health research on these topics has tended to focus on individual migrants and their medical needs or on specific diseases (particularly infectious diseases and mental health) or subpopulations; this narrow focus, they argue, has constrained understanding of the links between policies, health system responses and health outcomes (6). This applies particularly in the EMR, where the health system aspects of receiving and providing health care for these large mobile populations with their specific health needs, as well as aspects of health care worker migration, are poorly understood. The countries of the EMR are only beginning to develop policies to address the health system implications of massive flows of people within and from outside their borders.

Objectives and scope

The aim of the paper is to review the available published literature critically and to identify gaps related to the health of migrants, refugees and IDPs in the EMR, based on the WHO 6 health system building blocks.

Methods

With the assistance of a library sciences specialist, a comprehensive literature search was conducted on health system aspects of the health of migrants, refugees and IDPs in the EMR. To be included in the review, articles needed to fulfil the following inclusion criteria: address one or more of the following populations: migrants, IDPs, refugees, expatriates, asylum seekers and migrating or displaced health care providers; focus on these populations residing in one of the EMR countries (Afghanistan, Bahrain, Djibouti, Egypt, Iraq, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen); and include discussion of access to health care and utilization of health services/facilities, including health-related policies, recommendations for improving health care or challenges for accessing health services for the population of interest; and use a clear study design (cross-sectional or observational studies, clinical trials, case–control etc.); and be published in any language. As noted, the scope specifically excludes literature on migrants or refugees from the EMR who are currently residing in other regions of the world and sources that solely addressed health needs (not health system-related issues) of the concerned populations. Publications that did not offer new data, such as commentaries, were excluded. Review papers were also excluded but their bibliographies were screened to guarantee the inclusion of all related publications.

Results and discussion

Characteristics of the relevant published literature

A total of 4679 journal publications published between 1946 and January 2019 were retrieved from searching MEDLINE and POPLINE databases. After screening titles and abstracts, 306 articles were included for full-text screening, out of which 140 (7–146) met the inclusion criteria. An additional article was included by hand search bibliography (147). Also, 45 (148–192) articles were included after updating the MEDLINE search in December 2020. We were not able to update the POPLINE search due to its discontinuation in September 2019. Thus, a total of 186 published articles were included (Figure 1).

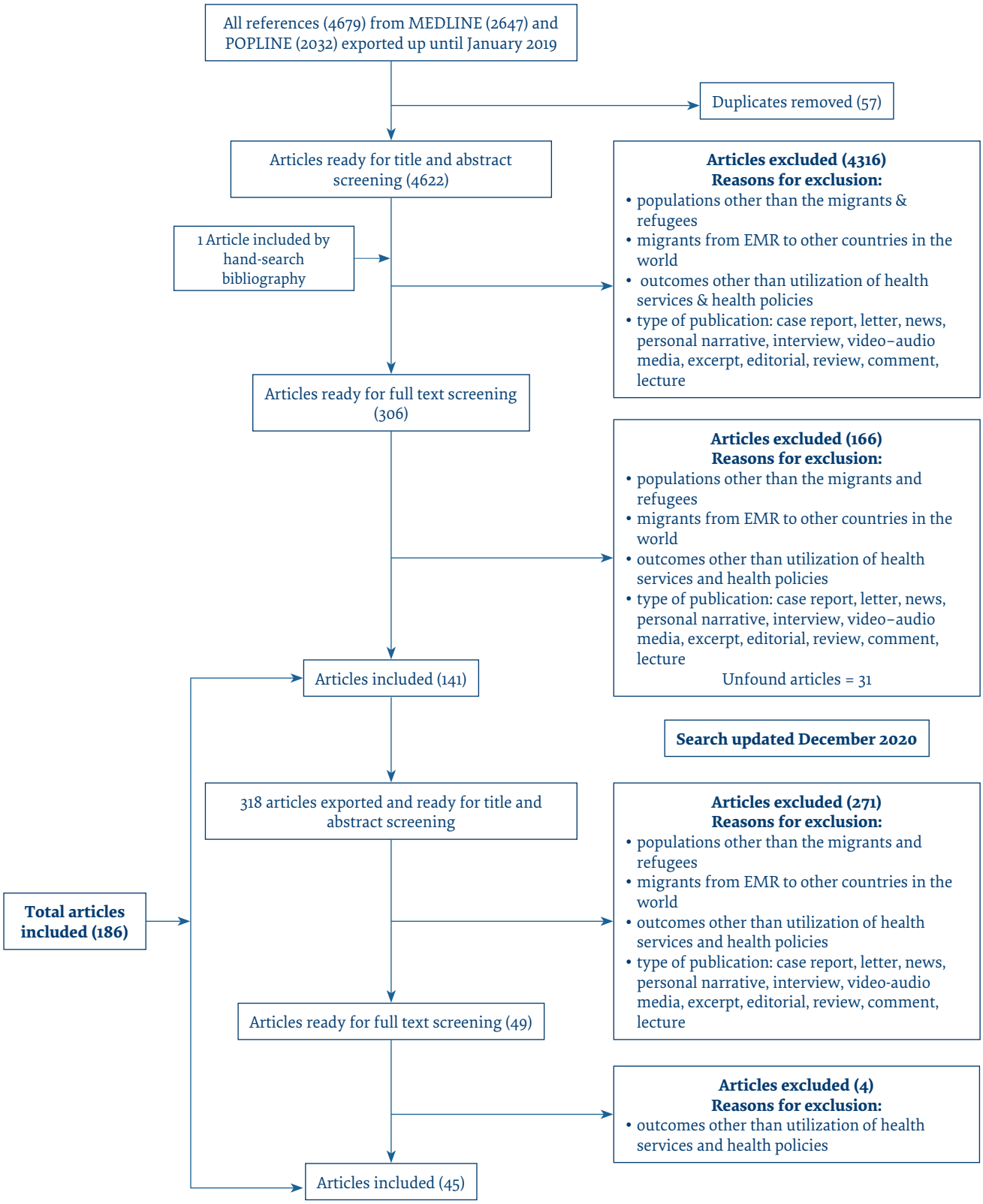
The identified literature according to the health system building blocks

