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Migration and Refugee Health Disparities

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ABSTRACT

Migration and refugee health disparities reflect persistent global inequities in access to healthcare, mental well-being, and social protection. This paper examines the complex interconnections between migration processes and health outcomes, emphasizing social, economic, and structural determinants that shape the lived realities of migrants and refugees across different contexts. Using conceptual frameworks from public health and social determinants of health, the discussion highlights the demographic and epidemiological profiles of migrant and refugee populations, underscoring the scarcity and heterogeneity of available data. The paper identifies how factors such as socioeconomic status, legal documentation, employment, stigma, and discriminatory policies exacerbate health inequities. Moreover, the analysis explores barriers and facilitators to healthcare access, with particular focus on mental health challenges, communicable and non-communicable diseases, and maternal and child health disparities. Policy dimensions, including international cooperation, legal rights, and universal health coverage, are discussed as crucial levers for mitigating disparities. Persistent research gaps and ethical concerns in data collection hinder a comprehensive understanding and response. Practical interventions, including community-based care models, hybrid academic-community health centers, and cross-sectoral collaborations, are proposed as strategies for equitable health outcomes. The findings reinforce the need for sustained global action, improved data systems, and migrant-sensitive public health planning to promote inclusion, resilience, and universal health equity.

Keywords: Migration; Refugee Health; Health Disparities; Social Determinants of Health; and Universal Health Coverage.

INTRODUCTION

Migration and refugee health disparities reflect pervasive inequities in physical and mental well-being across international borders [1]. Migration, the temporary or permanent relocation of individuals across geopolitical state boundaries, has historically facilitated the transfer of goods, services, technology, and knowledge, contributing to development and building resilience against climate change [4]. The overwhelming increase in the rate of migration to advanced economies, however, has drawn heightened scrutiny to the pressures that climate change and rapid population growth exert on low-income countries and to the multifaceted structural, social, and economic vulnerabilities that individuals from these countries often confront upon relocation [3]. Political refugees undertake flight from war or natural disaster, primarily to escape armed conflicts and persecution, and remarkably diverse pathways influence the health and well-being of such populations during transit and upon arrival in host countries [1]. Yet comparatively little research examines the health aspects of migration, and even less addresses the liability of migrants to adverse health outcomes at any stage of movement [2].

Conceptual Frameworks for Understanding Health Disparities in Migration

Migration constitutes a significant social determinant of health because it influences individual exposure to risk factors, access to services, and relevant policy context [1]. Migration health research examines how movement and displacement impact health status and conditions, and how health considerations affect decisions to migrate. Migration may contribute to health disparities through direct or indirect pathways [7]. Such disparities are

closely linked to social determinants, such as socioeconomic status, education, gender, physical environment, and social and community networks, which are unevenly distributed across populations and geographic locations [3]. These disparities shape and are modified by the specific arrangements and characteristics of migration [1].

Demographic and Epidemiological Profiles of Migrant and Refugee Populations

Migrant and refugee populations exhibit diverse demographic and epidemiological profiles shaped by income, inequality, demographic transitions, environmental changes, and exposure to violence and conflict [4]. In 2019, an estimated 272 million international migrants resided in 166 countries, comprising 3.5% of the global population. Approximately 27 million were refugees, with half under 18 years [5]. These figures have been exacerbated by the COVID-19 pandemic, which has heightened socio-economic vulnerabilities and often led to internal displacement.

Migrant populations typically have younger age structures than their host countries, thereby disproportionately influencing the demography of ageing societies [5]. Among migrants, young adults comprise the largest group, followed by children aged 0 to 14 years. Refugee populations, by contrast, have older age distributions than non-refugee migrants, stemming from large-scale outflows fostered by protracted conflicts [1]. Data on the prevalence and incidence of diseases in migrant and refugee populations remain scarce and heterogeneous. Most estimates pertain to migrants and refugees at national or regional levels, with limited disaggregation by specific origin or destination countries [4].

