



**Migration  
and Health:**  
Addressing Current  
Health Challenges  
of Migrants and  
Refugees in Africa  
- from Policy to  
Practice

**Final Report**

Commissioned by



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Description: Tanzania: Social marketing of condoms and other family planning supplies, information on HIV and HIV in the Work Place Programs by staff members of Community Health Funds.

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## Executive Summary and recommendations

This report presents findings from a study on migration and health in Africa commissioned by the African Union Commission (AUC) to generate evidence after launching a new thematic area on migration and health in 2020. This mixed methodology study of migration and health in Africa was ambitious in scope and breadth and collected interesting primary and secondary data relevant to understanding migrants' health better in different African contexts and the migration and health nexus more broadly.

**Keywords:** migration, health, Africa, African Union, refugees, regular migrants, irregular migrants, health policy, migration policy, health systems

### Problem Statement

As in other world regions, migration within Africa is projected to increase by 2050 because of urbanisation, economic growth, and climate change (IOM 2008, Teye 2018, and Migali and Münz 2018). Migration has potential health implications for migrants and health systems in origin, transit, and settlement countries. Migrants and refugees can be both victims and vectors of health risks, especially as a result of difficult migration journeys, and often face multiple barriers to accessing appropriate health care in settlement countries (WHO 2018f).

The AUC and its MS are committed to developing the health and the wealth of its populations, as set out in the AU's Agenda 2063 Strategy (AUC 2013). Managing migration flows effectively, and harnessing the contributions that migration makes to African economies, will be a key priority in the coming decades for African policymakers. However, health and migration policies (and therefore services and programmes) have often operated in silos, with insufficient regard for the need to consider the linkages between migration and health (WHO 2019).

Moreover, these challenges are exacerbated by a lack of data on migrant health and a lack of information about the degree of policy coherence (or otherwise) between health and migration policy frameworks at the continental, regional, and Member State levels (IOM, 2020a). Much of the research on this topic focussed on migration and health either at the continental and regional levels, or at the national or local levels. (c.f. Abebe 2017, Maru 2019, Sweilah et al 2018).

The AUC has identified migration and health as one of the cross-cutting issues in the 2018 Migration Policy Framework for Africa (MPFA). The current COVID-19 global pandemic has further highlighted the salience and urgency of these issues. To establish a programme and develop a continental approach towards the nexus of migration and health, the AU has defined priorities for research to first and foremost close knowledge gaps.

This study aimed to address some of these gaps by surveying migration and health policy and practice at the continental, regional, and national levels. This was complemented and enriched by primary data collection in Kenya, Nigeria, and South Africa from migrants and refugees, health workers, as well as AU, regional, and national officials and UN agency staff.

### Study components

A scoping study was conducted in 2020 as part of this research that aimed to map out relevant policy frameworks and key challenges regarding the migration and health nexus on the African continent (SLE 2021). A total of 575 policy documents and 508 scientific and other publications were reviewed, and pertinent secondary data was extracted from official government sources, UN-agency reports from fifteen African Union Member States (AU MS).<sup>2</sup>

This identified both significant gaps in the academic literature in relation to migrants' health and a lack of policy coherence between migration and health. Most previous relevant studies identified focussed on the international and continental levels or at the local level in a given African country or region.

The scoping study results provide information about which aspects should be subject to further analysis on a country- and region-specific basis in the analytical study. Five countries, each representing a different African

2. Mauritania, Morocco, and Tunisia for North Africa; Kenya, Sudan, and Uganda in East Africa; Angola, Botswana, and South Africa in Southern Africa; Cameroon, the Democratic Republic of Congo (DR Congo), and Gabon in Central Africa; and Nigeria, Senegal, and The Gambia in West Africa.

region, were included in this phase of the research: DR Congo, Morocco, Kenya, Nigeria, and South Africa, with in-depth study and primary data collection in the latter three countries.

In order to assess the needs of different sub-groups of migrants, the situation of people in refugee-like situations was assessed in Kenya, while the focus in Nigeria was on regular (labour) migrants and irregular migrants in South Africa.

Partner researchers based in Kenya, Nigeria and South Africa deployed survey questionnaires (in online and offline settings) and conducted semi-structured Key Informant Interviews and focus group discussions with migrants, health service providers, and government officials. A total of 965 eligible questionnaires were completed (Kenya n = 300, Nigeria n = 355, and South Africa n = 310), as well as 33 key informant interviews and five focus group discussions (n = 25). A further 10 interviews with continental and regional expert stakeholders were also conducted. In addition, for DR Congo and Morocco, extended desk reviews were conducted, supplemented with a small number of expert stakeholder interviews.

## Study Limitations

The limitations of time and other resources, combined with the challenges of conducting remote research during the current pandemic, will have affected the results generated. The selection of research sites was restricted to major urban centres, and so the needs of the most vulnerable migrant groups - people in refugee-like situations and internally displaced persons (IDPs) in remote or border area locations - could not be surveyed as part of primary data collection. In each of the study's research sites, the ability to collect data from respondents was significantly curtailed by public health restrictions in place.

Moreover, migration (especially irregular migration) can be a sensitive topic, and it proved challenging to secure respondents for the study. Building up trust is much harder within virtual settings. Migrants themselves who participated in the study were, in some cases, reluctant to speak to the researchers, either because of concerns about their legal status or other factors. This also reflects the charged nature of public and media discourses on migration found in many countries.

## Key Study findings

The scoping study showed the extent to which migrants' health care is addressed in policy frameworks varies significantly across countries in Africa. While policy instruments specifically targeting migrants' health provision were found to be limited, in the majority of cases, national constitutions and existing policy documents governing migration included a section on health.

On the other hand, health policies often did not address migrants directly but rather used more generic terms such as "all persons," while some health-related documents classified migrants and refugees as part of vulnerable groups in need of special attention. This lack of policy coherence underscores significant gaps between migration and health policy frameworks and also affects implementation. From a regional perspective, the Economic Community of West African States (ECOWAS) and the East African Community (EAC) regions arguably displayed the most integrated and coherent policy approaches.

## Data availability

The study also identified a dearth of systematic data collection and monitoring on migrants' health in AU MS, and one recommendation to the AUC, AU MS, and their international partners is to encourage greater investment in more systematic monitoring of migrants' health to improve policymaking and programming to migrant groups.

## Motivations to migrate

Results from the primary data collection countries showed that the most common reasons for migrants to leave their country of origin included improving their economic situation, family reunification, and difficult situations in the home country (especially in the case of the Kenyan respondents who were refugees or people in refugee-like situations). Across all 3 countries, the majority of respondents reported having lived in their current country of residence for at least 1-2 years, many even more than 5 years.

## Migrants' health needs

Migrants can face distinct health needs according to their legal status and migration journeys. The scoping study identified numerous challenges in relation to the provision of health services to migrants, including weak health systems, inequality of access, lack of health and WASH (water, sanitation, and hygiene) facilities, especially in remote locations, and insufficient health screening.

Many of these challenges were borne out in the survey data from the three study countries. Still, at the same time, it is interesting to note that respondents generally rated the availability, accessibility, and quality of health services available quite highly. Primary data collected further suggests there may be several factors behind this disparity.

Firstly, all three research sites were in urban centres where there is a higher density of available health services than in rural or remote areas. Secondly, perceptions of quality (and, to a lesser extent, accessibility) are relative. Many migrants in the three countries have moved from regions and countries of origin where the availability and quality of health services are typically lower.

## Migrants' health, social coverage, and the importance of livelihoods

Crucially, most of the migrants surveyed in all three countries enjoyed at least some access to health services because they either had legal status (even if only in the form of temporary documents) in Kenya and Nigeria, or because in the South African context, irregular migrants are able to access some health services. A majority of respondents, therefore, enjoyed a degree of social coverage.

In Nigeria and Kenya, accessibility of health services to migrants was also linked to affordability; in Nigeria, several respondents reported they would rather pay more to access health services that were nearer or more convenient, as it was more time- and cost-efficient for them. In Kenya, most of those surveyed had accessed public health services and reported improved health since they arrived in the country.

Moreover, most respondents in all three countries reported broadly good health. This is likely to be attributable to the 'healthy migrant effect' and people's legal and employment status. Across all three countries, the majority of respondents were either employed or self-employed, which meant they were allowed to access and could afford to access (some) health care (18 % of the sample were unemployed). This is not necessarily the case for different migrant groups in other African countries. Still, it does suggest that broadening social coverage supports improved health outcomes for migrants in all categories. This also shows the importance of employment and livelihoods in maintaining and improving health.

## Barriers to accessing health services

Respondents in all three primary data collection countries also reported barriers in accessing services. Language barriers were the most commonly cited, which could hinder access to services as well as consultation and treatment. Lack of awareness of the local system or of where to get help was also a common challenge. In South Africa, some respondents reported they were (illegally) asked for payment unless they had documents.

Respondents in all three countries also reported experiencing stigma, xenophobia, or discrimination in accessing health services as migrants. Whilst this sadly reflects common negative views and stereotypes about migrants found in many African states, this also acts as a barrier to accessing health services and treatment.

## Securitisation of Migration

Another concern raised by expert stakeholders was the securitisation of migration, which can be observed in countries further securitising their borders. For example, migrants are perceived as potential security threats and potential diseases vectors from one country to another. At the same, such narratives can lead to continued stigmatisation of migrants as transmitters of disease, thereby fuelling xenophobic sentiments already shared among some communities.

## Retention of skilled health workers

The need for trained and specialised staff to deliver health services is at an unprecedented high, especially in times of a global health crisis, and brain drain is a challenge facing many, if not most, health systems in Africa. To counteract high emigration levels of skilled health personnel emigration, coordinated approaches to adequately respond to such recruitment drivers should be adopted, including bilateral training agreements for health workers, as well as the expansion inter-African skilled migration schemes and South-South cooperation schemes.

## Migration, pandemic preparedness, and COVID-19

The study also revealed that migrant health was frequently omitted in pandemic preparedness planning at the AU MS level, although guidance issued by the Africa Centres for Disease Control and Prevention (Africa CDC) and other bodies noted that migrant groups should be subjects of concern. This is problematic as human mobility can be an important factor in disease transmission.

Kenya, Morocco, Nigeria, and South Africa all have relatively strong health systems compared to their neighbours, and all four countries include migrants in their pandemic preparedness planning, but this is far from universal in Africa. The ability to identify infections early is thus imperative, and enhanced health screening at border crossing points, and stronger infectious disease surveillance in cross-border and remote areas will be important in this regard. Nigeria has earned a good reputation for its efforts in enhancing health screening and disease surveillance systems. However, respondents included several recently arrived people who had not undergone any health screening, suggesting that these systems need to be strengthened further.

A high proportion of respondents in all three countries, over 66 %, reported that they were concerned about infection or transmission of COVID-19. This is significant, as it indicates a high degree of awareness of the current pandemic and its risks. This also suggests that they may be receptive to health promotion campaigns encouraging behaviour change as well as practical advice on how to protect themselves.

## Generic health care vis-a-vis the migrant specific provision

Migrant respondents across all three study countries reported a preference for migrant specific provision, while some officials and regional experts suggested the opposite, arguing that mainstreaming and widening access for migrants to more (non-migrant-specific) health services was the only sustainable way forward.

Potential solutions may include making mainstream health services as accessible and 'migrant friendly' as possible for migrant groups with specific health needs that would otherwise go unmet, such as refugees and IDPs, through a combination of training, guidance for staff, and the provision of specialist services

## Key Recommendations

Based on the findings of the scoping study and analytical study phases of this project, the research team makes the following recommendations for further action:

Increasing Social coverage for regular migrants	Term	Actors
<p>Although regular / labour migrants' resident in AU Member States may in principle be able to access health services like nationals, in practice they may not have the same equality / equity of access to health services as other groups. Potential measures to help address this include:</p> <ul style="list-style-type: none"> <li>Governments in AU MS should work with the private sector to reduce eligibility criteria for social insurance or social coverage (e.g., duration of residence, minimum amounts to be paid in) to enable more migrants to access social insurance and health care</li> </ul>	Short	MS

Health of refugees	Term	Actors
Potential measures to help address the ongoing health challenges associated with this group include:		
<ul style="list-style-type: none"> <li>Governments and humanitarian partners should allocate increased resources to enhance capacity of health and WASH services in camps and provision of medical supplies and protective equipment</li> </ul>	Short	MS, humanitarian partners
<ul style="list-style-type: none"> <li>Health authorities and humanitarian agencies should invest in health screening capacity in camps and settlements, as well as at border crossing points</li> </ul>	Short to medium	MS, humanitarian partners
Health of irregular migrants	Term	Actors
Potential solutions to help overcome the specific challenges faced by this group include:		
<ul style="list-style-type: none"> <li>Governments should consider implementing temporary registration schemes &amp; amnesties for irregular migrants at high risk of transmission to increase access to health services and screening, especially during the current COVID-19 pandemic</li> </ul>	Short	MS
<ul style="list-style-type: none"> <li>Enabling digital applications for registration and/or updating of documents for legal migration processes, especially during the current pandemic with the shutdown of some government offices, would improve access to health services for migrants and enable greater social coverage</li> </ul>	Short to medium	MS, AUC
<ul style="list-style-type: none"> <li>Greater coordination of health care is needed between public, private, and civil society providers to ensure better health coverage for migrants and refugees by developing crosscutting thematic programmes</li> </ul>	Medium	MS, AUC, RECs, internat. orgs, health providers
<ul style="list-style-type: none"> <li>Governments should consider developing health policies that move beyond social coverage to providing minimum 'social floors' to the population as a whole</li> </ul>	Medium to long	MS
Better data on migrants' health	Term	Actors
<ul style="list-style-type: none"> <li>The AU should consider developing specialised guidance for AU MS on adopting a systematic approach and common indicators to collect, analyse, and share data on migrant migrants' health</li> </ul>	Medium	AU, RECs
<ul style="list-style-type: none"> <li>Governments and international partners should consider investing in building capacity in AU MS for improved data collection, especially at the local level, to collect more and better-quality data on migrants' health</li> </ul>	Medium	AU, MS
<ul style="list-style-type: none"> <li>RECs also play an important role in developing and issuing region-specific guidance on data collection on migrant health</li> </ul>	Medium	RECs
<ul style="list-style-type: none"> <li>Research bodies at the national and international levels should be encouraged to support longer-term research on migrants' health in AU MS, in partnership with African research institutions and the diaspora, to improve the available evidence base for policy making and health programming</li> </ul>	Medium	MS, AU
<ul style="list-style-type: none"> <li>New methods should be applied to forecasts migration flows on various variables of countries, an open-source project by the Danish refugee council of this has predictions that COVID-19 will cause over 1 m more migrants from Nigeria, Mali, and Burkina Faso (Nair et al., 2020)</li> </ul>	Medium	MS, AU
<ul style="list-style-type: none"> <li>Gender-disaggregated data is needed to create evidenced based interventions to better target the specific health needs of female migrants</li> </ul>	Medium	MS, AU

Cross-border infectious disease surveillance	Term	Actors
<ul style="list-style-type: none"> <li>Existing models of good practice in cross-border disease surveillance in East and Southern Africa, such as use of mobile technology in partnership with local communities in border and rural areas to monitor disease outbreaks, should be replicated in other regions of the continent (see Annex II)</li> </ul>	Short to medium	MS, RECs
<ul style="list-style-type: none"> <li>The capacity of existing infectious disease surveillance networks should be enhanced to help identify disease outbreaks early in remote or cross-border areas associated with mobile populations of people and animals (nomads and their flocks, refugees, IDPs)</li> </ul>	Medium	MS, RECs, AU
Integration of health care for migrants	Term	Actors
<ul style="list-style-type: none"> <li>Governments should consider developing more integrated health care for migrants together with nationals, as this promises to improve health care for migrants as well as the broader populations among which they live. These synergies can also attract more activities and support from the international community who has seen positive effects from an integrated approach</li> </ul>	Medium to long	MS
Economic participation of migrants	Term	Actors
<ul style="list-style-type: none"> <li>Economically active and self-sufficient migrants are better able to contribute to the social (and health) system of their host countries. If their economic activities are restricted, they can increasingly become a burden for destination and transit countries. These will need to find the right balance between creating decent, sustainable jobs for their own growing populations, and enabling migrants to take up employment opportunities</li> </ul>	Long	MS, AU
Increasing numbers and skills of health professionals	Term	Actors
<ul style="list-style-type: none"> <li>Out-migration of health professionals and trained staff is problematic internationally, and there is a need for stronger coordination between AU MS to prevent unfair recruitment of important trained health workers and ensure ethical recruitment practices</li> </ul>	Short to medium	MS, RECs, AU
<ul style="list-style-type: none"> <li>AU MS and international partners should consider incentivising health professionals to work in rural or remote areas to address shortages in such areas (e.g., staff rotation schemes, higher salaries, support for professionals and families as in transport/communication/housing etc), as well as extension of mobile and health outreach services</li> </ul>	Medium	MS, internat. partners
<ul style="list-style-type: none"> <li>Improved South-South cooperation in training of professionals, and use of bi-lateral health workforce agreements between AU MS and others to promote circular return would also help reduce unsustainable 'brain drain' of skilled health professionals out of the continent</li> </ul>	Long	MS, RECs, AU

Specific recommendations for protecting migrants' health during the COVID-19 pandemic (see also Annex III)	Term	Actors
<ul style="list-style-type: none"> <li>• Governments and humanitarian partners should allocate increased resources to enhance capacity of health and WASH services in camps and provision of medical supplies and protective equipment</li> </ul>	Short	MS, humanitarian agencies, international partners
<ul style="list-style-type: none"> <li>• Targeted health promotion campaigns should be implemented with practical advice on minimising risks of infection and transmission</li> </ul>	Short to medium	MS, RECs, AU
<ul style="list-style-type: none"> <li>• The vulnerabilities of migrant workers in specific high-risk roles (for example health and social care workers) should be taken into account in planning vaccination campaigns</li> </ul>	Short to medium	MS, RECs, AU
<ul style="list-style-type: none"> <li>• Enhanced health screening at borders and crossing points, as well as in refugee settlements and reception centres, such as use of temperature checks and other measures, can help identify infectious persons and reduce transmission</li> </ul>	Short to medium	MS, UN agencies

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## Abbreviations

<b>AfDB</b>	African Development Bank
<b>AFSIM</b>	Association of Sub-Saharan Immigrant Women in Morocco (French: Association des Femmes subsahariennes immigrantes au Maroc)
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>AMO</b>	Compulsory Health Insurance in Morocco (French: Assurance Maladie Obligatoire)
<b>AMU</b>	Arab-Maghreb Union
<b>AU</b>	African Union
<b>AUC</b>	African Union Commission
<b>AU-CIDO</b>	African Union Citizens and Diaspora Directorate
<b>CAR</b>	Central African Republic
<b>CDC</b>	Centre for Disease Control
<b>CEN-SAD</b>	Community of Sahel-Saharan States
<b>CHV</b>	Community Health Workers
<b>COFESVIM</b>	Committee of Sub-Saharan Women and Children Victims of Immigration in Morocco (fr.: Comité des femmes et enfants victimes de l'immigration)
<b>COMESA</b>	Common Market for Eastern and Southern Africa
<b>COVID-19</b>	Coronavirus Disease Caused by SARS CoV2 Virus
<b>CRF</b>	Crisis Response Facility
<b>CSO</b>	Civil Society Organisation
<b>DALY</b>	Disability-Adjusted Life Year
<b>DRC</b>	Democratic Republic of the Congo
<b>EAC</b>	East African Community
<b>EC</b>	European Commission
<b>ECCAS</b>	Economic Community of Central African States
<b>ECOWAS</b>	Economic Community of West African States
<b>ECWC</b>	Eastleigh Community Wellness Centre
<b>ENSP</b>	Morocco's National School of Public Health (fr. Ecole Nationale de Santé Publique)
<b>FGD</b>	Focus Group Discussion
<b>GBV</b>	Gender-based Violence
<b>GDP</b>	Gross Domestic Product
<b>GC-R</b>	Global Compact on Refugees
<b>GC-SORM</b>	Global Compact for Safe, Orderly, and Regular Migration
<b>GHSA</b>	Global Health Security Agenda
<b>GIFSHIP</b>	Group Individual and Family Social Health Insurance Programme initiated by the Nigerian National Health Insurance Scheme
<b>GIZ</b>	German Corporation for International Cooperation GmbH (German: Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH)
<b>HDI</b>	Human Development Index

<b>HIV</b>	Human Immunodeficiency Virus
<b>ID</b>	Identity Document
<b>IDP</b>	Internally Displaced Person
<b>IGAD</b>	Intergovernmental Authority on Development
<b>ILO</b>	International Labour Organization
<b>IOM</b>	International Organization for Migration
<b>JEE</b>	Joint External Evaluation
<b>JLMP</b>	Joint Labour Migration Programme
<b>KII</b>	Key Informant Interview
<b>LMAC</b>	AU Labour Migration Advisory Committee
<b>MAIHDA</b>	Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy
<b>MHAC</b>	Migration Health Assessment Centre
<b>MGI</b>	Migration Governance Indicators
<b>MiGOF</b>	Migration Governance Framework
<b>MPFA</b>	African Union Migration Policy Framework for Africa
<b>MS</b>	Member State
<b>MSF</b>	Médecins sans frontières
<b>NCDC</b>	Nigerian Centre for Disease Control
<b>NCM</b>	National Coordination Mechanism on Migration
<b>NGO</b>	Non-Governmental Organisation
<b>NHIF</b>	National Hospital Insurance Fund
<b>NHIS</b>	National Health Insurance Scheme
<b>NPLM</b>	National Policy on Labour Migration
<b>NMP</b>	National Migration Policy of Nigeria
<b>NOI</b>	Nigerian poll instrument named after Ngozi Okonjo-Iweala
<b>NTD</b>	Neglected Tropical Disease
<b>OAU</b>	Organisation of African Unity
<b>OECD DAC</b>	Organisation for Economic Co-operation and Development's Development Assistance Committee
<b>PPP</b>	Purchasing Power Parity
<b>RAMED</b>	Regime for Medical Assistance to the Most Deprived (French: Régime d'Assistance Médicale)
<b>RCC</b>	Regional Collaboration Centre
<b>REC</b>	Regional Economic Community
<b>(R)SA</b>	(Republic of) South Africa
<b>SADC</b>	Southern African Development Community
<b>SDG</b>	Sustainable Development Goal
<b>SDH</b>	Social determinants of health
<b>SDU</b>	Sudan Doctors' Union
<b>SLE</b>	Centre for Rural Development (German: Seminar für Ländliche Entwicklung)
<b>STI</b>	Sexually Transmitted Infection

<b>TB</b>	Tuberculosis
<b>UHC</b>	Universal Health Coverage
<b>UN</b>	United Nations
<b>UN DESA</b>	United Nations Department of Economic and Social Affairs
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	United Nations High Commission for Refugees
<b>UNDP</b>	United Nations Development Programme
<b>UNCTAD</b>	United Nations Conference on Trade and Development
<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>UNPD</b>	United Nations Population Division
<b>USAID</b>	United States Agency for International Development
<b>USD</b>	United States Dollar
<b>WASH</b>	Water, Sanitation and Hygiene
<b>WHO</b>	World Health Organization



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Description: Social marketing in the public sector in Tanzania



# SECTION A

## **Approaches to migration and health in Africa**

# 1 Introduction

Migration is a worldwide, growing phenomenon, with more people on the move than ever before. According to the United Nations Department of Economic and Social Affairs (UN DESA), the total number of international migrants on the African continent has grown from roughly 15 m in 2000 to 26.5 m in 2019 (UN DESA, 2019). However, this increase is mainly due to population growth, while the relative number of international migrants remains stable at around 2 % (ibid). Contrary to widespread Eurocentric assumptions that African migration is primarily directed towards Europe, most African migration, in fact, takes place within the continent. Flahaux and de Haas (2016, p. 8) suggest that the emigration intensity of extra-continental African migration was only 1 % in 2000, an increase from just 0.6% in 1960.<sup>2</sup> To use another measure: while the number of African migrants living outside the continent in 2019 rose to nearly 19m, intra-African migration accounts for 80% of African migration flows (IOM, 2019e, p. 54).

Migration exposes individuals to situations that may affect their physical and mental well-being. On the migration journey, potential risks can include a lack of hygiene or clean water, gender-based violence or being a victim of human trafficking (Migration Data Portal, 2021). In host countries, a lack of adequate protection and restricted access to health care services due to legal status, stigma, language barriers, discrimination or a lack of income may further exacerbate migrants' health vulnerabilities (Bradby et al., 2015). This is particularly true for those who migrate involuntarily. At the same time, migration can be an opportunity to achieve improved health because the health care system in the country of settlement may be of better quality.

The current COVID-19 pandemic is exacerbating existing challenges regarding migrants' health. Pandemic response plans and measures to mitigate the effects of the pandemic often do not sufficiently consider the needs of migrants. In addition to higher risks of losing (often informal) jobs, migrants face higher risks of being infected due to often overcrowded living conditions and restricted access to health care services, e.g., due to missing documentation. Furthermore, the pandemic has led to increasing border restrictions, impacting people's mobility (Migration Data Portal, 2021).

Migration and health governance also needs to be more responsive to the health needs of diverse migrant groups, especially at the national level. While there are international agreements on migration and health, existing migration health policies usually operate at national levels and show a wide discrepancy between legislation and implementation on the ground. The AU has identified migration and health as one of the cross-cutting issues in the Migration Policy Framework for Africa 2018-2030 (MPFA) (AUC, 2018), and, in 2020, launched a migration and health programme area. In order to work towards a coherent continental approach to the migration and health nexus, this report seeks to illuminate existing policy responses to the health needs and challenges faced by refugees and migrants in Africa while also identifying gaps that require further research and action through collaboration and cooperation.

## 1.1 Objectives of the Study

The overarching objective of the study is to strengthen the governance of migration and health in AU MS by providing a concise picture of the migration and health nexus and an enhanced understanding of existing policy frameworks, their implementation, and respective barriers. In addition, it aims to support the AUC in guiding its MS to achieve greater coherence between migration and health in policy and practice.

The overall research objectives of the study were to:

- Provide consolidated information on existing national, regional and continental migration and health policy frameworks in Africa
- Compile existing research on migration and health governance in Africa, indicating existing research gaps
- Identify well-developed practices regarding the governance of migration and health, as well as areas for improvement
- Provide an in-depth analysis of the status quo of health care provision for migrants from a multilevel (national, regional and continental) and multi-stakeholder perspective (migrants, government and NGO officials, health care providers)

2. Flahaux and de Haas define emigration intensity as the number of emigrants divided by the population born in each country (Flahaux & De Haas, 2016).

- Provide recommendations to the AU to guide its MS in governing the migration and health nexus
- Provide a proposal for the contents of migration and health training modules for the AU to guide its MS<sup>3</sup>.

## 1.2 Problem Statement

As in other world regions, migration within Africa is projected to increase by 2050 because of urbanisation, economic growth, and climate change (IOM 2008, Teye 2018, and Migali and Münz 2018). Migration has potential health implications for migrants and health systems in origin, transit, and settlement countries. Migrants and refugees can be both victims and vectors of health risks, especially due to difficult migration journeys, and often face multiple barriers to accessing appropriate health care in settlement countries (WHO 2018f). Large-scale unplanned migration can place additional pressures on African health systems that are already overstretched.

The AUC and its MS are committed to developing the health and the wealth of its populations, as set out in the AU's Agenda 2063 Strategy (AUC 2013). Managing migration flows effectively and harnessing the contributions that migration provides to African economies will be crucial in the coming decades for African policymakers. However, health and migration policies (and therefore services and programmes) have often operated in silos, with insufficient regard for the need to consider the linkages between migration and health (WHO 2019).

Moreover, these challenges are exacerbated by a lack of data on migrant health and a lack of information about the degree of policy coherence (or otherwise) between health and migration policy frameworks at the continental, regional, and Member State levels (IOM, 2020a). Much of the research on this topic has focused on migration and health either at the continental and regional levels or at the national or local levels. (c.f. Abebe 2017, Maru 2019, Sweilah et al 2018).

The AUC has identified migration and health as one of the cross-cutting issues in the 2018 Migration Policy Framework for Africa (MPFA). The current COVID-19 global pandemic has further highlighted the salience and urgency of these issues. To establish a programme and develop a continental approach towards the nexus of migration and health, the AU has defined priorities for research to first and foremost close knowledge gaps.

This study aimed to address some of these gaps by surveying migration and health policy and practice at the continental, regional, and national levels.. This included a review of the AU's's, the REC's's and the national migration and health policy frameworks of 15 AU MS and those of migrant health and health provision of 5 AU MS, each representing a different African region. This was complemented and enriched by primary data collection in Kenya, Nigeria, and South Africa from migrants and refugees, health workers, AU, regional and national officials and UN agency staff.

## 1.3 Overview of key concepts

The following section provides an overview of the conceptual framework used to guide an empirical analysis of migration and health governance in Africa. It introduces the relevant concepts and working definitions used in this study and explains how they interconnect. The chapter will also narrow down the scope of the study and explain why certain aspects will be excluded.

### 1.3.1 Migrants

For the purposes of the study, the umbrella term "migrant" will be used. Even though it has no universal legal definition, it reflects the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons (IOM, 2019a, p. 132) Due to the heterogeneity of the group of migrants, a rigid categorisation that seeks to capture different perspectives, needs, and social dynamics is clearly impossible.

While existing terms can help to understand migration dynamics, it should be kept in mind that these classifications are not necessarily neutral and often reflect assumptions and values of those parties assigning the labels. Moreover, some terms, such as "refugee" or "asylum seeker", also have specific legal definitions

3. The Training outline and module developed by the Centre for Health, Law, and Development in Nigeria. For more information on this, contact the African Union Commission – Department of Health, Humanitarian Affairs and Social Development.

which can accord certain rights and entitlements to migrants (Abubakar et al., 2018). However, since some terms for subgroups of migrants enable the research team to draw on existing discourses and to differentiate between certain migration realities, there will be references to a number of other relevant categories. While the scoping study took all subgroups of migrants into account, in the analytical study, it was agreed, following consultation with the AUC, that there should be a more focussed approach to look at the specific needs of refugees, regular migrants, and irregular migrants in countries affected by different migration pathways in three different AU MS (see Chapter 2 below for more information).

The table below sets out definitions of migrant subcategories used in this study.

*Table 1: Definitions of different migrant subcategories*

<b>Migrant category</b>	<b>Definition</b>
International migrants	Individuals who remain outside their usual country of residence for at least one year (UNDESA)
International labour migrants	Individuals engaged in a remunerated activity in a state of which he/she is not a national, including persons legally admitted as a migrant for employment (ILO)
Irregular / undocumented migrants (sometimes also referred to as "illegal migrants") *	Individuals who enter a country, often in search of employment or other opportunities, without the required documents or permits or who overstay the authorised length of stay in the country (UN Population Division)  *There are few reliable data sources on numbers of irregular migrants
People in refugee-like situations*	Similar to refugees below, but this category is broader as it includes people who have been forced to leave their country of origin but who lack legal status as refugees and who have not registered claims for asylum. Typically, this latter group are irregular migrants (UNHCR) In this report, 'people in refugee-like situations' is used as an umbrella term that includes registered/ legal refugees, asylum-seekers, and irregular migrants who have been forced to flee their country of origin. *There are few reliable data sources on this broader category
Refugees	Individuals who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, are outside of the country of their nationality, and are unable to, or owing to such fear are unwilling to, avail themselves of the protection of that country, or return because of fear of persecution (UNHCR) The term refugee is typically used in a precise legal sense – i.e., someone who has been granted legal status as a refugee – as well as in a broader, more abstract sense.
Asylum seekers	Individuals who have sought international protection and whose claims for refugee status have not yet been determined (UNHCR)
Diaspora	People of African origin living outside the continent, irrespective of their citizenship and nationality and who are willing to contribute to the development of the continent and the building of the African Union' (AU CIDO, 2021).

(Source: Adapted from (Zimmerman et al., 2011))

It is notable that these categories are not necessarily constant. People's status and categorisation imposed on them by international law and states' application of these may repeatedly change on their journeys, a phenomenon which is increasingly termed "mixed migration" (MixedMigrationHub, 2021). As set out above, the groups of migrants that the study will not include will be so-called "internal migrants", including internally displaced people (IDPs) and rural-urban migration in-country, and 'diaspora' as the focus of the research is on migrants who have crossed national boundaries to move to other countries within Africa.

### 1.3.2 Migrants' Health

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946, p. 1). As the research is conducted from a governance perspective, the focus will be on the question of how mental and physical health care for migrants is reflected in national, regional and continental migration and health policy frameworks. Due to the limited scope of this study, the aspect of 'social well-being' will not be discussed in detail, considering its broadness and huge overlap with a variety of different policy areas (such as housing or social exclusion).

The WHO emphasises that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO, 1946, p. 1). Accordingly, this definition applies irrespective of people's mobility and/or migration status. In practice, the relationship between migration and health is more complex. On the one hand, the conditions surrounding a migration journey may impact migrants' health and exacerbate vulnerabilities and risk behaviours. For example, forcibly displaced people are more likely to suffer from trauma-induced disorders, e.g., women who are at a greater risk of gender-based violence during and after migration, which can have severe physical and mental consequences (Fiddian-Qasmiyeh et al., 2014). On the other hand, despite those heightened vulnerabilities, migrants often face difficulties in finding appropriate treatment in their countries of residence. Different factors such as the lack of a required legal status, stigma, language barriers, discrimination and lack of income may exclude them from accessing health care services (Bradby et al., 2015).

On the other hand, migration itself can be an opportunity to achieve better health care because the health care system in the host country may be of better quality. Furthermore, studies show that migrating populations are often healthier on average than local populations. This phenomenon has been described as the "healthy migrant effect" (Razum, 2008). It refers to (self-) selection processes prior to immigration, which can lead healthy and more resilient persons, in particular, to decide to migrate.

Consequently, the impact of migration on the health of those who migrate varies considerably across different migrant groups, depending, among other factors, on their previous health conditions, experience during the migration journey or gender (Migration Data Portal, 2021). However, how and if health conditions can be, and are, addressed mainly depends on the status of the health care system of the host community and its migration and health policies (as they define who has the right to access which kind of services) their effective implementation. Consequently, policy formulation and implementation play an essential role in migrants' health.

### 1.3.3 Governance of Migration and Health

IOM defines Migration Governance as "the combined frameworks of legal norms, laws and regulations, policies, and traditions, as well as organisational structures [...] and the relevant processes that shape and regulate States' approaches concerning migration in all its forms" (IOM, 2019a, p. 138) For this study, we will focus on the policy frameworks (i.e., policy documents, strategies, and laws) relevant to migration and health.

In reference to this broad definition, we will talk about "governance of migration and health" when referring to states' legal and policy approaches that directly or indirectly address migrants' health. This includes policies concerning migrants' health and the question of to what extent health concerns may lead to more restrictive migration policies. There is no single universal legal and normative framework addressing migrants and especially not migrants' health.. Instead, a variety of binding global and regional legal instruments, non-binding agreements, and policy understandings reached by states at the global, regional, and national levels (Koser, 2010). These will be further described in chapter 3 and the scoping study report of this research project.

## 1.4 Theoretical frameworks on migration and health

The systematic scoping review of the literature also identified the main theoretical frameworks used in research on migration and health. Perhaps the two most common of these – othering and health inequalities approaches, and cultural frameworks / acculturation hypotheses - are widely found in the literature and have influenced both research and policy making in migration over recent decades (Hossin, 2020).

In the first of these, migrants are affected, among other social minority or out-groups, as Grove and Zwi argue, by variety of mechanisms by which refugees, asylum seekers and irregular migrants are positioned as 'the other' and are defined and treated as separate, distant and disconnected from the host communities in receiving countries' (2006, p. 1931). Different migrant sub-groups are further affected in this regard, for example 'othering effects' are likely to be experienced more severely by forced migrants or refugees (ibid).

In the second of these models, cultural differences, which also influence lifestyle and other factors underpinning health, affect migrant groups, with health effects and inequalities in theory reducing as acculturation in the country of destination increases over time, whether in a migrants' lifetime or across generations (Viruell-Fuentes, 2007).

Acculturation models have been criticised for their inability to adequately address the structural underpinnings of culture, race which is sometimes seen in rather binary terms (Hossin, 2020). Indeed, one argument for using structural or othering and health inequalities approaches is that these are better able to account for structural factors underpinning health inequalities (Ingleby et al., 2019). However, both of the frameworks described above were largely developed from research into patterns of migrant health and immigrant experience in the Global North, which may limit their applicability in other contexts (Wickramage et al., 2018).

Considering the SDGs, but also, for our purposes the Global Compacts on Refugees and Safe, Orderly, and Regular Migration, the global strategic frameworks for health and development are grounded in a 'leave-no-one-behind' approach to public health and give expanding Universal Health Coverage (UHC) a central role in improving health outcomes for all (UN, 2018; UN General Assembly, 2017). Indeed, there is a significant body of public health research and policymaking on using rights-based approaches to identify and reduce health inequalities, often to achieve better health outcomes (Lougarre, 2016). Rights-based approaches have thus influenced research, policy formulation – including migration and migrants' health (Sweileh et al., 2018). Indeed, rights-based approaches can be especially valuable in relation to health advocacy for migrants, who are often excluded whether wholly or in part from UHC it is interpreted to pertain to national citizens only (Abubakar et al., 2018).

Social determinants of health (SDH) approaches are favoured by WHO and IOM, and stress that definitions of health need to incorporate the broader social dimensions underpinning health, such as (access to) employment, education, family status etc. (Braveman & Gottlieb, 2014; Wallace et al., 2018; WHO, 2011). Moreover, migration itself is increasingly seen as a determinant of health (Chung & Griffiths, 2018; Davies et al., 2006; IOM, 2017). However, SDH approaches have been criticised for inadequately considering migration (especially in their earlier iterations), and for focusing on socioeconomic status at the expense of other determinants such as race, gender, and legal status (Ingleby et al., 2019).

A further set of theoretical frameworks revolve around the health status of migrants and how migration affects migrants' health before, during and after the migration journeys. One common example cited above is the 'selectivity model', often described as the 'healthy migrant effect' which posits that migrants, as a self-selecting group, tend to be healthier than those who do not migrate (Constant et al., 2018). Another, and in some ways its reverse image, is the 'negative impacts' model, which looks at the negative health impacts of migration in the home country pre-departure,, such as malnutrition); difficult migration processes,, such as forced migration or risky journeys; and difficult conditions in the country of residence or transit, such as lack of employment (Attanapola, 2013).

More recently, intersectional approaches have become popular due to their usefulness in exploring inequalities in and between social groups, and its suitability for explaining inequalities in health status among groups, especially migrants (Green et al., 2017; Viruell-Fuentes et al., 2012). These originated in black feminist scholarship and consider the multiple ways in which aspects of an individual's identity - such as race, class, or gender - intersect to affect their life experiences (Carbado et al., 2013). Hossin notes that 'conventional structural and cultural frameworks have limited utility in explaining the multifactorial health disadvantages faced by migrants,' and argues that intersectionality can incorporate and highlight both pre- and post-migration contextual factors affecting migrants' health (2020, p. 4).

The two principal approaches to incorporating intersectionality in social research identified in the literature are the traditional fixed effects approach, which examines interactions between social categories or variables, and more complex multilevel models, such as the Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) approach (Evans et al., 2020). While the former is best suited to research where the number of aspects of identity and other variables under consideration are relatively limited, the latter is preferred for contexts where the number of identity and other variables under consideration is large (Green et al., 2017).

Wickramage, Vearey, Zwi et al. argue that a focus on migrants' health within different typologies of migrants is essential to understand the complex interlinkages between international (and internal) migration and health (Wickramage et al., 2018) and to avoid the exceptionalisation of migration and migrants. Accordingly, they propose two areas of research focus: a) exploring health issues across various migrant typologies and b) improving understanding of the interactions between migration and health to achieve better public health for all (Ibid.)