Given the focus of the review on health systems and access to health services, the identified literature is presented according to each population of interest and the 6 WHO health system building blocks (the framework used for this analysis): service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (193). Table 1 shows a quantitative summary of the distribution of articles that address issues related to the 6 health system building blocks. Service delivery (n = 47) is the topic that attracted the most research attention, followed by health workforce (n = 32) and the availability of medical products (including vaccines and technologies) (n = 28). While the majority of articles addressed refugee health followed by IDPs, very few studies pertaining to migrants were identified in relation to the 6 health system building blocks.

Service delivery

Around a third of the publications (34.1%) addressed the delivery of services for refugees and IDPs (Table 1); none addressed service delivery for migrants. Thus this section will focus on the 2 populations: refugees and IDPs. For refugees, primary health care and sexual and reproductive health services were the most addressed in the literature. Primary health care services were considered the first line health facility in camps. Overall, they were reported to be available but not always free for refugees. Antenatal care and delivery services were reported to be available but several access barriers were also reported such as cost, absence of skilled birth attendants and transportation issues. However, postnatal care was reported to be mostly lacking and even if available, not sought due to lack of social support and cost barriers. Other services such as those related to noncommunicable diseases, infectious diseases, mental health and child health were less addressed; however, it was clear that health care for children seems to be a priority in service delivery. A similar picture emerges concerning service delivery on IDPs, but the litera-

Figure 1 Flow chart showing the inclusion and exclusion process for this review



ture did not address services for IDPs as much as it did for refugees. Injury care (including treating the severely wounded, providing reconstructive surgeries and opening emergency rooms) was abundantly addressed in the literature, but reported as not always being available.

With funding shortfalls for the humanitarian response, particularly as crises in the Region are becoming protracted, there is a need for innovative and responsive service delivery models (*5*,*194*). In order not to leave behind the hard-to-reach populations, there is also a need for mobile service delivery models; however, only 2 identified

Table 1 Distribution of full-text articles (*n* = 186) included in the search according to each of the health system building blocks

Health system building block	No.	%
Service delivery	47	34.1
Health workforce	32	23.2
Health Information systems	9	6.5
Medical products	28	20.3
Financing	12	8.7
Leadership/governance	10	7.2

articles from the Region explored the potential of such delivery models or the potential of e-health for meeting the specific needs of mobile populations, who may lack awareness about available fixed services (*8,195*). Studies are needed on the effectiveness of such interventions but also their potential for being scaled up.

Two recent studies measuring health care access and barriers to access, specifically among Syrian refugees, were conducted among nationally representative samples in Lebanon and Jordan (*39,196*). In addition, only 2 studies addressed the needs of particular subgroups or vulnerable subpopulations among migrants or refugees; one was conducted in Lebanon assessing needs of the elderly subpopulation of Syrian refugees in Lebanon (*12*), while the second was in the Syrian Arab Republic looking at the health needs of the internally displaced and female-headed households (*25*). However, few identified studies from this review compared accessibility or utilization patterns across populations, comparing, for example, those of migrants and refugees to host populations. One exception is a study by Alnuaimi et al. in Jordan, which compared pregnancy outcomes among Syrian refugee and Jordanian women (*31*). Given the observed tensions between migrant and refugee populations on the one hand and host populations on the other during protracted crises in low- and middle-income countries with limited resources, redressing such differentials is critical.