Determinants of Health Disparities: Social, Economic, and Structural Factors

Health outcomes reflect the influence of various social, economic, and structural factors on the determinants of migration and refugee health [8]. The degree of social inclusion enables research, education, financial stability, and hazard proximity, contributing to the occurrence of both physical and psychological disorders [6]. As a specific aspect of socioeconomic status, educational attainment improves economic participation and facilitates access to various goods and services. Beyond individual knowledge, access to social networks supports information gathering on health issues, such as nutrition, physical activity, and substance use [7]. Employment enhances both financial and social capital, as employment creates and maintains social ties, which contribute to resilience and hazard mitigation [6]. Policies to enhance employed worker security and promote unemployed job market reintegration may support migrant economic activity and facilitate health. Meeting linguistic and cultural requirements exerts a strong influence over settlement patterns and service utilization, while paperwork documentation status directly affects housing, employment, and full-service access. Legal status associated with either short- or long-term residency constitutes a key factor in the migration process and shapes physical, emotional, or social hazard exposure [4]. Rather than simply a functional issue, stigma emerges as a potent factor influencing satisfaction and compliance. While stigma factors are universal, vulnerable groups experience unique levels of exposure that affect health service accessibility [3]. Employment and housing represent both fundamental requirements and major barriers for migrants. Moreover, discriminatory policies and practices act as obstacles to migrant progress, aggravating health burdens and disease transmission [2].

Access to Healthcare: Barriers and Facilitators for Migrants and Refugees

Health policies for migrants and refugees are often framed broadly at the system level and can lack a detailed focus on the individual and family-level barriers and facilitators that influence access to services [5]. Health system entitlement policies, eligibility criteria, and documentation requirements vary significantly from one country to another and often across regions within the same country, influencing the nature and extent of entitlements and access for migrants and refugees[3]. For example, in urban settings with high migrant inflows, navigating access to health services can be particularly complex. Other access-related factors include affordability, transportation, cultural competency of services, and trust in health-care providers, as well as the availability of interpretation services and culturally appropriate care [8]. Pervasive fear of deportation or expulsion, lack of information to understand their entitlements, and uncertainty over the status of their applications can inhibit migrants and refugees even in countries where legal and policy frameworks provide entitlement [7]. These considerations highlight the interplay of policies or legislation at a higher spatial scale with service availability and the actual experience of individuals or families on the ground, further complicated by the diversity of the migrant and refugee population [6]. Thus, the focus on migrants and refugees as distinct social groups is particularly relevant, alongside consideration of the specific migration route followed and the resulting entry category and administrative procedures [2].

Mental Health Outcomes and Resilience in Migrant and Refugee Populations

Migrant and refugee populations experience varied mental health outcomes. Refugees suffer trauma related to loss, exposure to violence, and displacement [12]. Unaccompanied minors and people under temporary protection encounter additional levels of vulnerability. Variability also arises from national contexts, in relation to social integration and economic recovery. Refugees undergo profoundly disruptive life events, loss of family, home, assets, jobs, and identity, leading to higher rates of post-traumatic stress disorder (PTSD), anxiety, and depression

than the general population [3]. Prevalence estimates of trauma-related disorders in refugee populations range from 5% to 86%. Community resilience and social connectedness emerged as protective factors [7]. Mental ill-health leads to reduced social integration, economic participation, adverse birth outcomes, and neglect, with intergenerational risk. Visibly injured refugees face increased stigma and social isolation, limiting access to support [6]. Access to screening and treatment remains a barrier even in low-prevalence countries [9]. Socioeconomic conditions, political context, and the process of migration influence refugee mental health. In countries that restrict the movement of asylum seekers, anxiety and depressive symptoms of incompatibility with the host country increase [10]. Experiences of captivity and trauma during migration enhance difficulties with re-adaptation in the host country. Historical legacies of racism or discrimination contribute to poor legal status, housing insecurity, and risk of homelessness, which exacerbate mental ill-health. Data on screening, treatment, and barriers remain scarce [11].