## 1.5 Conceptual Framework

The diverse theoretical approaches identified in the scoping review were used to inform the conceptual framework and methodology developed by the research team for the analytical study. Following Wickramage et al., this included surveying three different sub-groups of migrants in three different AU MS, and centred on migrants' health and access to health services in each country (Wickramage et al., 2018).

Given the challenges inherent in surveying respondents in three different locations over a short period, the research team decided to avoid more complex multilevel models and opted for a more traditional fixed-effects approach using a more limited set of variables drawn from the surveys, complemented and contextualised by data from interviews and focus groups.

The conceptual framework did not aim to test the theoretical frameworks set out above but instead try to answer the research questions set out in Chapter 1. Nevertheless, the findings may provide further insights into some of these theoretical frameworks, as seen in the discussion chapter (ch.10).

In light of these considerations, the study deployed a conceptual framework set out in Figure 1. As can be seen, this focuses on the migration and health nexus at the policy-framework level, as well as the implementation of these relative to the needs and health status of migrants.

## CONCEPTUAL FRAMEWORK

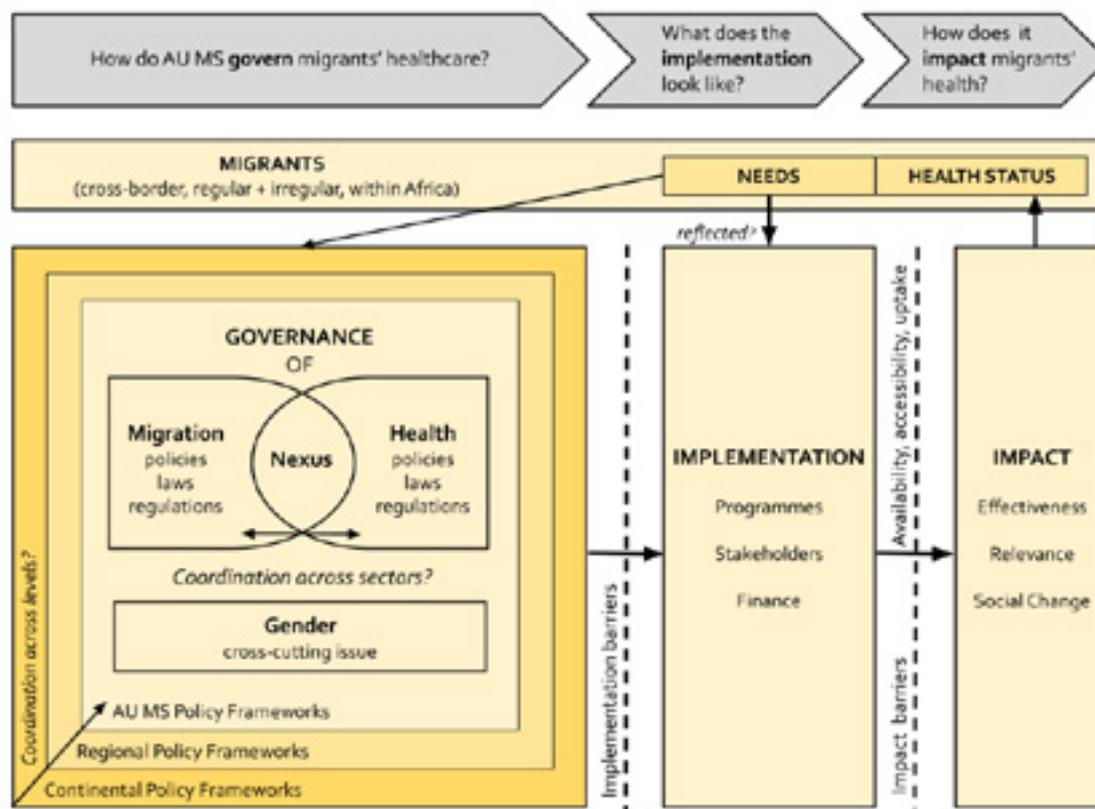


Figure 1: Conceptual framework of the study.  
(Source: own illustration)

## 1.6 Guiding Research Questions

This study was guided by and aimed to answer the following research questions:

- What migration and health policy frameworks exist on continental, regional and national levels? How effective and relevant are they?
- What are good examples and areas for improvement regarding the governance of migration and health?
- What are barriers to implementing existing policies and programmes (at the national, regional, and continental levels)? What resource deficits and capacity deficits can be identified?
- What role do relevant non-government stakeholders play in policy implementation at the national level? Do their programmes sufficiently fill the gaps?
- What specific health care needs do migrants have?
- What are the needs of vulnerable groups, in particular female migrants? Are these reflected in policies and programmes?
- What are the barriers to accessing health services for migrants? What measures have been / could be put in place to overcome / mitigate these?
- Are concerns about migration and health leading to more restrictive policies and programmes?
- Which practices/policies could be implemented in other AU MS?
- What measures on a regional and continental level would be necessary to substantially reinforce national efforts?
- What emergency measures could be put in place in relation to COVID-19 and/or pandemic preparedness to improve health outcomes?

## 1.7 Outline of the Study

The structure of the study set out in this report is as follows:

Chapter 2 describes describe the methodology devised and implemented for the different phases of the study, including the scoping study and the analytical study phases. Chapter 3 presents key migration and health policy frameworks in place at the global, continental, and regional levels. Finally, in chapters 4-8, we present a detailed assessment of migration and health policies and issues at play in the study's's focus countries of Kenya, Nigeria, and South Africa, followed by findings of comprehensive desk reviews for DRC and Morocco.

Chapter 9 discusses issues raised by regional and continental expert stakeholders, followed in chapter 10 by a discussion of the study findings. Finally, chapter 11 provides our conclusions and recommendations for potential action by governments, international partners and other stakeholders.

Annex I gives detailed sources of the provided country infographics. Good practice examples are presented in Annex II, followed by Annex III on COVID-19 and migration. Selected results of the surveys for Kenya, Nigeria, and South Africa are provided in Annex IV, and survey questions are presented in Annex V. Annex VI includes a code relationship matrix of key interview groups by country / region. Annex VII includes a breakdown of the key terms of definitions of different migrant groups used in the study, and Annex VIII lists the key informant interviews conducted by the SLE Berlin team as part of the study. Finally, Annex IX provides an overview of relevant inter-state dialogue processes on migration in Africa.

## 2 Methodology

In this chapter, the methodology of the inception, scoping study, and analytical phases of the study project are described, including the project’s partner researcher approach and the development of research instruments (surveys, key informant interviews, and focus group discussions). This study included two main phases, namely a scoping study phase and an analytical study phase.

### 2.1 Stakeholder Mapping

In the inception phase, the study team identified a variety of potential users of the results. As shown in Figure 2, these can be divided into direct and indirect users or stakeholders.

This research project has been commissioned by the Department of Social Affairs (DSA) of the African Union Commission (AUC) and the GIZ programme “Support to the African Union on migration and displacement”. The AU consists of its MS, as well as the AUC and its respective subunits and committees. At the MS level, this includes respective ministries and general administration. There is also a regional component of the AU which are the eight Regional Economic Communities (RECs).

Another direct user is represented by the Africa Centres for Disease Control and Prevention (Africa CDC) which is part of the AUC and is responsible for supporting public health initiatives of Member States and strengthening the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats. A further direct user within the AU is the Department for Political Affairs (AUC DPA). Regarding migration specifically, its mandate includes implementing sustainable solutions to humanitarian and political crises, displacement issues, and promotion of a Visa-Free Africa through the Agenda 2063 initiative.

The group of indirect users is composed of different entities. These include the ultimate beneficiaries of the study: migrants in Africa, whose health situation is to be improved based on the study’s findings and the implementation of its recommendations. In addition to migrants, health institutions and their staff are another important group of indirect users. Intergovernmental organisations such as IOM, ILO or UNHCR, the scientific community, as well as International non-governmental organisations (INGOs) and civil society in Africa and globally, may also benefit from more detailed information on this complex topic.

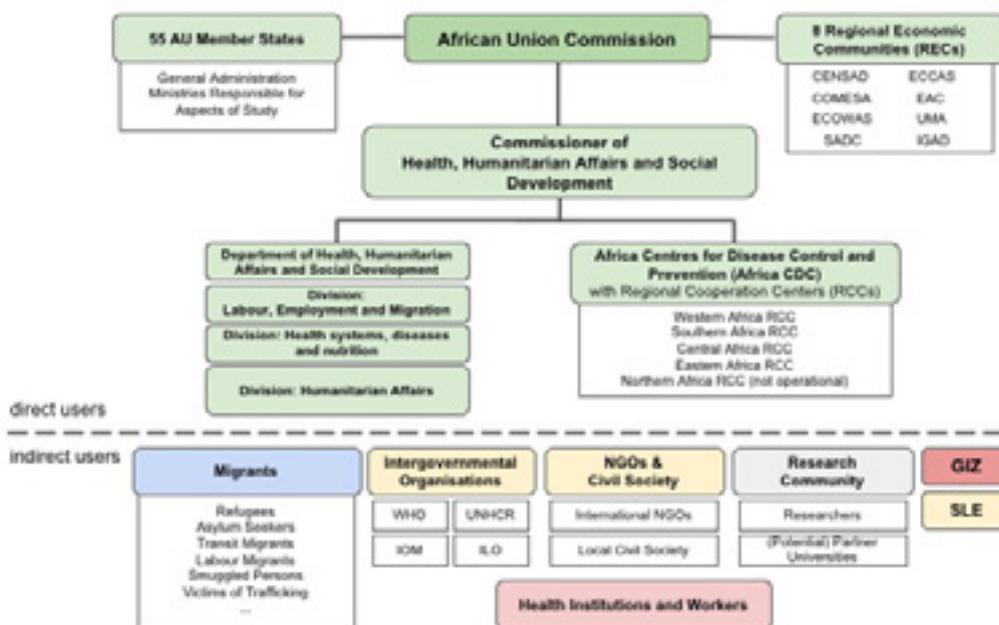


Figure 2: Stakeholder mapping of the study.  
(Source: own illustration)

The selection of countries for the scoping study was based on the geographical location of the countries along migration routes, the overall share and number of migrants in or transiting the countries, the characteristics of

these migrants, such as their legal status, and different types of migration flow. Further considerations were given to diverse country characteristics such as population size, language, and socio-economic factors. The decision to choose an equal number of countries in all of the five regions was based on the AU principle to include regional representation in all of their projects.

The 15 countries selected for the scoping study phase were: Mauritania, Morocco, and Tunisia for North Africa; Kenya, Sudan, and Uganda in East Africa; Angola, Botswana, and South Africa in Southern Africa; Cameroon, DRC, and Gabon in Central Africa; and Nigeria, Senegal, and The Gambia in West Africa.

## 2.2 Scoping Study Phase

The scoping study phase took place between late August and mid-October 2020. The scoping study comprised two parts: a policy review and a systematic scoping review of available literature. In the policy review, relevant migration and health policy frameworks at the international, continental, and regional levels were assessed, as well as in the 15 countries.

In the systematic scoping review, relevant academic and other literature such as reports, profiles, evaluations, information sheets, and scientific publications of international organisations and NGOs were considered. Search strings were developed in English, French and Portuguese (see Scoping Study for details) and used in the following databases: ScienceDirect, PubMed, African Journals Online (AJOL), Wiley and JSTOR. As a result, a total number of 10,243 publications were identified. In the next step, the research team evaluated the identified scientific literature via an elaborated process using the DistillerSR, a software specifically designed to facilitate systematic reviews, as set out in Figure 3 below:

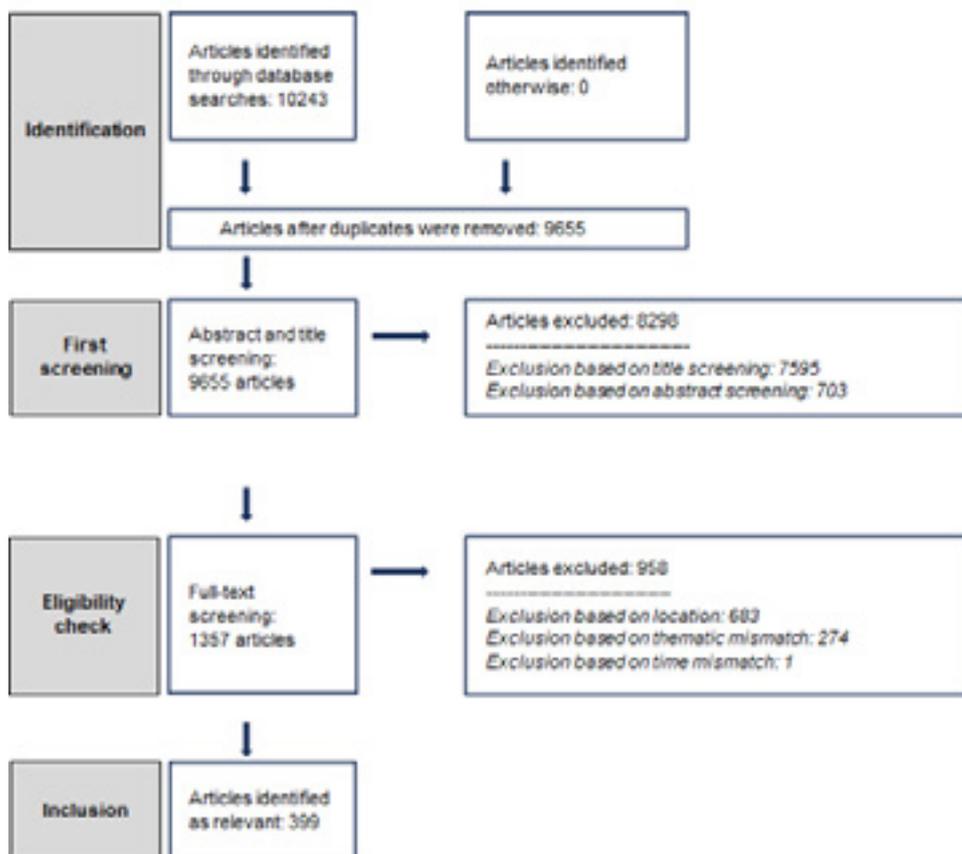


Figure 3: Scoping review.  
(Source: own illustration)

Items were also added to the literature’s scoping review on an iterative basis, including searches for articles and texts in Russian and Arabic. The DistillerSR process identified 399 relevant articles for review. Using

snowball techniques based on a review of these documents and others suggested by expert stakeholders consulted as part of the study project, a further 108 publications were also identified.

In total, the team reviewed over 500 relevant publications gathered as part of the scoping review and 575 policy documents from the continental, regional, and national levels.

An overview of relevant policy frameworks and situational analysis in each of the 15 countries was provided within-country profiles in the scoping study report. These included general background context about the countries, the circumstances and numbers of migrants, and the policy landscape on migration and health. These national profiles were complemented by information on the regional and global level.

## 2.3 Selection of countries for the analytical study

Based on the scoping study results, the research team proposed countries for further in-depth analysis in an online webinar with the AUC and GIZ on October 17th 2020. In agreement with these commissioning partners, three countries were selected for the primary data collection in the analytical phase: Kenya, Nigeria, and South Africa. The selected countries were chosen to cover the principal migration pathways in Africa, namely the Southern mixed migration pathway towards South Africa and countries involved in the Rabat and Khartoum processes.<sup>4</sup> In each of these countries, a focus was set on a specific sub-group of migrants to ensure the very different needs and experiences of these sub-groups were considered.

In Kenya, it was agreed that the study should focus on refugees, acknowledging the importance of refugee flows to the country. In Nigeria, although irregular migration and internal displacement due to conflict and desertification are significant drivers of migration, it was agreed that the focus should be on regular migrants, as freedom of movement in the ECOWAS space is an impotent driver for mobility in the region. Finally, considering the importance of mixed migration, South Africa was selected to focus on irregular migrants. Furthermore, to enable representation of countries from different African regions, DR Congo and Morocco were chosen as the focus of comprehensive desk reviews. Here, the respective findings from the scoping study were complemented by further in-depth desk research and expert consultations where feasible.

These three separate sub-groups of migrants were chosen because the different legal status and migration journeys, as well as different migration routes, raise specific health challenges for each.”

Given the limitations of time and the need to cover these key sub-groups, it was decided to focus on a different sub-group in each country case study. While this might create challenges in the comparability of the findings across these three different subgroups in three different contexts, it was interesting to consider differences and similarities in their experiences of health. Furthermore, as the aim of the study is rather to inform recommendations than comparing countries, we decided that comparability was not the main criterion.

## 2.4 Analytical study phase - survey design

The analytical study phase was conducted over six weeks between October and December 2020. Given the limitations of time imposed by the project and travel restrictions to the 3 study countries in Africa, a remote methodology was developed. Nevertheless, there was a potential for generating in-depth knowledge on the context, content and ramifications of migrants’ health in the different study countries (Fauser, 2018; McKim, 2017). As such, the team deployed a simple mixed-methodology study model comprising quantitative (surveys) and qualitative methods (key informant interviews and focus group discussions). In addition, the study deployed a combination of purposive sampling and snowball methods to reach as wide a range of potential respondents as possible.

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4. The Euro-African Dialogue on Migration and Development (Rabat Process) is a regional migration dialogue. Since 2006, the Dialogue has offered a framework for consultation, bringing together countries of origin, transit and destination of the migration routes linking Central, West and Northern Africa with Europe (Rabat Process ICMPD, 2021). Similarly, the Khartoum Process is a platform for political cooperation amongst the countries along the migration route between the Horn of Africa and Europe established in 2014. It aims at establishing a continuous dialogue for enhanced cooperation on migration and mobility. (Khartoum Process ICMPD, 2021).

## 2.5 Partner research project with a remote approach

Due to the COVID-19 pandemic beginning in early 2020 and the resulting travel restrictions, this study was planned and executed as a digital project by the SLE team working from Berlin. However, this study would not have been feasible with only the Berlin team involved, as there was an urgent need for expertise and information from the field. We, therefore, developed and implemented a partner researcher process with a remote approach.

In order to realise this, we engaged partner researchers in the three selected focus countries of Kenya, Nigeria and South Africa to conduct research in the field. After launching a tender process and completing interviews with prospective partners, the SLE Berlin team chose research partners to work with in each country.

In Kenya, this was Prof. Dr Othieno Nyanjom of the Technical University of Kenya. In Nigeria, partner researchers were Onyekachi Wambi, Mgbechikwere Nana Nwachukwu, and Stella Opoku Owusu from the African Foundation for Development. In South Africa, the partner researchers were Dr Khangelani Moyo, Sibonginkosi Dunjana, and Kumbi Madziwa from the University of the Witwatersrand.

The survey instruments were developed in consultation with partner researchers, by the Berlin research team and piloted in Europe and subsequently in each of the 3 study countries. The team drafted guidelines and questions for KIIs and FGDs, compiled a survey questionnaire, and set up an online platform for the survey. While the partner researchers conducted the surveys, interviews and focus group in the three countries with the relevant target groups of migrants, health professionals, and policymakers, the Berlin team conducted additional interviews with continental and regional experts in health and migration. By January 2021, the teams completed 44 interviews and five focus groups with migrants, health workers, government officials, representatives of international organisations such as ILO, IOM, WHO and AU, and representatives of various NGOs.

### Selection of research sites

Due to the challenges imposed by local and national restrictions linked to the pandemic and other factors in each of the study countries, partner researchers were given the flexibility to propose research sites for data collection to the research team. In each country, different considerations influenced the choice of research sites.

The research in Kenya was conducted with the Eastleigh Community Wellness Centre (ECWC) described in the Kenya chapter. Here, in the urban neighbourhood of Nairobi, the third biggest refugee population in Kenya is situated. This setting is of special interest since much research has focussed on the situation in the camps. However, the refugee communities in Nairobi are rather spread out, and surveying them is a problematic endeavour not many researchers have been able to accomplish.

In Nigeria, travel to areas in the north of the country where the ongoing insurgency has led to considerable forced displacement was deemed unsafe and impractical by the Nigerian partner researchers. In addition, coronavirus travel restrictions, and political instability following protests against police brutality in Lagos and other cities, made travel to different sites extremely difficult. Given the focus on regular migrants, it was decided to focus data collection on sites in Lagos only.

In South Africa, the research sites were Johannesburg and Pretoria. In both cities, partner researchers covered the central business districts to capture data from those who dwell there and those commuting in from high-density suburbs and informal settlements. The team also collected data from other, less densely populated areas of both cities associated with irregular migrants.

Given the limitations of time and travel restrictions, the researchers in each study country deployed both chain and random sampling methods to recruit respondents from each of the three migrant sub-groups and other relevant stakeholders.

## 2.6 Research Tools

### 2.6.1 Key Informant Interviews (KIIs)

Semi-structured KII questions were developed for three target groups of respondents: migrants, government officials (either from a migration or health policy background), and health workers. These interviews consisted of a range of questions about migrants' experiences of accessing health services and, where appropriate, respondents' knowledge of relevant migration and health policies and programmes in the three in-depth study countries and at the regional or continental level. In addition, each team of partner researchers conducted outreach to and completed key informant interviews with the three respondent groups of respondents in Kenya, Nigeria, and South Africa, respectively, as set out in the table below:

*Table 2: Total number of interviews completed by country and interviewee group  
(Source: own illustration)*

Country	Migrants	Officials	Health providers
Kenya	5	5	5
Nigeria	5	4	5
South Africa	2	2	1
Total	12	11	11

In addition, the research team interviewed 10 officials, at the regional and AU levels, as well as staff from intergovernmental agencies such as IOM, WHO, UNHCR, and a migrant reception centre. The table in

Annex 9 lists the key informant interviews completed by the research team regarding interviewees' professional roles.

The research teams also had numerous off-the-record discussions with expert stakeholders, information from which was used to inform the study findings and the stakeholder mapping (see Chapter 1).

For the interviews, the research team deployed an induction (grounded theory) approach due to its potential for allowing respondents to identify themes and topics and generate interesting insights into the research topic. Interviews typically lasted between 40 minutes to 1 hour.

Key informant interview data was transcribed by each research team (Germany, Kenya, Nigeria, and South Africa) using automated transcription software and then corrected manually and coded in MAXQDA software

### 2.6.2 Focus Group Discussions

The focus groups aimed to generate targeted discussion amongst each group on topics relevant to the study. Different questions were developed for each group to find answers to a broad range of the study's original research questions. As with the key informant interviews, the research team used an inductive approach for its potential to generate valuable insights from respondents on the research topic. Focus group sessions lasted between one and two hours and were conducted online and in person. Partner researchers in the three countries held 5 FGDs with a total of 25 migrants and service providers. Focus group data was collected and automatically transcribed, and then corrected manually before being coded in MAXQDA software.

### 2.6.3 Survey

A survey was conducted to collect quantitative data on migrants' health and access to health services, which could then be validated against the qualitative findings. Therefore, existing surveys from the Health on the Move Project and relevant WHO surveys were adapted to this project's specific needs and context.<sup>5</sup>

The questionnaire comprised a total of 60 questions, of which only two were mandatory: "What country are you currently living in?" and "What were the main reasons for you to come to this country?": 15 questions aimed to provide personal / demographic information, such as age, occupation, and residence status. Based on those criteria, intra-group comparisons can be made within the countries. The remaining 45 questions assessed personal health status and specific health issues and subjective assessment of the access and quality of the health system in general. The complete questionnaire is provided in Annex V.

5. See: (SurveyMonkey, 2020; WHO, 2020c)

The questionnaires were distributed digitally and in print format by partner researchers among the specific groups of migrants. Surveys were distributed in English and translated into local languages by partner researchers. Surveys included multiple selection, single selection, ranking and open answer fields. Quantitative data collection ran from November until December 2020. Respondents could fill out questionnaires if they had the link to the survey provided by research teams and distributed among migrant networks in each country. Some answers were also collected through field teams in an interview manner, where the data collectors addressed people and went through the surveys question by question. A total of 965 eligible surveys were acquired with South Africa n = 310, Nigeria n = 355, and Kenya n = 300, respectively. Surveys were excluded if the respondents did not live in any of the three countries or were not from the African continent. By this, seven respondents were withdrawn from the dataset.

The research team supports the Principles of Digital Development approach and will be happy to provide other scholars with the anonymised dataset upon request (Principles for Digital Development, 2021).

### 2.6.4 Data Analysis

In terms of quantitative data analysis, the data was cleaned according to respondents' eligibility criteria. In the remaining dataset, new categories were produced to gain further insights. This included a less specific class of residence status: some documents. This was introduced whenever people did answer that they have permanent documents (working permit) or temporary documents (educational stay, asylum seekers or refugees). This less specific category allowed comparison between people with some documents (n = 562) and people with no documents (n = 292), thus irregular migrants. People who did not state their status (n = 26), left the question open (n = 16), or people with citizen status (n = 69, e.g., Fulani nomads in Nigeria) were excluded for this comparison.

Most of the analysis was completed descriptively using R, SPSS, Excel, and Kobo Toolbox. These software packages were used due to the different functionalities of each. As survey samples were not collected randomly and different sample sizes of independent variables explain portions of the impacts on dependent variables, all measures of significance should be taken with caution. However, capitalised letters in result tables indicate a significance level of 5 %.

Qualitative data were analysed using MAXQDA software to code interview and focus group data and examine interactions between respondents and themes identified. 169 themes and sub-themes were identified, and the research team used different data tools to analyse the qualitative datasets, including code relations matrices, word frequency counts, simple and complex coding queries, and lexical searches to compare sets of responses within and between groups of respondents.

## 2.7 Scope and Limitations of the Study

As is not uncommon with research on migration and health, interviews with migrants and officials were the most challenging to arrange for the research teams. Partner researchers and interviewees put forward various explanations for this, including lack of time, lack of incentives, the general stigma attached to migrants (in both Africa and Europe), fear that participating in the study might in some way have a negative impact, and (for government officials and health workers) concern that their participation might have negative professional or political consequences.

Travel and other restrictions due to the pandemic impacted the design and implementation of the study. This was particularly the case in the three study countries, as traditional face-to-face data collection methods, where meetings and gatherings can be used to collect data from multiple respondents, were not always possible due to local travel and other health restrictions in place.

There were a number of other limitations to this study, caused by several factors. First and foremost, the definitions and terminology used for migrant groups are in practice not always distinct. Indeed, migration can be involuntary and can even occur unintentionally. Understanding 'migrants' as individuals crossing international borders is not always the most useful definition for this group, as it excludes IDPs and other internal migrants (e.g., rural-urban migration) who may face similar challenges to international migrants, especially people in refugee-like situations, as can be seen in particular with the many IDPs in DR Congo or in Nigeria. The scope of the research focussing solely on cross-border migrants thus represents a further limitation of the study.

Similarly, the different categories of migrants, such as labour migrants and refugees, are not always clear-cut, which lead on occasion to target groups being mixed up in interviews. Again, however, some delimitation between groups was necessary to narrow down the study, achieve results within the available time and resources, and reflect the differing needs of various sub-groups and their different legal status.

Secondly, the sample size of the respondents does not represent the total size or distribution of the target population, and therefore cannot be regarded as a true representation of the total population, let alone a continent of over a billion people. Selection of study countries may also be another limitation, as no three countries can truly represent all 55 AU MS. The three primary data collection countries in particular share some features - notably their economic and political importance in each AU region - therefore, findings may prove difficult to apply to other AU MS depending on their national contexts.

Indeed, there are very distinct contexts at play in the different AU Member States, and different migrant groups face different challenges and have different needs. The research team anticipated this before the start of the survey and made attempts to compensate by adopting an element of purposive and random sampling methods. Nevertheless, the total research sample collected from across the three primary data collection countries was a rich dataset and can provide useful insights for understanding the needs of the three migrant sub-groups concerned in Kenya, Nigeria, and South Africa.

Thirdly, irregular migration is a sensitive topic. Even when conducted anonymously, participants reported concerns during the interviews about being identified. This makes it harder to gain information from this group as people are less likely to open up. People may not disclose their actual health status or health problems to strangers. Issues regarding full disclosure may also be amplified through the digital approach of this study. In order to confirm social distancing needs, focus groups and some of the interviews were conducted digitally, and the survey was distributed partly remotely. Building up trust is harder within virtual settings. Partner researchers in the field collected many questionnaires to mitigate this problem, but this limitation cannot be completely eliminated.

So-called 'Zoom fatigue' was another challenge in securing and organising interviews and focus group discussions with respondents in online settings. The fact that people already spend significant periods of their working day using such online communication tools meant motivation to participate in online interviews and focus groups was often low. Scheduling multiple participants for FGDs was also a barrier to participation.

The design of the research tools was also a potential limitation on two levels. Firstly, despite efforts to pilot the research tools (survey, interview, and focus group questions), it is possible the language used was insufficiently clear or was prone to be understood in certain ways by some respondents. The use of English as the primary survey language also posed challenges. For example, some survey respondents in Nigeria seem to have understood the question 'where is your country of residence?' as 'where is your country of origin?', on the basis that they still consider their country of origin as their country of residence (indeed, the Nigerian partner researchers did further checks on respondents' answers to confirm this). In Kenya and South Africa, partner researchers had to translate the survey and interview questions into local languages (Kiswahili, Ndebele, Tigrinya, Shona and Somali). Finally, the survey contained some multiple-choice questions in which respondents could select multiple answers, which affects the analysis and

## 3 Migration and health in Africa - key policies and issues

This chapter aims to inform the following chapters on the five study countries and provides an overview of relevant migration and health policies at the international, continental, and regional levels.

### 3.1 Migration and health - key policies and issues at the global level

The global institutional and legal architecture for public health is relatively well-developed at the international level. Health, on the one hand, has long been understood as a key component of socio-economic development, and on the other, the role of health in humanitarian emergencies is also well understood. The primary definition of health used in this study is ‘an absence of disease and suffering’, but health – and this is also true for migrants’ health – is also understood as being made up of a range of social determinants such as family, access to employment, or (access to) education (IOM, 2020).

The right to health is enshrined in Article 25 of the UN Universal Declaration of Human Rights, which states that ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care (UN General Assembly, 2008).

The Sustainable Development Goals (SDGs) provide clear targets on different aspects of health; for example, 3.2 focuses on ending preventable deaths of infants and children under five years of age by 2030; see SDG targets 3.1-3.13 for more information. Health policy and programming have formed an important part of development (and humanitarian) practice for some time now, although there are concerns about how achievable these are by 2030. Leaving aside the broader (if related) challenges of health system financing, the global ‘financing gap’ that needs to be bridged in order to achieve the SDGs by 2030 is significant, estimated to be US\$ 2.5 – 3 tn per year (UN, 2015; UNCTAD, 2014).

Other SDG targets are also relevant to migration and health in particular, such as SDG 10.7, which calls on countries to facilitate orderly, safe, regular, and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies. In addition, indicator 10.7.2 describes the state of national migration policies and asks: ‘Does the government provide non-nationals equal access to the following services, welfare benefits and rights: essential or emergency health care, public education, equal pay for equal work, social security and access to justice?’ (UN DESA, 2020).

In recognition of this, IOM has also developed a Migration Governance Framework (MiGOF) to help define what “well-managed migration policy” might look like at the national level (IOM, 2020). Additionally, Migration Governance Indicators (MGI) have been developed to assess national frameworks and help to operationalise the MiGOF. The MGI is a tool based on policy inputs, which offers insights on policy levers that countries can use to develop their migration governance. Again, the aspect of health is considered within this framework. In addition, the “migrants rights” dimension of the MiGOF assesses the extent to which migrants have the same status as citizens in terms of access to basic social services such as health, education, and social security (IOM, 2019c). Indeed, the MGI indicators for SDG 10.7 include several subcategories, the first of which under Domain 1 is “essential and/or emergency health care” (UN DESA, 2020).

Similarly, the Global Health Security Agenda (GHS) provides clear frameworks for managing health security and strengthening the capacity of health systems to monitor and respond to disease outbreaks at the national, regional, and international levels (GPMB, 2020). WHO also published its Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants and associated Action Plan 2019-2023 out of recognition of the clear health needs of these groups and their potential impact on broader populations in countries of residence (WHO, 2019).

By contrast, the global frameworks in place focussing specifically on migration have arguably been far less well developed, and have tended to develop organically and on a piecemeal basis in response to events (Flahaux & De Haas, 2016). The agreement of the Global Compact for Safe, Orderly, and Regular Migration (GC-SORM) and the Global Compact on Refugees (GC-R) in Marrakesh in 2018 was the first time UN Member States have agreed to a global framework for managing migration and migration flows (UN, 2018; UNHCR, 2019e).

These include a range of actions relevant to health, such as Action (e) of Objective 15: Provide access to basic services for migrants, which calls on Member States to ‘incorporate the health needs of migrants in national and local health care policies and plans’ (UN, 2018, p. 23) However, these are not legally binding and may be politically challenging to implement in some contexts due to highly charged public and political debates about migration, especially in (but not restricted to) destination countries.

## 3.2 Migration and health - key policies and issues at the continental level

Before assessing migration and health frameworks, capacities, and responsibilities at the continental level in Africa, it is worth stressing the fact that the vast majority of African migrants – 79 % - move within the continent (both intra- and inter-regionally) and that intra-African mobility is an important driver both for economic growth and also for employment and job creation (IOM, 2020b, p. 17; UNCTAD, 2018).

In 2017 the principal receiving countries of intra-African international migrants were South Africa (2.2 m), Côte d’Ivoire (2.1 m), Uganda, Ethiopia, Nigeria, and Kenya (each exceeding 1m, in descending order). The main countries of origin for migration primarily to other countries on the continent were Burkina Faso (1.4 m), the Democratic Republic of the Congo (1.5m), Mali (nearly 1m), Somalia (1.9 m), and South Sudan (1.7m) (UNCTAD, 2018, pp. 44–47). This suggests that conflict and political instability are important drivers of (irregular) migration flows, but it is important to restate that these factors only account for 24 % of African migration flows (Hassan, 2020; Williams, 2019).

Motives and drivers for migration are rarely singular, however, and it is striking that in UNCTAD’s 2019 Scaling Fences report on irregular migration in and from Africa, no respondents cited conflict or political instability as their primary motivation to migrate, although 26 % included these as a driver when prompted to state more than one motivation for migration ((UNDP, 2019b, p. 41). Of those migrating to Europe, only 6 % of respondents cited ‘personal issues/freedom’ as their most important reason for coming (Ibid.).

Drivers of intra-African emigration patterns are therefore diverse. For example, political instability in Somalia and Sudan, conflict in the Democratic Republic of the Congo, Mali, and northern Nigeria have been important drivers of forced displacement and irregular migration from these countries. Irregular and forced displacement can carry their own risks to migrants’ health.

Economic motives remain a key driver of regular and irregular migration to South Africa and West Africa, for example, as well as to North Africa and to Europe. Many people migrate in search of a better quality of life, better labour opportunities, both in-country (e.g., from rural to urban areas to sustain families back home) and across international borders. Developments such as increasing urbanisation, climate change, and environmental degradation are significant emerging drivers (IOM, 2019e).

Moreover, migrants themselves are just one beneficiary of migration. Countries of origin, transit, and destination can also benefit. Intra-African migration patterns, as well as diaspora investments and remittances, for instance, are playing an important role in the structural transformation of African economies. Remittances to family members are also used to pay for health care costs. In addition, diaspora health professionals’ networks are active in exchanging skills and expertise with their counterparts in African countries of origin and heritage, as well as mobilising medical supplies and other resources, to help strengthen health systems and respond to humanitarian crises, including the current COVID-19 pandemic (DEMAC, 2018; Sudan Doctors Union UK, 2020, personal communication with AU-CIDO August 2020).

The AU recognises the benefits of intercontinental migration and has made the free movement of persons a key principle of its efforts towards greater economic and political integration, as set out in its Agenda 2063 strategy, one goal of which is to achieve free movement of African citizens across the continent (African Union, 2015, p. 4). Similarly, the African Continental Free Trade Agreement, which was launched in 2018 and was due to come into force as of January 2021, aims to create a single market, deepening the economic integration of the continent (African Union, 2020b).

At the same time, despite this direction of travel at the AU level, the different AU Member States and RECs are at different stages of implementation of this agenda, and local economic, political, and security considerations can act as barriers to achieving free movement provisions, and managing migration flows (whether regular, irregular or mixed) in particular.

Considering the potential development opportunities to be harnessed that are associated with, as well as the potential challenges posed by, migration on the African continent, in 2006 the AUC adopted the AU Migration

Policy Framework for Africa (MPFA). This Framework provides comprehensive and integrated policy guidelines for the AU MS and RECs to promote migration and address emerging challenges. After an evaluation in 2016, the AUC updated the MPFA and formulated a plan of action for its implementation. The guidelines identify “migration and health” as one of the MPFA’s cross-cutting issues, along with topics such as human rights, migration and gender, and migration data management (AUC, 2018).

Furthermore, at the AU Kigali Summit in 2016, a pan-African passport was launched, seeking to foster beneficial visa regimes across the region. Two years later, the AU adopted a continent-wide protocol (Protocol to the Treaty Establishing the African Economic Community Relating to the Free Movement of Persons, Right of Residence and Right of Establishment) which aims to enable freedom of movement for all people within the African continent (African Union, 2018). If fully implemented by all MS, this can enhance intra-regional migration significantly and bring socio-economic benefits (McAuliffe & Kitimbo, 2018). And despite some reservations, a majority of MS signed the AU Free Movement Protocol that was passed at the 2018 Extraordinary AU summit held in Kigali, Rwanda, although as of November 2019, only four MS -Rwanda, Niger, Mali and Sao Tome and Principe - have ratified this (African Union, 2018; IOM, 2020c).

As several expert stakeholders interviewed for the present study noted, the structures of the AU imply that it can be very effective at providing guidance and improving governance at a cross-border and continental level, but the ultimate responsibility for migration or health lies at the national level, and Member States need to implement the relevant instruments with support from the relevant AU organs and the RECs.

### 3.3 Migration and health - key policies and issues at the regional level

At the regional level, Africa’s 8 Regional Economic Communities / Regional Mechanisms and 5 Africa CDC Regional Coordination Centres play a role in the governance of migration and health, as well as, in the latter case, coordination in disease surveillance. There are also eight inter-state dialogue processes on migration in Africa, the most well-known of which are the Rabat and Khartoum processes; a full list of these is presented in Annex X.

#### 3.3.1 North Africa

In North Africa, the Arab Maghreb Union (AMU) and the Community of Sahel-Saharan States (CEN-SAD) included free movement of people and capital provisions in their respective establishing treaties (AMU, 1989; CEN-SAD, 2013), although these provisions have yet to be fully implemented. AMU Identity cards are also under discussion to facilitate movement within the AMU region. However, security concerns over the last decade among North African states have forced these to focus on border security and surveillance, as well as managing irregular migration, for example the 2010 CEN-SAD Security Charter or the 2017 Niamey Declaration on Irregular Migration and Security Issues in the Sahelo Saharan Area (Laaroussi, 2019).

However, these typically do not reference migrants’ health, and no substantive regional health policies were found during the scoping study phase of this research. Indeed, it should also be noted in this context that the North Africa Regional Collaboration Centre (RCC) of Africa CDC is not yet operational, and this will have an important role to play in coordination between the seven states in this region, as well as development of relevant regional policies and guidance.

North African states are also active participants in the Rabat and Khartoum Processes, which seek to manage regular and irregular migration flows from West Africa and the Horn of Africa to Europe; and states such as Morocco, Libya, and Sudan are important countries of residence as well as transit for African migrants. Morocco, in particular, has sought to provide pathways for regularisation for African and other international migrants, as seen in two regularisation campaigns in 2014 and 2017, respectively (Mechaï, 2018), and also provide access to some health services (typically, primary and emergency care).