Overall, out of 45 articles that reported on research about service delivery, the majority studied the responsiveness of health services to the needs of migrants, refugees and IDPs. A strikingly absent dimension in this literature on the health system building blocks is assessment of the quality of services offered to refugees and migrants and their perceptions of their experiences using the available services. One exception is a study of perceptions of reproductive health services provided to refugees in Yemen (*107*). Another study addressed perceived barriers to accessing health care among Syrian refugees in Jordan (*40*). A qualitative study addressed ethical challenges facing health care providers in Jordan to Syrian refugees when resources did not allow them to provide the evidence-based care they would strive to provide (*192*). And another study in Jordan included data collection with Syrian refugees about their priorities for health care as well as with providers, who reported the need for more emphasis on mental health and noncommunicable diseases (*147*).

Few of the identified studies address legal barriers to accessing services or the particular situation of undocumented migrants in the Region. This global topic was emphasized by Legido-Quigley et al. who considered that "health coverage cannot be described as universal if it excludes migrants, but many countries do so." (*197*) As countries develop plans for meeting the 2030 Sustainable Development Goals (SDGs) of "No one left behind," and specifically SDG 3, target 8, achieving universal health coverage, and SDG 10, target 7, focusing on well-managed migration policies, ensuring that migrants (including the undocumented) and refugees (including those unregistered) are included is essential. None of the identified studies addressed this challenge explicitly or tested approaches to doing so.

A key area of needed future work, although not sufficiently addressed in the available published literature, is the integration of refugees and migrants in plans for emergency preparedness. Two exceptions are an article by Wasay and Mustaq on health issues of IDPs in Pakistan and preparation for future disasters and an article by Delargy et al. on contingency planning and emergency preparedness for reproductive health in Iraq (*84,120*). Qayum et al. also assess primary health care services in Pakistan according to SPHERE standards and indicators (*73*). Spiegel et al. argue that, globally, the predominant focus of humanitarian funding on post-emergency assistance has meant that the potential for pre-emergency preparedness and risk sharing before emergencies occur has often been overlooked (5).

Workforce

This health system building block was addressed in 32 articles, which corresponds to 23.2% of the literature meeting inclusion criteria (Table 1). Migration or forced displacement of health care providers, including nurses, physicians and medical students from and within the EMR, was highlighted in 17 out of the 183 publications. Other workforce related topics were the lack of skilled birth attendance and not considering trans-cultural medical care issues such as the absence of midwives or female gynaecologists. Two articles focused on concerns about refugees and migrants (mainly male food-handlers and female domestic workers) who were considered potential vectors for transmitting microbial infections (*27,83*).

A well-trained workforce with appropriate skills is required to respond to the health needs of migrants and refugees, particularly to overcome barriers in health care access. Typically, countries in conflict experience a brain drain of trained health care personnel (*71,78*). Health care personnel are among the refugees fleeing to neighbouring countries, yet their training and qualifications may not be recognized in the new host countries and they are often not legally entitled to provide health care despite the evident need among refugee populations. In countries hosting refugees there may be a need for legislative change or special provisions, as has happened in some European countries, to allow continuous education and credentialing and ultimately to allow refugees to serve

(as a minimum) the health needs of populations from the same countries. In Turkey, for example, Arabic-speaking Syrian doctors have been allowed to staff the migrant centres set up to meet the needs of predominantly Syrian refugees (*198*,*199*).

The existing studies on health care worker migration identified in this review focused on the motivation for the migration, rather than the health system consequences of brain drain or strategies for retention. Moreover, these studies focused overwhelmingly on issues pertaining to medical personnel and much less on other categories of health workers. One exception is a study on community health workers and their role in trachoma control in a Somali refugee camp (*142*).

Information

Data on information systems addressing these populations were few (6.5%) (Table 1); however, some successful examples were provided in terms of referral and tracking of patients, such as the Refugee Assistance Information System (RAIS), e-health at UNRWA's primary health care centres and various apps (*8*,*76*,*77*). Other publications focused on the importance of having a well-structured e-system in order to track cases and referrals. In order to optimize the use of scarce resources in humanitarian contexts, it is essential to have a well-established health information system. However, basic data are often lacking in the EMR, particularly in countries experiencing conflict, on the population size of migrant and refugee populations, particularly of those not legally registered. There is no consensus as to how to measure migrant status appropriately and there are methodological and logistical challenges to collecting information on displaced populations, particularly undocumented migrants (*197*). There is, therefore, a lack of population-based data disaggregated by migration status, which makes it difficult, if not impossible, to assess the health needs of these groups. For the data that do exist, safeguarding confidentiality is particularly critical concerning refugees and migrants, with understandable fears among such populations as to how such data might be used.