Non-Communicable and Communicable Diseases in Migrant and Refugee Health

While some populations experience an increase in non-communicable diseases following migration, possible mechanisms are unclear, and refugees and asylum seekers can have elevated rates of conditions such as tuberculosis and sexually transmitted infections [11]. Factors influencing these disparities include health status at departure, exposure to health risks during transit, and integration support in destination countries [4]. Access to healthcare influences the prevalence and care of communicable and non-communicable diseases following migration [13]. Refugees often remain in transitional housing and temporary accommodation for long periods, contributing to the spread of measles, rubella, and tuberculosis [7]. Refugee-specific barriers to preventive healthcare, such as difficult access to antenatal and postnatal services, can lead to increased risk of perinatal complications. Post–World War II international policies have emphasized the health rights of refugees, asylum seekers, internally displaced persons, and returnees [16]. In 2015, the WHO reiterated its longstanding commitment to global health legislation, emphasizing the health rights of migrant populations and harmonizing national policies to protect these rights. Acknowledging the continuous movement of people, the UN High Commissioner for Refugees (UNHCR) and the Norwegian Institute of Public Health have called for a reexamination of the health rights of mobile populations [5].

Maternal and Child Health in Migration Contexts

Maternal and child health disparities among migrants have profound societal implications on both a short- and long-term basis [10]. Migration has been correlated with adverse reproductive and child health consequences in certain settings, such as low antenatal care visit coverage and poor neonatal outcomes, including preterm or low birthweight delivery [12]. Differences in maternal and child health indicators persist even when key determinants of health are controlled. Parental migration can also modify child health indicators significantly. Intra-household health-behaviour adjustments, social networks, and groups vary, which gives rise to new health determinants that affect the children of migrants differently compared to those of non-migrants [13].

Health Policy, Legal Rights, and International Cooperation

The interrelationship of health policy, legal rights, and international cooperation forms a significant angle in the analysis of migrant health issues [12]. The work of the World Health Organization (WHO) emphasizes the link between universal health coverage and health and progress on the continuum from access to health services to health system strengthening [11]. The WHO's framework for refugee health includes legal rights, international cooperation, and both communication technologies and mental health [14]. Similarly, a conceptual model reinforces the interdependence of national legal policies and international legal commitments and illustrates pathways through which communication technology improves well-being [1].

Data Gaps, Methods, and Ethical Considerations in Migration Health Research

Migration health research remains underfunded and has substantial gaps that hinder an understanding of closely related health disparities [10]. Compared to other population groups, migrants and refugees are hardly studied as vulnerable groups and receive little empirical, nationally representative attention [12]. Efforts to address migration-related knowledge gaps are constrained by a lack of harmonization in terminology and indicators. Tracking population health estimates over time is impossible due to the infrequent collection of basic data [13]. Data from hard-to-reach populations, such as those lacking documentation or recent arrivals, are rarely available, giving the impression that certain groups do not exist. Such coverage issues compound difficulties of unscientific and politicized framing of migrants and migration [1]. The frameworks and concerns surrounding migration health research remain captured by the ethical implications associated with data collection. Collecting migration-related data poses additional ethical questions of confidentiality and how to use the information. Politics and a desire to prevent stigmatization can limit both the collection of and access to data on migration. Solid ethical frameworks are therefore necessary to guide migration-related research [15].