#### 3.3.2 East Africa

The East African region incorporates several overlapping RECs, notably the East African Community (EAC), the Common Market for Eastern and Southern Africa (COMESA), and the Intergovernmental Authority on Development (IGAD). These have introduced policy and legislative frameworks to regulate mobility, including the 2001 COMESA Protocol on the Free Movement of Persons, Labour, Services, Rights of Establishment and Residence, and the 2011 EAC Market Protocol and the Free Movement of Persons Regulations (COMESA,

2001; EAC, 2012). Of these, EAC arguably has made the most progress on regional integration and mobility, and implementation in practice across all RECs has been somewhat inconsistent (ICMPD, 2013). However, while such agreements may include portability of some benefits, including access to social insurance / social coverage schemes for health services, these often include conditions on the duration of registration or residence that many migrants cannot meet.

In particular, East Africa and the Horn of Africa have experienced waves of forced migration following protracted conflicts, as well as periodic droughts and extreme weather events such as the Puntland Cyclone in 2014. In addition, countries in the region such as Kenya, Ethiopia, and Uganda host large communities of refugees and people in refugee-like situations. The 2012 IGAD Regional Migration Framework underlines the role of migration, including pastoralists in the region, in the spread of communicable diseases, particularly HIV/AIDS and TB, and notes health as a cross-cutting issue in relation to migration (IGAD, 2012).

This framework also calls on MS to formulate policy and legislative frameworks to facilitate adequate access of migrant children and adolescents to health and other services (IGAD, 2012, p. 34), and urges states to extend access for adult migrants to appropriate health care and psychosocial counselling, including voluntary testing and counselling for communicable diseases such as HIV/AIDS and other STIs (IGAD, 2012, p. 42). IGAD is also concerned with the impact of COVID-19 on migration in the region and is organising its second Scientific Conference in February 2021 on 'Migration and Displacement Human Mobility in the Context of COVID-19' (IGAD, 2021).

However, the gap between policy aspirations and the challenges facing several states in the region in managing migration flows and providing health and other services to citizens, let alone to migrant groups, is significant. For example, Sudan already has experience of hosting significant refugee communities from Ethiopia and Eritrea. However, it has recently received tens of thousands of refugees from Ethiopia's Tigray region fleeing the conflict there, at a time when its health systems have been stretched to breaking point by the COVID-19 pandemic and the most severe flooding in nearly 100 years (Sudan Doctors Union UK, 2020).

### **3.3.3 Central Africa**

In Central Africa there has been uneven progress on the integration agenda. The Economic Community of Central African States (ECCAS) Treaty adopted in 1992 aims to provide a legal framework for free movement of people (Art. 4) (ECCAS, 1992). However, only Cameroon, CAR, Congo and Chad currently apply this. Freedom of movement in ECCAS is limited and is generally restricted to stays of 3 months or less for migrant workers. Separate arrangements are in place for students, professionals in certain high priority sectors, tourists, and workers in some cross-border roles (ICMPD, 2013, p. 61).

Barriers to regional integration have not been diminished, for example a passport is still required as a legal travel document (ICMPD, 2013, p. 63). Central African states such as DR Congo already manage large populations of refugees and IDPs; while those who are based in camps have limited access to basic health services, those living in refugee-like situations have little or no access as they lack the means to pay to access health care (UNHCR, 2019c). In addition, DR Congo has had to manage an Ebola Virus outbreak since 2019 that only ended in September 2020, placing enormous pressure on its health systems (WHO, 2020a).

A platform for intra-regional cooperation on migration issues, the Migration Dialogue for Central African States (MIDCAS) was established in 2012 with ten participating MS. Topics included migrants' health, integration and also migrants' rights. Unfortunately, to our knowledge, the last meeting was held in 2015, so its current status and impact are difficult to assess (IOM, 2020g).

### **3.3.4 Southern Africa**

The southern African region includes one of the main migration routes for African migrants as migrants seek economic opportunities in the region's countries, notably in Angola and South Africa.

Aspects of social protection of refugees, migrants and foreign workers are further touched upon in the Southern African Development Community (SADC) Code on Social Security (2008). With the vision of free movement of persons within the region, it calls on the MS to promote the protection of "all lawfully employed immigrants" by ensuring their ability to participate on an equal basis with nationals in social security systems (Article 17.2). Irregular migrants, on the other hand, should at least be provided with "basic minimum protection and should enjoy coverage according to the laws of the host country" (Article 17.3). In recognizing migrants' health as a crucial element of social protection, the 2016-2019 SADC Labour Migration Action Plan

(2016) sets as one objective to ensure migrant workers have access to health care across borders and at their respective workplace.

However, as in other African regions, there are limitations on the portability of benefits for migrant groups, and while irregular migrants are legally entitled to access health care services in South Africa, health services do not always recognise this fact, a state of affairs exacerbated by language barriers in some cases (see the South Africa country section below).

Southern Africa also faces migrant health challenges associated with different occupations. For example, long-distance truck drivers suffer from higher rates of HIV/AIDS and other STIs, while the significant communities of migrants working in the mining sector in South Africa, Botswana, and other countries in the region suffer from higher prevalence of lung conditions, in particular TB; the SADC region hosts the highest per capita burden of TB (AUDA NEPAD, 2019). One interviewee for this study, Chimwemwe Chamdimba of AUDA-NEPAD, noted a pilot project to develop an electronic health data-sharing system in Botswana, Eswatini, South Africa, and Lesotho to improve how data on migrants with TB is shared across borders. However, there remain challenges in the continuity of care across borders for migrant workers, both for TB or HIV and more broadly.

### 3.3.5 West Africa

The Economic Community of West African States (ECOWAS) was among the first regional bodies to facilitate mobility. Its 1979 Protocol Relating to the Free Movement of Persons, Residence and Establishment (ECOWAS, 1979) was developed in response to the call by the ECOWAS founding treaty for the abolition of obstacles to free movement of persons, services and capital. Subsequent supplementary protocols in the 1980s meant that the ECOWAS region was the first African region to introduce freedom of movement for its citizens, with the ECOWAS passport introduced from 2001 (Abebe, 2017).

ECOWAS MS have also established a regional platform to enable MS to coordinate migration issues and discuss potential solutions. The Migration Dialogue for West Africa works on topics such as student exchange, border management, and migration data, with more than 15 countries participating (IOM, 2020h).

ECOWAS states involved in the Rabat Process have benefitted from significant financial and technical assistance to build capacity in relation to migration and development from international partners such as the EC, IOM, and UNHCR (ICMPD, 2013). This has in turn encouraged the development of regional and national policy and legislative frameworks in West Africa, providing greater protection for migrants, routes to regularisation for displaced people and irregular migrants, and greater portability of benefits (ibid.).

This relatively high degree of policy integration, if not exactly coherence, in the ECOWAS space, is also evidenced in regional health policy frameworks and structures. One example is the West African Health Organisation (WAHO) in Burkina Faso, formed in 1987 to foster a more unified approach to health policy and practice in the region between anglophone and francophone Member States (West African Health Organization, 2020).

The Protocol adopted in 1987 was subsequently ratified by each government in the sub-region (ibid). This grants WAHO status as a Specialised Agency of ECOWAS and describes the organisation's mission as "the attainment of the highest possible standard and protection of health of the peoples in the sub-region through the harmonisation of the policies of the Member States, pooling of resources, and cooperation with one another and with others for a collective and strategic combat against the health problems of the sub-region" (Article III).

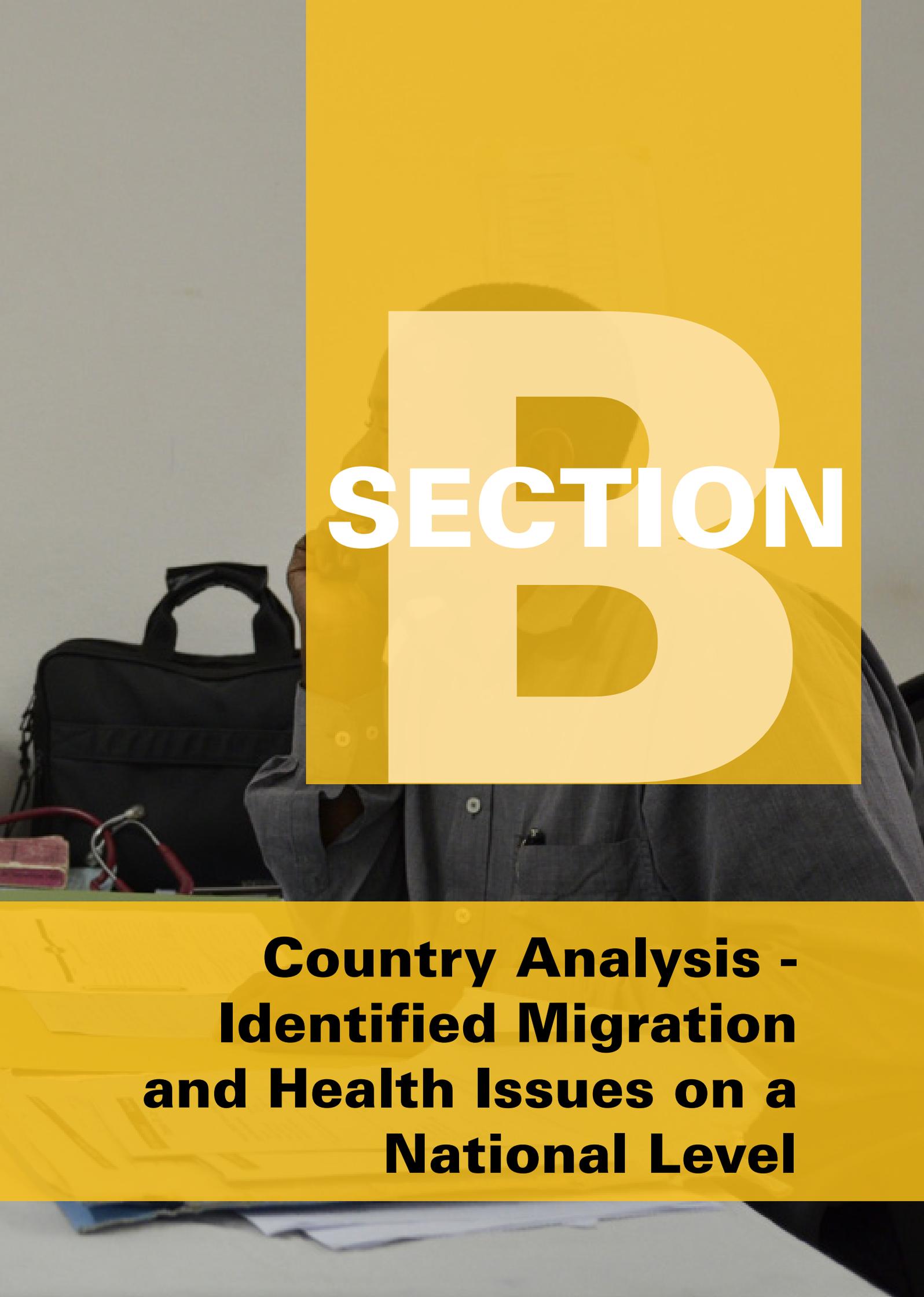
The ECOWAS Regional Centre for Disease Control (RCDC) was established in Nigeria in 2017 as part of the Nigerian Centre for Disease Control (NCDC), and the Western Africa RCC of Africa CDC is also co-located there. Health screening and disease surveillance systems in the region are relatively strong following significant investment in capacity in reaction to the Ebola Virus outbreak in the region from 2014-2016 (Olumade et al., 2020).

However, despite an impressive range of frameworks and structures and greater regional integration, there remain significant gaps in relation to detailed regional guidance on migration and health issues for ECOWAS Member States. As in other African regions, while portability of benefits for migrants is enabled through regular migrants' rights to access social insurance schemes, often there are eligibility criteria linked to length of residence or amounts paid-in which limit migrants' access to health in real terms (for example, see the Nigeria country chapter below).



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Description: Hospital visit in Tanzania with quality checks for infrastructure, equipment and processes.



# SECTION B

**Country Analysis -  
Identified Migration  
and Health Issues on a  
National Level**

This section of the report presents data and analysis from five countries, each representing a different African region: DRC, Morocco, Kenya, Nigeria, and South Africa. Whilst the first two form extended case studies examining migration and health issues in each country, the latter three draw on primary data collected by and analysed with partner researchers in each country as part of the study project, including surveys, KIIs, and FGDs.

As noted above in section 3 on methodology, for each of these three countries, the research team selected three different sub-groups of migrants to focus on, each representing different migration pathways and potentially distinct sets of health needs. It was agreed with AUC and GIZ partners that the analytical study phase would focus on the following migrant sub-groups:

- Kenya: people in refugee-like situations
- Nigeria: regular (labour) migrants
- South Africa: irregular migrants.

Analysis and trends for each of the countries in this section are presented on a country basis. Each country presents its own unique context and has developed its own responses to its challenges in terms of migration and health.

Given the sheer diversity of geographical, economic, and socio-cultural contexts found across 55 AU Member States, it can be difficult to draw comprehensive or universally applicable conclusions or recommendations.

Nevertheless, there are some clear overarching trends and common gaps in policy and practice in relation to migration and health that could be applied to achieve better migrants' health and better public health across most, if not all AU Member States.

## 4 Democratic Republic of Congo

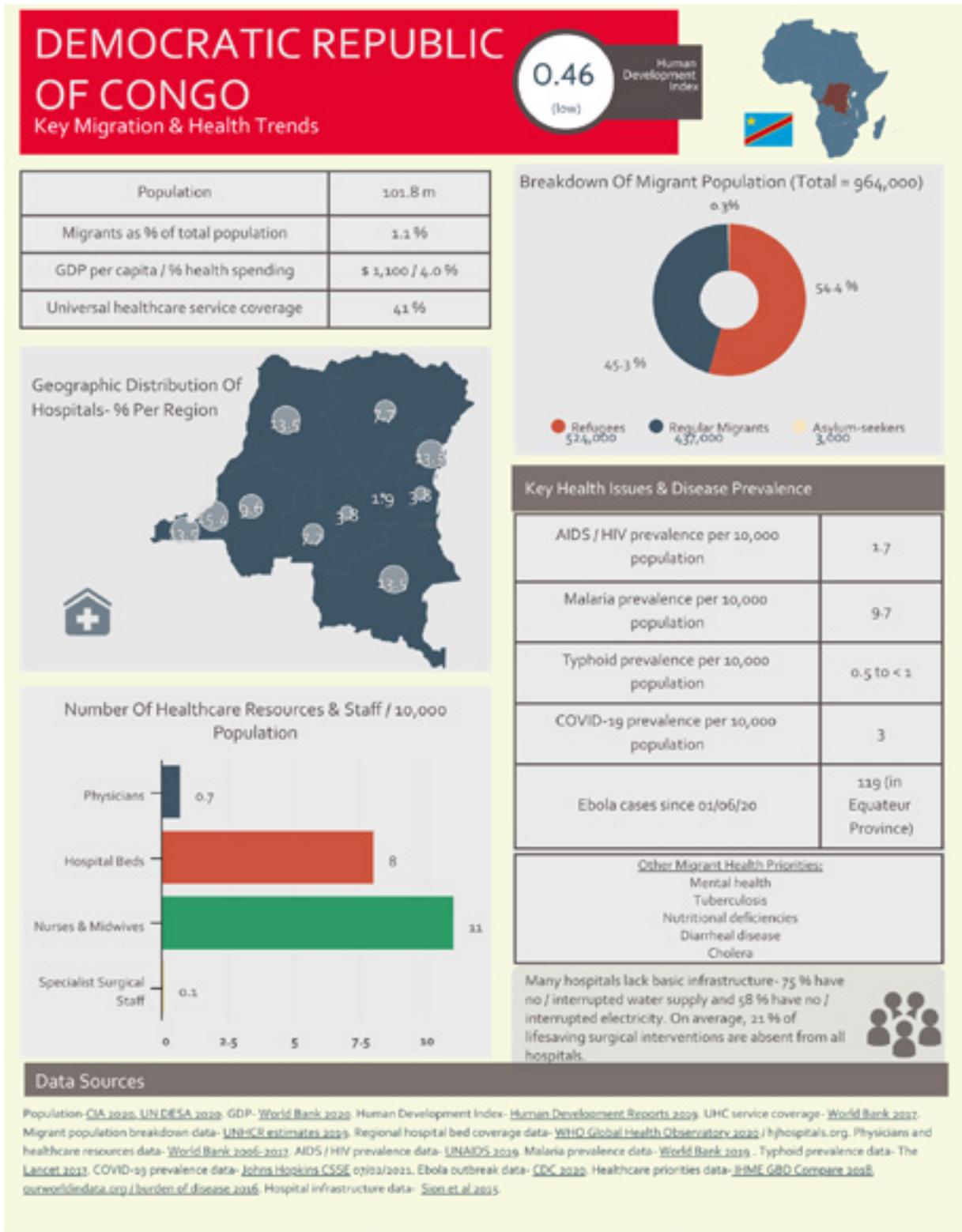


Figure 4: Infographic on Key Migration and Health Trends - DR Congo. (Source: own illustration)

## 4.1 Overview and Country Context

The Democratic Republic of Congo (DRC) is located in the southeast of Central Africa and has a population of around 102 m (Central Intelligence Agency, 2020) which makes it the most populated country in the region. Most of its 964,000 migrants come from Central African Republic (CAR) (330,000), Rwanda (250,000), Angola (180,000), South Sudan (90,000) and Burundi (60,000) (United Nations Population Division, 2019). However, there remains considerable uncertainty in statistics as different UN agencies apply different figures (Schoumaker & Flahaux, 2016). Additionally, the borders of DRC are known to be highly porous (Bedford, Akello, 2018), thus unrecognised crossings are likely to add high numbers to those official numbers (IOM, 2020b). The main reason for people to migrate to DRC is insecurity in neighbouring countries such as CAR. Consequently, 530,000 migrants were designated as refugees in 2020 (UNHCR, 2020f). DRC still witnesses ongoing domestic conflict, which forces many people and of course also migrants to keep moving around. This further displacement of people impedes the efforts of the authorities to reinforce public services (Bureau of Democracy, Human Rights, and Labor, 2019).

DRC has a GDP per capita in PPP of \$ 1,100 which, based on income, makes it one of the poorest countries in the world (World Bank, 2019g). The most significant pillar of the economy is the mining and extractives sector, with copper and cobalt being the main exports. The country is shattered by pervasive conflicts, and this is one reason why many humanitarian organisations are active in the country, providing food and health services to people in need. The life expectancy at birth was 60 years in 2018, which is just below the average in Sub-Saharan Africa with 61 years (World Bank, 2018c).

The health system in DRC has significant room for improvement: the number of physicians (0.07 /10,000 population) is a third of SSA average, which may result from low health spending by the government (\$ 3 per capita per year in PPP, (World Bank, 2021a), and which is reflected in the UHC score of 0.41. The diseases which cause the most deaths (DALYS) are malaria (13 % of deaths), disorders of newborns (11 %) and diarrhoea (6 %) (Institute for Health Metrics and Evaluation, 2019). Out-of-pocket health expenditure in 2017 was 40 % (\$ 8) per capita, which is likely to present a financial barrier for low income groups, to which migrants, IDPs and other vulnerable groups often account (WHO 2018) (World Bank, 2017c). Development assistance adds \$ 7 per capita, and insurance \$1 so overall health spending a year is \$ 19 per person (Institute for Health Metrics and Evaluation, 2015).

In 2019, 7.7 m people were of concern according (UNHCR, 2019b). Of this overall number, 7 m were IDPs and by definition of this research not addressed within this study. However, it is not advisable that measures targeting migrants' health focus on cross-border migrants only, as this may exclude the needs of the largest group of concern. Over 2 m of them have just returned in the last year; if this trend of resettlement continues, the numbers increase further throughout the next year. Thus, policies and programmes need to recognise that mixed migration pathways and journeys - especially in zones of insecurity or conflict - can bring together both international migrants and IDPs, so it is advisable not to exclude IDPs from migrant health policies and programmes.

With regards to demographics of refugees in DRC, 63 % of them are children (330,000) and 19 % are women (100,000) and 2 % elderly persons (12,000). Those figures will be readdressed within the vulnerable group section (UNHCR, 2019b). Further, 25 % of the refugees live in officially supplied camps in designated areas, additionally 73 % just outside those settlements and 1 % in urban areas.

## 4.2 Migration and Health Policies and Programmes

The 2005 Constitution of DRC guarantees the right to health, right to life, human dignity, and non-discrimination to all, thus including migrants, at least notionally (Art. 11 and Art. 16). Additionally, the right to asylum for all is recognised, the right to health and food security is mentioned (Art. 33, Art. 47) and the prevention of epidemics is ascribed to the provinces (Art. 204) (Democratic Republic of the Congo, 2005). The 2016 National Social Protection Policy highlights its principles to be universal and mentions migrants' rights to social protection in particular. The policy aims to provide access to health care and social protection (Politique Nationale de Protection Sociale, 2016). Further, Law n°021/2002: The Status Refugees in DR Congo led to the establishment of the National Commission of Refugees whose mandate is to address health care, housing, and education among other aspects (République Démocratique du Congo, 2002).

For labour migrants, Decree n° 70/0010 regulates the percentages of foreigners allowed to work in certain sectors, which varies from 1 to 10 %. A special focus is put on mining areas as residence and movement in this sector is prohibited by Law n° 86/007: Stay and movement of foreigners in mining areas (ILO, 1986).

## 4.3 Spotlight: Pandemic preparedness

DRC has been continuously challenged by epidemic diseases such as Ebola Virus, Measles, Cholera and now COVID-19. As the NGO Malteser International notes, the already strained health system is overburdened with any event of outbreaks, and the capacities for effective disease response are not sufficient (Malteser International, 2020).

Nevertheless, the eleventh Ebola outbreak was declared to be over in November 2020. For this, 40,000 people have been vaccinated, despite logistical challenges, like the need of the vaccine to be kept frozen at -80°C (WHO, 2020b). Such success stories may show that direct actions, such as detection of outbreaks and immediate response can function better than widely anticipated.

In the global health security index, DRC only occupies rank 40 out of 54 African countries (Global Health Security Index, 2020). In line with this indicator are the recurring outbreaks of different diseases: in 2020, DRC was challenged by a Measles epidemic, which started in early 2019 and was declared over by August 2020. Within this time, over 380,000 measles cases were reported, as a result of which 7,000 children died. A massive vaccination program for over 5.7 m children enabled the measles outbreak to be overcome (Ducombe & Gignoux, 2020).

The experience of past pandemics may have helped prepare DRC for new diseases. Regarding COVID-19, the number of total confirmed infections as of 10 February 2021 amounted to around 8,060 while the number of total deaths is estimated at approximately 122 (Johns Hopkins University, 2021a). While the number of deaths is high in relation to infection rates, the number of infected people is not. Measures such as night curfews and a ban on gatherings have been put in place when numbers were still low. Thus, the ongoing struggle against recurring epidemics may help build resilience for future outbreaks. At the same time, uncertainty remains due to test capacities. In January 2021, every third test was positive (Ourworldindata, 2021), so it is still too early for an overall assessment. However, a digitally connected health system may help prevent this in earlier stages (Volbrecht, 2019).

There is no evidence that migrants are regularly included in pandemic response plans. For example, by July 2020, no positive COVID-19 cases had been confirmed among migrants, IDPs or other people of concern, according to (UNHCR, 2019b). However, there is considerable uncertainty about this data, not least because of their mobility, their location in remote rural areas and the low number of testing, resulting in a high potential for undetected cases.

## 4.4 Health needs of vulnerable groups of migrants

According to UN OCHA, the most vulnerable migrant groups in DRC are women, children, people with disabilities, and of those, pregnant and nursing women in particular (UN OCHA, 2019, p. 69) The refugee population consists of 63 % minors below the age of 18. General protection risks for this group are family separation due to flight or armed conflict, forced recruitment for the military, forced labour in mines, lack of birth registrations and GBV. The latter may characterise a case of intersectionality of vulnerabilities as female children experience discrimination on more than one level. Also, the lack of birth registrations may have long-term consequences as unregistered people can suffer from limited access to health and educational provision. Further, a lack of documentation makes regular employment status, marriage and further migration and travel harder (UNHCR, 2019b, p. 12). Particular health risks affecting children are a higher mortality of children below 5 and measles (ibid. p.13).

52 % of the refugees in DRC are female. SGBV is a major issue in DRC in general as the estimates of women who have been victims of rape in DRC are very high, studies estimate them between 1.69 m and 1.8 m (Peterman et al., 2011). These estimations have been made based on the demographic and health survey in 2007, by this time 30 m women lived in DRC, which means around 6 % have been victims of rape. Additionally, more than 3 m have reported experiencing intimate partner sexual violence (ibid.). This problem is exacerbated because such crimes are more often committed in regions with a certain degree of legal insecurity, precisely the kind of regions migrants often have to move to due to their predicament, an example being North Kivu (ibid.). Consequently, humanitarian action focuses on prevention and response to SGBV (e.g., (Internal Medicine Associates World Health, 2017), (Panzi Foundation, 2020)), for example 85 % of the CAR victims received follow up psychological counselling (UNHCR, 2019b).

Reproductive health issues are also widespread in DRC. With 2,800 infant deaths, 2,700 stillbirth deaths and 473 maternal deaths out of 100,000 live births in 2017, this health field needs improvement. As a means of

comparability, Kenya suffered 2,000 infant deaths, 2,300 stillbirth deaths, and 342 maternal deaths, which is around 25 % less (Healthy Newborn Network, 2018).

People with disabilities generally face a bigger set of challenges. In DRC, the observation has been made that they face higher risk in several regards even in designated camps: food distribution may be a problem as mobility is reduced and people do not reach dispensing stations. Therefore, logistical services and inclusive infrastructure within camps may reduce such discrimination (CBM, 2014). Besides such physical disabilities, mental disorders may not be forgotten, which are connected with unemployment for every second person (On'okoko et al., 2010).

Following differentiation by countries of origin, migrants from Burundi, CAR, South Sudan, and IDPs are among the most vulnerable in DRC (UNHCR, 2019b). The vulnerability derives from the volatile security situation and their more recent arrival in the country, through which adaptation is still ongoing. Most refugees from other countries, such as Angola and Rwanda, have been in the country for two decades now, and the level of health assistance provided is decreasing as the focus is shifted towards their long-term integration (e.g., provision of education) rather than short-term humanitarian action (e.g., medical provision) (ibid.).

An overview of refugees is provided in Figure 5 below. As may be expected, most camps and settlements are in border areas.

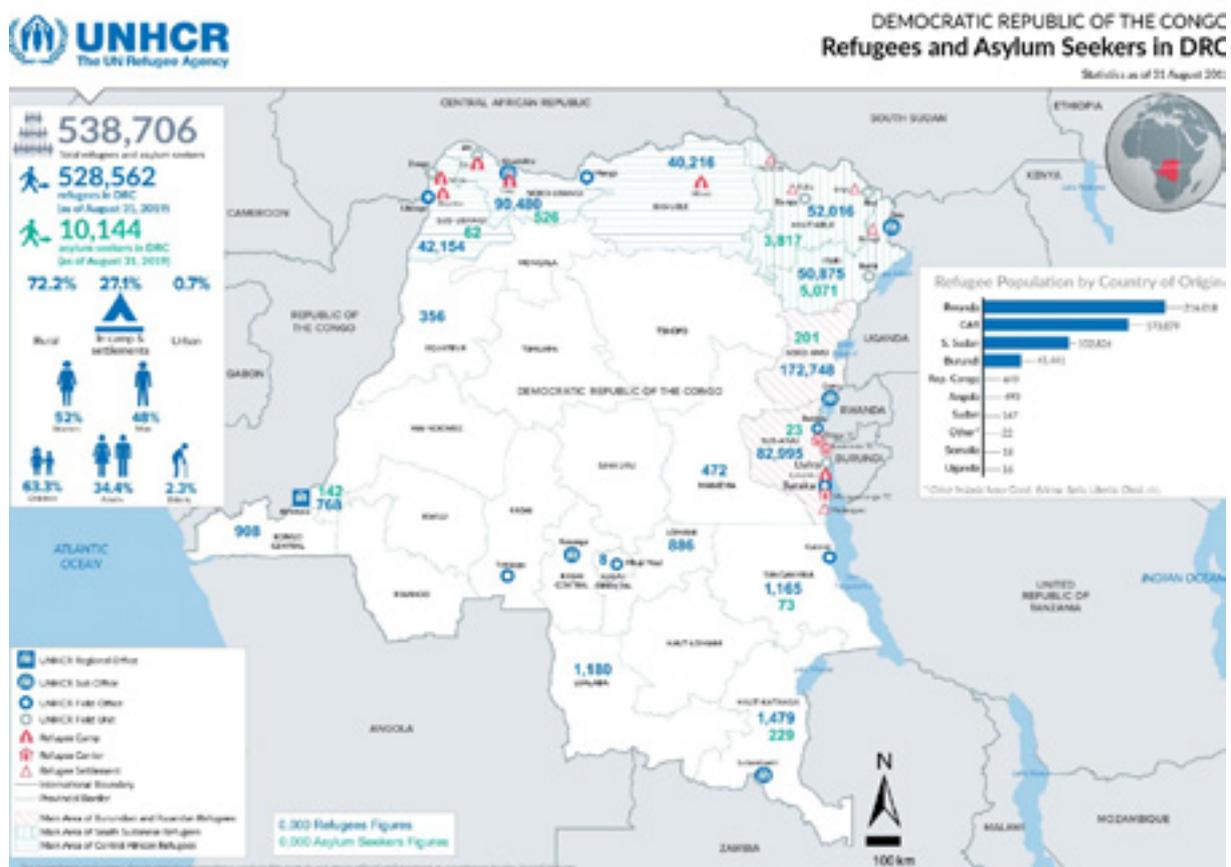


Figure 5: DRC's refugee population.  
 (Source: UNHCR, 2019a)

People from CAR reside mainly in the North West of DRC. 65 % of the 170,000 migrants from CAR live in rural areas outside of camps, and it is harder to reach them with humanitarian assistance (UNHCR, 2019b). This is why registration not only of refugees but also of migrants' new-borns remains an issue and presents further challenges to improving health care provision to these groups. Also, insufficient prevention and response activities against SGBV exist outside the refugee camps. Regarding the difficulties between different accommodation sites, a UN official mentioned:

"You know, there are different reports of people, actors providing different migration, health systems. [...] It's a range in which it's difficult to find a way of assisting in a systematic way

of measuring the impact of all this assistance provided. and this is mostly in the case of immigrants who are undocumented or in informal settlements, whereas you can consider refugees and IDPS as one form of migrants.”

Refugees from South Sudan mostly live in the North East of DRC. 63 % of the overall 90,000 migrants live among their respective host communities rather than in camps. However, the additional need for medicine puts pressure on the existing health centres, so health care is not always guaranteed. Furthermore, a lack of housing can force health complications as only 58 % have adequate shelter. In addition to this, existing camps are overcrowded, which can make it hard to fight COVID-19. A further challenge is the educational provision for children, which is not sufficient and may decrease the well-being of children (UNHCR, 2019b).

48,000 refugees from Burundi are mostly located in the east of DRC, namely South Kivu province. Generally, verification processes are slow, so obtaining or renewing an ID card is not straightforward for this group. This can make it difficult to access health insurance or health care. Moreover, the quality of services in sexual and reproductive health and rights (SRHR) are in need of improvement, e.g., through training of medical staff. Lastly, procurement of medicine was a challenge in 2019 (UNHCR, 2019b).

Internally displaced people are mostly found in the central and eastern region of DRC, namely in the provinces Ituri, Kivu, Kasai. Those IDPs mainly originate from these regions but move away from home due to violence. Because of ongoing conflicts, locations and numbers may vary significantly. At the beginning of 2020, more than 7 m IDPs were estimated by (UNHCR, 2019b). Many lives of the IDPs are vulnerable due to the conflicts. Also, overcrowding of shelters or camps is a major issue. These facilities are rare and provide a good breeding ground for diseases such as Cholera, Ebola, or COVID-19, which can rapidly turn into epidemics due to the high density of persons. For the IDPs, the risk of sexual violence and exploitation of women and girls is increased, while the lack of courts makes the prosecution of perpetrators more difficult. In addition, prevention and response activities are rare in the conflict areas (UNHCR, 2019b)

In general, people in vulnerable situations are mentioned within the National Social Protection Policy (Politique Nationale de Protection Sociale, 2016), in particular the promotion of gender equality is listed as one of the basic principles, although it states that this should be achieved through capacity building, without further specification. Based on the listed statistics, efforts may be enhanced in providing health services to vulnerable groups.

## 4.5 Policy Assessment

The long-lasting internal conflicts in DRC complicate the provision of health care services for migrants and citizens. The issue of migrants’ health is one of the many symptoms of the regional conflict. The health of approx. 25.5 million people are defined as “in need” as a result of this humanitarian crisis. Just over 2 million of them are reached by international response plans (Humanitarian InSight, 2020). This high share relative to the overall population suggests that policies meet significant barriers of implementation.

The health sector in DRC is unregulated in many regards, which causes an under-provision, in terms of quality and quantity, of goods and services (Kalisya et al 2015, MSF 2019). The provision of medicine is a key issue in DRC, and medication circulation is below international standards (WHO 2015). Pharmaceutical businesses but also health clinics are uncontrolled and have sometimes even opened up illegally (SHOPS Plus 2019). The quality of the institutional infrastructure also suffers; for example, some clinics are not connected to basic infrastructures, such as roads but also telephone network or internet connection. In addition, the quality of staff is not always consistent within uncontrolled health care providers, as a UN official interviewed notes:

“To accompany, health structure in the establishment and to avoid any utilisation by others who are not the health care professional to do the job. So we need, to reinforce local law in terms of politics. This is the first point I can recommend. The second part is, to support them, to accompany them in terms of training, because they need training to improve the quality of care”

Consequently, there is a discrepancy between public and private health facilities (Systems for Improved Access to Pharmaceuticals and Services, 2017).

Population movements impose public health issues on areas affected by conflicts and disasters, which further weakens local health systems. Those most affected are refugees, returnees, IDPs, and parts of the host communities, particularly children under 5 years, pregnant and nursing women and persons living with disabilities (UN OCHA, 2019, p. 69).

Primary health care and sexual and reproductive health services reach over 90 % of people in need. However, a lack of secondary health services is evident, as only 15 % of 208,000 people in need benefited from it, as funding remains an issue (Humanitarian InSight, 2020). Further, of the 5 million people affected by Cholera or measles epidemic, 25 % benefit from sectoral care (Humanitarian InSight, 2020). Overall shortcomings occur in several aspects, while exact numbers are subject to change (ibid.).

The National Social Protection Policy recognises the vulnerability of women. Thus GBV is followed up in some cases and medical care provided to victims, but in 2020 just 16 % of people in need were reached. As such, efforts also need to increase in this regard (Humanitarian InSight, 2020). The health and safety standards specified by the law °92/007: Labour Code and other working migrants' rights cannot be controlled sufficiently, as only 200 labour inspectors are employed (Bureau of Democracy, Human Rights, and Labor, 2019, p. 47). By law, working conditions that endanger the health and safety of workers, inspectors shall request the employer to remedy the situation (Sec. 96: (1), this cannot be guaranteed. Especially in the mining sector, this may occur. A possible solution of this was mentioned by an interviewee from AU NEPAD, to engage unions with policymakers:

“One of the issues we noted was that workers themselves are [not] engaged in the process of policymaking and the broader community, most of the time is not involved when it comes to policy formulation and since we are working with countries in trying to address this, [...] to ensure that the unions are involved to set up committees in the countries where we are working”.

## 4.6 Recommendations

Achieving adequate health care provision in DRC is challenging, and the health system in the country requires investment and capacity-building to improve health outcomes for all population groups, including migrants and refugees. This study makes the following recommendations in relation to migration and health in DRC:

- The quality of the health facilities could be improved by offering training to staff and also regular examinations if private and public facilities meet necessary standards
- Strengthen hospital infrastructure: all hospitals should be connected to telecommunication networks
- Accessibility of health facilities should be improved, including siting health services near significant migration routes
- To improve migrants' health in particular: development of more effective policy frameworks, such as entitlement to health check on arrival, and better implementation of existing health strategies for vulnerable groups, could improve the overall situation of migrants' health.
- Existing policy frameworks should be extended through ratification of international conventions which ensure birth registration for all, which would be a useful step in improving migrants and refugees' access to health services.
- Occupational safety and health measures should be put in place in a participatory process (e.g., advocacy by unions) and controlled (JLMP, 2020c)
- The government should continue to work with international partners on minimum health standards for all and enhance on delivery of health services for refugee camps to comply with. The WHO essential health package, including medicine, regular examination and treatment in case of emergencies (e.g., accidents), adapted to different country contexts, could be used (WHO, 2008).
- In the context of the current COVID-19 pandemic, there is a need for increased investment in WASH facilities and medical supplies and personnel for refugee camps and settlements in DRC.
- DRC has been successful in combating pandemics such as the Ebola Virus or the containment of COVID-19 so far. Potentially, DRC could draw on its experience of vaccination programmes to inform AU MS for the development of a vaccination plan against COVID-19.
- Further research is needed on the health needs of different migrant groups in DR Congo, as well as on how migrants and refugees can be better included in pandemic preparedness planning.

## 5 Morocco

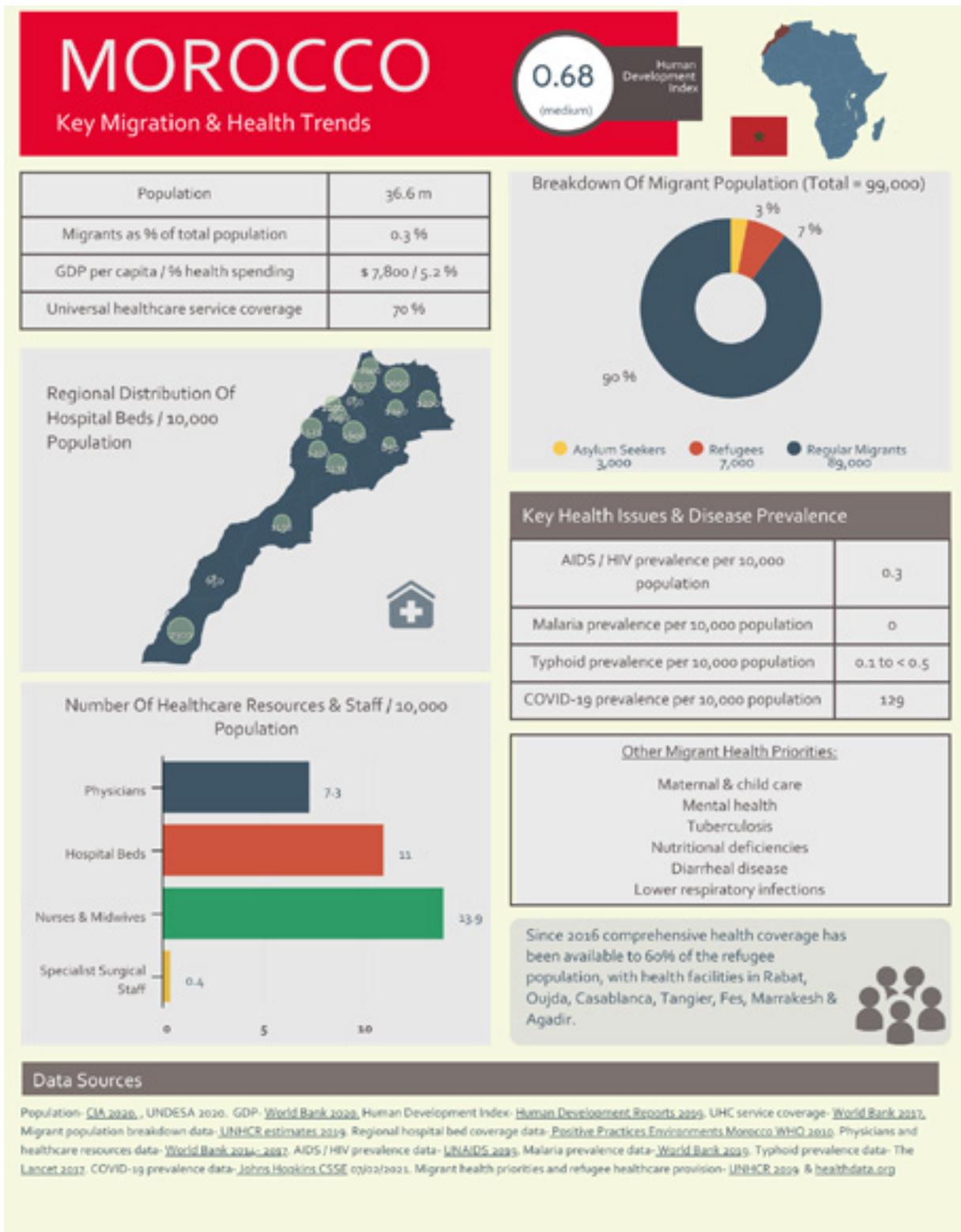


Figure 6: Infographic on Key Migration and Health Trends - Morocco. (Source: own illustration)

## 5.1 Overview and Country context

The World Bank ranks Morocco as a lower-middle-income country, with a total GDP of roughly \$ 120 Billion in 2019 (World Bank, 2020d). The total population was estimated at 36.5 m in 2019 (ibid) with a GDP per capita of \$ 3,204 PPP in 2019 (World Bank, 2020b). The economic sectors of services, industry, and agriculture, account for 56.5, 29.5 and 14 % of the GDP, respectively. The life expectancy at birth is estimated at 76 years (World Bank, 2020c), while the infant mortality rate has continuously declined over the years to approximately 18.3 cases in 1,000 live births in 2019 (World Bank, 2020e).