Given the mobility of these populations and the frequent lack of established sampling frames which allow for drawing representative samples to assess health needs on a representative basis, it is challenging to conduct rigorous studies. Yet it is only with adequate and disaggregated information that governments and humanitarian actors, in collaboration with funders from international organizations, can intervene to address actual health needs. There is therefore an urgent need in the Region for well-designed information systems to analyse data separately between refugees, migrants and citizens in order to evaluate interventions and assess needs over time. Only 2 retrieved articles addressed this challenge, an article by Rossi et al. on the implementation of an information system for the Palestinian Red Crescent Society in Lebanon (*92*) and another on nurses' use of global information systems to offer reproductive health services to IDPs in Somalia (*100*).

Medical products

The proportion of studies on medical products and technologies (20.3%) was similar to that on the health workforce. Unlike vaccines, medications for sexually transmitted infections, mental health and vitamins were reported to be rarely or not available at all for refugees and IDPs. Medications for noncommunicable diseases were variably offered depending on context, but were often reported as inaccessible due to cost or being out of stock. Equipment in health centres varied widely: some were well-equipped and others lacked basic necessities such as electricity. Only one study addressed the different vaccination strategies for migrants and refugees in the EMR countries (Egypt, Jordan and Tunisia) (*23*).

Financing

Financing was the third least addressed of the WHO health system building blocks (accounting for 8.7% of the literature) (Table 1). The main finance-related aspect mentioned was related to out-of-pocket payments for consultations, hospitalization and medication, although some international organizations such as WHO and nongovernmental organizations such as Médecins Sans Frontières were able to provide funding for vaccination for migrant and refugee populations.

Funding is a key constraint to ensuring access and utilization of health care services for refugee and migrant populations. High out-of-pocket expenditures on health care by these populations exacerbates existing poverty levels, especially given the restrictions on employment for refugees in the EMR. At the same time, low- and middle-income countries hosting refugees from neighbouring countries assume a major financial burden that has not been adequately offset by aid funds. As noted, there is a need for hosting governments and humanitarian agencies whose resources have been stretched by the volume of displacement and by the protracted nature of recent conflicts to develop and test innovative financing models so that they are able to provide more sustainable and effective health services to migrants, refugees and IDPs. However, only one article identified in this review addressed this challenge explicitly, although it has a global, not EMR, focus (*5*). Some countries of the EMR, such as the Islamic Republic of Iran, report having already succeeded in achieving universal health coverage and integrating legally documented refugees within their health system. Most EMR countries reported relying on UNHCR for refugees.

Governance and leadership

Though minimally addressed in the identified literature (7.2%) (Table 1), the main concern singled out was the lack of leadership and well-conceptualized health policies for migrants and refugees. Lack of adequate governance and leadership in the health systems of countries experiencing major flows of refugees and migrants tends to lead to fragmentation of services and unclear lines of responsibility. Emergency preparedness and readiness are key issues when building a well-structured system by earmarking funds for emergency crises (*200*). Preparedness

reduces the country's risk of health system fragmentation by preventing the creation of a parallel system that does not align with national strategies. This lack of system preparedness is perhaps one reason accounting for the peak in publications in 2014–2019, starting 3 years after the beginning of the Syrian crisis when the needs of refugees needed to be studied and priorities established. The formation of emergency multi-disciplinary teams which include health care providers, public health practitioners, political scientists, social workers, lawyers, information technology personnel and financing staff is a key means of preparing for emergencies as they would be responsible for dealing with problems arising in-place, improving what is available and suggesting long-term strategies (*201*). Moreover, governments and NGOs should benchmark the experiences of other countries to learn from successes and failures. One recent study employed the concept of "resilience" to analyse, through qualitative interviews with keys stakeholders, the "resilience" of the UNRWA health provision for Palestinian refugees in Lebanon, including its ability to weather adversity and tensions between refugees and host populations (*191*). Governments also need to address projected returnees to their home countries in their health strategy response. However, only one study (on Jordanian returnees from Kuwait) (*123*) addressed this issue, which will become more and more relevant as current conflicts in the Region ultimately come to a long-awaited conclusion.