Practical Interventions and Best Practices for Reducing Disparities

A health disparity remains a global health challenge, as one of the world's largest movements of people, including long-distance migrants and displaced persons, continues. Despite international efforts to reintegrate health concerns into the migration agenda, the health consequences of these population movements remain inadequately understood and insufficiently addressed [16]. A lack of disaggregation by migrant status and other characteristic differences persists in existing literature; retention of a life-course perspective is imperative, with a focus on temporal vulnerabilities, contingent trajectories, and the coalescence of determinants and factors across time and distinct steps in the migration journey [5]. Data corroborates immense population flows, expansive risk exposure, and, in many contexts, greater vulnerability; a strong emphasis on universal access implicitly framed as a universal healthcare, social protection, and development challenge is vital. Community-based, transdisciplinary interventions and collaboration among research, practice, policy, and education partners in different sectors create opportunities to reduce disparities and support healthy integration [3]. In urgent settings where conventional services cannot meet pressing needs, the establishment of mobile units and hybrid community-academic centers can ameliorate risk exposure; partnerships with schools to provide preventive and therapeutic services also address needs-specific entry points, particularly for youth [15]. Priority evidence-based measures include community-based care models for early-stage migrants; outreach and service navigator programs assist with resettlement, service selection, and habitual use, while flexible delivery, intensive services, and technology augmentation help structure care [12]. Effective interventions acknowledge diverse migration contexts; encounter temporal vulnerability, cohort variation, and the formative influence of exposure situations; and attend to care entry points that accelerate health-seeking and continuity [11]. Extensive supplementary factors discourage entry along migration trajectories, intervene extensively across the resettlement life cycle, and require customization even for similar migrant types. Widespread risk exposure is recognised, early health and clinic attendance improve, and community-academic health centers providing universal health cover and services for irregular migrants facilitate access. Research and experience cover additional sectors beyond health, encouraging intersectoral engagement; assistive interventions incorporate services outside the immediate focus. Broad heterogeneity among predefined migrant types and background circumstances limits uniform applicability or fit, posing challenges for larger, multi-centre trainee-community collaborations [12]. Progress remains insufficient against the background demand, even along promising new sectoral pathways; availability of effective, generalized intervention across key topics remains scarce and constitutes a further obstacle. Community-engaged, practice-oriented research, collaboration across relevant sectors, participation of junior personnel, co-development, phased longitudinal designs, data-science methods, and centre-specific problem-oriented engagements represent important opportunities for further involvement [13].

Implications for Health Systems and Public Health Planning

Migrants and refugees face diverse challenges to health systems and public health planning. Migration crises prompt large-scale population movements within and across countries, exacerbating existing vulnerabilities and creating new health challenges across the life course [14]. Refugees may have to navigate a range of health systems, if at all during their journeys; those who eventually settle in new countries confront integration into a national system that may not recognize their particular health care needs. Many migrants and refugees find themselves at the intersection of multiple crises that profoundly affect their health; yet, such issues receive insufficient attention in service provision and policy deliberation [17-20]. The public health needs of refugees and migrants vary considerably across geographical regions and population subgroups [15]. These variations occur not only with respect to macro determinants, such as the environment or the socioeconomic situation of the origin country, but also the type of displacement, whether internal, cross-border, or resettlement for long-term stay [16]. Public health planning, therefore, should consider the specific population under question during the initial evaluation framework, situating supply and access to services within the context of a health systems framework [21-23].

CONCLUSIONS

Migration and refugee health disparities constitute one of the most pressing public health challenges of the 21st century. The intersection of socioeconomic, structural, and policy determinants profoundly influences the health trajectories of displaced populations. Migrants and refugees often experience compounded vulnerabilities arising from pre-migration conditions, perilous transit journeys, and systemic inequities in host countries. Despite international recognition of the right to health for all, fragmented legal frameworks, restrictive immigration policies, and inconsistent entitlement provisions continue to impede access to quality healthcare and essential social services. Addressing these disparities requires a paradigm shift that integrates migration within the broader agenda of universal health coverage and sustainable development. Strengthening intersectoral collaboration between health, legal, and social protection systems is critical for ensuring that migrants and refugees are not

excluded from national health strategies. Community-driven, evidence-based interventions including mobile health units, culturally responsive care, and multilingual service delivery represent promising models for overcoming barriers. In addition, the collection of disaggregated, ethically sound data is vital for designing responsive and inclusive health policies. Ultimately, achieving health equity for migrants and refugees demands not only technical solutions but also political will and global solidarity. Prioritizing equity in health system design, expanding international cooperation, and embedding migration considerations in public health planning will ensure that mobile populations are protected, resilient, and fully integrated into the pursuit of global health for all.

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