The health system in Morocco consists of a public as well as a private sector, the latter comprising both a not-for-profit and a private for-profit branch (H. Semlali, 2010). In 2017, Morocco spent 5.2 % of the GDP per capita on health which meets the minimum 5 % recommendation advised by WHO (WHO, 2003). The total health expenditures can be divided into government (42.9 %), private (56.9 %) and external (0.2 %) expenditures. On average, 53.9 % of the total health expenditure was out-of-pocket expenditure, i.e., costs borne by patients themselves to acquire health services. Morocco counted approximately 7.3 medical doctors and 13.9 nursing and midwifery personnel per 10,000 population in 2017 (WHO, 2020d). Non communicable diseases such as cardiovascular diseases, neoplasms and mental disorders are some of the most pressing health challenges in Morocco. In contrast, health issues such as maternal/neonatal health, respiratory infections, including tuberculosis, enteric diseases (caused by contaminated food or water), and other infectious diseases have seen a sharp decline over the past years (IHME, 2020d).

### Political context & migration overview

Youth-led protests and uprisings demanding radical political change, a wider regional movement which would go on to be known in the Western world as the “Arab Spring”, were first observed in Tunisia in 2011, and also reached Morocco. Albeit not being as violent and not counting nearly as many casualties as some of its neighbours, Morocco witnessed thousands of youths taking to the streets over better living and working conditions, as well as profound political reforms (Sater, 2011). Some of the underlying root causes such as high youth unemployment and lack of economic opportunity can also be considered major drivers of migration both globally as well as in the region.

Several years earlier, in 2003, a terrorist attack shook the city of Casablanca and claimed the lives of 33 civilians plus 12 suicide bombers (BBC News, 2009). This devastating attack marked a turning point in Morocco’s national security policy and had tangible ramifications for migrants in the region. As a result, the government ordered an additional 8,000 guards to further secure its borders, abandoning its former rather lenient attitude towards Sub-Saharan migrants, many of whom transiting through Morocco on their way to Europe (Ijzerman, 2020).

Morocco was readmitted to the AU in 2017 (African Union, 2020a) after a 33-year absence over disputes concerning the recognition of Western Sahara (cf. Hicks, 2017). The readmission has in part been attributed to the adoption of its 2013 National Strategy for Immigration and Asylum, praised for its coherent and human rights-based approach, that laid the ground for the regularisation of larger numbers of undocumented migrants (cf. Crétois, 2016). Subsequently, some 50,000 irregular migrants, mostly coming from Sub-Saharan African countries, were regularised as part of two regularisation campaigns in 2014 and 2017, respectively (Mechai, 2018). Incidentally, a study conducted by the University of Rabat found that more than 67 % out of 1,400 migrant respondents who had applied for regularisation actually stated that they intended to stay in Morocco rather than to continue their journey towards Europe (Mourji et al., 2016, p. 37).

The adoption of the National Strategy for Immigration and Asylum, along with the development of new draft laws and a new strategic approach towards Moroccans resident abroad (Marocains résidents à l’étranger or MRE), can arguably be seen as part of a general change of direction in Morocco’s migration management in an attempt to adopt a more human rights-based approach in addressing migration related issues, after a report denounced alleged violations of migrants’ rights in Morocco (Conseil national des droits de l’homme, 2013).

Morocco plays an important role in the Rabat Process, having assumed the role of a key strategic partner to European countries, notably France and Spain, who have urged the North African country to put in measures to manage migration flows of Sub-Saharan migrants reaching Europe (El Ghazouani, 2019b). Morocco established a National Migration Observatory in the Migration and Border Surveillance Directorate under the Ministry of Interior in 2014, thereby consolidating the legal basis of the EU-Morocco relationship (ibid). The African Union also established an African Migration Observatory in Morocco in 2020 (African Union,

2020e). In his second report on the establishment of the Observatory, King Mohammed VI, in his role as appointed leader of migration issues by the AU, stressed the importance of putting Africa at the heart of the implementation of the Global Compact for Safe, Orderly and Regular Migration (GC-SORM) (MAP Express, 2020).

Historically an emigration and transit country, Morocco has increasingly become a country of destination in recent years, especially for migrants originating from Sub-Saharan Africa. There are an estimated 60,000–70,000 registered migrants and refugees (IOM, 2020j), plus an additional 20,000 persons on the move without formal status (WHO, 2016), with numbers expected to continue to rise. Besides migrants originating from Europe (Spanish and French nationals accounting for more than 40,000 of the approximately 100,000 reported migrants), the majority of persons from African countries originate from Algeria (14,200), Tunisia (2,700), and the Republic of the Congo (2,000) (UN DESA, 2019a).

UNHCR reports a total of roughly 12,000 people of concern, including 7,600 refugees and 4,400 asylum seekers, with Syria (4,200), Guinea (1,200), and Cameroon (1,000) constituting the main countries of origin (UNHCR, 2020d). According to UNHCR, there was a 30 % increase of new registrations across 52 different locations in Morocco in 2019 compared to the year before, the total number of refugees represented having increased by 12 % over the year (UNHCR, 2019d). This wider dispersion might enable migrants' integration more effectively than large, enclosed complexes, but at the same time poses challenges in terms of effective outreach, which UNHCR has identified and sought to address through the expansion of cash-based interventions to include very remote locations (ibid).

According to Permanent Representative of Morocco in Geneva, Ambassador Omar Zniber, cooperation between UNHCR and the relevant Moroccan authorities in line with COVID-19 measures has paved the way for full access to health for refugees and asylum seekers, including access to specialised health care services through a partnership agreement concluded with the National Council of the Order of Physicians (Kingdom of Morocco, 2020).

## 5.2 Migration and Health Policies and Programmes

In addition to the Constitution (2011) which promises to ban all forms of discrimination, be it based on regional origin or other personal characteristics, Morocco has carved out several political frameworks promoting migrants' health care provision. These are in line with the Draft Global Action Plan Promoting the health of refugees and migrants for the period 2019–2023 (WHO, 2019) and predominantly consists in the National Strategy for Immigration and Asylum (2013). The Strategy aims to both prompt a more holistic approach amongst involved state bodies working to promote migrants' health as well as to ensure that migrants and refugees have access to health care under the same conditions as Moroccans. The latter has been announced to be further elaborated in a National Strategic Plan on Health and Immigration (2019) which has been revised with IOM support as commissioned by the Moroccan Ministry of Health (IOM, 2019d).

These policies and strategies add to the Rules of Procedures of Hospitals (Royaume du Maroc, 2011b) which state that non-Moroccan patients are to be admitted in hospitals, irrespective of their administrative situation and under the same conditions as Moroccan patients. Morocco was one of the first countries to sign and ratify the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (UN, 1990), which states that “[m]igrant workers shall enjoy treatment not less favourable than that which applies to nationals,” referring to work-related health in general (Art. 24), emergency care (Art. 28) and access to social security and health care schemes (Art. 43 e). The National Health Plan 2025 includes strategic pillar 10 “Strengthen health promotion for populations with special needs” which includes as an action (47) to “Launch and implement the National Strategy on Migrant Health” (Royaume du Maroc, n.d.).

While the adoption of new asylum and migration laws is pending, the law 02-03 on the entry and residence of foreigners in the Kingdom of Morocco (2003) continues to serve as the country's main immigration document, detailing how migrants can acquire official status within the country and outlining legal guidelines and rights of foreigners, it does not touch upon health care for migrants directly. It does, however, regulate how migrants can acquire an ID card (Article 16) which in turn determines the extent to which they have access to different health care services (Haden, 2020). This is particularly relevant regarding secondary care, as all migrants are entitled to free primary health care services, even though there are indications that this practice is not always effectively implemented (cf. Plateforme Nationale Protection Migrants, 2017).

Also, migrants are included in health programmes targeting HIV/AIDS, tuberculosis, malaria and vaccination rollouts (ibid). Similarly, in the past Morocco has stated its willingness to set up a national asylum procedure

through an asylum law but this has not been finalised (cf. Royaume du Maroc, 2018; El Haïti, 2019).

Additionally, there have been efforts to sensitise health care service providers for the particular needs of migrants, as could be seen in a training of health professionals from primary health care facilities in the Casablanca-Settat region, co-developed by the Ministry of Health, Morocco's National School of Public Health (ENSP) (fr. Ecole Nationale de Santé Publique) and IOM (IOM, 2018b)

According to Prevent Epidemics (2020), a group of global health experts that collaborates with governments to promote the implementation of evidence-based strategies, Morocco's ability to respond to future epidemics shows room for improvement, despite having put in place a National Action Plan to fight COVID-19. They identified gaps in the areas of antimicrobial resistance, biosecurity, national legislation, and financing. In the aforementioned National Action Plan (Royaume du Maroc, 2020a) developed by the Ministry of Health, migrants are not explicitly mentioned. However, the Ministry does state elsewhere that migrants and refugees are indeed included in the National Action Plan and provide a hotline which all migrants and refugees are invited to contact if they need information or if they present with symptoms (Royaume du Maroc, 2020b). Other implications in relation to the current pandemic, such as migrants' effective access to health services or other supportive measures, are not further elaborated.

For the total population in Morocco, 8,424 deaths specific to COVID-19 have been reported in total as of 10 February 2021 (Johns Hopkins University, 2021b). To stop the further spread of the virus (between 2,000 and 4,000 confirmed daily infections were reported in the last week of November 2020) (IHME, 2020a), the Moroccan government announced in early December 2020 that it will use the COVID-19 vaccine developed by the Chinese pharmaceutical group Sinopharm as part of its announced national COVID-19 vaccination campaign (Hatim, 2020). The vaccine rollout, which comprises vaccines both from Sinopharm as well as AstraZeneca, started on 28 January 2021 (Rédaction AfricaNews, 2021). Asked about the price individuals will need to pay in order to get vaccinated, Minister of Health Khalid Aït Taleb announced in November 2020 that "the country has done everything possible to make [the vaccine] available to its citizens" (Telquel, 2020), adding that affiliates with the Compulsory Health Insurance AMO (fr.: Assurance Maladie Obligatoire) will be reimbursed. The aforementioned insurance scheme covers "any person exercising a lucrative activity" (Royaume du Maroc, 2018a, p. 13), which implies that any person engaged in (formal) employment should be covered in this sense. Individuals who are not eligible for this comprehensive security scheme can apply to be covered by the RAMED (Regime for Medical Assistance to the Most Deprived, fr.: le Régime d'Assistance Médicale). There are indications that persons affiliated with the RAMED will also be reimbursed for their costs for the anti-COVID-19 vaccine (Asmlal, 2020). In conclusion, non-nationals residing legally in Morocco are expected to benefit from free COVID-19 vaccination, while persons in an irregular situation are reportedly excluded (InfoMigrants, 2021).

On an intergovernmental level, IOM, in cooperation with WHO, UNHCR, UNICEF, translates and disseminates information developed by the Ministry of Health around COVID-19 prevention measures to make them accessible to migrant communities. In addition to that, IOM examines the impact of COVID-19 on the most vulnerable migrants in order to identify and address specific needs, such as food, shelter and hygiene (IOM, 2020e).

## 5.3 Health needs of vulnerable groups of migrants

Besides Article 26.7 / 26.8 in the 02-03 law on the entry and residence of foreigners in the Kingdom of Morocco, which explicitly forbids the expulsion of non-national pregnant women, the level of consideration of female migrants' particular (health) needs has to be described as rather low (cf. El Ghazouani, 2019a). The National Strategy for Immigration and Asylum (2013), for example, does not differentiate migrants by gender and therefore fails to acknowledge female migrants' heightened vulnerability, as they are at higher risk of falling victim to human trafficking, assault and sexual violence (cf. MSF, 2010). This contravenes important international guidelines for the protection of women, such as those developed as part of the International Conference on Population and Development. Its 2014 Programme of Action calls on all countries to "eliminate all forms of exploitation, abuse, harassment and violence against women" and especially those in potentially exploitable situations such as migrant women (UNFPA, 2014, Action 4.9). It is noteworthy, however, that Morocco adopted law n° 27.14 in 2016, which aims to combat trafficking in persons, as well as the instalment of a national commission on counter-trafficking in 2018, which has since launched activities (Royaume du Maroc, 2016a).

Resulting health needs are not always adequately met by services, seeing that victims of sexual exploitation or violence are not sufficiently protected by state authorities and therefore need to rely on support provided

by civil society (cf. El Ghazouani, 2019a, van den Aamele et al., 2013) which tends to be more present in urban areas whilst service provision in rural areas is often less well established (Euro-Mediterranean Human Rights Network, 2012). Thus, comprehensive and multi-level prevention actions against sexual violence and exploitation of migrants could lead to a significant increase in migrants' safety and health-related outcomes (Keygnaert et al., 2014). This could be facilitated by better coordination and information sharing between different agencies to ensure needs are identified and adequately addressed.

There are several civil society organisations that advocate specifically for the rights of female migrants in Morocco such as the Association of Women Sub-Saharan Immigrants in Morocco (AFSIM) (fr.: L'association des Femmes subsahariennes immigrantes au Maroc), the Committee of Sub-Saharan Women and Children Victims of Immigration (COFESVIM) (fr.: Le Comité des femmes et enfants victims de l'immigration) or The Voice of Migrant Women in Morocco (fr.: La Voix des Femmes Migrantes au Maroc) (Royaume du Maroc, 2016b).

## 5.4 Policy Assessment

Despite the anchoring of migrants' health in the policy documents listed above, the question remains whether (all) migrants are actually able to access adequate health services in practice. IOM's 2016 Migration Governance Index ranks the rights of migrants in Morocco, which includes the extent to which health care services are accessible, as "emerging". This corresponds to a score of 2 out of a maximum of 4 (IOM, 2016).<sup>6</sup>

While all migrants have a right to provision of basic health care and treatment in case of emergency (cf. Bentaleb, 2019) and to seek assistance from civil society organisations (IOM, 2016), formal registration is a prerequisite in order to access more comprehensive medical care and, since 2015, qualify to be enrolled in health security schemes such as the RAMED (Royaume du Maroc, 2015). Nevertheless, there are indications that knowledge of the existence of such programmes amongst migrants seems to be rather limited (Mourji et al., 2016). In the case of refugees whose inclusion into the RAMED is yet outstanding, UNHCR is one of the leading actors providing medical coverage (UNHCR, 2020d).

There are also common beliefs across broader Moroccan society linking the arrival of sub-Saharan migrants to the spread of disease, drug abuse, and prostitution (Ijzerman, 2020). Initiatives such as one by the Anmar Federation of Local Communities in Northern Morocco and Andalusia, which aims to debunk stereotypes about (irregular) migrants through sensitisation campaigns, could help challenge the prevailing narrative on migrants (Dumpis, 2021).

Migrants residing in Morocco, whether they are engaged in formal or informal activities, are eligible for cover through an insurance scheme similar to the RAMED, provided a regular residency status (IOM, 2019c), while according to UNHCR the extension to refugees is pending as of September 2020 (UNHCR, 2020d). These developments should be further observed, not least considering that in his address to parliament on 09 October 2020, King Mohammed VI presented a far-reaching plan to extend social security measures which includes the vision to extend Universal Health Coverage to benefit an additional 22 million individuals by the end of 2022 at the latest (Royaume du Maroc, 2020c).

## 5.5 Spotlight: Regional cooperation to promote migrants' health

In February 2020, Morocco's National School of Public Health (ENSP) (fr. Ecole Nationale de Santé Publique) in cooperation with IOM Morocco, with the support of the Moroccan Agency for International Cooperation and the Ministry of Foreign Affairs of Finland, held the first Regional Winter School on sexual and reproductive health, mental health and psychosocial support for migrants. The initiative partnered with the Moroccan Ministry of Health, whose Secretary General Abdelilah Boutaleb chaired the event, and the Ministries of Foreign Affairs and International Cooperation Deputy Ministry for Moroccans residing abroad and Migration Affairs. This event was one of several activities conducted following the signing of a framework agreement on the promotion of migrants' health between ENSP and IOM Morocco in February 2018 (ENSP, 2020).

The Winter School falls under IOM Morocco's programme "Promoting the health and protection of vulnerable migrants transiting Morocco, Tunisia, Libya, Egypt and Yemen", which was carried out in partnership with

6. According to the level of the overall institutional development, different subcategories were quantified as either "nascent", "emerging", "developed", or "mature" (IOM, 2016)

the Moroccan Ministries of health and migration. In adopting this regional approach, the event facilitated cross border collaboration and information sharing between Member States, with the aim of replicating good practices at the regional level.



Figure 7: Participants at the opening of the first Regional Winter School.  
(Source IOM (2020), photo credit: ENSP)

57 international participants, including researchers, health professionals, civil society organisations (CSO's), social workers, and international organisations, convened to discuss and foster mutual learning in the field of migrants' health (including mental health) and protection (including psychosocial) and also to guarantee the sustainability of the actions implemented in the different countries involved (IOM, 2020d) The event provided an opportunity for the different stakeholders to exchange and network across sectors, discuss recent studies on migrants' health and, based on insights from information sharing from the different Member States involved, propose recommendations for policy development as well as practical interventions for service providers that work directly with these target groups (ENSP, 2020)

## 5.6 Recommendations

In line with previous recommendations made by scholars and international organisations, the study concludes that the following recommendations will have a positive impact if implemented:

- Making migrants' health needs the joint responsibility of different state actors will strengthen the consideration of migrants' health care needs across projects and decisions in other sectors
- Extending UHC, including extension of health insurance schemes to migrants residing in Morocco, irrespective of their status, thereby adopting a 'social floors' model
- Further specialised training for health care professionals tailored to the specific needs of migrants could help to further improve the quality of health care service delivery on the ground, especially in the field of mental health and psychosocial support as well as mainstreaming the need of particularly vulnerable groups of migrants such as women and children
- Extending existing and developing new partnerships with international organisations and also diaspora health networks could help strengthen health and disease surveillance systems, especially in cross-border areas, through capacity-building and skills exchange. For example, IOM's Health, Border and Mobility Management Framework, successfully implemented in border regions in DRC (IOM, 2020f), could be adapted to the Moroccan context to strengthen capacity of frontline workers, thereby improving surveillance, contact tracing, flow monitoring and hygiene promotion
- Increase efforts to promote the development and adoption of the announced Migration and Health Policy, which includes full consideration of migrants in health insurance schemes, as well as for the announced asylum law
- Further efforts for the integration of international migrants and social cohesion, as demonstrated in an initiative by Anmar Federation of Local Communities in Northern Morocco and Andalusia. Initiatives that combat prejudice and stereotypes towards migrants, such as "Vivre Ensemble", launched by the Spanish Agency for International Development Cooperation and supported by the EU, should continue to be supported and expanded.

- Continue to foster regional collaboration to promote migrants' health, as was the case with the Regional Winter School on SRHR and mental health (especially in light of AMU's inactivity)
- Further strengthening pandemic preparedness and response to emergency health crises that comprehensively consider migrants
- Further enhancing the collection and analysis of data on migration and health through quality disaggregated data, including migration indicators in the National Compulsory Health Insurance Scheme (AMO)
- Adopting best practices in epidemiological surveillance in exchanging with other African Union Member States

## 6 Kenya: Refugees

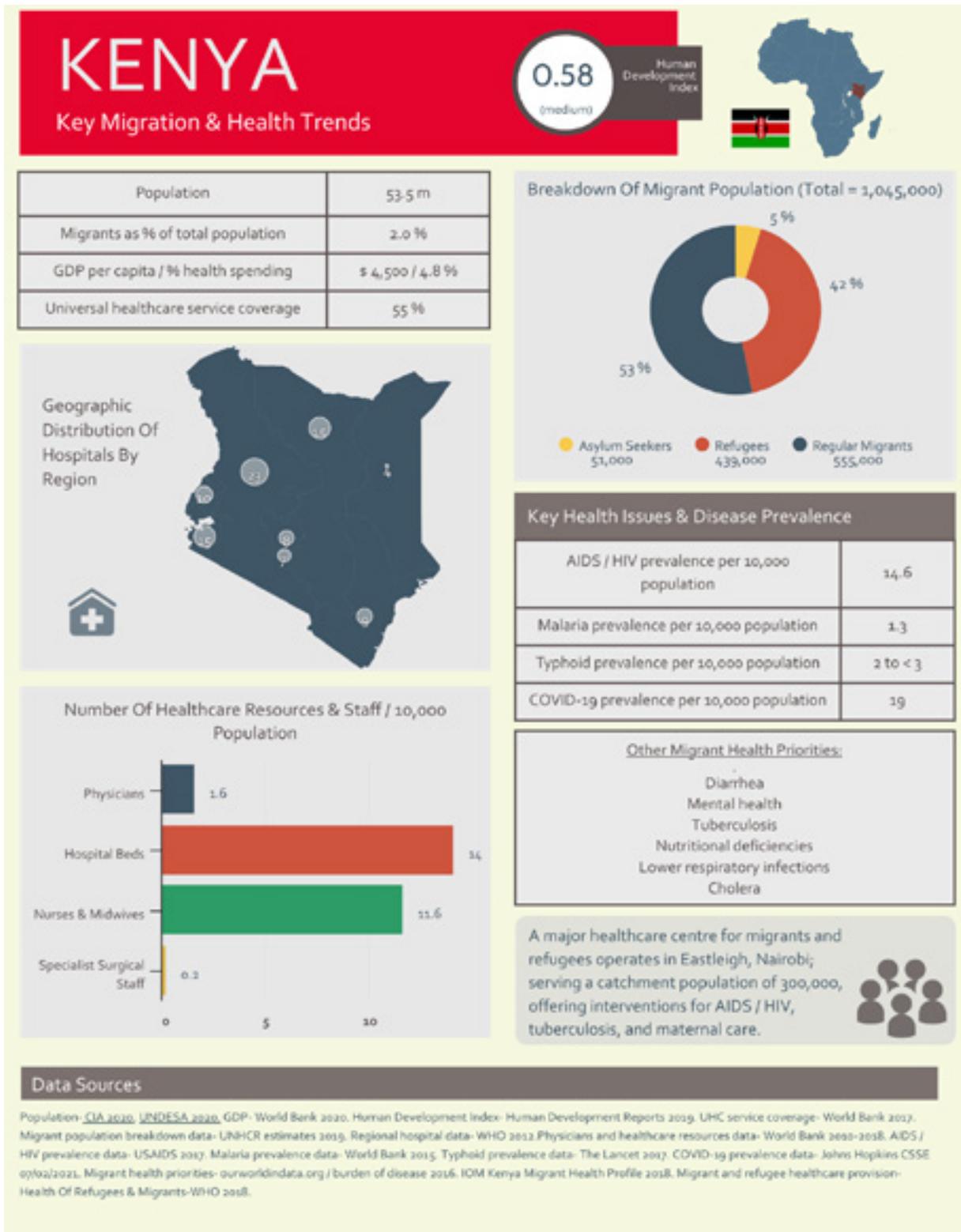


Figure 8: Infographic of key health and migration data - Kenya.  
 (Source: own illustration)

## 6.1 Country context

Kenya is primarily a destination and transit country with high importance for migration movements in the region. Aside from traditional migration patterns of nomads and pastoralists, and Kenya's position as an important destination country for circular and long-term migration for the region, there is significant irregular migration into and transiting through Kenya. In addition, forced displacement due to conflict, political instability and natural hazards also bring migrants into the country (Hargrave & Leach, 2020). However, Kenya has had an average net migration of -50,000 people, meaning that more people leave the country every year than enter it (World Bank, 2019c). These numbers are of course estimates which need to be assessed critically, given the large human trafficking and smuggling movements in and out of Kenya.

The country has long been a host for migrant populations, and is currently hosting approximately 1 m migrants making up approximately 2 % of the population (Hargrave & Leach, 2020). These originate mainly from Somalia (450,000), Uganda (310,000), and South Sudan (90,000) (United Nations Population Division, 2019). Of these migrants, almost 500,000 are refugees. 44 % (220,000) of them reside in the Dadaab refugee camp complex in the northeast of the country, 40 % (200,000) in the Kakuma complex in the northwest and 16 % in urban areas mainly in Nairobi (UNHCR, 2020a). These numbers make Kenya the fourteenth biggest host of refugees worldwide and the fifth biggest in Africa (World Bank, 2019a). The refugees come mainly from Somalia (53.7 %) and South Sudan (24.7 %) (Hargrave & Leach, 2020). While it is technically possible for everyone entering Kenya to obtain a work permit, there are administrative barriers, high cost and skills requirements in place that restrict refugees in particular, but also other migrants, from entering the formal labour market. This pushes them into informal labour and irregularity with the associated difficulties accessing health care or a bank account (Hargrave & Leach, 2020).

Kenya is also a transit country to Southern Africa (especially South Africa), the Arabian Peninsula and Europe due to its long and relatively uncontrolled borders with Somalia, good land and air transport connections, and well-developed smuggling networks (Danish Refugee Council, 2016). However, voluntary migration to Kenya in search of better livelihoods is also an important factor. Compared to other countries in the region of Eastern Africa, Kenya attains a higher Human Development Index (HDI) score of 0.58 (Roser, 2019) and GDP per capita of \$ 4,330 PPP (Purchasing Power Parity) (World Bank, 2019g). This attracts migrants from the region, who intend to stay, rather than transit through the country. The Kenyan economy is one of the fastest growing economies in Sub-Saharan Africa with a GDP growth of 5.7 % in 2019 (World Bank, 2019f). The economic growth of the country was expected to reduce to 1.5 % for 2020, due to COVID-19 and a locust crisis which both started in early 2020 (World Bank, 2019f). The recovery of the Kenyan economy is of crucial importance, especially because the manufacturing and financial industries, as well as information technology and communication, construction, and transport, have spill-over effects not only to other Kenyan sectors, but also to neighbouring countries (Santander, 2021).

The country's security situation is mainly influenced by its neighbouring countries. Conflicts spill over the border, as is the case with terrorist organization Al-Shabaab from Somalia, which is also active in Kenya. Their activities have caused the Kenyan government to intervene militarily in Somalia since 2011 and tighten refugee regulations (Hansen, 2020). This included an announcement of closing the Dadaab complex in 2016, since the government suspected members of the organisation of operating from the camps, which was not realised (Amnesty International, 2019).

Health care is provided publicly, with tasks shared by national and county governments (Kenya Ministry of Health, 2015). Lately, an increasing number of private health facilities can be observed in urban areas (Allianz Care, 2020) large numbers of migrants and refugees, especially in the camps, receive health care and support in other areas by international organisations and NGOs. Prominently, UNHCR is co-managing the two refugee camp complexes, while IOM is managing a health care facility in Nairobi (IOM, 2014; UNHCR, 2020c, 2020i) 70 % of the health care system is funded publicly through taxes, government loans, donations and mandatory insurance contributions. 30 % of the funds come from charitable contributions from NGOs, and private service and insurance plans. The most prevalent causes of death, however, show a different picture. According to the CDC, these are diarrheal diseases, HIV/AIDS and tuberculosis, neonatal diseases, other non-communicable diseases, and mental and substance abuse (CDC, 2020)

The National Hospital Insurance Fund, the public insurance fund of Kenya providing secondary and tertiary health care, sees 7 m of the 51 m Kenyans enrolled. Increasing this number to 21 m by 2022 is one of the priorities of the health care system (NHIF, 2021) especially refugees, may enrol as a family for \$ 5 a month but need documentation to do so. UNHCR is cooperating with county governments to ensure an integrated approach to health care, treating nationals and migrants alike (WHO, 2018f)

Some key indicators can be considered to illustrate the health care system in Kenya. In 2017, Kenya spent 4.8 % of the GDP p.c. on health, corresponding to \$ 158 p.c. PPP, which is very close to WHO's 5 % recommendation (WHO, 2003). The total health expenditures can be divided into government (42.7 %), private (39.4 %) and external (17.9 %) expenditure (WHO, 2018b). On average 24 % of the total health expenditure was out-of-pocket expenditure, i.e., costs borne by patients themselves to acquire health services. With the numbers on spending overall, Kenya is similar to other countries in the region. However, the share of expenditure provided by the government far exceeds that of most of Kenya's neighbours, except Tanzania (43.2 %) (WHO, 2018b).

The country has 1.6 physicians and 11.7 nurses and midwives per 10,000 population (World Bank, 2018b, 2018a). While the number of doctors is low compared to Organisation for Economic Co-operation and Development (OECD) countries, which are on average 29 physicians and 96 nurses, Kenya exceeds most of its neighbours in this indicator, except Sudan (2.6). The same is true for the number of nurses and midwives, except that it is Uganda who has a higher value in this indicator (14.7). However, according to World Bank data, Kenya's numbers are on par with the average of countries in Sub-Saharan Africa, which is 2.7 physicians and 7.2 nurses (World Bank, 2018b, 2018a). As in many other countries, health professionals are concentrated in the urban areas and the refugee camps in Kakuma and Dadaab.

The most widespread health issues following the Disability-Adjusted Life Year (DALY)<sup>7</sup> analysis in Kenya's general population are HIV/AIDS and STIs, maternal and neonatal disorders, respiratory infections and tuberculosis, enteric infections, cardiovascular diseases, and neglected tropical diseases and malaria (IHME, 2020c).

According to Prevent Epidemics, Kenya receives only a score of 50 out of 100 for its epidemic preparedness (Prevent Epidemics, 2021). Although progress has been made, the global team of health experts warns about a high potential death toll and the spread of a potential epidemic starting within Kenya and spreading across its borders. While strengths in the Kenyan preparedness system are real-time surveillance and immunisation from known diseases, the main gaps lie in taking medical countermeasures and a shortage of medical personnel. This is why the current COVID-19 pandemic is a cause for such concern in Kenya. As of early February 2021, there have been more than 102,000 cases of COVID-19 in Kenya according to Johns Hopkins University (Johns Hopkins University & Medicine, 2021c). Compared to many other countries globally, this is a low number. However, it is high compared to the numbers of its neighbours Uganda (40,000), Somalia (5,000), and South Sudan (5,000). Case numbers are similar only in Ethiopia (144,000) (Johns Hopkins University & Medicine, 2021a). The accuracy of these numbers has, however, been the subject of debate, as testing numbers are far lower than in high income countries. For example, a recent study of COVID-19 prevalence in Sudan suggested that as much as 38 % of Khartoum residents may have contracted the infection, with most cases going undetected (Watson et al., 2020).

## 6.2 Migration and health policies and programmes

Until recently, the policy landscape of Kenya consisted of rather isolated policies, and there were few overarching frameworks. One example regulating aspects concerning refugees in particular is the Refugee Act (2006b) for recognition, protection and management of refugees. This makes no mention of health aspects. The Children Act (2001) and its amendment, the National Children's Policy (2010b) address all children, including migrants, and ensure their health protection. While both stress the rights of all children, the Children Act does not mention migrants specifically and the National Children's Policy only mentions refugees. The Citizenship and Immigration Act (2011) regulates attainment of visa and stay. The Counter-Trafficking in Persons Act (2010a) addresses trafficking with special protection of women and children and reserves stricter punishment should the health of victims be harmed. Both are restricted to their own respective field.

Kenya has recognised the need for a unified and mainstreamed approach to the topic of migration and health and has undertaken several actions. In 2011, the National Consultation on Migration Health brought together government bodies, international organisations and civil society "to reach a common consensus on securing quality and equitable health services for migrants and mobile populations in Kenya" (IOM, 2011, p. 1). This resulted in the creation of a Technical Working Group by the Ministry of Health in 2013 to further promote the migrant-health agenda and analyse existing policy frameworks concerning migration and health (Odipo, 2018). In 2016, the government launched the National Coordination Mechanism on Migration (NCM), an inter-agency platform responsible for the national migration management. The NCM drafted the country's first unified National Migration Policy in 2017, containing comprehensive migration management guidelines, in line with the UN Sustainable Development Goals (IOM, 2018c).

7. One DALY - a disability-adjusted life year - "can be thought of as one lost year of 'healthy' life" (WHO, 2013, p. 4)

This increasingly mainstreamed policy landscape is also recognisable in the Refugees Bill (2019), which replaces the Refugees Act (2006a). Indeed, as its predecessor, the 2019 Refugees Bill, promises special protection and attention to health needs of women, children, people with disabilities, and other vulnerable groups, the Refugees Act expands by separately naming those who are traumatised and mentions their particular care needs. The Bill further adds a health screening of all refugees and asylum seekers that enter Kenya to stop the spread of contagious diseases. Further, it stipulates the equal treatment and integration of refugees as well as the sensitisation of host communities of the presence of and coexistence with refugees.

Another example of improved policies is the Health Act (2017), as it aims at the health rights of all persons in Kenya and is thereby fully inclusive. Another good example of more inclusive and mainstreamed policies is the Menstrual Hygiene Management Policy (2019), which includes migrants and especially refugees as target groups. The forthcoming National Migration Policy and National Labour Migration Policy currently in development are expected to continue unifying Kenya's policy approaches to migration and health. The large number of migrants poses a "national health challenge" to Kenya, which was acknowledged in the Kenya Health Policy 2014–2030 (2014, p. 18).

Migrants residing in Kenya can access health care through various channels. Those who officially reside in Kenya, i.e., those who have legal status or are registered as refugees, may access the National Hospital Insurance Fund (NHIF) (IIED, 2019; WHO, 2018d). It provides unrestricted secondary and tertiary health care to subscribers. Initially, non-nationals were only allowed to subscribe when presenting a work permit or student visa (*ibid.*). As work permits are virtually inaccessible to refugees, they were driven into informal labour markets without health care (Hargrave et al., 2020).

As of 2014, however, migrants, and refugees in particular, have access to the fund for the price of \$2 per month per person or for \$5 per month per family. There are, however, still significant barriers to accessing these services. Even migrants with theoretical access are often excluded due to missing documentation. Newly arrived migrants in particular may have to wait for their documents for extended periods of time, while there have also been cases of migrants waiting for their documentation to be processed by the agencies for years (IIED, 2019). Concerning other barriers that migrants face when trying to access health services, an important distinction between the locations has to be made. This is especially true for refugees.

In 2014, after a series of attacks in Kenya by the terrorist organisation Al-Shabaab, Kenyan politicians changed course in their refugee policy. This came from the fear that the terrorist organisations may recruit heavily among the Somali refugee community or even enter the country masked as refugees. Therefore, refugees were required to relocate to camps. The two biggest are the Dadaab Refugee Complex, hosting 220,000 refugees and the Kakuma Refugee Camp, hosting almost 200,000 refugees. These numbers are so large that the Kenyan government relies on significant assistance in the management and support of the camps by UNHCR (UNHCR, 2020c, 2020i). Both camps host numbers far beyond their initially intended capacity. Kakuma was planned for 58,000 refugees, while the Dadaab complex had to be expanded by two new locations in the complex after the Horn of Africa crisis in 2011, and as of 2020 is one of the largest such complexes globally (UNHCR, 2020b).<sup>8</sup>

As refugees in Kenya are rarely able to procure a working visa and cannot raise cattle or crops since they cannot own land, an active informal economy within the camps has developed which includes host communities. However, residents are still mainly reliant on provisions of UNHCR. In addition, adequate health care delivery is difficult due to the large number of migrants and subsequently there have been recurring disease outbreaks within the camps.

Although progress has been made in the provision of clean water and sanitation, diarrheal diseases remain a constant threat to the health of refugees there. Hepatitis E virus, cholera, and wild poliovirus can be attributed to poor sanitation in the camps (Brown & Cetron, 2014; UNHCR, 2011; WHO, 2017). Scurvy (a micronutrient deficiency) has also been reported in one of the camps (Ververs et al., 2019). In addition, safety has been reported as an issue in the camps, resulting in reported cases of GBV. While there are services for GBV survivors, barriers such as stigmatisation, fear of future violence, denial of access by camp guards, fear of non-confidentiality and a lack of knowledge about the service, hinder the usage of it (Muuo et al., 2020).

A third significant population of refugees of 60,000 is located in Nairobi. These are mainly refugees from Somalia who reside in a community named Eastleigh, where there is already a large diaspora community of Somalis. Several United Nations organisations are active there, led by the efforts of IOM, providing care to refugees and locals alike in a model facility at the Eastleigh Community Wellness Centre (ECWC), in

8. The Government of Kenya has announced plans to close the camps in the past already and has reiterated the plans in March 2021 (Al Jazeera, 2021)

collaboration with the Kamukunji Sub-County Health Management Team (WHO, 2018f, p. 9). Michela Martini, regional migration health specialist for East and Horn of Africa at IOM, explains the clinics approach as follows:

“The interesting part is that we provide treatment and services for free. And the second element that is a non-discriminatory approach. We don’t ask for any ID or document. According to the latest data, the clinic is serving half migrant and half Kenyan patients. And I really think it’s an interesting, more than integrated approach. And this is confirming and further endorsing our advocacy messages which is enhancing the systems for migrants and maintenance for the population itself, because we don’t want a parallel system.”

The health care provided covers HIV, sexual and reproductive health services, maternal and child health services, immunisation and growth monitoring, nutrition services, health promotion through community mobilisation and health outreach, and interpretation services for disease prevention. Common barriers for migrants in accessing health care in rural settings are partly similar to those that Kenyans face, such as long waiting times, drug availability and cost, and transportation. However, a different set of barriers is faced exclusively by irregular migrants. These are for example the threat of harassment due to lack of documentation, fear of deportation, or severe punishment in case of lack of valid residency documents, real or perceived discrimination, and language barriers (Arnold et al., 2014).

### 6.3 Key observations and findings - primary data collection

Kenya has hosted large migrant and refugee populations even prior to its independence in 1963 due to the country’s relative political and economic stability compared to most neighbours. Consequently, both UNHCR and IOM have centred their regional operations in the country.<sup>9</sup> In this context, Kenya’s Kakuma and Dadaab refugee complexes remain among the largest refugee camps globally. Generally, the country follows an encampment strategy for refugees but allows refugees to live among the host population under certain circumstances, which is mainly done in Nairobi. As outlined above, the narrow time frame, COVID-19-based travel restrictions, and administration related barriers made it impossible for partner researchers to access the two complexes located some 600km and 400 km from Nairobi, respectively. Time constraints also led to a focus on a sample around the capital city’s Eastleigh district, the focal point of refugee presence in Kenya outside the UNHCR camps. Together with support from the staff of the ECWC a sample of 300 surveys was raised at this location. The surveyed persons were patients at the health clinic and members of their communities. The questionnaire used can be found in Annex V. The basic characteristics of the sample will be described below. It needs to be pointed out that a full set of answers from the respondents was not achieved in any of the questions. Therefore, the given shares refer to the number of answers attained.