Conclusion

This paper critically analysed the available literature on the entire EMR on health and migration from a health system perspective. It has identified areas of strength, but also major gaps in which there has been little research. As a region disproportionately affected by migration and forced displacement, it is important to take stock of the existing scientific knowledge in order to learn from experience. The ultimate aim is to support the admirable efforts of countries to cater for the health needs of those who live beyond their own countries of origin, whether by choice or due to humanitarian emergency. With migration becoming a major issue worldwide and the number of migrants and displaced persons increasing, the focus on migration-responsive health systems will benefit the general population and thus ultimately serve the needs of all if executed with quality standards.

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Considérations des systèmes de santé relatives aux déplacements volontaires et forcés dans la Région de la Méditerranée orientale : analyse critique de la littérature disponible

Résumé

Contexte : La Région OMS de la Méditerranée orientale présente depuis longtemps des schémas migratoires complexes, avec des niveaux élevés de migration vers la Région, en provenance et à l'intérieur de celle-ci, auxquels viennent s'ajouter les récents déplacements forcés en masse. Très peu d'informations sont disponibles sur la réponse des systèmes de santé à cette mobilité à grande échelle.

Objectifs : Effectuer une analyse critique de la littérature sur la Région, identifier les lacunes et suggérer les domaines nécessitant une attention particulière de la part des chercheurs et des responsables politiques.

Méthodes : Une recherche de la littérature publiée dans Medline et Popline a été effectuée dans le domaine de la santé et des migrations. Celle-ci se concentrait principalement sur les éléments constitutifs des systèmes de santé de l'OMS, sans limitation de date ni de langue.

Résultats : Sur 4679 articles récupérés, publiés entre 1964 et janvier 2019, 140 répondaient à nos critères d'inclusion ; 45 articles supplémentaires ont été inclus lors d'une mise à jour en décembre 2020. La plupart des publications portaient sur les réfugiés et la prestation de services.

Conclusion : Peu d'études examinaient la réactivité du système de santé face aux réfugiés et aux migrants, comparativement à celles menées pour les communautés d'accueil, ou évaluaient la qualité des services, ou encore s'intéressaient à la perception des réfugiés/migrants à l'égard des services de santé disponibles. Peu d'études suggéraient de nouvelles approches pour financer l'accès de ces populations aux soins de santé, ou de nouveaux mécanismes de gouvernance.

اعتبارات النظام الصحي المتعلقة بالنزوح الطوعي والقسري في إقليم شرق المتوسط: تحليل نقدي للمؤلفات المتاحة

إيمان شرارة، شذى عقيق، ميكايلا مارتيني، جوسيلين ديونج

الخلاصة

الخلفية: يحفل تاريخ إقليم شرق المتوسط لمنظمة الصحة العالمية بأنماط هجرة مُعقَّدة، ذات مستويات عالية من الهجرة من الإقليم وإليه وداخله، بالإضافة إلى النزوح القسري الهائل الذي حدث مؤخرًا. ولا يُعرف سوى القليل نسبيًّا عن استجابة النظم الصحية لهذه التنقلات الواسعة النطاق.

الأهداف: هدفت هذه الدراسة إلى استعراض المؤلفات المنشورة بشأن الإقليم استعراضًا نقديًا، وتحديد الثغرات، واقتراح المجالات التي تحتاج إلى اهتمام على صعيد البحوث والسياسات.

طرق البحث: أُجْري بحث في المؤلفات المنشورة باستخدام قاعدة بيانات مدلاين وقاعدة بيانات بوبلاين بشأن الصحة والهجرة مع التركيز على اللبنات الأساسية لِلنظام الصحي لمنظمة الصحة العالمية دون تحديد تاريخ أو لغة.

النتائج: من بين 4679 مقالة نُشرت بين عامي 1964 ويناير/ كانون الثاني 2019، استوفت 140 منها معايير الإدراج التي وضعناها؛ وأُدرِجت 45 مقالة إضافية في تحديث خلال ديسمبر/ كانون الأول 2020. وركّزت معظم المنشورات على اللاجئين، وعلى تقديم الخدمات.

الاستنتاجات: استكشفت دراسات قليلة مدى استجابة النظام الصحي للاجئين والمهاجرين مقارنةً بالمجتمعات المضيفة، أو قيّمت جودة الخدمات، أو تصوّرات اللاجئين والمهاجرين حول الخدمات الصحية المتاحة. واقترح عددٌ قليلٌ من الدراسات نُهُجًا جديدةً لتمويل إتاحة الرعاية الصحية لهؤلاء السكان، أو ترتيبات جديدة للحوكمة.

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