In our sample, most respondents have a similar background in terms of their country of origin. Two thirds of them (65 %) are originally from Somalia. This large proportion reflects the composition of the neighbourhood, which is dominated by a large Somali population. 20 % of the sample came from Ethiopia, while the remaining 15 % is split up mainly between Eritreans, Tanzanians, Ugandans and individuals from Sudan, Djibouti, Libya, Guinea-Bissau or South Sudan. Further, the sample is characterised by a dominance of female respondents (69 %). This may be a result of sampling, such as the availability of female versus male respondents. Another possible explanation is that all 6 enumerators from the clinics staff were female. It is nevertheless an interesting dataset through which to examine particularly refugee women’s experiences of health and accessing health services.

Considering the residence status, most respondents have temporary documents, with 76 % of the total sample being recognised as refugees and 7 % of the total sample being asylum seekers. Further, 11 % of the sample answered the question as them being citizens. This is curious, as the naturalisation process in Kenya is rather arduous. However, it is not completely unlikely considering the length of stay in Kenya found in the sample. More than half of the respondents (53 %) claim having been in the country for more than 5 years, while a further 35 % have resided in Kenya for two to five years. The respondents stated the main reasons for their migration decision to be a difficult or even critical situation in their previous country of stay, their will to improve their economic situation and family reunification. Other reasons were seeking education and health provision. The survey asked to give the primary, secondary, and tertiary reason. When aggregated, the main reason was the improvement of the economic situation, which was quite surprising, as more than 80 % of the respondents are refugees or asylum seekers.

9. Incidentally, Kenya hosts the global headquarters of the United Nations Environment Programme (UNEP) and the United Nations Human Settlement Programme (UN Habitat).

Looking at the educational qualifications, 38 % of respondents completed primary school, while a quarter each have either not completed any formal schooling (27 %) or completed secondary school (26 %). Looking at the occupational situation of the respondents, more than half (52 %) are self-employed while 28 % are unemployed. 9 % work part-time, while those in full-time employment, presumably waged, and those studying each accounted for 4 % of the sample. This employment picture is unsurprising given that 27 % of the respondents had no formal schooling, 38 % had primary level education, and 25 % had secondary education. Considering that work permits require a high degree of qualification and fees and pose administrative barriers, the number of employed is understandably low. For more detailed information on descriptive variables of the survey sample, please refer to Annex V Table 1 and Table 2.

## 6.4 Migrants' experience of health and accessing health services

The following subchapter will consider health needs and vulnerabilities and migrants' access to health services in the Kenya sample.

### Migrants' health care needs and vulnerabilities

In this subchapter, the health needs of migrants in Kenya will be analysed based on the survey findings. The Kenyan survey respondents were asked whether they encountered health complications since they have come to Kenya. In this special set of respondents in Eastleigh, the majority answered 'no' (69 %). Those who responded with 'yes' (89 individuals) were asked to specify their health complications and could answer with more than one complication. Results are visualised in Figure 9 below. Here, the most common answer was chronic diseases (obesity, diabetes, hypertension etc.) (63). This was followed by far fewer mentions of eye problems (15) and infectious diseases (12). Minor factors were physical issues (e.g., fractures) (7), dermatological problems (6), dental problems (5). The figures in the category 'other' comprise nutrition issues and sexually transmitted diseases (both 4), mental health issues (2) and issues with reproductive health (1).

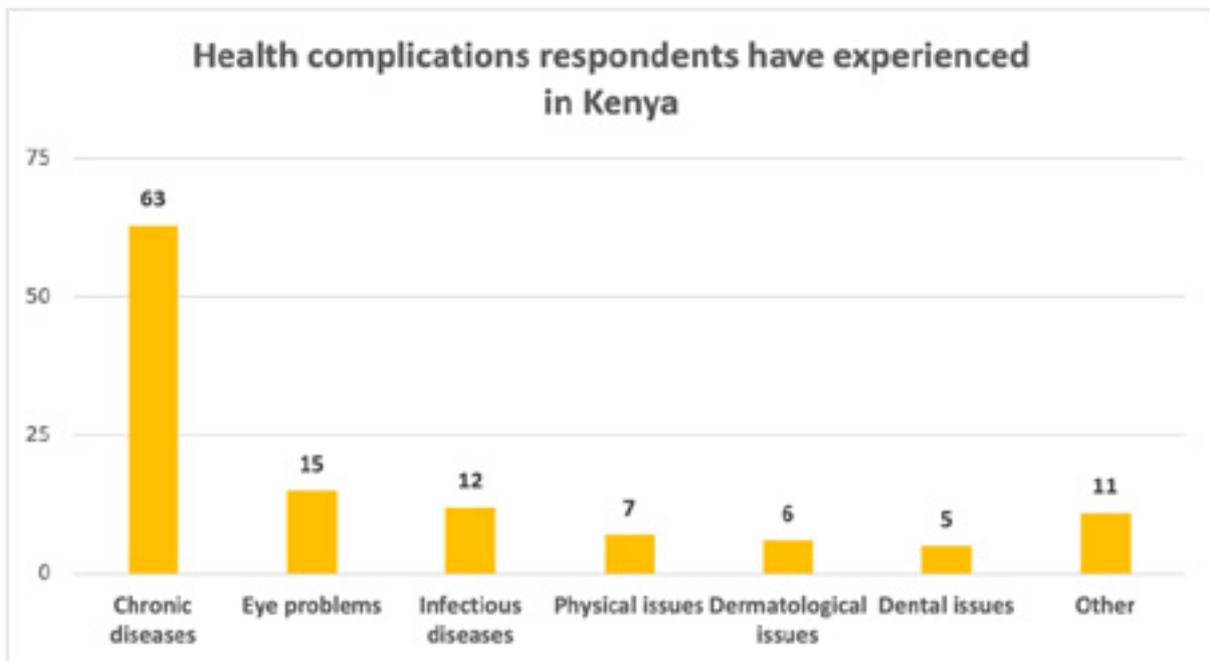


Figure 9: Health complications respondents have experienced in Kenya. 89 respondents named 119 complications in the multi select question. (Source: own data collection)

The following multi select question about which complications the respondents were most worried about is visualized in Figure 10. The most common answer was the corona pandemic (223). With some distance, chronic and infectious diseases were named in second and third place (108 and 103). Sexually transmitted diseases (71) followed these two, while the health situation of their children was also a comparably large concern of the respondents (34). Further complications as names were stated in a comparably limited frequency.

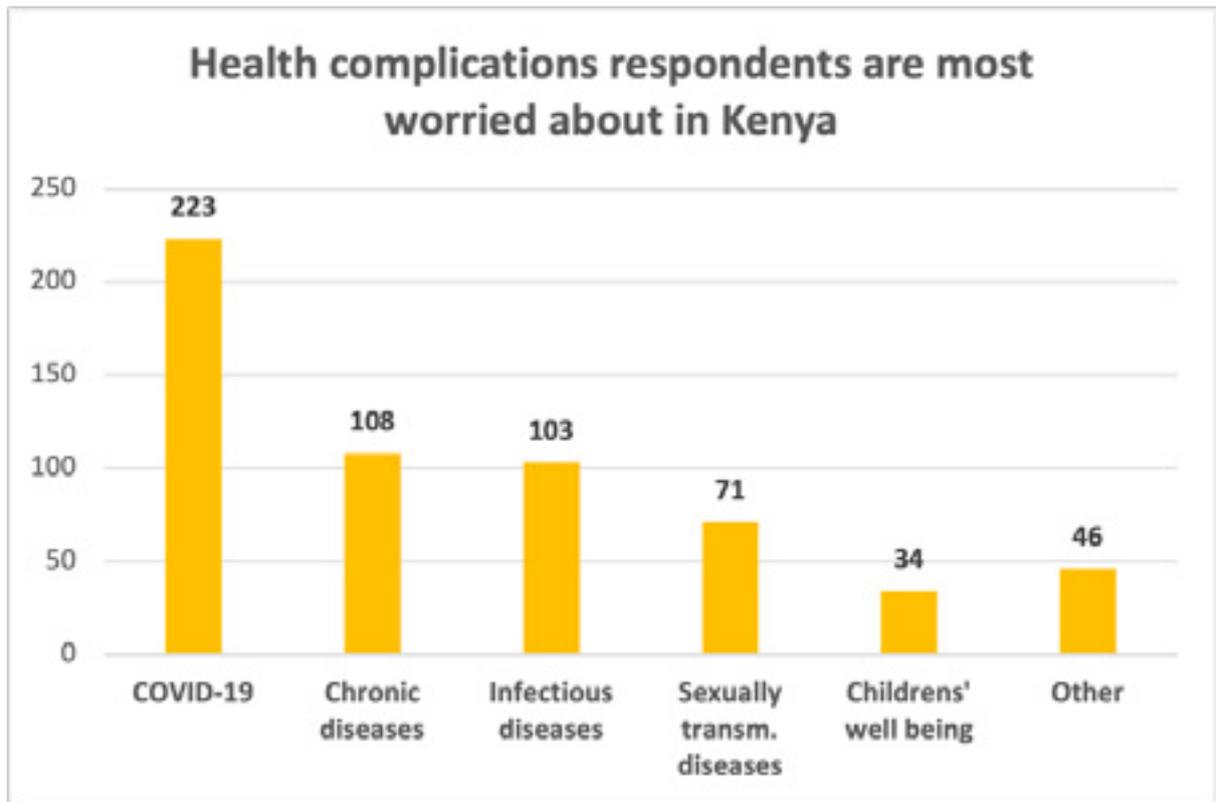


Figure 10: Health complications respondents are most worried about in Kenya. 295 respondents named 585 complications in the multi-select question. (Source: own data collection)

The actually experienced complications fit the statements of worry rather well, so one can see that migrants are aware of the health complications they are most likely to be affected by. A comparison with the complications which affect the Kenyan population most, as was given by DALY in the chapter above (IHME, 2020c), is hardly possible above since the respondents only stated which and not how heavily their complications affected them. However, based on the limited sample, there are signs that sexually transmitted diseases play a larger role in the general population than the ECWC sample. Maternal and neonatal disorders are also underrepresented in the sample, which is surprising, given the large number of female respondents. For other chronic and infectious diseases, parallels can be drawn between the sample and the general population. This makes sense, as the respondents live among the Kenyan host community in the district of Eastleigh and are much more integrated than the migrant, and especially refugee population in the camps.

### Migrants' experience of health care system and accessing health services

As can be seen in Figure 11, the respondents of the survey have a rather good opinion of their own access to health care services in Kenya. Two thirds (67 %) would rate their access as 8 or above on a scale of 1 (heavy limitations) to 10 (perfect health). The following chapter shall serve as an exploration into some of the reasons why respondents were pleased or not pleased with their access to health services in Nairobi. As a result, a consideration of the quality of the health service provision is presented. The following observations and findings are heavily influenced by the nature of the ECWC. Migrants and locals alike are treated without documentation requirements and almost always free of charge. Therefore, the findings should not be taken as a generalization to the situation of other refugees in Kenya but considered exclusively within the context of Kenya's capital Nairobi and within the environment of the Centre.

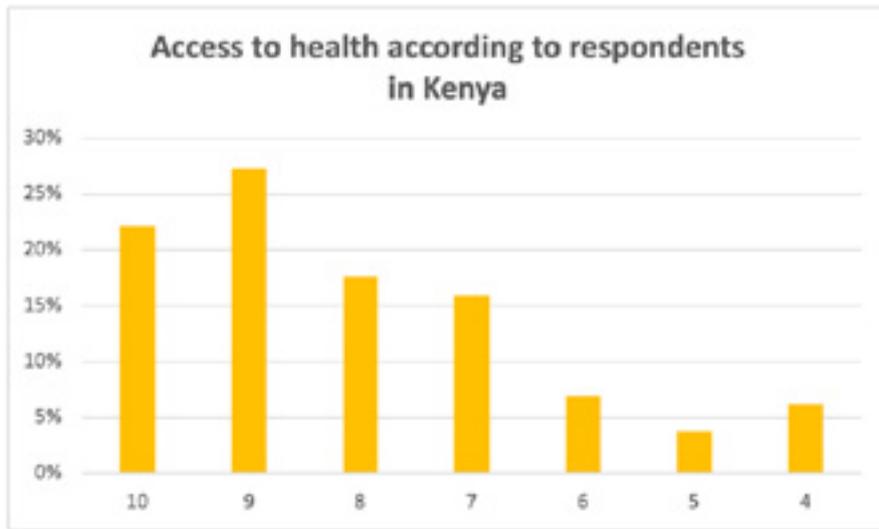


Figure 11: Access to health according to 289 respondents in Kenya on a scale from 0 to 10. (Source: own data collection)

Of the 281 respondents who sought health care, a large 72 % attended a public health facility or other primary care, with women slightly more likely than men to seek public care (74 % versus 67 %) (Annex V: Table 4). The data shows that the dominant health care source for all respondents was the public facility, which comes as little surprise as Eastleigh itself is a public health centre. However, the larger refugee communities have people with the means to use alternatives to the government facilities, i.e., private providers, which were used by 67 % of the 185 Somalis interviewed and 69 % of the 55 Ethiopians interviewed. As mentioned above, these two are the largest national groups in the sample and account for 80 % of the sample. Other major sources of health care are NGOs and pharmacies.

77 % of the sample stated to never having experienced restrictions in accessing health services. While 7 % state they have never tried, only 15 % of the sample, representing 45 respondents, experienced restrictions. Their multi-select answers are visualised in Figure 12.

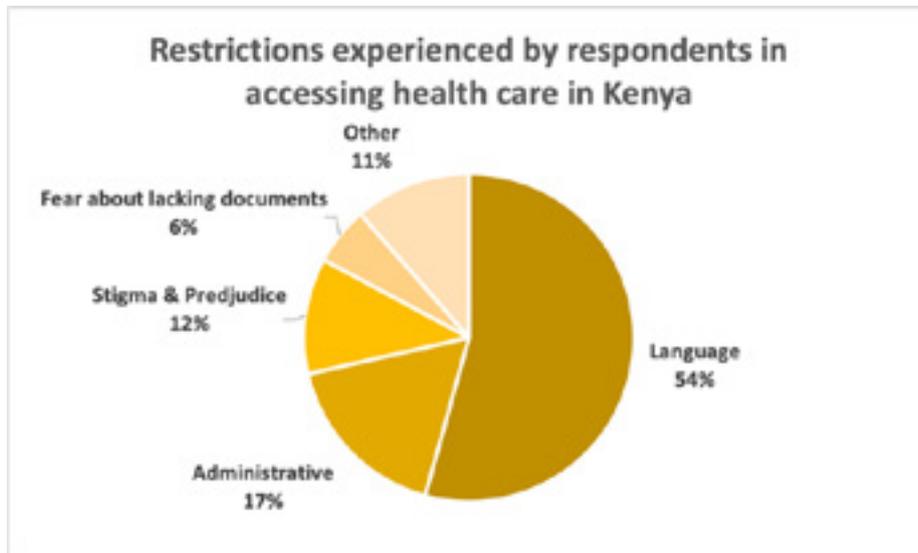


Figure 12: Restrictions experienced by respondents in accessing health care in Kenya. 45 respondents named 70 restrictions in the multi-select question. (Source: own data collection)

The majority of these restriction experiences have been due to the language barrier. Language was the issue for 54 % of all named restrictions. The language problem – primarily the lingua franca is Kiswahili – is curious: Kiswahili is a language that is comparably easily picked up on the streets of Nairobi, through interaction in marketplaces, public transport, electronic media, etc. This Kiswahili problem was especially prominent among the younger migrant/refugee age categories. In addition, the fact that nearly 80 % of the respondents have lived in Kenya for at least two years, underscores the intentional or unintentional insularity of some migrant and refugee communities.

Of the 16 respondents who had made attempts to overcome the language barrier, 9 – preponderantly women, were learning the language while 7 employed an interpreter. While some respondents suggested ostracisation and prejudices as a barrier to their access to health, these adversities were rarely listed among the obstacles. Further answers included administrative barriers (17 %), stigma (12 %) and the fear of being undocumented (6 %). The section of 'other' is made up of occupational obligations, religious and cultural restrictions, no medicine, or a strike of health facility personnel. As mentioned, service provision at Eastleigh is usually free of charge. When contacting private providers, the respondents stated to have paid for themselves, while facilities of other NGOs usually also do not require payment. Those relatively few respondents who had limited access usually went to a pharmacy and bought their medication there. Herbalists or other traditional healers are not contacted by the surveyed group, except for a very limited number of individuals.

Access to health is also a matter of information about the health system. Due to the long-standing migrant communities in Nairobi, it comes as little surprise that most respondents in this multi select question named friends and family as their source for information (89 %). NGOs, pharmacists and public system professionals were also named. Even more than these three however, it is the community health volunteers (CHVs) who inform the migrants about the system (CHW Central, 2021). These volunteers are responsible not only for information about the health system, but also inform their community (usually 10 CHVs per 5.000 population as one community health unit) about basic health measures they can take to protect themselves and also perform basic treatment for common health complications. They are in turn supervised and trained by Community Health Extension Workers who are government employees.

These can provide more services or even refer persons to specialised health facilities. This Kenyan programme has been successful, even though by the end of 2019, only 6.000 of the 10.000 planned community health units were in place, their work has shown results. Districts that provide community health units show better indicators in vaccinations of kids, maternal care, preventive malaria treatment and more. Considering that only 14 of 47 districts pay a varying incentive to their CHVs, the number of units could be easily increased if more districts would incentivise the programme.

When asked about their preferred information sources, respondents stated to favour primary health service centres (54 %) over friends, family, and their personal network (23 %). This is a turn-around compared to the current information channels, where the personal network was very dominant, and only one in ten respondents stated to be informed by public system professionals. To a lesser extent, pharmacies and religious communities are also a place to turn to, when in need of information.

Indeed, when asked the source from which respondents preferred to get health systems information, 54 % chose public facilities while 23 % opted for family and friends. However, others cited religious communities, government websites and pharmacies as alternative sources.

In addition to the circumstances in access, its barriers and limited information provision, the survey also asked about migrants' assessment of the quality of the Kenyan health system. The results can be seen in Figure 13 They show that 82 % of respondents approve of the system's quality, by grading it with 8 to 10 points on a scale from 1 to 10, while no one answered with a score below 4. This speaks for the approach of the Eastleigh Community Wellness Centre, but this may be a case of sample bias, as mentioned before. Respondents are those, who are already in contact or close to the good facilities run by IOM, which cannot be taken as a representative for the system of the whole country.

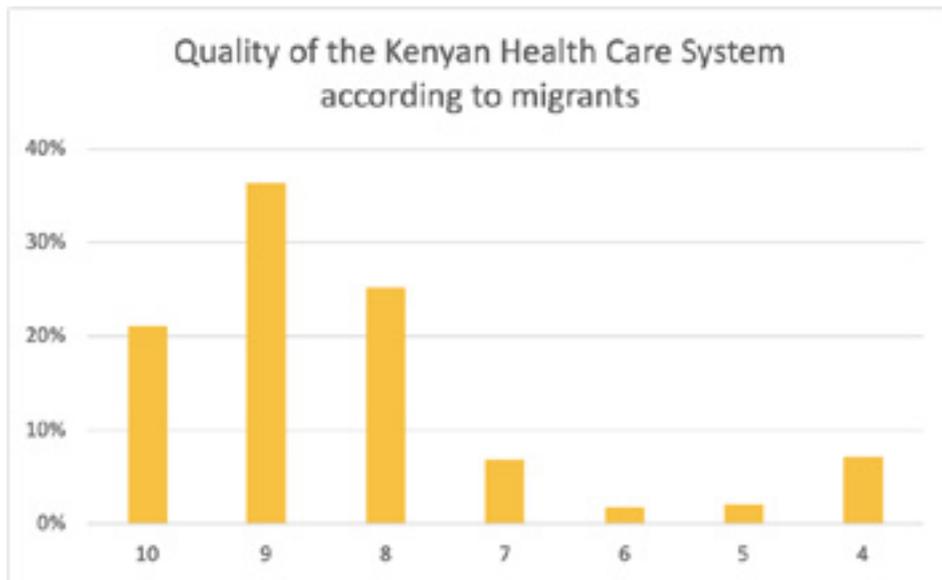


Figure 13: Quality of the Kenyan Health Care System according to 295 respondents in Kenya, out of a score of 1-10. (Source: own data collection)

To see which result the Kenyan health system has for the migrant population in Nairobi, the survey included a very interesting question regarding the migrants' self-assessed health. Since this study has no technical measure of the health status of migrants and refugees, it, therefore relies on their own self-assessment on a scale from 1 to 10 (1 being very bad health, 10 being perfect health). This was to be done at three points in time: before the migration journey to Kenya, upon arrival in Kenya and at the current point in time. Figure 14 illustrates the answers. These results are interesting, as the needs and vulnerabilities of the migrants are combined with the access to and the quality of the health system. The numbers suggest that the share of refugees with comparatively poor health – scores of 4 and 5 – have reduced estimate at current health status compared to that at departure from country of origin and arrival in Kenya. The picture is somewhat ambiguous for score 6, 7 and 8. While the share of respondents scoring 9 have decreased significantly from 40 % to 26 %, those scoring 10 have doubled from 16 % to 38 %. Overall, the numbers say that respondents' health improved after their migration. As was discussed before, most migrants use public health facilities. Since such public facilities implement Kenyan health policies and programmes, it is fair to conclude that these have contributed to the improved health status of migrants and refugees.

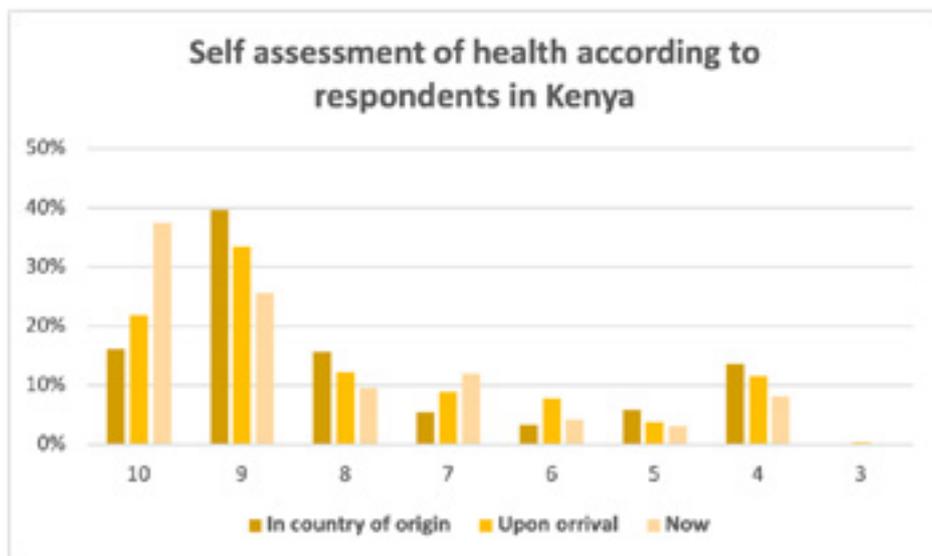


Figure 14: Self-assessment of health according to 293 respondents in Kenya on a scale from 1 to 10. (Source: own data collection)

Looking at the average health self-assessment there is only a marginal increase from the health status' average in the country of origin of 7.9 (7.87) towards arrival in Kenya, which is also 7.9 (7.92). The high initial

health rating could be explained by the 'healthy migrant effect', i.e., unhealthy or older people are less likely to decide to undertake an exhausting journey than younger and healthier people. Another reason for the constant rating is the initial network and information about the health system within Kenya, which would support stable health outcomes. However, over time the self-assessment increases to a higher score than the initial health situation, with an average health assessment of 8.4 at the time the respondents answered the survey. The trend of increasing self-assessed health also holds when including South Africa and Nigeria. Over the whole sample, the average health scores increase from 8.0 before migration to 8.8 at the time of the survey (Annex V: Table 3).

Further disaggregation of the data also shows that migrants' self-assessment improves as they spend longer time in Kenya. The study considered the usual three points in time for three different groups. Those who have been in Kenya for one to two years (30) show an increase in their average self-assessment of health of 0.3 (before 7.1, upon arrival 7.3, now 7.4). Those who have been in Kenya between two and five years (104) show an increase in their average self-assessment of health of 0.5 (before 7.9, upon arrival 8.0, now 8.4). Finally, those who have been in Kenya longer than five years (157) show an increase in their average self-assessment of health of 0.6 (before 8.0, upon arrival 8.0, now 8.6). As there were only two respondents who have been in Kenya for less than a year, we excluded them. The data also shows that the overall average increase in health grows with the time the respondents have spent in Kenya. This speaks for the positive long-term health provisions in the country.

This can, for one, be explained by the better living conditions in Kenya compared to most of its neighbours and also the relatively good medical provision in the country. Another possible explanation is the special characteristic of this set of migrants, who live in the country's capital within their own communities instead of separate camps. The surveyed group has been in the country for a rather long time (80 % more than two years), can usually access a standing network of persons with the same nationality (Somali) and many work to generate income, which can also help to increase health conditions if one can independently purchase necessary goods and services.

## 6.5 Spotlight: the impact of COVID-19

As previously noted, Eastleigh is a high population density commercial and residential neighbourhood, with a day-time population that is several times greater than the night-time/residential population. Eastleigh hosts a lucrative commercial centre handling many imports of household goods due to the strong ties of Somali traders to the gulf states, which are distributed across Nairobi, Kenya and beyond. At the March 2020 outbreak of the COVID-19 pandemic, the existing conditions made Eastleigh a high transmission risk neighbourhood, with modest scope for adhering to the public health pandemic containment measures. As noted above, there were challenges of water and sanitation services, as well as social distancing due to crowding, which undermined the effectiveness of face masks. Thus, Eastleigh would eventually remain under lockdown even after the government lifted its initial shutdown of four counties, including Nairobi. Thus, the large migrant and refugee population in Eastleigh has suffered disproportionately – even though unintentionally – from the anti-pandemic measures instituted by the government.

## 6.6 Health needs of vulnerable groups of migrants

Migrants, especially those in refugee-like situations, are subject to various vulnerabilities. UNHCR (2017) divides only into situational and individual vulnerabilities.

Situational vulnerabilities, i.e., the circumstances of migration, are threats from and exploitation by other persons (e.g., combatants, xenophobe populations, smugglers, corrupt officials, traffickers etc.) and unsafe travel or transportation which is prone to accidents (old or unfitting vehicles, difficult climatic circumstances etc.). Other factors are the lack of a supporting network, a new language, and a difficult documentation situation. Of course, these vulnerabilities are not exclusive to cross-border migrants, but these are more likely to encounter situational vulnerabilities. Individual vulnerabilities are the result of the characteristics of individual migrants within the given circumstances. This combination can result in a more exposed risk situation for certain migrants like children, especially when unaccompanied, female migrants, people of higher age, or individuals living with disabilities or medical needs.

Looking at the composition of the survey with 70 % female respondents, a consideration of the results disaggregated by gender can offer insights on the situation of one of the most important target groups in

international cooperation. When discussing the data, the study will, for simplicity, refer to women or women in Kenya - within the particular case of the Kenyan survey context. Surprisingly, the survey results show a picture in which there is rarely a significant difference between female and male respondents.

The women in the Kenyan sample have an equally high opinion of the quality and accessibility of the country's health care system as their male counterparts (8.3 and 8.0). On average their health self-assessments exceed that of their male counterparts before the migration journey (8.0 vs. 7.6) and upon arrival slightly (8.1 vs. 7.7) and is equal to the assessment at the current point in time (8.4) (Annex V: Table 3). Women just as men migrate predominantly due to difficult and critical situations in their previous countries, followed by the goal to improve their economic situation and family reunification. So again, there is not much of a difference to be seen here. There are also only few peculiarities in the specific health complications the women have reported. Women are, for example, more likely to report health complications related to their eyes.

Regarding the concerns of the migrants surveyed, far fewer women stated they were worried about sexually transmitted diseases and infections than their male counterparts, with respectively only 19 % as opposed to 36 % in men. Whether this is due to different practices or stigma surrounding a potential statement on this question or another set of reasons remains unclear. A health complication that concerns women more than their male counterparts is the COVID-19 virus (78 % vs. 70 %).

A further topic in which women differ from men is the facility where they seek help when having health issues. Men more often consult private facilities (39 % vs. 50 %) and pharmacies (26 % vs. 33 %), while women significantly more often prefer to consult NGOs (34 % vs. 29 %), as well as friends and family (6 % vs. 1 %) (Annex V: Table 4). In connection to this, there is a rather suspect finding in the multi-select question of who was to pay for the services. Although men more often visit private facilities and pharmacies, they are almost only half as likely to have to pay for the services themselves (66 % vs. 36 %). Almost complementary to this, men stated much more often that the government paid for their bills (35 % vs. 55 %). Half of both subgroups state that NGOs have paid for their services before. While some access restrictions are slightly more present (e.g., religious, language), women have fewer problems with administrative barriers (24 % vs. 36 %).

An issue that unfortunately shows a significant disadvantage is the gap between the provision of care and the needs migrants bring. Only 52 % of migrant women claimed to have all their needs covered by the health opportunities. Compared to 72 % of men, this is a considerable gap. In combination with the KII and FGDs, we can assume that this is to be ascribed to services and issues related to female health and provisions of maternal and neonatal health. One example is the reservation of the 'Linda mama' programme to Kenyan nationals. Speaking against this is that only one respondent reported having experienced issues with reproductive health.

Potential explanations of the self-assessed good health situations without much disparity from the male survey respondent should look at the ECWC, which provides health services to all, not differentiating between gender, documentation status, or nationality. Another possible explanation could be the close communities among migrants which can be encountered here. As was seen, female respondents often turn to their friends and family for assistance. This goes in line with a model on vulnerability determinants by IOM (2019b, pp. 3–8) which identifies individual, structural, community, as well as household and family factors to determine the final vulnerability of a migrant.

These vulnerability factors can mitigate or intensify the situational and individual vulnerabilities of the UNHCR model. In the case of our sample, it is not unlikely that the strong support from their community, as well as household and family factors, can balance out the individual vulnerability determinants the women face. Examples to illustrate this suggestion of family factors include that women, who show a higher share of unemployed individuals than men, are supported by their personal network when paying for services themselves.

A community factor is the Eastleigh Community Wellness Centre, which provides accessible health care to all. A potential structural supporting factor is the migration and health policies that are developing positively in Kenya. However, due to the particular case of Eastleigh with mainly IOM based health care provision, this should not be the dominant factor. This is a further argument for enabling integration and economic participation of this migrant group. What can be concluded from this is another point speaking for the integration of migrants among the local population and allowing them to support themselves and their communities through employment.

## 6.7 Good practice examples and areas for improvement

In the chapter about the experience of migrants with the Kenyan health system, the access and quality of the system was already discussed. Overall, the migrants attested to good quality, with more than 80 % of them choosing a rating of 8 or above. However, this leaves 20 % of respondents who were not as satisfied with the quality. This chapter will discuss aspects that are implemented well and put closer consideration on certain aspects that leave room for improvement. Asked which points they appreciate in particular, survey respondents referred to accessing treatment without documentation.

While the status of the migrants and refugees in the two main camp complexes Dadaab and Kakuma should be clear, and they, therefore, need not present documentation when trying to access health, the Nairobi subset is different. While fear of police harassment and deportation due to documentation issues was not as strong as in other countries, it was still a topic that came up several times. This prevents refugees from accessing health care. Especially in the situation where refugees live among the host population, their health is an essential factor to the overall health situation.

Therefore, the no-documentation-needed approach of the IOM clinic benefits Kenyans as well. Further, the integrated approach of serving migrants and host populations is an important step towards integration and peaceful coexistence of the two population groups. However, service providers have pointed out that there are barriers to referring migrants to more specialised care facilities if they cannot provide documentation. Therefore, it is important for the Government of Kenya to extend its efforts to provide all migrants with the necessary documentation in a timely manner. This, of course, requires the migrants to also make efforts for their documents.

Another well-developed point is the broad provision of medical services and quality of the medication in the ECWC. Patients praised that most of their issues can be resolved. To further this, they are pleased that these services are free and therefore accessible for all, disregarding their financial status. Several migrants pointed especially to the health staff in their praise:

**“[The overall quality of care] is good, the doctors are qualified, they take their time with you asking questions and giving out good medication.”**

This quote came from a person who has experienced very different standards in their home country and was therefore very happy with the provision in Kenya.

But also, aside from the free service provision in the ECWC, Kenya is making positive decisions for the social security of migrants. Opening its public insurance fund (National Health Insurance Fund) to migrant families for a reduced fee (\$ 5 per month) is an essential step to further integrating migrants into its health care system. Considering the large numbers of migrants in Kenya (1.3 million), they are a key group in the attempt to cover 21 m of the 51 m inhabitants of Kenya with insurance by 2022. The scheme provides secondary and tertiary care. Here, the issue of documentation and the long time to acquire it is an inhibiting factor yet again.

Another strong point in the health system of Kenya is the community health volunteer programme. Within their community health units of 5.000 inhabitants, 10 volunteers consult the population on basic health issues and provide them with basic services and information about the Kenyan health system. The volunteers are in turn supervised and trained by community health extension workers - government employees who can provide further care and also refer patients to other health units. The programme services all inhabitants of their communities - nationals and migrants alike. It has been shown that those districts implementing the programme show better indicators of public health (CHW Central, 2021).

These good practices in Kenya contribute not only to improved health in the country and in particular in the community in Eastleigh, but also towards the trust of migrants in the system. This trust has been built over years and in many individual sessions and is now spreading through the migrant communities. Everyone involved should value this trust as it can bring out more and more migrants to consult with their health practitioners and thereby further the effort of the Kenyan government and its international and local partners in improving the health outcomes of all in Kenya.

At the same time, the study has also found points for improvement of the health system. Considering the backdrop of the high pressure of migrants coming to Kenya and the current pressures on the Kenyan health system we will suggest realistic improvements.

A first recommendation comes with the peculiarities of the Eastleigh Community Wellness Centre that is currently financed by IOM and operated with their partner NGOs. As it stands, the health services provided are donor-funded and thereby not self-sustainable.

The Government of Kenya's is making efforts to integrate this facility, which is providing services to a vulnerable population of both Kenyans and migrants, within its own health system. This would send a very strong signal and further expand Kenya's commitment to migrant's health. In doing so, it would be desirable to maintain the clinic's non-discriminatory and free-of-charge approach, as it serves an area under special financial hardship.

While most respondents were satisfied with the quality of the Kenyan system, they also noted that the quantity of provision is inadequate. This concerns the number of health staff and the number of facilities. The insufficient number of both of these leads to long waiting lines to access service, which was reported by many of the migrants. They also pointed out rather large distances to the next facility. This point is certainly amplified by reoccurring strikes of workers demanding timely payment of their salaries and the clinics opening hours, which do not extend to the weekend.

The response of 'disrespectful staff' points towards an at times difficult relationship between the patients and the providing side. This has also been reflected in some of the KIIs of service providers. These frictions are problematic for two reasons. For one, they influence the quality of care and thereby the health outcomes of patients negatively. For another, the fostered mistrust and negative emotions connected to the health facility and system, which individuals can share to influence its community, therefore having a negative impact that reaches much further.

Further, "more medication" and "more services" was also a repeating proposition. In combination with explanations from KIIs with migrants, we were informed that the clinics' medicine supplies can run out. It can also refer to the expansion of certain medication programmes like "Linda mama" (from Swahili kulinda, 'to guard, defend, watch'), a programme for expectant mothers within the NHIF providing maternal and neonatal health services. Unfortunately, the programme is only accessible to Kenyan nationals. Other services in need but not provided enough according to the surveyed migrants are specialists like dentists or ophthalmologists. Here, the challenge is finding skilled staff and the high-priced specialised devices needed for these services. Another type of service highly requested is mental health experts. As in all other contexts and countries, the migrants and service providers speak of traumatising experiences and the need to address these.

Although the CHV programme is well received by the migrants, there are still calls for more information provision from the government. It is not only information about the health system, but also civic education, i.e., the rights and duties migrants have in Kenya. This can curtail exploitation by health care providers, the police and other people in authority. This speaks for an expansion of the aforementioned CHV programme in Eastleigh.

A factor not directly connected to the health sector is about the neighbourhood of Eastleigh. It is a commercial and residential neighbourhood with high population density hosting formal and informal structures. Therefore, it is not surprising that many respondents should propose attention to the environment and cleanliness of the district, including managing sewage and garbage. An improvement of these circumstances will definitely also bring positive outcomes for the residents' health situation.

## 6.8 Kenya - Conclusion and recommendations

Considering the information the study has compiled, from its remotely conducted policy review and the quantitative and qualitative instruments of survey, key informant interviews and focus group discussions implemented on the ground, several findings emerge. This chapter will draw conclusions based on these and make recommendations for further measures.

It is evident that Kenya is dealing with a large number of migrants in the country, which is a huge challenge and responsibility. The Government of Kenya (GoK) is taking measures to improve the health provisions for migrants steadily. The increasing policy mainstreaming of migration and health and the National Consultation on Migration Health and opening the national insurance fund to migrants are evidence of the government's commitment. The many good practices provide a solid base for further efforts. So far, rather understudied migrant population in Nairobi received special attention in this study. While it would be fallacious to generalise based on this distinct group while most migrants in refugee-like situations reside in the camp complexes in rural areas, this subpopulation opens the possibility of a special consideration. It is the country's largest population that is living among the locals and therefore enables the study to observe possibilities for the integration of migrants and refugees in Kenya.

With this in mind, the following recommendations are made for Kenya:

- The GoK should continue to integrate migrants in their measures to improve the health policy of all in Kenya.
- The GoK should enable regularisation pathways for all migrants in the country, especially those who have not sought to register in camps
- The GoK should further follow its advances of integrating health insurance to all at risk, just as it did by opening the NHIF to refugees at reduced fee.
- The GoK should expand its existing programme Community Health Volunteers to fulfil its self-imposed goal of 10.000 community health units. Supporting the districts in providing incentive payments to the volunteers could accelerate this effort significantly.
- In accordance with its security provisions, the GoK should further extend the integration of service delivery and accommodation of local and refugee populations, as it is doing with the Eastleigh Community Wellness Centre and the Kalobeyei Integrated Settlement. Both have shown promising results and could be scaled up.
- Considering the situation in Eastleigh, migrants stay in Kenya for several years and have standing networks of their national community. Health approaches should include these communities, build on the already gained trust and implement long term strategies.
- In order to ease several issues of documentation that have been shown to present barriers to the health needs of migrants and especially refugees, the GoK could increase its administrative capacity in this regard. This can improve migrant's health situation in e.g., signing up to the NHIF or in referrals to specialised health facilities and thereby also benefit the local population in settings where these two live side by side.
- Respondents of the survey, KIIs and FGDs proposed the use of digital services in health provision to overcome barriers in access, like electronic identification and referrals to more specialised facilities.
- In case of an increasingly integrated settlement approach rather than the existing encampment approach, health staff needs to be trained to be able to respond to migrants and their special set of health needs. Hiring staff from the refugees' home countries or hiring more translators can also help smooth the frictions in service delivery to migrants and refugees.
- In order to continuously address migrants and refugees with policies and measures, the GoK can continue and expand its efforts to include the target groups in migration and health policy consultations and their formulation. This way, the policies can become more cost-efficient and effective, saving valuable resources or producing a better outcome.
- GoK should encourage greater integration of longer-term migrants and refugees through signposting to Kiwashili language classes and through programmes that encourage interaction with other groups
- GoK, international organisations, and other health providers should raise awareness of the potential risks to migrants of using 'traditional' healers
- GoK and international organisations should work with academic centres in Kenya to undertake further research on the needs of migrants and refugees, especially refugees in camps and irregular migrants in other parts of the country
- GoK should maintain efforts to counter corruption amongst public servants and health workers, as irregular migrants, in particular, can be particularly vulnerable.
- GoK and health providers should improve mental health and psychosocial services available to refugees and asylum-seekers
- Health services targeting migrants should offer a broader range of services, such as access to x-rays or dental treatment

## 7 Nigeria: Labour Migrants

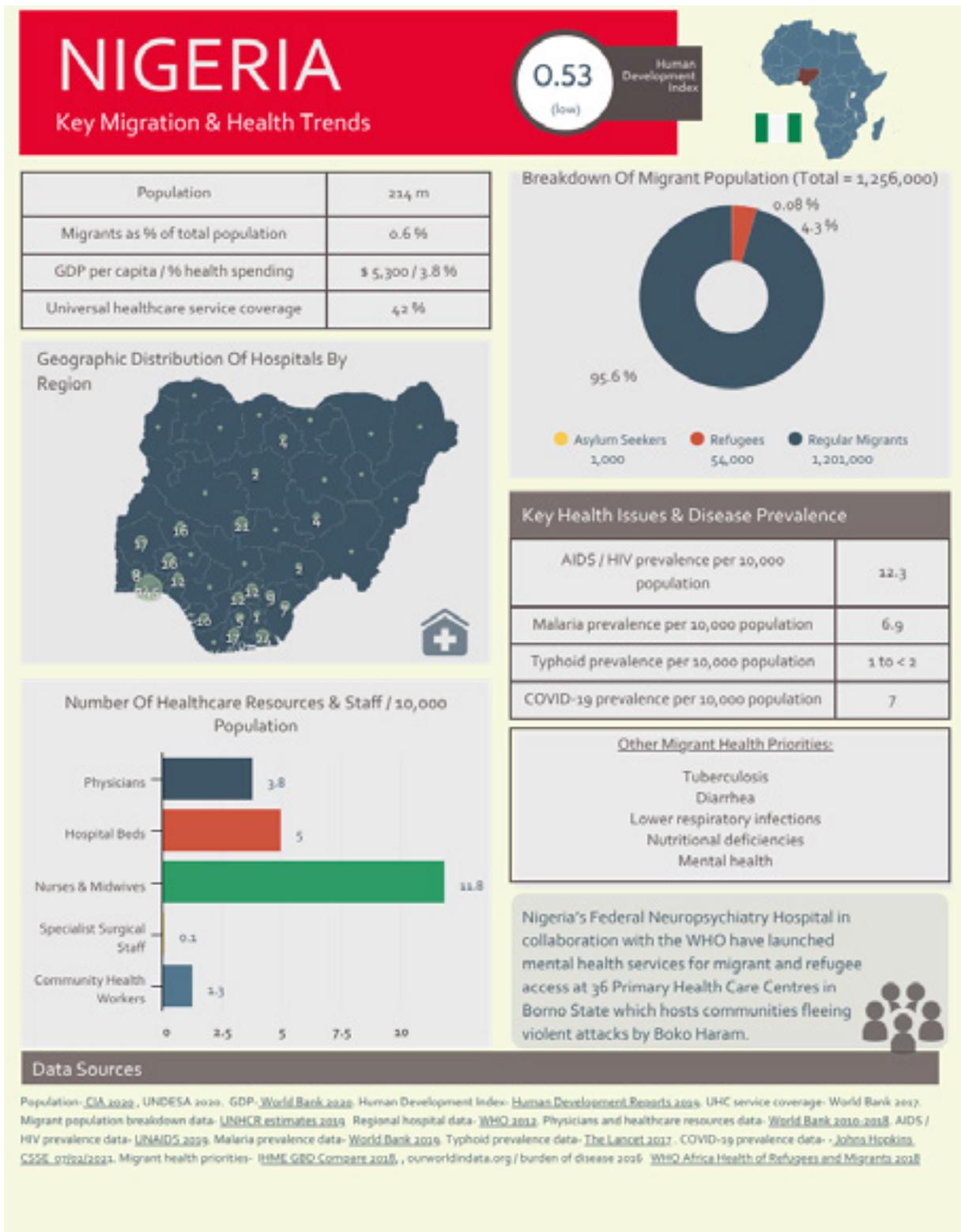


Figure 15: Infographic of key migration and health data - Nigeria.  
(Source: own illustration)

## 7.1 Country context

Nigeria continues to experience high internal and external migration due to the size of its population, economic climate, as well as its porous borders. IOM estimates the country's net migration rate between 2015 to 2020 at -0.3 migrants per 1,000 population (IOM, 2021b). With a GDP per capita (PPP) amounting to around \$ 5,400 in 2019 (World Bank, 2021b), Nigeria remains on the OECD DAC list of Official Development Assistance recipients categorised as a 'Lower Middle-Income Country' (OECD, 2020a). At the same time, Nigeria continues to be one of the five biggest African economies, alongside Algeria, Egypt, Morocco, and South Africa (AfDB, 2020, p. 16). Moreover, Nigeria is Africa's biggest oil exporter, and crude petroleum is at the top of Nigeria's exported goods, amounting to around 75 % of the overall country's export in 2018 (The Observatory of Economic Complexity, 2020). The biggest sector of the Nigerian economy remained crop production (26.1 %), followed by trade (12.8 %) and telecommunications and information services (7.8 %) (National Bureau of Statistics Nigeria, 2020, p. 93).

The internal situation in Nigeria remains tense. An important contributing factor to conflict and instability is the Boko Haram insurgency in the North-Eastern part of the country, which over the last ten years has caused significant forced internal displacement with an estimated 8 million Nigerians displaced across the three states constituting North-eastern Nigeria, of which 80 % are women and children. In addition, another 226,000 Nigerians have crossed the border to Cameroon in search of safety (Norwegian Refugee Council, 2019; IOM, 2019c, p. 65). Another source of conflict and displacement are increasing tensions between semi-nomadic pastoralist Fulani people and other ethnic groups, caused both by the insurgency and environmental degradation in the wider Sahel region (Amnesty International, 2018). On the governance level, Nigeria's federal structure grants individual states a fair degree of autonomy to interpret and implement national-level policies at the state level. This can also be a source of tension between the federal states and the central government.

Home to over half of ECOWAS total population, Nigeria is an important destination country, especially for labour migrants from other countries in the region, with Benin, Ghana, Mali, Togo, and Niger being the principal countries of migrants' origin (United Nations Population Division, 2019). Nigeria's immigrant population amounts to 1.3 m, making the country home to the second-largest immigrant population in the whole ECOWAS region (after Côte d'Ivoire with 2.5 m immigrants) (UN DESA, 2019a). Considering Nigeria's population of just over 200 m (World Bank, 2019e), the share of immigrants makes up 0.6 to 0.7 % of the total population. However, the large absolute number does reflect ECOWAS' progress towards socio-economic integration of the region and facilitation of free movement of capital, services, and persons. Among main factors attracting migrants to Nigeria are its economic dynamism, absence of visa requirements for ECOWAS citizens as well as the porosity of the borders (IOM, 2015a, p. 28). At the same time, it is a significant country of origin for regular and especially irregular migration northwards (ibid.).

As of October 2020, the total refugee and asylum seeker population in Nigeria amounted to some 65,700 (1,700 asylum seekers and 64,000 refugees), with Cameroon being the main country of origin by far (61,800) plus an approximate 1,000 persons from CAR and 800 from DRC. Most urban refugees resided in Abuja (600), Lagos State in the Southwest (2,700), and Kano state in the North of the country (500) (UNHCR, 2020h). Furthermore, the country counts nearly 2.7 m IDPs, predominantly residing in the North-East (UNHCR, 2020e).

The majority of immigrants into Nigeria are migrant workers (Federal Republic of Nigeria, 2015, p. 55; IOM, 2015a, p. 27), with large numbers employed as agricultural, forestry and fishery labourers, plant and machine operators, clerical support workers as well as service and sales workers (AUC & JLMP, 2020, pp. 44-45).

Over the last decade, Nigeria's overall disease burden has been steadily decreasing (IHME, 2018b). According to the 2019 Burden of Disease assessment, measured in DALY, some of the main health issues of Nigeria's broader population were maternal and neonatal disorders, enteric infections, respiratory infections and TB, as well as neglected tropical diseases (NTDs) and Malaria (IHME, 2020). Unfortunately, there is next to no data on health needs and prevalence of health issues within different migrant groups, especially among regular migrants/migrant workers, which this study aims to address.

According to the 2018 Demographic Health Survey, one in every eight Nigerian children does not survive to their fifth birthday (National Population Commission Nigeria, 2019), while Nigeria's infant mortality rate is estimated at 74 deaths per 1,000 live births. The maternal mortality rate is approximately 800 per 100,000 live births and a total of 58,000 maternal deaths in 2015, making it the country where nearly 20 % of all global maternal deaths occur (WHO et al., 2015). This could be, in part, attributed to the fact that only 61 % of pregnant women have access to antenatal services (Fagbamigbe & Idemudia, 2015).

Regarding the current COVID-19 pandemic, the number of total confirmed infections as of 10 February 2021 amounted to around 141,000, while the number of total deaths is estimated at approximately 1,700 (Johns Hopkins University, 2021c). Nigeria's overall pandemic preparedness capacity has increased over the last three years, as shown by a Joint External Evaluation (JEE) conducted by Resolve to Save Lives, NCDC, and other external evaluators. According to Resolve to Save Lives (2020), areas for further improving Nigeria's pandemic preparedness include aspects of national legislation, policy and financing.

About 3.8 % of Nigeria's GDP is invested in the health sector (Varrella, 2020). According to the Nigerian Health Facility Registry (Federal Republic of Nigeria, 2021), there are just over 40,000 operational hospitals and clinics in Nigeria, of which 73 % are public while 27 % are private. Around 85 % of the registered health facilities are primary health care facilities, 14 % secondary health care facilities, while less than 1 % are tertiary health care facilities. Governmental spending on health is lower than private contributions (Varrella, 2020). In 2017, out-of-pocket expenditures as a percentage of the current health expenditure amounted to 77 %, which was the highest in the entire ECOWAS region (WHO, 2020e). In 2017, 60 \$ was spent out-of-pocket and 11 \$ by the government on health per person (IHME, 2020b). In 2019, resources allocated to health care amounted to up to 6 % of the overall Nigerian household spending on average, whereas in rural areas, figures were higher (Varrella, 2020). In 2018, about 97 % of Nigerians did not have any health insurance, whereas insurance of those who were insured was predominantly employer-covered (ibid).

In 2018, Nigeria had the second-highest density of medical doctors in Western Africa with around 3.8 per 10,000 population (WHO, 2020d), yet a higher need still has been documented (Varrella, 2020) In this context, the brain drain of health professionals is a significant challenge. Ogaboh et al. (2020) report that "[m]ore than half of Nigerian doctors lived and practised abroad". In 2017, Nigeria's polling agency, NOI Polls, in partnership with Nigerian Health Watch, found that most doctors seek work abroad. "The trend of doctors emigrating to other countries is at an all-time high," Chike Nwangwu, head of NOIPolls, told Al Jazeera in Abuja. "Our survey [...] showed that 88 per cent of doctors are considering work opportunities abroad." The reasons stated for emigrating include better facilities and work environment, higher salaries, career progression and an improved quality of life (Abang, 2019).

## 7.2 Migration and health policies and programmes

The Nigerian Constitution (1999) does not explicitly guarantee the right to health, even though Article 173.d highlights that state policies should be directed towards the provision of "adequate medical and health facilities for all persons". Although not mentioning migrant workers specifically, the Constitution outlines several principles of state policy regarding people in employment without limiting these to nationals. It mentions, for instance, that "the health, safety and welfare of all persons in employment" have to be "safeguarded and not endangered or abused" (Art. 173.c). Furthermore, it mentions the need for protection against exploitation, especially of particularly vulnerable groups such as children or young persons.

Among central stakeholders working in the area of labour migration and migrant workers' health in Nigeria are different governmental bodies such as the Federal Ministry of Interior and its Nigeria Immigration Service, which is responsible for the entry and stay of foreigners, the Federal Ministry of Labour and Employment and the Ministry of Foreign Affairs (Devillard et al., 2015, p. 260). The joint effort of the Federal Government and IOM have resulted in the establishment of a Migration Health Assessment Centre (MHAC) in Nigeria, which aims to promote the health of migrants through preventative and curative interventions.

Furthermore, the Federal Ministry of Health and the Nigeria Centre for Disease Control (NCDC), as the lead agencies responsible for controlling and preventing communicable diseases and protecting public safety and health, play a significant role in the governance of health issues, including health care of (labour) migrants.

IOM and ILO are also key international organisations in the area of migration that support the Nigerian government through capacity-building, technical assistance on migration matters, advisory services, as well as in counter-trafficking measures and in promoting good governance of (labour) migration (ILO, 2016; IOM, 2018a) While 4 out of 5 health service providers interviewed for this survey stated that there is no international finance for the health care provision of migrants in Nigeria to their knowledge, support from international organisations has included technical guidance on the formulation of relevant policies such as the 2015 National Migration Policy (NMP) and the National Policy on Labour Migration (2014).

The former plays a crucial role in governing migration in Nigeria and covers a broad range of issues such as migration and development, border management, statelessness, and information management. In the document, the term 'migrants' is used in a more general sense while also differentiating between different

subgroups. Migrants' health is treated as one of several cross-cutting issues as seen in one of the NMP's objectives which aims to "facilitate migrants' access to health services in the same way as those of nationals" (p.60). Another objective states that persons wishing to enter Nigeria must meet the national standards of health (p.60), without further defining what this entails precisely. Among other areas, the NMP pays close attention to labour migration as a significant area of policy intervention (sections 4.7.1 & 4.7.2). One of the policy's goals is to promote "organised labour migration" (p.55) of both foreign workers coming to Nigeria and Nigerians going to foreign countries for labour purposes. The need to "[p]romote and strengthen gender-specific approaches to policies and activities on labour migration" (p.56) is specifically mentioned, reflecting the increasing importance of feminisation of migration for employment (cf. Pophiwa, 2014).

The health care of migrant workers is further addressed in the 2014 National Policy on Labour Migration (NPLM) which has as one objective the protection of migrant workers and promotion of their and their families' welfare (p. 6). Specific goals contributing to achieving this objective include promoting the right to decent work and access to social protection, ensuring equality of treatment and non-discrimination for all workers, as well as labour standards and code of ethics for employment of migrant workers (p. 6). Applying inclusive language, the NPLM explicitly stresses that the human rights of migrant workers must be promoted and protected regardless of their status (p.9), implicating that migrants in both regular and irregular situations are addressed.

Further, it highlights the special protection needs of vulnerable persons such as female migrant workers, although its effective implementation may vary, as suggested in a recent assessment of migrant women's protection in Nigeria (ILO, 2020, p. 48). The promotion of an "orderly and equitable process of labour migration" (p.9) and therefore the resolution of "problems of irregular migration" (p.11) are listed under good governance in labour migration which constitutes another one of the NPLM's overall objectives (Federal Republic of Nigeria, 2014b). Nigeria has ratified several key international documents on labour migration, such as the 1949 ILO Migration for Employment Convention No. 97 (ILO, 1952) and the 1990 UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. However, as the NPLM points out, some work has still to be done to incorporate international norms formulated by these treaties into national legislation (p. 4).

Regarding social security, the current legislative framework does not explicitly guarantee migrant workers' access to insurance and compensations for occupational illness, injury, or death. Nevertheless, the language used in documents such as the 2010 Employee's Compensation Act is non-restrictive, and the inclusion of labour migrants can be interpreted as given. As no exclusion on the grounds of citizenship or residence status is made, access of migrant workers - occupied both formally and informally - to social security provisions articulated in this Act may be interpreted as implied (Taran & Youtz, 2015, p. 15).

Several of the migrants interviewed stated they did not have any experience of using the national health insurance system, while others are covered through health insurance plans through their employers in the form of Health Management Organisations. Hence, the extent to which migrant workers can benefit from the Nigeria National Health Insurance Scheme (NHIS), if not directly through their employment schemes, appears to depend on their ability to pay for it. As one service provider interviewed notes:

"[...] in Nigeria, the insurance system is very, very poor. I'm a citizen and a doctor. So I do not belong to any insurance. I don't have any insurance cover. So let alone a migrant that's just coming. So if you want to have an insurance system which normally gives priority to the way you are treated, it is usually the health insurance that does that for you. So if a migrant has health insurance in Nigeria, he or she is more likely going to access health care better than me or any citizen and vice versa."

The NHIS launched a programme titled "Group Individual and Family Social Health Insurance Programme" (GIFSHIP). While a government official interviewed for this study indicated that GIFSHIP, in an attempt to expand the scope of health care coverage towards Universal Health coverage, might be open to migrants in Nigeria, the Ministry of Health's press release (2020) states that the programme "[...] offers citizens the opportunity to participate and benefit from health insurance by subscribing to affordable premium payments [...]" which implies that Nigerian citizenship is a prerequisite to be enrolled in the programme.

Contrary to employment policies and legislations, Nigerian health policies and legal frameworks do not explicitly address migrants. For instance, the 2016 National Health Policy stating its overall goal as strengthening Nigeria's health system 'to deliver quality effective, efficient, equitable, accessible, affordable, acceptable and comprehensive health care services to all Nigerians' (Art. 3.3) deploys terminology which excludes non-citizens. The 2017 National HIV/AIDS Strategic Framework 2017-2021 uses the exclusive term 'Nigerians'

and inclusive terms' populations' or 'people living with HIV' interchangeably, though not addressing migrants explicitly. Similar language is used in the 2014 National Health Act, which speaks of 'Nigerians' and 'persons living in Nigeria' or 'people of Nigeria' (Federal Republic of Nigeria, 2014a).

Nigeria has a comprehensive policy framework on epidemic preparedness consisting of guidelines and plans developed for both particular diseases and generic epidemic response. Yet, in most cases migrants or refugees are not specifically mentioned, e.g., in the 2018 National Action Plan for Health Security (2018-2022), the 2018 National Strategic Health Development Plan II (2018-2022), or the 2019 One Health Strategic Plan (2019-2023). At the same time, some policies on preparedness and response to particular diseases mention migrants and refugees as vulnerable populations explicitly. Policies such as the 2013 Nigeria National Pandemic Influenza Preparedness and Response Plan or the 2019 National Guidelines for Yellow Fever Preparedness and Response point out that special plans to identify and reach migrants and displaced populations as well as to respond to their specific needs have to be developed. The Nigeria COVID-19 Preparedness & Response Project targets both refugees and migrant workers as vulnerable or disadvantaged groups (World Bank, 2020f).

Over the course of the research, we examined several academic and non-academic assessments of implementation of existing policies, although the extent of secondary literature on governance of migration and health in Nigeria is limited. As stressed by many authors, the area of mental health care shows room for further improvement. The burden of disease from mental & substance use disorders, measured in DALYs per year, was estimated at 2.6 million in 2016 (Our World in Data, 2021). This large number was met by 250 psychiatrists and another 200 psychiatry trainees which is insufficient to meet people's mental health care needs, including those experienced by migrants (Association of Psychiatrists of Nigeria, 2021). It can be assumed that these aspects also present challenges to other migrant groups experiencing mental health issues, including labour migrants, as the lack of mental health care professionals can be considered a widespread problem of the Nigerian health care system (Adepoju, 2020a)

Some studies point out that access to (accurate) information is an obstacle for migrants to enjoy adequate health care. Okanlawon et al. (2010), for instance, identified an alarming level of misinformation and / or lack of education about use of contraceptives among youths in the Oru Refugee Camp. More recently, UNHCR has identified similar problems in its recent assessment of the socio-economic impact of COVID-19 pandemic among persons of concern (UNHCR, 2020d. pp. 11-12).

### 7.3 Key observations and findings - primary data collection

The findings for Nigeria are derived from the quantitative survey deployed and the Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) that were conducted in Nigeria. Respondents to the KIIs and FGDs were randomly selected from the three categories the research covered: labour migrants, government officials and service care providers. The respondents for the survey included labour migrants from all over Nigeria, the staff at foreign embassies and migrant communities across Nigeria. The embassies were also used as a data collection/survey dissemination point. As noted in Ch.2, regular labour migrants were selected due to the importance of regular migration within the ECOWAS space.

The respondents for the key informant interviews are from government agencies working on migrants and migration, service providers working with migrants and labour migrants from different sectors in Nigeria. The respondents for the health service providers are from government hospitals in Iseyin, Iwere ile and Ejioku (all border towns in Oyo State, Nigeria) and an official of the Nigeria Health Watch in Abuja, Nigeria. The labour migrants are self-employed workers and employees of private institutions in Lagos, Port Harcourt and Abuja, Nigeria. The respondents for officials are from the Nigerian Refugee Commission, Nigeria Immigration Service and the National Health Insurance Scheme (NHIS). Fieldwork was largely restricted to Lagos due to travel restrictions associated with the COVID-19 pandemic, security concerns, and time and other constraints.

The survey was completed by a total of 360 respondents, of which 355 responses met the eligibility criteria for inclusion. Roughly one third was female (36 %). Just under half of the respondents lived in Nigeria for less than two years and the other half for more than two years. Of those that indicated their country of birth (171 out of 355), many respondents (39 %) stated that they were born in Nigeria. This is slightly surprising as the target sample were labour migrants who have crossed an international border. However, cultural connotations of residence and origin are reflected in completing the questions. Some of the persons who completed the survey regard home as where their parents, wives or children are based. As migrants and pastoralists who were prominently represented in the sample do not necessarily move with family, questions such as "where

do you live?” might have been misleading. Also, persons married to a Nigerian often regarded themselves as Nigerians regardless of where they were born.

Besides Nigeria, most persons who disclosed their country of birth originated from Cameroon (20 %), Ghana (17 %), Togo and Gabon (12 % each). Regarding documentation, 23 % claimed not to have legal documents (e.g., an application as a refugee or a working document was denied), 22 % with temporary documents, either as recognised refugees or asylum seekers. Another 21 % stated to have temporary documents tied to an educational stay, while 17 % held permanent documents in the form of an unlimited working permit. Finally, another 10 % stated to hold citizenship, which can be, in part, explained by explanations given above regarding respondents’ country of origin. For more detailed information on descriptive variables of the survey sample, please refer to Annex V Table 1 and Table 2.

Important drivers of the decision to come to Nigeria include to improve their economic situation, a critical situation in the country of origin, education, and family reunification. Also, the prospect of quality health care provision was named as a motivating factor.

## 7.4 Migrants’ experience of health and accessing health services

### Migrants’ health care needs and vulnerabilities

The health problems of regular migrants (and to a lesser extent refugees and IDPs) in Nigeria are similar to those of the broader Nigerian population, in part because migrants and citizens share the same doctor population, hospital bed population, health facilities, disaster management systems, solid waste disposal and sewage disposal system, water supply, air or noise pollution, environmental radiation and degradation. Data collected reveals that the health care needs of migrants in Nigeria are not related to specific health complications: 84 % of the migrant respondents surveyed noted that they had not had any health complications since they had left their home country for Nigeria (Annex V: Table 6).

Of those who had experienced health complications, the most common health issues reported included physical issues like fracture from accidental injuries, Malaria, mental health issues, and chronic diseases (obesity, diabetes, hypertension), which could be related to lifestyle and eating habits. Other health care needs for this group include issues with reproductive health (e.g., during pregnancy or menstruation, etc.), eye problems and nutritional health-related issues.

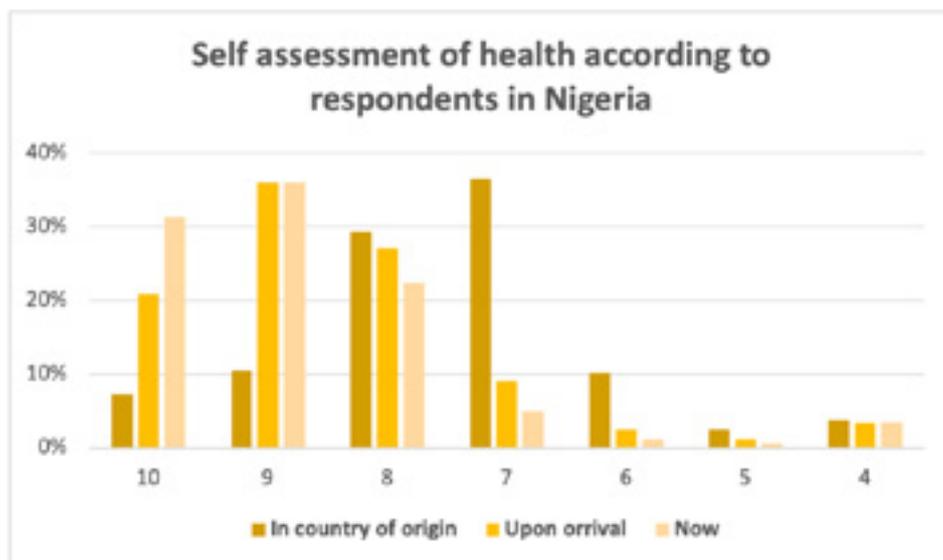


Figure 16: Self-assessment of health according to 354 respondents in Nigeria on a scale from 1 to 10. (Source: own data collection)

Moreover, the survey results showed that, on average, the self-perceived health status was higher at the time of answering the questionnaire than in the country of origin and higher than when arriving in Nigeria, for that matter Again, this (Figure 16). was consistent with results reported by partner researchers in the other

two study countries. Incidentally, the self-rated health status of persons born in Togo was significantly lower than that of respondents born in Nigeria, Ghana, Gabon, or Cameroon (these being the main countries of origin in the sample). However, the relatively small sample size, 20 persons who stated they were born in Togo, poses a challenge to the robustness of this finding.

The survey asked 350 people in Nigeria which health complications they were most worried about in multiple selection questions. The biggest concern to the respondents was mental health, which was named by 135 respondents. COVID-19 was another dominant concern (76). Nutrition (60), dermatological issues (59), their children’s wellbeing (48), eye problems (31), and chronic diseases (27) were also significant concerns in the sample, but with less prevalence (see Figure 17). This finding is particularly interesting in that it differs from the results from Kenya and South Africa, where concerns about COVID-19 were most frequently expressed. This could be, in part, explained by the high level of hustle and bustle in Nigeria migrants experienced compared to their home countries. Some consider this busy lifestyle and operation in Nigeria as stressful and mentally draining, thereby inducing stress to the point that it can lead to the development of affective disorders such as depression. Another reason for this finding could be the relatively low incidence of COVID-19 in Nigeria, which is further elaborated in the discussion section of this report.

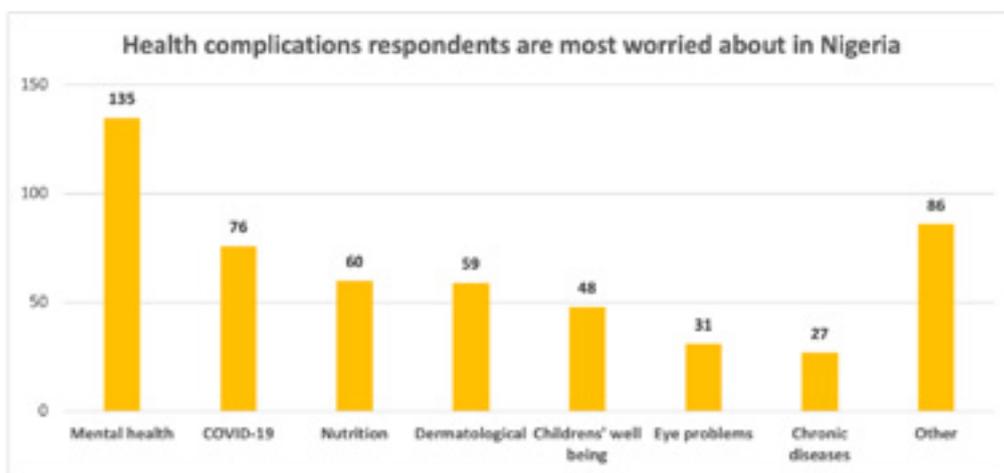


Figure 17: Health complications respondents are most worried about in Nigeria. 350 respondents named 522 complications in the multi-select question. (Source: own data collection)

Migrants also raised concerns about the increasing level of food prices and general cost of living in light of the COVID-19 pandemic. Moreover, some migrants noted that they feel vulnerable to contracting the COVID-19 virus due to the nonchalant attitude of citizens towards taking precautionary measures amidst the second wave of the virus.

To a great extent, the vulnerability of migrants to health problems can be considered quite similar to that of Nigerian citizens. Service providers and government officials interviewed raised this point repeatedly based on their experience of treating migrants, who generally share the same health facilities and health personnel as citizens. However, the difference in the level of vulnerability to health problems of a citizen and a migrant also depends on the availability of health care service information. While a citizen might find it very easy to know where to access health care, migrants, especially if newly arrived, might find it more challenging to know what health care facility to visit due to the unavailability of health care service information in easily accessible platforms.

This is also reflected in how respondents stated the way they received information about the health care system. 26 % indicated they did not (yet) know how the Nigerian health system works. Those who understood it indicated to have obtained this information primarily through informal networks such as friends and family, stated by 74 % of the respondents. In comparison, other important sources of information included health workers or other public sector staff (42 %), the internet (22 %), and NGO’s (7 %). The high importance of informal networks of friends and family could be, in part, explained by the fact that language presents a barrier for many persons, which also includes the lack of information available in different languages (Annex V: Table 7).

When asked about how they would like to obtain information, personal networks and primary health centres are the preferred options (named by just over 60 % of the sample each), while religious communities and pharmacies were both named by just over 30 % of respondents.

## Migrants' experience of the health care system and accessing health services

Regarding restrictions in access to health care services, the survey showed that out of the 350 respondents, 66 % encountered problems when they tried to access health services, 27 % had not tried to so far, and only 7 % reported having faced any difficulties in doing so (Annex V: Table 7), which is also reflected in the finding that on average respondents rated the general accessibility of health care services at 8.5 out of 10 (Annex V: Table 3). Those who did face barriers primarily attributed those to language barriers, geographical distance and administrative reasons (Annex V: Table 7). Another frequently raised issue was experienced stigmatisation and xenophobia when trying to access health services by migrants, which was also recognised by a government official in a KII:

*"Nigerians kind of side-line [migrants] when it comes to access, access in health care because to a large extent, you want to take good care of yourself, your own countrymen, and they say 'Hey you just sit one side, let me take care of the Nigerians that are here.' So they face a lot of stigma and discrimination"*

Available financial means also play an important role in determining what kind of health services can be accessed. During a KII, one migrant noted that health care is available in Nigeria if one can afford it. The respondent noted that while she could afford to use health services in Nigeria due to Health Management Organisations' coverage in place in her present workplace, some of her migrant friends always complain about the price of health care in Nigeria.

When asked about where they seek help when encountering health issues, public health centres and other primary health facilities were named by half of all respondents, while private facilities are used by almost the same share of respondents (45 %). Friends and private networks also played an important role in this regard and were referred to by 43 %. Support from non-conventional medicine such as traditional healers or support from religious communities was sought by 29 %. Also, pharmacies (23 %) and the internet (9 %) seem to be relevant points of contact, while NGOs do not appear to play a significant role in this regard (2 %) (Annex V: Table 4).

When unable to access health services, the survey results revealed that many respondents turn to traditional forms of medicine, herbal treatment, and pharmacies. While this trend requires further investigation, potential explanations could be that persons use traditional medicine because they do not have the necessary information on how the health system works. Or, conversely, some people might prefer to use traditional forms of medicine and therefore do not seek information or have very little exposure to the modern health system. Price and availability may also be major factors, as one interviewee pointed out:

*"Traditional medicines are affordable for the poorest man to afford, unlike the Western medicine, they need to get prescribed drugs from a doctor. Most times it's quite expensive when you can be provided for, so traditional medicine is the basic health facility for a poor man to achieve."*

Moreover, the research revealed that migrants who seek mental health care sometimes find it difficult to know which health care facility to visit. For example, one of the migrants who took part in the FGD noted she had difficulties in finding a mental health specialist to visit. She recounted that even some of her Nigerian friends could not recommend anyone to her, and she was not ready to visit an ordinary health facility due to the sensitivity of the issue.

Nevertheless, generally speaking, the respondents claimed that their experience of health services in Nigeria has been positive, rating its quality on average 8.5 on a scale of 1-10 (Annex V: Table 3). One of the respondents in a KII noted that she would rate her general experience of health service access in Nigeria 9 out of 10 compared to her home country, which she would rate 5 out of 10, but some persons rated the quality of health services available in Nigeria as poorer compared to their home countries.

## Impact of COVID-19 pandemic

The COVID-19 pandemic has put the government's efforts towards the health needs of migrants and non-migrants to test, although Nigeria has fared better than most of the countries with reported cases of the disease. A key factor in Nigeria's pandemic response journey is the government's approach at the national and sub-national level, including building synergy with international health agencies, embassies, and migrant associations to fight the pandemic.

When asked about the impact of COVID-19, one migrant interviewed stated:

“Just the range of health services you can have access to. There has been a cut off, although it is not a major change, from the number of services my HMO could cover, so right now there’s a reduction in what is being covered [...].”

In another KII, one respondent noted that in addition to sensitisation campaigns about social distancing and hand sanitising, the health care system in Nigeria has up to date health care facilities and workers trying their best to maintain a good medical culture. While service providers and government officials were clear in pointing out that generally, migrants should be able to access the same health care provision as citizens, the importance of sound medical history, especially for people who come to Nigeria from outside the country, was highlighted:

“And what in some cases, like the case of COVID-19 it is that it becomes a major part of concern so ask whether someone has had a history of travel or the person is just coming to the country so cases like that when it comes to pandemic, that history of whether the patient or individual just travel or frequently coming to place.”

## 7.5 Health needs of vulnerable groups of migrants

Migrant women are likely to experience different health needs than men which becomes particularly apparent when applying an intersectional perspective. This is, for example, reflected in the fact that a majority of service providers who took part in the KIIs and FGDs answered that issues around reproductive health are one of the most predominant cases presented by migrants at their facilities. When those health care needs such as sexual and reproductive care are not sufficiently available or accessible, the risk of maternal mortality and morbidity, sexually transmitted infections, as well as unplanned pregnancies increase. In addition, some of the female migrants interviewed in Nigeria attested to frequently facing challenges pertaining to access to education particularly in maternal, new-born and child health, sexual and reproductive health and the effective service delivery thereof:

“The major barriers I face was difficulty to access the health care centre because it was very far, very far from my home. It was very, very far. And because it was far from my home, I found it very difficult to access the antenatal services when I was pregnant and during my childbirth. So, when I was pregnant, going to the hospital was difficult. I had to use these local women who helped people to give birth.”

Asked about the general quality and accessibility, female migrants surveyed gave slightly lower ratings than their male counterparts. However, the data does not suggest that women attribute this fact directly to the fact that they are women. Another finding from the study shows that women rated their health status significantly poorer than men since they have been in Nigeria. Additional health care needs could possibly explain this they present with, which should be subject to further research.

Another aspect is that women more often than men express worries about potential health issues, particularly regarding sexual and reproductive health, including STIs. Possibly explained by this heightened apprehension of potential health risks, female migrants tend to be better informed about the health system in Nigeria than men. This information was stated to be disproportionately more often generated through informal networks than was the case for men.

## 7.6 Good practice examples and areas for improvement

With the establishment of Migration Health Assessments Centres (MHACs) in various countries, including in South Africa, Kenya, DRC, and Nigeria, national governments in cooperation with IOM assess migrants to ensure that they are fit to travel in a safe and dignified manner. MHACs carry out health assessments for various categories of migrants, including resettling refugees, labour migrants and displaced persons, either before preparation for departure or upon embarkation. The purpose of health assessments is to identify and address conditions of public health and public safety concern and conditions impacting health and social services. Some of the health-related provisions include testing and treatment for medical conditions which pose a risk to public health, such as TB, HIV and STIs, immunisation against vaccine-preventable diseases, prophylaxis against Malaria, tuberculosis and opportunistic infections in immuno-compromised individuals etc. In 2019, 429,000 health assessments were conducted through the MHACs globally, and roughly 140,000

on the African continent (102,000 migrants who move on a voluntary basis and 38,000 refugees). Among the main destination countries were the United States of America, the United Kingdom, Australia, Canada as well as European countries such as France, Germany, Ireland, Portugal and Spain (IOM, 2020i). The need for tighter regional and international collaboration in this regard shows the 2014 case of Ebola virus dissemination in Nigeria which started with a traveller from Liberia.

Looking at cross border disease surveillance as part of the present study, four migrant key informants disclosed that they did not have a health check on arrival to Nigeria and were not given any information about health care services. This realisation is somewhat concerning, given that the four migrant key informants are not irregular migrants and possess necessary documentation. However, while IOM Nigeria is making efforts to support the health assessment of Nigeria returnees and immigrants, it would impact the health of migrants and Nigerian citizens positively if IOM or other bodies also supported health assessments of migrants. The importance of cross border disease surveillance was widely shared amongst health practitioners, as this statement illustrates when asked about the most urgent issue regarding migrants' health in Nigeria:

"I think what I would say is that any migrant coming in should be properly screened which I think they do and I believe when any migrant is coming into the country."

Another issue frequently raised was the need for the Nigerian health care system to improve on health care sensitisation in rural areas. As one migrant interviewed put it:

"Health care availability and sensitisation of medical importance to the rural areas will be better because the man in the village will be the last man to think of a hospital. So it takes them time to actually know what's wrong with them. But with proper sensitisation and spread of medical staff to the rural communities, I think, it will enhance the medical sector."

This can also be related to the unbalanced medical provision evident in non-urban areas and the difficulties with staff recruitment and retention in these areas.

Further, the same respondent noted that Nigeria should improve their emergency health care services and provide a functional emergency response phone line. While comparing the emergency response in his country to that in Nigeria, the respondent noted that in Benin, at the slightest case of an emergency, an emergency team responds immediately. This was seen as a particular issue in Lagos, as bad traffic can make it hard to receive timely medical care.

Another respondent noted a need to improve access to health care for migrants by subsidising charges for health care services. The respondent, who had access to health care through insurance provided by her employer, recounted the restrictions experienced by her fellow migrants who have to pay exorbitant sums because they are not national citizens. This is in line with findings from the survey, which show that out of 24 respondents who were willing to disclose this information, 20 persons stated they paid for medical services themselves, while insurance covered the (partial) costs of only 4 respondents. However, a distinction needs to be made between payment for services delivered in a private setting as opposed to public health facilities, a view shared by a migrant key informant:

"So, for instance, I would say accessibility to health care [is a strong point about the Nigerian health system], but to be honest, is really based on who can afford [it]. So I think it's really unfair... if you cannot afford decent health care, unless you go to the government hospitals, which, you know, in many cases are really poorly funded, they don't have things [...]."

Regarding health financing, the general response from the respondents interviewed for this study is that international organisations tend to not finance health care provision for migrants in Nigeria directly. When asked if they get financial aid from international organisations, only 1 out of 5 service providers answered that international organisations helped finance health care provision for refugees and internally displaced persons. In contrast, the other 4 answered that there is no international finance for the health care provision of migrants in Nigeria. However, this does not paint the whole picture, as several respondents highlighted existing and planned partnerships including with IOM, UNICEF, WHO, USAID and other international organisations and NGOs. Regarding external funding for health care facilities, one service provider acknowledged that

"[...] there are some non-governmental organisations that are getting involved in health. So in my own facility, we don't get that, but in other facilities, they can be getting that. For example, there are some diseases that some NGOs supply drugs on a regular basis. So we can't overrule that, so it exists, but in my own facility, it doesn't exist. "

Several government key informants also highlighted the need for specific policies specifically dedicated to migrants' health. They argued that such policies would provide the policy framework for a plan of actionable measures that would help enhance the quality of migrant health in the country.

Asked about positive aspects of the health system in Nigeria, migrants listed general efficiency, skilled staff, standardised procedures, good equipment, availability of services (if one can afford it), little discrimination, and a large number of facilities. Generally, migrant respondents rated the Nigerian health system rather favourably:

*"On a scale of 1 to 10, I'll give [the Nigerian health system] a 9. And this is excellent because there are more specialist doctors you can have access to, and they are readily available as you don't need to travel a long distance to access health care."*

Besides many positive aspects, migrants also identified several points to improve their own health situation in Nigeria. According to the respondents, a reduction of service fees and migrants' inclusion in health insurance schemes would pave the way to better health outcomes. Interestingly, higher pay for service providers was also suggested by migrants, which might be in line with a call for the extension of services provided to rural areas, one aspect of making services more accessible which was also of concern to migrants. Further, migrants considered more information on how to protect themselves from infectious diseases like COVID-19 beneficial for their own wellbeing. Lastly, migrants pointed out that any form of racist treatment should be put a stop to, which some experienced at the hands of Nigerian service providers.

## 7.7 Conclusion and recommendations

Generally, health care service providers and government officials were united in their replies that health care provisions set out for Nigerians also apply to non-migrants as the government operates a non-discriminatory policy towards health care, as illustrated by a health care service provider:

*"There's no segregation. We treat everybody equally, as a doctor by your qualifications, you've actually sworn an oath that everybody that comes your way, you'll treat, irrespective of gender, religion, age or ethnic background. "*

Aspects impeding adequate health care provision for all persons residing in Nigeria, migrants and citizens alike, include inadequate funding of the health sector in the country, rising brain drain with the migration of health care professionals out of the country. Migrants might face additional barriers such as difficulties with local languages, stigmatisation and discrimination, and limited social coverage.

From the survey and key informant interviews conducted, Nigeria could further promote migrants' wellbeing by introducing more comprehensive institutional frameworks that are specifically tailored to the health needs of migrants. This also entails facilitating migrants' inclusion into the NHIS, as one health care service provider points out:

*"[...] Anybody that is allowed to come in should be placed on health insurance by doing so that will reduce a lot of morbidity that comes with medical treatment in Nigeria. We need insurance, there should be insurance that covers anybody that comes in, there should be a way to get them to pay for it, obviously. But that is the most important, most important thing that the government needs to put in place."*

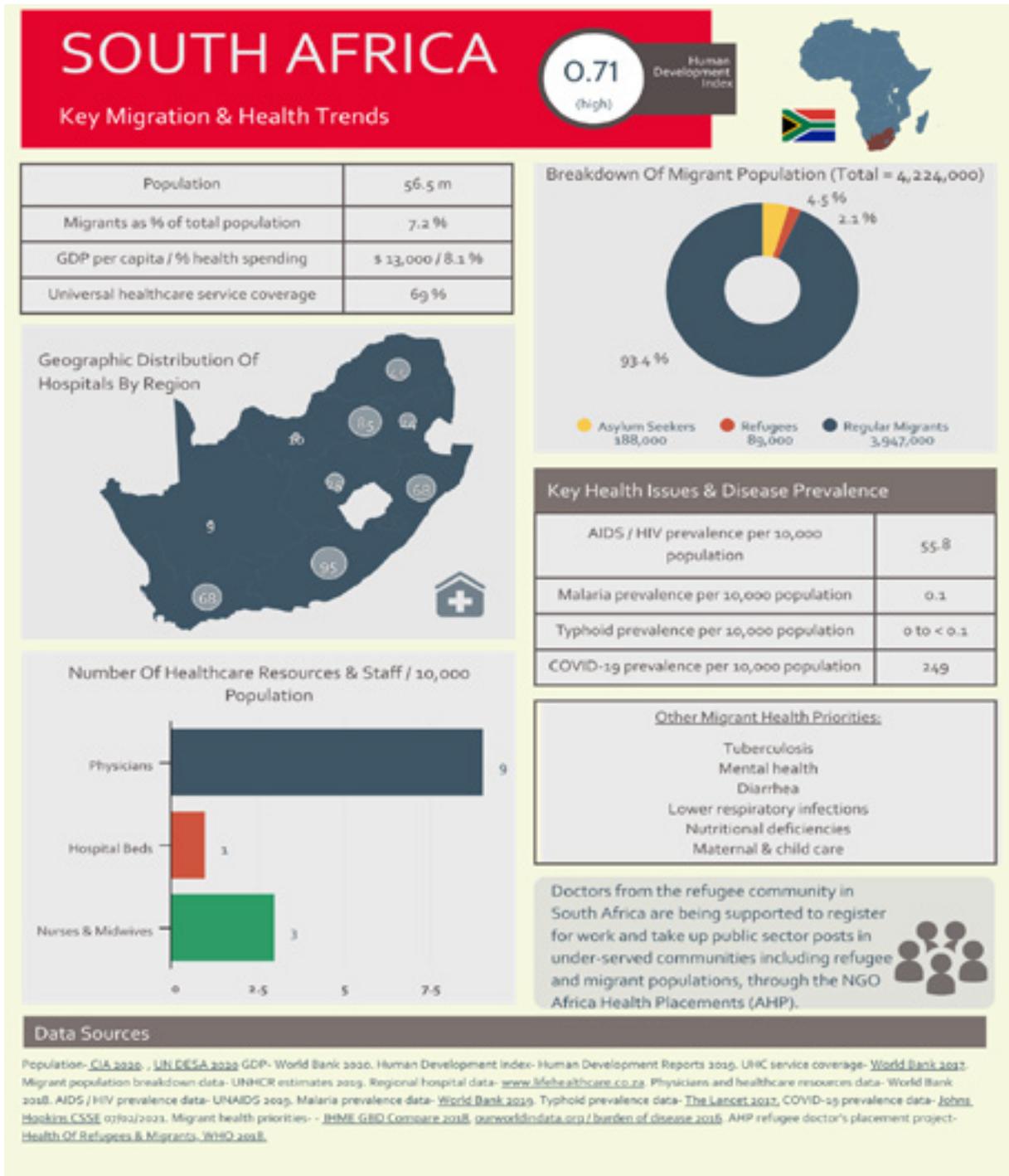
To further enhance national efforts, more attention should be paid to improving the communication gaps between key players in the health sector and migrants, which will go a long way towards building trust between both parties. Further, subsequent policies for migrants should include areas targeted to improving their access to health and reduction in the reported barriers.

Following the data collected and analysed by the group of researchers, this study makes the following recommendations for Nigeria:

- Health care provision should be extended to provide equitable and universal access on demand for every person living in Nigeria (c.f. WHO, 2019).
- Health careThe NHIS should be extended to include migrants as well as citizens in line with the continental social protection and social security

- Measures such as flexible working hours, competitive salaries, and personal development strategies should be put in place to improve recruitment and retention of trained health workers, particularly to improve retention in rural or remote areas.
- Allocating greater resources to the health sector and liberalisation of the health sector are two important approaches to overcoming the challenge of inadequate health facilities in Nigeria.
- Government and international partners should provide comprehensive health assessment (as well as education programmes for migrants) to limit the spread of communicable diseases through migration. Such health assessment programmes could be initiated in the form of a Memorandum of Understanding that obligates cross-border migrants to provide authorised health assessment certificates on arrival to Nigeria.
- Access to affordable health care is limited by a lack of facilities and provision. Governments, international partners, and the private sector should invest in building additional facilities, especially outside urban centres.
- A culture of continuous monitoring and evaluation of health programmes should be encouraged in order to enhance the efficient use of resources channelled to health care. This would also help to provide important data that can improve the planning and implementation process for subsequent health programmes and interventions targeting migrants in the country.

## 8 South Africa: Irregular Migrants



**Data Sources**

Population- [CIA 2020](#) , [UN DESA 2019](#) GDP- World Bank 2020. Human Development Index- Human Development Reports 2019. UHC service coverage- [World Bank 2017](#). Migrant population breakdown data- UNHCR estimates 2019. Regional hospital data- [www.lifehealthcare.co.za](#). Physicians and healthcare resources data- World Bank 2018. AIDS / HIV prevalence data- UNAIDS 2019. Malaria prevalence data- [World Bank 2019](#). Typhoid prevalence data- [The Lancet 2017](#). COVID-19 prevalence data- [Johannesburg CSSE 02/02/2021](#). Migrant health priorities- [IHME GBD Compare 2018](#), [ourworldindata.org / burden of disease 2018](#). AHP refugee doctor's placement project- [Health Of Refugees & Migrants, WHO 2018](#).

Figure 18: Infographic of key migration and health data - South Africa. (Source: own illustration)

## 8.1 Country context

South Africa has a relatively high GDP per capita compared to other countries in Africa, its \$ 13,000 PPP (World Bank, 2019g). The country is currently the second biggest economy on the continent, after Nigeria (IMF, 2020). However, SA remains on the OECD DAC list of Official Development Assistance recipients being categorised as an “Upper Middle-Income Country” (OECD, 2020b), and is still burdened by a relatively high rate of poverty, unemployment<sup>10</sup> (28.5 % (World Bank, 2020g)) and high income inequality (Gini coefficient in 2014: 63 (World Bank, 2015)). The richest 10 % of the population held around 71 % of net wealth in 2015, while the bottom 60 % held 7 % respectively (World Bank, 2019d). The country is characterized by what is considered a mixed economy, with key economic sectors being, mining, agriculture and fisheries, vehicle manufacturing and assembly or food processing. There has been evidence that such sectors attract more irregular migrants than others (e.g., (IOM, 2020b, p. 29), (Long, Crisp, 2011)). Further, numbers from ILO show that informal employment makes up a third of total non-agricultural employment ((Rogan, 2018).

Due to its relative wealth and perceived economic and political stability, SA plays a key role regarding migration on the continent and experiences high levels of mixed (regular and irregular) migration (Freedman et al., 2020) mostly from neighbouring countries, the Horn of Africa and West Africa (IOM, 2018d). Besides high numbers of refugees, irregular and regular (labour) migrants, it is also a source, transit and destination country for people trafficked for forced labour and sexual exploitation (IOM, 2003). Lastly, it has been a destination for medical travel flows motivated by lack of access to basic health care in the countries of origin or by seeking specialist diagnosis and treatment (Vaillancourt, Vaillancourt, 2014). SA is also a springboard for migration to Europe and the Americas (IOM, 2020). According to UN DESA, there were 4.2 m migrants in South Africa in 2019. This constitutes about 7.2 % of the entire population. Out of the 4.2 m, 190,000 were asylum seekers and 90,000 refugees. (UN DESA, 2019a). Unfortunately, those numbers only include regular migrants. We will focus on this specific group in this section - irregular migrants living in South Africa - no accurate estimates exist. This is problematic because, on the one hand this gives migration-critics the floor to estimate and use exaggerated numbers and, by that, to politicise the discourse (Makou, 2018). On the other hand, the lack of accurate numbers makes governance processes and political decisions challenging.

SA's overall disease burden has been steadily decreasing since 2005 (IHME, 2018b). Main health issues of the broader population are HIV/AIDS and other STIs, respiratory infections and tuberculosis, cardiovascular diseases, maternal and neonatal diseases as well as consequences of self-harm and violence (IHME, 2020e). With 7.1 million people living with HIV constituting 18.9 % of adults between 15 years and 49 years old, the country has the biggest HIV epidemic in the world (USAID, 2020).

Since there are no reliable statistics on stocks of irregular migrants, there is also not much data on the well-being or health issues of migrants in irregular situations (Migration Data Portal, 2020). However, studies show that migrants' rights to access health care is routinely denied. Health professionals refuse to treat people because they are not able to provide the “correct” documentation (IOM, 2009). When able to access services, migrants report verbal and physical abuse, insults, being pushed to the back of the line, and being asked for money that they should not have to pay (Crush & Tawodzera, 2011) (Crush & Tawodzera, 2014). Migrants' common experiences of sexual violence but also transactional and forced sexual relations provoked by lack of economic resources expose especially women to high risks of HIV and other STIs (Freedman et al., 2020). In addition to existing health risks, the current COVID-19 pandemic has hit the country severely.

Regarding COVID-19, the number of total confirmed infections as of 10 February 2021 amounted to around 1,479,000 while the number of total deaths is estimated at approximately 46,900 (Johns Hopkins University, 2021d). That is among the highest numbers of cases in Africa. Migrant vulnerabilities are further exacerbated due to the COVID-19 pandemic: mobility restrictions, suspension of labour migrants, and missing access to health care services are only a few factors that affect their well-being. This study provides further evidence in the topic of health access of irregular migrants in most of the issues mentioned.

The pandemic reveals existing and long criticised flaws in the health care system of SA. Due to the parallel existence of private and public health systems, there is a stark divide between rich and poor. While 71.5 % of households asked in a National Household Survey of 2018 reported to depend on public health care provision when falling ill, 27.1 % reported consulting private medical schemes. Only 0.7 % indicated consulting with traditional healers. Yet, the country's (Stats SA Statistics South Africa., 2020, p. 25). Yet, the country's expenditure does not meet those needs correspondingly. In 2017, SA spent 8.1 % of its GDP / \$ 10978 in PPP per capita on health (WHO, 2018a). Of that, 53.7 % was government, 44.4 % private and 2 % external

10. Due to COVID-19 unemployment increased up to 30,8 % in end of 2020 (Republic of South Africa, 2020)

expenditure. On average, 7.8 % of the total spending was out-of-pocket expenditure (WHO, 2018e) This uneven distribution is resulting in a great mismatch in the quality of health care provision, especially considering that users of private health care tend to be more satisfied with the services than users of the public health care facilities (Netherlands Enterprise Agency, 2017, p. 4). Another major weakness of the system is inadequate human resources. The country has on average 9.1 physicians per 10,000 population. The number of nurses and midwives being only slightly higher at 13.1 per 10,000 population (World Bank, 2017a). This lack is further worsened by an unequal distribution of health professionals between the private and public sectors, coupled with unequal distribution of public sector health professionals and facilities among the provinces (Maphumulo & Bhengu, 2019), most of them being concentrated in urban areas. Furthermore, the country loses many qualified medical professionals due to brain drain, especially to Western countries. This loss can only partially be counterbalanced by many health professionals coming to SA from other AU MS, which has been stated in the interviews.

To address those discrepancies between people's health care needs and existing public services, the government is working to establish a national health insurance (NHI) system, which aims to provide universal access to health care to all citizens based on need rather than ability to pay (Netherlands Enterprise Agency, 2017, p. 4 + 8) which will be explained further in the next section.

## 8.2 Migration and health policies and programmes

Art. 27.1 of the South African Constitution (1996) (South African Government, 1996) guarantees everyone "the right to have access to health care services, including reproductive health care." It further states in Art. 27.3 that "no one may be refused emergency medical treatment"

The National Health Act, No. 61/2003 of 2003 (South African Government, 2003) seeks to "protect, respect, promote and fulfil the rights of the people of SA to the progressive realisation of the constitutional right to access health care services" including "free health care services for all pregnant and lactating women [...], free primary health care for all, and free emergency care at the point of use for all". According to a clarification by the National Department of Health, this includes both documented and undocumented migrants as well as refugees and asylum seekers (IOM, 2009) (Matlin et al., 2018). Accordingly, in theory, no documents are required for accessing services.

In contradiction to the previously mentioned laws, the Immigration Act, No. 12/2002 (2002) (South African Government, 2002) and its Amendment, No. 8/2016 (2016) (South African Government, 2016) state in Art. 16 that medical staff must find out the legal status of patients before providing care, with the exception of emergency health care. In Art. 29a, the Act furthermore restricts "those infected with or carrying infectious, communicable or other diseases or viruses as prescribed" from applying for a visa.

The Occupational Health and Safety Act, No. 85/1993 (1993) (South African Government, 1993) aims to protect workers by demanding that employers provide safe and healthy working conditions. It does not specifically refer to migrants but does protect all workers without any reference to documentation or nationality.

In December 2015, the White Paper on National Health Insurance was published for public comments, followed by the National Health Insurance Bill in 2019. In section 4.2 it states, "[a]n asylum seeker or illegal foreigner is only entitled to—(a) emergency medical services; and (b) services for notifiable conditions of public health concern". However, to access these services, migrants must register as a user of the fund. In order to do that, one needs to provide biometrics (including fingerprints, photographs, proof of habitual place of residence) and—(a) an identity card, (b) an original birth certificate, or (c) a refugee identity card, which irregular migrants often do not possess. In addition, due to fears of being arrested and deported, many undocumented migrants already tend to avoid public health care services in general (Crush & Tawodzera, 2014). The need to register therefore may exacerbate already existing access barriers.

In terms of Gender Equality, SA's progressive legislation has often been at the forefront. The Constitution not only provides the right to equality and addresses multiple challenges women face but, as can be seen, also guarantees certain health care services specifically tailored to women. However, gender-based considerations are not integrated into migration legislation; for instance, the Immigration Act does not consider gendered migration patterns nor vulnerabilities (Farley, 2019).

In March 2020, in the rise of COVID-19, the government of SA approved a National Infection Prevention and Control Strategic Framework in order to prevent, reduce and control the development of health care associated infections. However, neither the framework nor realised plans to mitigate the impacts of lockdown measures considered migrants' precarious circumstances. For example, in order to access food distributions

or to receive financial support, a national ID or special permit is required, which irregular migrants are unlikely to possess. To take a SARS-CoV-2 test, in most parts of the country, people must provide information on their nationality, which is challenging, especially for those fearing to be exposed because their permits expired (Mukumbang et al., 2020). In addition to this lack of protection, (Zanker & Moyo, 2020) argue that the pandemic could lead to more restrictive migration policies: the sudden building of a border fence to Zimbabwe and xenophobic lockdown rules about which shops are allowed to remain open are two examples illustrating this tendency (Zanker & Moyo, 2020).

### 8.3 Key observations and findings - primary data collection

The findings for South Africa are based on the described quantitative and qualitative elicitation of data. In detail, the questionnaire was answered by 312 people, of which 310 meet all eligibility criteria to be included. The research team selected research sites in Johannesburg and Pretoria. In both cities, partner researchers covered the central business districts in order to capture data from those who dwell there as well as those commuting in from high-density suburbs and informal settlements. The team also collected data from other, less densely populated areas of both cities associated with irregular migrants. However, this urban research focus may positively bias access to health. Qualitatively, two interviews with migrants, two with policymakers in South Africa and one talk with another health researcher were conducted. Additionally, one focus group discussion was held with nine migrants participating collaboratively.

The goal of the survey was to target undocumented migrants. Thus, the characteristics of the respondents of the surveys are not always distributed uniformly. Potentially, the groups which are overrepresented are more often undocumented in South Africa. Of the 310 eligible respondents, (66 %) were undocumented and (19 %) asylum seekers; additionally, some working migrants (7 %), refugees (4 %) and educational migrants (3 %) have been reported. 52 % of female respondents are in the dataset, and less than 5 % live at other destinations than cities. The highest education level is for 70 % the secondary but 20 % report even higher with undergraduate (10 %), postgraduate (6 %), and vocational training (4 %) respectively. When we look at occupation, 38 % report self-employment, 23 % work full time, 21 % part-time, and around 13 % are currently unemployed. Their length of stay in South Africa tends to be long term, as only 6 % arrived within the last year, 12 % have stayed in between 1 and 2 years, 37 % between 2-5 years and 45 % even longer than those 5 years. For more detailed information on descriptive variables of the survey sample, please see Annex V Table 1 and Table 2.

### 8.4 Migrants' experience of health and accessing health service

For the following chapter, the migrants are grouped based on their residence status in the country. People without documents (n = 204) form the first group, the second group (n = 101) consists of asylum seekers (n = 60), labour migrants (n = 20), refugees (n = 12) and educational migrants (n = 9), lastly people who did not want to give information about their resident status (n = 2) or said to be citizens (n = 2) are not considered in the analysis in regards of documentation. This means that when we analyse with a focus on gender, they will be included. However, the presented effects are not fully explained by the documentation status, as other relevant factors, such as education, occupation or language level, are not equal between the groups.

By applying this approach, we follow evidence from previously mentioned literature. Also, in the interviews, most respondents believed their health care needs and access would subsequently be improved if there was no differential treatment on the basis of documentation. For example, some of the responses were as follows:

**“Stop sending away foreigners because of permits which lead to people losing their lives and for those who are pregnant, losing babies”**

**“The xenophobic treatment must stop. Foreigners must not be charged large sums of money if they do not have documents or sent away if they don't have it”**

Overall, the 310 respondents rate their own access to the health care system in South Africa with a mean of 7.8 (out of 10 points), people with documents rate a mean of 8.3, while undocumented ones by average rate 7.6. The quality of the system is rated with a mean of 8.6, with variations depending on their residence status: undocumented people only rate it with 8.5 on average, while documented people assess with 8.8.

The differences in rating quality and access in between the groups are statistically significant. Consequently, the rating of health increases slightly from 8.8 upon arrival to 8.9 where it is now, surprisingly in the group of people with documents, this value decreases by 0.1. Again, this argues that other underlying factors, which are uneven in between the groups, also impact those outcomes. Annex V: Table 3 and 4 provides more detailed information.

In a multiple selection question, most survey respondents (n = 190) reported that they access health services from public health facilities, also 119 citing private doctors or clinics, while pharmacies were mentioned by 31 of the survey population. While the government provides health services, the information about the system is acquired from family and friends by 87 %, and only 10 % receive this knowledge from public system officials. Thus, providing one generation of migrants with information may positively impact future generations as well.

45 % of the respondents have experienced health complications since they have moved to South Africa. Of these complications, physical issues are cited most (28), along with dental problems (28), and reproductive health-related issues (24). Results are visualised in Figure 19 below. In this regard, people without documents are more likely to face physical issues by 8 percentage points and people with documents more often face dental issues by 8 percentage points. Potentially, this is explained by working conditions (Annex V: Table 6 and Annex V Table 8).

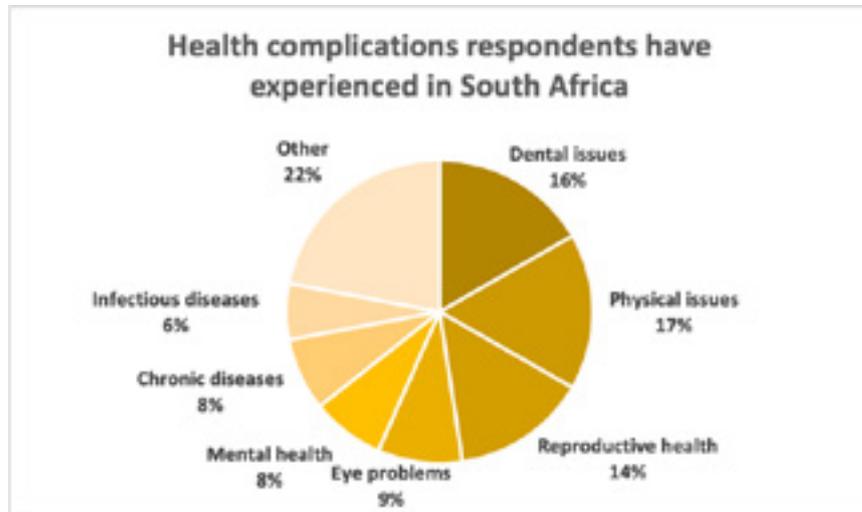


Figure 19: Health complications respondents have experienced in South Africa. 138 respondents named 169 complications in the multi select question. (Source: own data collection)

The most commonly experienced restrictions to health access are language barriers (52) and administrative barriers (37). In addition, 24 migrants reported discrimination because of their lack of official documents and 24 because of occupational obligations and 23 stigma and prejudices. Results are visualised in Figure 20 below.

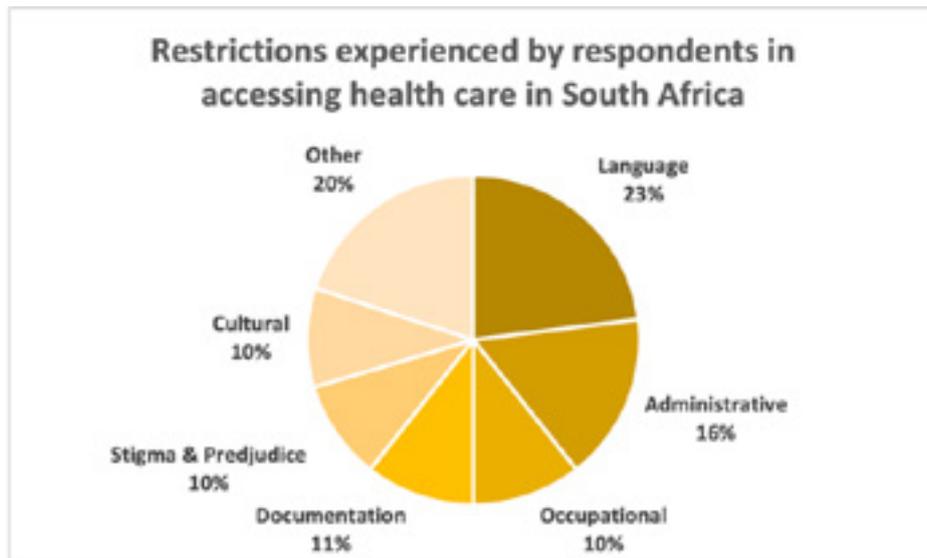


Figure 20: Restrictions experienced by respondents in accessing health care in South Africa. 115 respondents named 226 restrictions in the multi select question. (Source: own data collection)

While the general likelihood of experiencing restrictions does not differ a lot according to documentation status, language barriers and geographical issues are mentioned more often by undocumented respondents. It is evident that administrative issues and a lack of documentation are connected, as it was mostly experienced within this group, as an interview with a health official also revealed:

“When you visit the clinic and the computer is opened. the first thing that they ask you, is, what is your ID number? They need a 13-digit ID number, but the policy says don’t discriminate and that’s where the problem starts...and they will be honest that they can’t proceed without the ID number. They will tell you that, “I’m stuck. I need your 13-digit ID number and the refugee number or whatever is not accepted.”

In the multiple selection question, which disease they are most worried about at the moment, COVID-19 was named the most often (205), followed by mental diseases (137) sexually transmitted disease (137) and chronic disease (122). Results are visualised in Figure 21 below. Here, undocumented people seemed to be more worried about mental (by 8 percentage points) and chronic (by 9 percentage points), while people with documents had higher fear of COVID-19 by 10 percentage points. Subsequently, information material in several languages regarding those diseases could be useful in places where people seek help when facing health issues.

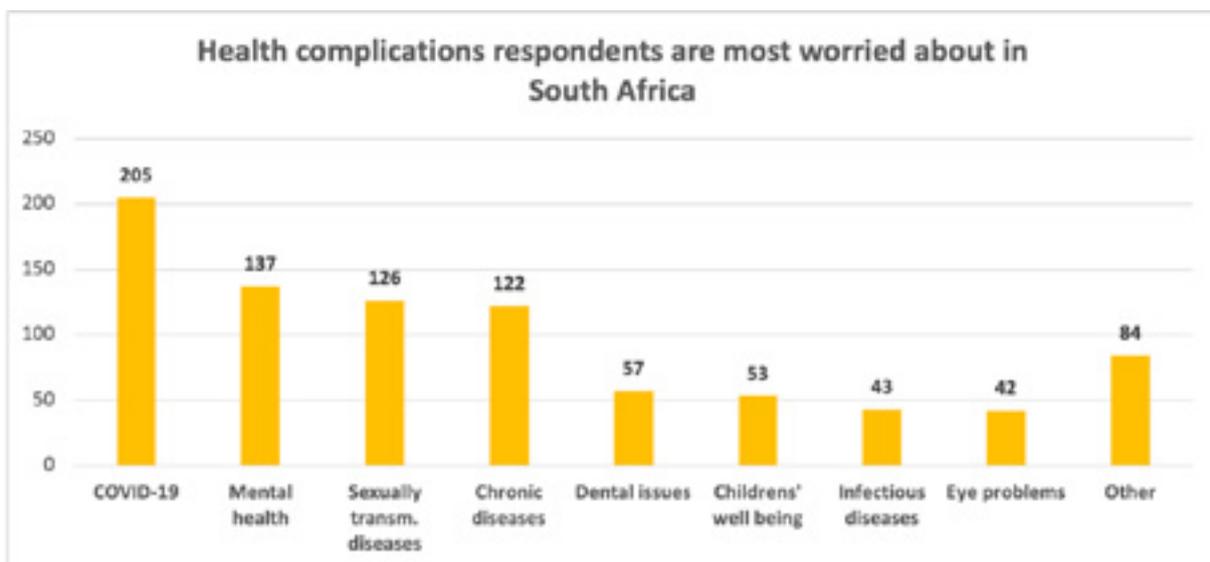


Figure 21: Health complications respondents are most worried about in South Africa. 304 respondents named 869 complications in the multi-select question. (Source: own data collection)

In order to reduce discrimination, access to testing for COVID-19 shall be regardless of the status of the migrants, which means anonymous testing need to be possible (JLMP, 2020c, p. 6). Although documented people worry more about COVID-19, with 63 % selection within the undocumented cohort, it was still the disease with the highest interests among this group.

Commonly cited forms of xenophobic treatment included being made to wait in queues longer than everyone else, regardless of how ill one is; being shouted at for not having documentation and threatened with non-attendance in future visits to the facilities.

Some respondents pointed to a need for migrant-specific health facilities and hiring more health workers from migrant backgrounds with the relevant language skills to make services more accessible to this group. As one migrant interviewee noted:

*“They must employ qualified doctors or nurses [from] outside the country because they will understand our circumstances as they will be immigrants also.”*

However, the creation of health facilities specifically for migrants may lead to increased separation between the two groups and perceptions among local people that migrants are being treated preferentially. This suggests that improving health worker training on the needs of migrant patients within existing clinics, rather than creating parallel structures, especially in the context of South Africa’s apartheid legacy and recurring xenophobic incidents.

Indications from interviews with migrants are that the maternity care available, especially during childbirth, still varies according to documentation status:

*“At Mamelodi (a high-density suburb in Pretoria) this woman lost her baby during delivery because the nurses ignored her cries for help when the baby was coming. So the baby came out with no one to receive it and it fell from the high hospital bed and died.”*

*“Documents are a big issue because even if you get attended to when you are pregnant and you do routine check-ups, when it comes to childbirth, they need papers or else you pay R6000.”*

Other respondents have travelled back to their home country to give birth only. This is detrimental in several aspects: firstly, heavily pregnant women travel across borders. Secondly, newborns receive birth certificates from a country they are not living in and face an irregular status in South Africa straight away. Thirdly, this likely affects an integration process negatively.

In general, the payment for health services [multiple selection] is mostly covered by the government (73 %) but also by individuals (60 %). Surprisingly, undocumented respondents have services paid for more often by the government (80 % vs. 56 %); and only 55 % of undocumented migrants pay for services themselves, in contrast with 71 % of documented respondents.

These multiple selection statistics suggest that the burden of the health system for the government decreases when people obtain documentation status. Potential reasons for this might be that they are enabled to pay for services for themselves or are better integrated into the local society. This is also reflected in the numbers of documented migrants who stated they attend private doctors rather than public hospitals. Another possibility is that health needs may change because of occupational status. Regardless of other influencing factors, from a budget planning perspective, this strongly argues in favour of increasing regularisation of migrants in South Africa.

Nevertheless, many individual statements indicate that financial restrictions are widespread, which the survey did not ask for in particular, so we recommend including this in future studies.

## 8.5 Health needs of vulnerable groups of migrants

The literature suggests different health needs, health access or restrictions based on gender. Therefore, the findings have been grouped by gender, which results in a sample of 160 female and 148 male respondents.

Surprisingly, the mean health care access is 7.9 points (out of 10), disaggregated 0.1 higher for the female cohort and in line with this, their health status increases slightly by 0.1 after their arrival, while men’s health status remains stable. Potentially, this difference is explained by different occupations or education: self-employment is 15 percentage points more likely for male respondents., 34 % of female migrants report restrictions compared to 42 % of male migrants. These restrictions are not always specified. However, men

reported facing more documentation and geographical restrictions, while women named their family and language more often as barriers. Another major aspect that the survey data reveal is a financial restriction on accessing specific health services, in particular, giving birth was mentioned here as a barrier, which suggests discrimination against female migrant respondents.

In general, males have slightly more often health complications than females (47 % to 44 %). Most evident are differences in reproductive health, which are only reported by females (34 %) and physical issues, which are reported by 29 % males in comparison to 11 % females.

## 8.6 Good practice examples and areas for improvement

In general, South Africa's health system is well developed, which is also reflected within the rating of 8.6 / 10 as its quality in the survey. Some of the arguments in favour of the health system are the availability of medication, technology, equipment and the expertise of the health staff. One of the migrants noted:

*"The quality of health care is good here compared to the one in Zimbabwe because there is no medication there."*

Although respondents pointed out a varied range of challenges pertaining to health care in South Africa for undocumented migrants, these also had recommendable aspects. For those who had not faced challenges such as payment for services because of being undocumented, free access to health care was identified as good practice. This practice is supposed to be in place for all. However, some migrants note irregularities:

*"Upon giving her the passport, she noticed that it was stamped outside. She then said because of that I should pay for the services which would include the cleaning of the cervix. I then went to the cashier to make the payment who declined taking the money and said there is nothing that I should pay for. I personally think the payment that I was instructed to make by the nurse was an attitudinal issue out of her opinion, because my passport was stamped outside. It was not a policy issue, because if it were policy it would uniformly apply everywhere, and the cashier was going to take my payment."*

Potentially, the gap in the system is with individuals, not with general laws.

In the interviews, respondents mentioned initiatives of the Johannesburg Migrant Health Forum which reports on migrants who have been denied care and encourages different NGOs to work together and exchange knowledge. Another example mentioned was an HIV technical working group in South Africa. This suggests that joint working on thematic and regional issues and advocacy on migrants' health are potential means to effect change. As a further example of this, Médecins sans frontières (MSF) has also piloted the SADC health passport, to ensure continued treatment across borders for people on the move (MSF Southern Africa, 2013)

Although the South African health care system offers high-quality services and is also very inclusive (in theory at least), there remain areas for improvement: the access to treatments differs on the basis of nationality. User fees for undocumented migrants restrain them from accessing health. Health officials are not always sensitive to migrants' needs, which results in discriminatory behaviour and sometimes unequal treatment. The regional collaboration with neighbouring countries could be expanded, whereas most migration occurs; for example, the SADC health passport could be implemented to ensure continuity of care for people on the move.

## 8.7 Conclusion and recommendations

Although access to health services for irregular migrants was far broader than is the case in other study countries, there remain many challenges in improving migrants' health. Recommendations for South Africa to address these include the following:

- Health policies should be driven by health ethics, where health officials have an obligation to save life above everything. In this regard, at the point of care, providing health care service and saving lives should matter first before documentation, which is a Home Affairs jurisdictional matter.
- The South African government should adopt a robust public health approach in dealing with migration and health issues. This is an approach that acknowledges that it is not just the health of migrants that matters, but as people who are resident in host communities, their health needs are everyone's health

needs. If for instance, infectious diseases go untreated due to access limitations, it will be difficult for the government to contain the spread even to the locals

- A consideration of differences within the migrant populations and their needs, for instance language barriers and the need for translation, affects migrants from different regions differently. Without appreciating the heterogeneity of migrant groups, although they may all be irregular, the potential repercussions of communication breakdown at the point of care may also be overlooked as they affect certain groups more than others.
- Information material about health issues should be distributed throughout health facilities in several languages
- The national health insurance system to be established must be migrant-inclusive and unconditional. Primary health care should be accessible unconditionally. The proposed need to register creates additional barriers for migrants
- To acquire knowledge about irregular migration in general, new approaches are recommended for data collection. Phone networks would be a possible source, if ethic, privacy and security issues have been addressed (IOM, 2020b, p. 34) also forecasts of movements could be implemented (Nair et al., 2020)
- The SA government should consider abolishing birthing charges for migrants and refugees, irrespective of status
- Health providers should improve training for frontline staff to minimise instances of discretionary behaviour such as refusing to accept patients without a 13-digit ID number
- The South African government and international and national partners should consider increasing budget allocations for health provision to address the strain on under-resourced services and also mitigate community perceptions about the impact of migrants on provision



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Description: Group enrolment for Community Health Funds and access to health care in Tanzania.

A photograph of a pharmacy. In the background, there are wooden shelves filled with various bottles and boxes of medicine. In the foreground, a person wearing a white lab coat is visible, their hands are positioned as if they are handling or preparing medication. The image is overlaid with a semi-transparent yellow rectangle that contains the text.

# SECTION

**Cross-cutting  
findings and  
discussion**

## 9 Cross-cutting continental and regional themes

The research team undertook 10 key informant interviews with expert stakeholders at the regional and continental levels to complement interviews and focus groups discussions conducted by partner researchers in the study countries. These expert interview respondents also provided additional information and context in relation to the three in-depth study countries. In addition, the interviews also served to validate and explain data collected both during the scoping study phase and during the analytical study phase. Key themes identified that arose out of these interviews with regional and continental expert stakeholders are set out below.

### 9.1 Common barriers to accessing health care

Most expert stakeholders interviewed from this group (8 out of 10 respondents) drew attention to the multiple barriers that migrants can face in accessing health care. The most commonly cited barrier (by 7 out of ten respondents from this group) was the lack of, or limited access or entitlement to, health care for migrants, especially irregular and/or undocumented migrants and people in refugee-like situations.

This should also be considered in the broader context of a lack of access to social coverage for citizens in AU MS; one respondent, Gloria Moreno-Fontes from ILO, noted, “89 % of Africans are not protected by social security schemes, as they are in the informal economy, and this, of course, includes... [many] migrant workers.” This should also be seen in the context of African health systems that are already overburdened before any influx of migrants.

Respondents from this group noted that a lack of status (and documentation) affect migrants’ access to health care, as well as to better-paid employment opportunities, which in turn limits their ability to pay for health care. Regular and irregular migrants alike can find themselves out of work if they become sick. This can result in them having to return to their country of origin ‘empty-handed’, and fear of losing employment through illness can mean that migrants delay or fail to access treatment. Moreover, access to free or subsidised health care for migrants is often limited to certain types of primary or emergency care interventions. The lack of financial support for follow-up consultations and treatment thus means migrants’ health conditions can go untreated. Expert stakeholders interviewed also pointed out that migrants’ lack of status or documentation often caused migrants to avoid accessing health care or registering with health providers out of fear of deportation.

Language and cultural barriers were also cited by 6 out of 10 interviewees from this group. Such barriers can severely limit migrants’ ability to navigate local health services and their awareness of entitled access to these. For example, in Morocco, the inability to speak Arabic limits many West African migrants’ access to health care. Indeed, language and cultural barriers were identified in each of the five countries examined in this report. Moreover, language barriers and the fact they are mobile populations also limit migrants’ ability to benefit from other health activities and disease mitigation measures, such as health promotion or vaccination campaigns.

The location of health services was also another barrier cited (6 out of 10 respondents from this group). In particular, the lack of health provision in remote and cross-border areas and a lack of health service provision along migratory routes (health care provision tends to be concentrated in urban areas) means that migrants can be forced to travel long distances to access health services.

Related to this was a lack of appropriate health provision for migrants. For example, 5 out of 10 respondents noted that one of the barriers experienced by migrants was that health workers, in many cases, did not know how to treat migrants appropriately or did not understand the specific health and other issues faced by migrants. Respondents also suggested that training for health workers on treating migrants’ health needs appropriately was inconsistent or absent. This was exacerbated by the lack of mental health treatment capacity and provision for this group.

## 9.2 Migrants' health status

7 out of 10 regional and continental expert stakeholders interviewed also reported specific issues relating to the health status of migrants, even if they acknowledged that migrants typically enjoy better health than non-migrants before, during, and after their migration journeys (the so-called 'healthy migrant effect'). Nevertheless, because of their mobility, migrants were at increased risk of some health issues, particularly infectious diseases such as TB or HIV, although respondents stressed that this was because they were more likely to pass through cross-border areas rather than because they were migrants. This had implications both for migrants' health and for the broader health of local populations and increased the risks of migrants being stigmatised (see below). The marginal economic position of many migrants can also increase their vulnerability to common 'diseases of poverty' such as diarrhoea, TB, and typhoid, exacerbated by overcrowding and a lack of access to WASH provision in many migrant settlements in African countries. One interviewee, Emma Orefuwa of the Global Action Fund for Fungal Infections (GAFFI), also noted that migrants' weakened immune systems also make them susceptible to fungal infections, contributing to up to 20 % of deaths globally.

5 out of 10 respondents from this group further noted that irregular migrants, and the forcibly displaced, may be at increased risk of specific health complications either before or during their migration journeys. These ranged from the commonplace – such as malnutrition and dehydration – to health risks associated with particular sub-groups of migrants, such as victims of trafficking or sexual exploitation. Access to sexual reproductive health and rights (SRHR) services was also more limited for migrant groups, the effect of which is most felt by migrant women. Indeed, one interview respondent who manages a reception centre for African migrants noted that many irregular female migrants from Africa used contraception before migrating, as they expected to be raped during their migration journey.

Finally, some respondents noted that migrants' marginal economic and social position meant they could be more vulnerable to substance misuse, in particular alcohol, but also cannabis, methamphetamine (in southern Africa), and q t (khat) (especially in migrants from the Horn of Africa). Respondents also pointed out that substance misuse is often comorbid with other health issues, notably in relation to mental ill-health.

## 9.3 Equity of access to health care

The equity of access to health care for migrants and other groups was a recurrent theme amongst expert stakeholder interviews, raised by 9 out of ten respondents. All expert stakeholders interviewed from this group stressed the need not just for social coverage for migrants (which tended to be limited to different types of regular migrant), but also for the adoption of minimum 'social floors' for all groups in the population – including migrants – and especially for vulnerable groups such as women and children. As noted above, while, in theory, different migrant groups have access to social coverage in many countries of transit or residence, this is often limited in practice. 7 out of 10 expert stakeholders interviewed noted the restrictions migrants can face in accessing social insurance schemes, such as eligibility criteria around the duration of residence or minimum amounts to be paid before claiming.

Underpinning discussions of migrants' access to health care by interviewees was also the question of health care financing and investment. 6 out of 10 respondents stated that domestic spending on health care in African states was low relative to other parts of the developing world. Indeed, several interviewees noted the need for increased advocacy for health and migrants' health, in particular, to encourage AU MS to increase investment in health provision and universal health care. One respondent, Michaela Martini from IOM, suggested that in Kenya, this could be facilitated by adopting a more integrated approach to health provision for migrants, as well as incorporating modest charges for migrants to access some services, encouraging a gradual extension of universal health care access.

## 9.4 Continuity of care

Similarly, 50 % of this interviewee group (5 out of 10 respondents) stressed the need for stronger continuity of care for different migrant groups. For example, one interviewee working in public health at the continental level noted that gaps in continuity of care meant that if someone were receiving free treatment for HIV or TB in Ethiopia if he or she moved to Nigeria, they would be expected to pay to continue treatment, which many migrants will not be able to afford to do. Moreover, besides affordability, sometimes availability of medicines becomes a problem when people cross-borders, which can affect people with chronic diseases who require regular medical prescriptions.

Two interview respondents cited continuity of care and information-sharing concerning TB and other lung conditions in the mining sector in Southern Africa as a model of good practise involving coordination between the public sector, civil society, and the private sector. Other interview respondents made further suggestions on how continuity of care and improved social coverage could be achieved for migrant groups, including the adoption of a social floors approach for all population groups by all AU MS and the introduction of temporary registrations or amnesties for (irregular) migrants during the current COVID-19 pandemic.

Indeed, in what has been described as a “model of pragmatism and humanity” by the UN High Commissioner for Refugees Filippo Grandi, Colombia’s President Iván Duque announced on 08 February 2021 to extend a ten-year temporary protection status to the approximately 1,7 million Venezuelan migrants living in Colombia. This will ensure that migrants in the country are granted access to a wide range of services, including Colombia’s national COVID-19 vaccination programmes (IOM, 2021c).

## 9.5 Governance and policy integration of migration and health

The importance of strengthening the governance of migration and health was cited by 7 out of 10 regional or continental respondents. This applied to the governance of different types of migration flows but (predictably perhaps) centred on labour migration as well as refugees. Respondents noted that while continental or regional level policy frameworks on migration and health were in some cases strong (for example, in relation to refugees in East Africa), there were challenges embedding and operationalising these policy frameworks at the national level.

One barrier cited in this regard was a lack of detailed guidance from RECs about how MS should best operationalise and also monitor these; 5 out of 10 respondents noted the need for detailed indicators for MS or were involved in developing such indicators in relation to different aspects of migration, such as on labour migration, or information- sharing between AU MS about cross-border migration flows. However, the need for ongoing dialogue between states on migration and health issues was also seen as important. One respondent, Chimwemwe Chamdimba of AU/ NEPAD, noted that:

“One pressing issue is dialogue between governments, because they still are not on the same page when it comes to migration and health. Each country thinks it’s addressing the migrant health issues on its own, but it’s not working, it’s hardly working, it might be working in a small way, but I think there has to be that honest, open dialogue on how this should be handled.”

7 out of 10 respondents from this group also called for better integration of policy frameworks at the regional and MS levels and linked this to the need for improved integration of health and other services available to migrants at the national level.

## 9.6 Integration of health care for migrants

6 out of 10 regional and continental experts interviewed stressed the importance of adopting a more integrated approach to enabling migrants’ access to health and other services and the need for health to be embedded in other policy areas relevant to migration (for example, border management and health screening (see below).

A related issue raised by these respondents was the need for health care for migrants to be integrated into broader health care provision at the national level. Three main arguments were deployed in this regard: availability and sustainability of health care provision, the importance of promoting greater equity in access, and avoiding stigmatisation of migrants that can result from the migrant-specific provision. The case for integrating migrants’ health care into national and local health systems was strongly made by this group of respondents, who argued that it increases the availability of health services to migrants, reduces duplication of provision, and is more sustainable and cost-effective. One example of good practice cited in this regard was the IOM-supported treatment centre in Eastleigh in Kenya, which serves both migrant and non-migrant populations in the area.

Moreover, the provision of health care services for refugees in camps in some countries was perceived by interviewees as important but potentially problematic in terms of equity of access. Many camps are in border regions, where health system capacity for local people is often limited, so people in camps can have better access to health care than local citizens. This was also an issue in terms of promoting specialist health services for refugees, in many cases funded by external partners. 6 out of 10 regional and continental experts interviewed argued that strengthening health service provision for the broader population, especially in border or remote areas, which migrant groups could also access, would be more sustainable and equitable in the medium term. Other respondents pointed out that increased equity of access to health care for migrants and other groups, in contrast to migrant-specific provision, could help avoid popular resentment and stigmatisation of different migrant groups.

## 9.7 Stigmatisation and securitisation of migration

Regional and continental experts interviewed also identified stigmatisation of migrants as a concern (6 out of 10 respondents). They noted that migrants were vulnerable to stigmatisation on account of their health (i.e., being seen as sources of disease) and because of fears about the increased burden on health systems (and wider economies) that migrants can bring. It is also a widely popular perception that migrants are taking away jobs from local people or representing security or other threat. For example, the IGAD Regional Migration Framework observes the fact that migrants can be both vectors for disease transmission across borders, and also be victims of stigmatisation and xenophobia because of health concerns (Maru, 2019). Managing such concerns will thus be key to ensuring effective health security.

Regional and continental stakeholders also highlighted the role of popular (and populist) media discourses about the impact of migration on local communities. This could even undermine measures to manage migration flows more effectively; respondents gave examples of how bi-lateral labour migration agreements could be paused or even undermined by media coverage exaggerating the influx of migrants, which can, in turn, encourage migrants to use irregular pathways for migration.

Competition for limited health and other resources means that migrants' access to health care is prone to be politicised. Respondents noted this could be a cause for popular resentment towards migrants, who might be perceived as receiving preferential treatment in accessing health care. One measure proposed by interview respondents to address was increased provision of integrated health care accessible to migrants and other population as groups; another measure was awareness-raising campaigns in local communities about the wider health benefits of extending health care access to include migrants.

A related theme that emerged from interviews with this group was the securitisation of migration. This has two distinct aspects; 5 out of 10 interview respondents stressed the first of these, the importance of migration to health security. In the words of one interviewee, "diseases do not respect borders and do not announce themselves at border posts." Respondents stressed the need for robust disease surveillance mechanisms cross-border; and some strong infectious disease surveillance networks are operating on the continent (see good practices section in Annex II: Good Practice Examples below).

Specifically, in relation to the current COVID-19 pandemic, Africa CDC's Partnership for Evidence-based Response to COVID-19 also observes that xenophobia towards foreigners has been recorded in many African states (Partnership for Evidence-Based COVID-19 Response, 2020). There is also some evidence that states may seek to use COVID-19 emergency regulations to pursue more restrictive policies towards migrants as well as other groups (Orcutt et al., 2020; Zanker & Moyo, 2020).

The second aspect linked to securitisation relates to security concerns about migrants, even though few regional and continental experts interviewed referred to this aspect directly. This trend can be seen in the way some AU MS have expressed reservations about free movement, principally due to security concerns, and some countries have delayed implementation, and further securitised their borders. A good example is the border from Somalia to Kenya and Somali's request to join the EAC in 2019, which EAC members rejected after failing to meet its eligibility criteria (Mutambo, 2019).<sup>11</sup>

11. It should also be noted in this regard that some African migrant and diaspora communities support conflicts or insurgencies in their countries and regions of origin through material support (e.g., remittances) to different factions involved. It is important therefore to acknowledge and mitigate such concerns for MS to ensure that security concerns about migrants do not undermine improved health security – of mobile populations, as well as of local communities – and improved access to health services.

## 9.8 The importance of health screening for migrant groups

Parallel to the increasing trend for intra-continental mobility within Africa, and indeed inter-continental migration from Africa to Europe, there has been an increasing focus by countries of transit and destination on health screening of migrants. This issue was raised by 5 out of 10 regional experts interviewed, who noted that regular / labour migrants from Africa to Europe (as well as to some other African states) often have to undergo health screening as part of their visa or regularisation processes. Respondents agreed that while this is good practice from a health security/biosecurity point of view (not least because pathogens such as TB can be extremely infectious and expensive to treat if undetected), if not handled sensitively, it can feed into negative media and populist discourses about migrants, risking (further) stigmatisation.

## 9.9 Managing 'brain drain' of medical professionals

Finally, the emigration of skilled health professionals is a recurrent issue in the literature and was raised in 6 out of 10 expert stakeholder interviews. It was also a concern raised by respondents in Kenya, Nigeria, and South Africa (see country sections below). This is a long-term systemic issue for many African states, which struggle to retain trained medical staff due to a lack of attractive remuneration and training packages, especially for health professionals in rural or remote areas. As one interviewee, Dr Ahmat of WHO noted, this existing trend has been exacerbated by the coronavirus pandemic, with European states, Australia, the US and even Japan seeking to recruit African health care professionals during the pandemic.

Proposals to address this, the ones raised by interviewees, included for AU MS to adopt a more coordinated approach in response to such recruitment drives, and more inter-African skilled migration schemes for health care professionals, South-South cooperation in training of health workers, and incentives to promote retention of health workers in remote and cross-border areas. One example cited was of Sudan, which has established bilateral health workforce training schemes with Qatar, which aim to develop more sustainable health professional training capacity in the country.

## 10 Discussion of Study results

### Discussion of continental and regional findings

As we have seen in the previous chapter, findings from key informant interviews with continental and regional stakeholders showed considerable consistency around the key issues identified and with recommendations to address these. On the one hand, this likely reflects a common understanding - and a common discourse - among this group of expert stakeholders. Many of their assessments and policy and programme recommendations do not necessarily represent a radical break with existing policy and practice in the sector. Rather, they suggest potential incremental changes to improve migrants' health and strengthen overall health systems available in AU MS.

Reducing barriers to access and increasing equity in health care for migrants health care in Africa was a primary concern for regional and continental experts interviewed. Arguably the two main barriers identified in this regard concerned migrants' access to social coverage/ protection and (a related point) migrants' documentation status (see below). Experts interviewed from this group were unanimous in arguing that social coverage should be extended to include different migrant groups, with most arguing that AU MS should move to a 'social floors' approach to increase universal health care access.

The need for greater policy coherence between migration and health was also a recurrent concern for continental and regional interviewees, raised by 7 out of 10 respondents. By contrast, this was only raised by three national level respondents. However, this does not mean that it was not an issue of concern at the national levels; instead, this issue was perhaps articulated slightly differently concerning the need for integrated health care (5 out of 21 respondents).

A related issue raised was the gap between policy and implementation at the national level. Most respondents from this group argued that the AU and RECs had an essential role in continental and regional leadership and expertise in relation to migration and health. This included policy formulation and political leadership, research and advocacy on migration and health, as well as provision of detailed guidance on migrants' health and sharing best practice. For example, the AU Labour Migration Advisory Committee (LMAC) has recently published a series of policy briefs looking at the impact of COVID-19 on migration in Africa (JLMP, 2020a, 2020b).

### Discussion of country-specific findings

There is surprisingly little difference between the access to and outcomes of health services between female and male respondents in Kenya. While there is a significant difference of far fewer female respondents reporting that all their needs have been met, they are more or less on par with their male counterparts in all other aspects of the survey and can increase their self-assessed health during their stay in Kenya also. Further research could inquire which of women's needs have not been met and how this gap can be bridged. Potentially, the sample group surveyed in Kenya was too homogenous to detect clear differences based on gender.

Much like the non-discriminatory, free-for-all approach for the IOM run Eastleigh Community Wellness Centre, the community health workers programme addresses all people in a certain community. As there are rarely migrants to be found outside of the camps in Kakuma and Dadaab or the metropolitan area of Nairobi, this programme is benefitting mainly Kenyans but is still basically open to all. Since health facilities are often far and wide in between, these volunteers make an invaluable contribution to people's basic health needs in their communities. However, so far, only 6,000 of the targeted 10,000 communities are supported with the appropriate number of volunteers. The Government of Kenya could increase this push by supporting some of the districts in financing the incentive payments to the volunteers.

In Nigeria, most migrants expressed that they were concerned about their mental health, which is in contrast to respondents in Kenya and South Africa who stated that COVID-19 was their most pressing health concern. This could be, in part, explained by the hectic lifestyle described by some respondents that they experienced in Nigeria as compared to their home countries. However, another plausible explanation lies in the actual (and perceived) severity of the COVID-19 pandemic: In November 2020, when the data was collected in all three countries, the number of total deaths per 100,000, specific to COVID-19, was much lower in Nigeria

(0.53 on 01 November and 0.54 on 30 November) than was the case in Kenya (2.0 on 01 November and 2.9 on 30 November), and drastically lower than in South Africa (34.8 on 01 November, 38.7 on 30 November), with similar patterns reflected in the number of daily infections (numbers taken from IHME (2020e)). While the actual numbers might have been much higher due to lower test capacity and underreporting (de Vrieze, 2020), the fact that Nigeria has been relatively successful in fighting the pandemic has been attributed to the country's experience in fighting Ebola, which presented in an early and strict lockdown in April 2020, cash transfers to low-income citizens and adherence to restrictions that were exemplified by the country's leadership (Priborkin, 2020).

According to Chikwe Ihekweazu, director of the Nigeria Centre for Disease Control, the fact that people perceive the virus as less of a burden than in other parts of the world can be attributed to the fact that people in Nigeria have to cope with many other difficulties in their everyday lives (de Vrieze, 2020), therefore considering the virus "just another issue". This presumption could be further investigated by generating more qualitative data on how migrants living in Nigeria perceive the threat of the ongoing pandemic with a more detailed set of questions around COVID-19. However, it emphasises how health measures need adaptation for different contexts.

In South Africa, a good-quality health system meets mostly low-cost care for all, which usually ensures a very good state of health. However, there are shortcomings in the implementation of policies. On the one hand, individuals try to profit from the unfamiliarity with the system. On the other hand, some areas have been neglected by the system, e.g., births or weaknesses in the application for documents. However, these results are based almost exclusively on surveys of urban areas. Quality and care are likely worse in rural areas, that needs differ, and that other diseases are more prevalent. While it is a strength of the report that it focuses on urban migrants and thus achieves a larger sample, it could also be seen as a weakness that rural migrants were not considered.

In DRC, migrants face a health system with several weaknesses: the staff is not always optimally trained, and the infrastructure of the country (e.g., roads) or the hospitals (e.g., telephone and internet connection) is not always guaranteed. In addition, legal vacuum exacerbates situations for vulnerable groups, e.g., women are at high risk of GBV, and informal workers in mines are often particularly vulnerable due to low safety standards. It will take a lot of efforts to tackle such fundamental issues. The state needs to enforce competencies more. Financial support could accelerate this process.

Morocco has taken a new course in its migration governance approach, acknowledging the country's shift from being mainly a transit country for Sub-Saharan migrants en route towards Europe to being an important country of destination. Concerning migrants' health, Morocco could build on the progress made so far in further improving the policy landscape and pursuing the adoption of its announced Migration and Health Policy, in addition to a proposed Asylum and Migration Law.

## Discussion of (vulnerable) migrant groups

Most respondents in all three countries reported broadly good health. This may be attributable to the 'healthy migrant effect', but is more likely to be linked to people's legal and employment status - across all three countries, the majority of respondents were either employed or self-employed, which meant they were allowed to access and could afford to access (some) health care. This is not necessarily the case for different migrant groups in other African countries, and it suggests that broadening social coverage supports improved health outcomes for migrants across all categories.

It also shows the importance of employment and livelihoods to maintaining and improving health. If pathways to regularisation of migrants in Africa are not enabled, many will feel forced to undertake difficult and dangerous journeys as irregular migrants, with attendant negative impacts on their health as well as broader public health.

Although regular labour migrants may, in principle, be better able to access health services than migrants in an irregular situation, they might still face more hardships in doing so than citizens would. For example, insurance schemes sometimes require eligibility criteria founded on the duration of residence or minimum amounts to be paid in before claiming. In some cases, labour migrants are also able to benefit from insurance schemes through their employers. At the same time, in some sectors such as the mining industry, labour migrants often face difficult living conditions, which can expose them to higher risks of, for example, contracting diseases due to often overcrowded living conditions. To improve the general working conditions and promote occupational health and safety, one promising approach consists of strengthening labour migrants' (self-)

advocacy, e.g., in the form of supporting workers unions' who are then invited to participate in policy- and decision making.

In the Kenyan setting, most refugees are very much dependent on the health care provided in the camps of Kakuma and Dadaab. There is little room for them to handle this situation by themselves due to the encampment policy. The IOM clinic of Eastleigh has shown an interesting approach to a more integrated model of health care. Nationals and migrants alike are provided care without costs. This donor-funded approach in itself is not yet self-sufficient. If the Government of Kenya and its partners like IOM or UNHCR could increase the number of people enrolled in the NHIF, such facilities could potentially turn into self-supporting models.

Irregular migrants reported poorer access to health care which results in lower health. More often, their health is financed by the government rather than themselves. Consequently, handling out documents may enhance health (which was also reflected in a self-rating of health status) and reduce the government's financial burdens. Countries may wish to follow a Colombian initiative of regularisation of migrants with a ten-year protection status (IOM, 2021c). However, building such capacities would probably also require additional international support.

Two regularisation campaigns in Morocco in 2014 and 2017 led to the regularisation of some 50,000 migrants. These campaigns form part of the new and human rights-focused approach to migration that Morocco initiated in 2013 with its National Strategy for Immigration and Asylum (2013) which has received international acclaim (IOM, 2015b). These developments are encouraging, especially considering that the 02-03 law has not been revised since its introduction in 2003 and has been criticised as primarily trying to prevent illegal and migration and to "legitimise the expulsion of migrants from the country" (Baida, 2019, p. 100). Morocco may also be able to share the expertise they have gained with other AU MS.

Female migrants rated the health access and the health systems quality less than men, although, with an average variance of 0.1 percentage points, this difference is very slight. Consequently, this lower rating of access and quality could indicate why their self-assessed health status increases less in the new country of residence. While other explanatory variables may partly explain this effect, it also suggests that the health needs of women are different and not always adequately met.

Examples include the need for free childbirth care in South Africa and treatment of GBV in DR Congo. Often, shortcomings arise through under representativity of women in data and thereby a lack of evidence for policy making (Criado Perez, 2019). With 489 female to 461 male respondents in the survey (15 people did not answer this question), this issue was mitigated within this study. Nevertheless, it is likely that not all special health needs of women are identified, which could be addressed by setting a research focus just on this matter.

When a person faces multiple vulnerabilities, intersectional discrimination may occur. This leads to qualitative vulnerability of a people or groups. The potential occurrence of this in the research context could be undocumented women. Evidence for this was observed in Nigeria, as undocumented migrant women rated their health access and their health status lower than men, suggesting that undocumented women face intersectional discrimination. On the contrary, in South Africa, undocumented women had better access and equal health status. An explanation of this might be the theoretical access to health in South Africa regardless of the residence status. However, documentation status has a positive impact on access to health care in general, so further research is needed on the underlying factors behind this.

## Discussion of thematic health needs

Migrants have distinct health needs according to their legal status and migration journeys, and yet the lack of systematic, robust data collection makes it much harder for policymakers to recognise these and develop and implement effective health programmes targeting the health needs of migrants.

Among the issues frequently raised by respondents were equity of access to health care for migrants and social security coverage. These are of particular importance when considering migrants' health care provision, seeing that migrants are oftentimes insufficiently included in social security schemes and that due to their patterns of movement (e.g., in the case of circular migration), continuity of care (and coverage of treatment costs) across different countries is vital.

Particularly in times of a global health crisis, this calls for the introduction, at least temporarily, of registration or amnesties for irregular migrants (see regularisation campaigns in Morocco and Colombia). However, in the long run, health care should be made available for every person living in a country, which could be achieved by providing a comprehensive health care insurance policy that will cover both citizens and migrants.

Health officials and health providers in the three countries also raised the importance of integrated health provision for migrants and citizens, although less often than regional or continental level respondents (5 out of 21 respondents, or 29 % of this group, as opposed to 6 out of 10 of regional/continental respondents).

The continuity of health care and treatments could further be addressed with health passports or internationally valid recipes for medicals. This would require higher capacities of the health systems in regions with many migrants. At the same time, funding would have to be clarified. A potential starting point for improvements may channel through acknowledging health as a key necessity of migrants in the borderland initiative (UNDP, 2021).

The scoping study identified numerous challenges in providing health services to migrants, including weak health systems, inequality of access, lack of health and WASH facilities (especially in remote locations), and insufficient health screening. Many of these challenges were borne out in the survey data from the three study countries, but at the same time, it is interesting to note that respondents generally rated the availability, accessibility, and quality of health services available quite highly, although in the case of Kenya this was perhaps more nuanced.

Data from the analytical study suggests there may be several factors behind this disparity:

1. All three research sites were in urban centres where there is a higher density of available health services than in rural or remote areas.
2. Perceptions of quality (and, to a lesser extent, accessibility) are relative, and many migrants in the three countries have moved from regions and countries of origin where the availability and quality of health services are much lower.
3. Once people actually faced health complications, their perception of quality and access decreased. Thus knowledge about those facts may be inaccurate.

Robust disease surveillance mechanisms would promote safety from a health perspective, and at the same time, could help reduce the notion of migration exacerbating the general state of health. These efforts could be complemented by educational programmes for migrants themselves to limit the spread of communicable diseases through migration and for receiving communities to dismantle prevailing prejudice.

The need for trained and specialised staff to deliver health services is at an unprecedented high, especially in a global health crisis. To counteract high levels of skilled health personnel emigration, coordinated approaches to adequately respond to such recruitment drivers should be adopted, and as well as the expansion of inter-African skilled migration schemes could be considered.

## **Discussion of barriers**

National-level officials and health providers interviewed shared concerns in reducing barriers to accessing health care for migrants (12 out of 21 respondents, compared to 8 out of 10 regional/continental respondents). Predictably, barriers (in a non-specific sense) were also cited most often by migrant respondents across the three countries (11 out of 12 interview respondents and 3 focus groups with migrants).

The primary barriers identified by national-level interview and focus group respondents of all categories included the cost of health care (raised by 8 out of 34 or 24 % of interview respondents), which is consistent with the 30 % of continental and regional respondents who cited barriers as a concern. Understandably, perhaps, cost was a bigger concern for migrant respondents interviewed, with 6 out of 12 citing this as a barrier. The financial aspects were not really the focus of the survey. Nevertheless, people kept mentioning it as an issue. More than half answered that they partly pay for their health care.

Health care financing is a controversial topic in many African states, as this entails making difficult decisions around allocation and prioritisation of limited resources and puts the spotlight on African states' ability to generate the revenue needed to pay for public services; both clearly have political dimensions. Moreover, while arguments that AU MS should increase their public spending on health in order to bring them in line with developing countries in other parts of the world are not new, achieving this in practical terms will not be easy, given the multiple, competing budget pressures at work in all AU MS.

However, as several expert stakeholders interviewed noted, improving migrants' access to health care - and ultimately their health - is also likely to have a broader positive impact on the health of the population. Requirements for residence permits and other eligibility criteria can limit both access to social insurance schemes and migrants' ability to pay into these. This is why an extension of the social security coverage

is recommended. The knowledge that the health of migrants is essential for the health of the population could help to communicate the need for such measures with the broader population and address potential stigmatisation of migrants.

Another related commonly identified issue was documentation status (12 out of 34 or 35 % of all national-level respondents; 9 out of 10 continental or regional respondents in interviews); respondents reiterated the central importance of documentation to enable access to health care services and national social insurance schemes. This issue was the highest in South Africa, as the sample was focused on irregular migrants there. Health workers could not admit them to hospitals, and undocumented people rated health access lower than people with documents (see irregular migrants). Additionally, administrative barriers arose without documents and were stated frequently by respondents (n = 61 in all countries). This root cause of lower health needs a lot of political will to be tackled. Potentially, temporary regularisation for a certain period of time or for a local group (e.g., nomads) may provide a means to extend social coverage sustainably in the near- to mid-term.

Similarly, there was a wide consensus in the interviews that increasing access to documentation for migrants, even if only temporarily for the current pandemic, would significantly improve migrants' access to health, and therefore health outcomes for migrants overall. Obviously, this point is principally relevant for those migrant sub-groups lacking status and/or documentation. Nevertheless, there is also a broader point to be made about how regularisation of migrants can reduce the health burden on the state, as data from this study strongly suggests that regularised/documented migrants (and refugees) are more likely to pay a higher share of their health costs than those without documentation.

Language barriers were also raised by 18 out of 34 national-level respondents, although more officials and health workers raised this as an issue (15 out of 21 respondents) than migrants themselves did (4 out of 12 interview respondents). Most of these responses (15 out of 18) were clustered in Kenya and Nigeria. To the contrary, especially migrants in South Africa named this restriction. Of course, this issue is more prominent when neighbouring countries do not share the same language and highly dependent on migrant and health staff potentially sharing a second language. In South Africa, occasionally, it was mentioned that staff started learning new languages. While individual solutions are appreciated, a macro solution would be a multi-language information system made available through digital applications or analogous brochures in health centres.

Another aspect frequently raised concerns the securitisation of migration which can be observed in countries further securitising their borders, for example, as migrants are perceived as potential security threats and potential disease vectors from one country to another. At the same time, such narratives can lead to continued stigmatisation of migrants as transmitters of disease, thereby fuelling xenophobic sentiments already shared among some host communities. While there was some evidence presented in the scoping study and confirmed by respondents that pandemic restrictions were affecting migrants, with border restrictions affecting migrant workers, there was little evidence suggesting that concerns about migration and health leading to more restrictive policies and programmes targeting migrants.

Respondents in all three countries where primary data collection took place also reported experiencing stigma, xenophobia, or discrimination in accessing health services as migrants. Whilst this sadly reflects common negative views and stereotypes about migrants found in many African states, it also acts as a barrier to accessing health services and treatment.

## 11 Conclusion and recommendations

Migration has proved important to social and economic development in most, if not all, African states, both through migrants' contributions to local economies and their support for family members in countries of origin through their remittance-sending. At least 50 % of migrant remittances are used to cover vital household expenses, including health services (IOM, 2019e). This means that migration and health will continue to be increasingly important areas for African policymakers and practitioners.

Moreover, greater access to information – including real-time information on potential routes and challenges as well as idealised cultural and media tropes about life in other countries - continues to feed the dreams of young people in Africa who may feel, to use Pankaj Mishra's phrase, 'confined to the anteroom of modernity', compelled to seek improved economic, educational, and other opportunities elsewhere (Mishra, 2015) (Mishra, 2015).

Although the recent travel restrictions and economic lockdowns have slowed this trend for the moment, the prospect of viable vaccines in 2021 promises a return to earlier levels of cross-border travel and economic activity. The drivers of migration in Africa - economic, environmental, and political - are only set to increase in the coming decades, and enabling greater mobility in Africa will be central to achieving the AU's Agenda 2063.

As seen in this study, it is important not to assume that migration has negative impacts on health: the majority of respondents reported being in good health. There is also a link between migrants' health and migrants' wealth. Healthy migrants are better able to work (whether in the formal or informal economies), and the economic participation of migrants increases their ability to pay for health services. However, the study also showed that migrants of all types face multiple barriers to accessing health.

The state of Africa's health systems, which have suffered from underinvestment historically, and efforts by AU MS to extend UHC also form part of this equation. More could and should be done to extend UHC to migrants, irrespective of their status, adopting a 'social floors' model.

This makes it all the more urgent for AU MS to address the gaps in their policy frameworks and health programmes in relation to migrant's health. While different migrant groups can face very different health challenges and outcomes as a result of their migration journeys, it is clear that improving access to health for all groups of migrants - refugees (and IDPs), regular migrants, and irregular - is important to broader public health in African states.

This study on migration and health in Africa has shown both the health challenges that migrants and African states face due to migration, but also that there is a reservoir of expertise and good practice in relation to migration and health issues within Africa that can be applied across the continent to address these challenges.

### Recommendations

Based on the findings of the scoping study and analytical study phases of this project, the research team makes the following recommendations. These are for further action at the programme implementation and policy levels to increase policy coherence concerning migration and health and to improve health outcomes for migrants (as well as the broader population) in countries of origin, transit, and destination (see also the conceptual framework for this study set out in Chapter 1):

Social coverage for regular migrants	Term	Actors
Although regular / labour migrants' resident in AU Member States may in principle be able to access health services like nationals, in practice they may not have the same equality / equity of access to health services as other groups. Potential measures to help address this include:		
<ul style="list-style-type: none"> <li>Governments in AU MS should work with the private sector to reduce eligibility criteria for social insurance or social coverage (e.g., duration of residence, minimum amounts to be paid in) to enable more migrants to access social insurance and health care</li> </ul>	Short	MS

Health of refugees	Term	Actors
<p>Potential measures to help address the ongoing health challenges associated with this group as well as during the current COVID-19 pandemic include:</p>		
<ul style="list-style-type: none"> <li>• Governments and humanitarian partners should allocate increased resources to enhance capacity of health and WASH services in camps and provision of medical supplies and protective equipment</li> </ul>	Short	MS, humanitarian partners
<ul style="list-style-type: none"> <li>• Health promotion campaigns targeting refugees should be implemented with practical advice on minimising risks of infection and transmission</li> </ul>	Short	MS, RECs, AU
<ul style="list-style-type: none"> <li>• Health authorities and humanitarian agencies should invest in health screening capacity in camps and settlements, as well as at border crossing points</li> </ul>	Short to medium	MS, humanitarian partners
Health of irregular migrants	Term	Actors
<p>Potential solutions to help overcome the specific challenges faced by this group include:</p>		
<ul style="list-style-type: none"> <li>• Governments should consider implementing temporary registration schemes &amp; amnesties for irregular migrants at high risk of transmission to increase access to health services and screening, especially during the current COVID-19 pandemic</li> </ul>	Short	MS
<ul style="list-style-type: none"> <li>• Enabling digital applications for registration and/or updating of documents for legal migration processes, especially during the current pandemic with the shutdown of some government offices, would improve access to health services for migrants and enable greater social coverage</li> </ul>	Short to medium	MS, AUC
<ul style="list-style-type: none"> <li>• Greater coordination of health care is needed between public, private, and civil society providers to ensure better health coverage for migrants and refugees by developing crosscutting thematic programmes</li> </ul>	Medium	MS, AUC, RECs, internat. orgs, health providers
<ul style="list-style-type: none"> <li>• Governments should consider developing health policies that move beyond social coverage to providing minimum 'social floors' to the population as a whole</li> </ul>	Medium to long	MS
Better data on migrants' health	Term	Actors
<ul style="list-style-type: none"> <li>• The AU should consider developing specialised guidance for AU MS on adopting a systematic approach and common indicators to collect, analyse, and share data on migrant migrants' health</li> </ul>	Medium	AU, RECs
<ul style="list-style-type: none"> <li>• Governments and international partners should consider investing in building capacity in AU MS for improved data collection, especially at the local level, to collect more and better-quality data on migrants' health</li> </ul>	Medium	AU, MS
<ul style="list-style-type: none"> <li>• RECs also play an important role in developing and issuing region-specific guidance on data collection on migrant health</li> </ul>	Medium	RECs
<ul style="list-style-type: none"> <li>• Research bodies at the national and international levels should be encouraged to support longer-term research on migrants' health in AU MS, in partnership with African research institutions and the diaspora, to improve the available evidence base for policy making and health programming</li> </ul>	Medium	MS, AU
<ul style="list-style-type: none"> <li>• New methods should be applied to forecasts migration flows on various variables of countries, an open-source project by the Danish refugee council of this has predictions that COVID-19 will cause over 1 m more migrants from Nigeria, Mali, and Burkina Faso (Nair et al., 2020)</li> </ul>	Medium	MS, AU

- Gender-disaggregated data is needed to create evidenced based interventions to better target the specific health needs of female migrants

Medium

MS,  
AU

#### Cross-border infectious disease surveillance

**Term**

**Actors**

- Existing models of good practice in cross-border disease surveillance in East and Southern Africa, such as use of mobile technology in partnership with local communities in border and rural areas to monitor disease outbreaks, should be replicated in other regions of the continent (see Annex II)

Short to medium

MS,  
RECs

- The capacity of existing infectious disease surveillance networks should be enhanced to help identify disease outbreaks early in remote or cross-border areas associated with mobile populations of people and animals (nomads and their flocks, refugees, IDPs)

Medium

MS, RECs,  
AU

#### Integration of health care for migrants

**Term**

**Actors**

- Governments should consider developing more integrated health care for migrants together with nationals, as this promises to improve health care for migrants as well as the broader populations among which they live. These synergies can also attract more activities and support from the international community who has seen positive effects from an integrated approach

Medium  
to long

MS

#### Economic participation of migrants

**Term**

**Actors**

- Economically active and self-sufficient migrants are better able to contribute to the social (and health) system of their host countries. If their economic activities are restricted, they can increasingly become a burden for destination and transit countries. These will need to find the right balance between creating decent, sustainable jobs for their own growing populations, and enabling migrants to take up employment opportunities

Long

MS,  
AU

#### Increasing numbers and skills of health professionals

**Term**

**Actors**

- Out-migration of health professionals and trained staff is problematic internationally, and there is a need for stronger coordination between AU MS to prevent unfair recruitment of important trained health workers and ensure ethical recruitment practices

Short to medium

MS, RECs,  
AU

- AU MS and international partners should consider incentivising health professionals to work in rural or remote areas to address shortages in such areas (e.g., staff rotation schemes, higher salaries, support for professionals and families as in transport/communication/housing etc), as well as extension of mobile and health outreach services

Medium

MS,  
internat. partners

- Improved South-South cooperation in training of professionals, and use of bi-lateral health workforce agreements between AU MS and others to promote circular return would also help reduce unsustainable 'brain drain' of skilled health professionals out of the continent

Long

MS, RECs,  
AU

#### Needs of vulnerable migrant groups

**Term**

**Actors**

- Migration and health policies and programmes need to recognize the gendered dimension of migration to mitigate and respond to women's risks and vulnerabilities

Medium

MS, RECs,  
AU

- Stronger focus on psychosocial support systems for refugees, victims of trafficking or GBV, and other vulnerable groups of migrants and their effective delivery, including specialized training of health personnel to respond to migrants' health care needs Medium MS, health providers
- Governments and civil society should work together to address the potential for xenophobia / stigmatisation of migrants around health issues through raising awareness among the domestic population that their health status can only be maintained in the long term if migrants in the country also receive good health care Medium MS, civil society groups
- Strengthening law enforcement against perpetrators of violence or other people who want to exploit unfortunate situations Medium MS

**Policy recommendations**

**Term** **Actors**

- The AUC should consider developing specific guidance and training at regional and MS level on good practice in relation to migration and health and meeting the specific health care needs of migrants, building on the 2018 AU MPFA (An outline of a potential training programme is included in Annex IV) Medium AU
- Migration dialogue platforms should be encouraged to establish working groups on migrant health care Medium RECs
- AU MS should consider developing, adopting, and implementing national migration policy frameworks that include health as a cross-cutting issue Medium MS
- AU MS should include the needs of migrants in policy formulation and implementation across a wide set of policy areas Medium MS
- AU MS should consider providing migrants with information on local health systems, their rights to access health, common illnesses and other topics in several languages digitally but also in written form in health centres, pharmacies, hospitals and doctors Medium MS
- Consultation of refugees and migrants as part of regular needs assessment and policy formulation processes on health and migration issues Medium MS, RECs, AU
- Greater policy coherence is needed between migration and health at the regional and MS levels, to this end, existing migration dialogues could be improved in terms of regularity, funding and participation by MS and their international partners, where migration dialogues are not in place, they should be established between neighbouring countries in each region Medium to long MS, RECs
- Health needs of migrants and refugees should routinely be considered as part of all health and migration policies and programmes - including pandemic preparedness planning Short MS, RECs
- Research should be undertaken to understand barriers to migrants' inclusion in pandemic preparedness plans at the MS and REC levels. Medium to long MS, RECs
- Communicate to national citizens that investing in migrant health care helps maintain the health of the entire population Medium to long MS

**Training and retention of health workers**

**Term** **Actors**

- In countries that produce large numbers of health workers, the absorption of these workers can be increased by other AU MS Medium MS
- Countries with high training numbers but lacking absorption and those with lacking personnel can increasingly engage in bilateral south-south agreements to "recruit" unemployed health workers Medium MS
- The AU can maintain or even increase its efforts in demanding adherence of all nations to the WHO Global Code of Practice in the international recruitment of health personnel, to avoid a brain drain of experienced health workers from their member states Medium MS

- |   |      |          |
|---|------|----------|
| • AU MS could establish incentivisation schemes to encourage health workers to work in rural and/or remote areas of the countries, as these areas often lack trained health workers | Long | MS       |
| • In countries that lack necessary health personnel, the training of these workers can be increased by the AU MS by means of bi- or multi-lateral training agreements               | Long | MS, RECs |
| • AU MS should offer training in specialist medical disciplines to health workers where this is unavailable in their home country   | Long | MS       |

### COVID-19 and migrants' health

Basic Mitigation Measures	Term	Actors
• AU MS and AUC should consider implementing health promotion campaigns, including translated materials, should be implemented to encourage behaviour change (e.g., raising awareness of the importance of social distancing, not touching your face, regular handwashing where possible, avoiding unnecessary social gatherings)		MS
• Improving access to, and promoting the use of, facemasks		MS
Working with employers	Term	Actors
• Health authorities in AU MS and AUC should produce guidance for businesses employing migrants on how to protect their workforce as much as possible from COVID-19	Short	MS
• Where possible, businesses and employers employing migrants should implement protective measures – such as use of distancing and screens - to reduce the risks of transmission to employees and workplaces	Short	MS
Health Screening	Term	Actors
• Enhanced health screening at borders and crossing points, such as use of temperature checks and other measures, can help identify infectious people and reduce transmission for regular migrants in transit	Short	MS
• For people in refugee-like situations and the forcibly displaced, enhanced health screening at camps and settlements as well as refugee reception centres and clinics can help identify cases and reduce transmission in this group	Short	MS
• Where practical/ feasible, workplace health screening would also help reduce transmission of cases	Short	MS
Vaccination strategies	Term	Actors
• The vulnerability of certain migrants (e.g., people hosted in collective accommodation) must be recognized and such groups be prioritized accordingly within vaccination strategies	Short	MS
• Vaccines should be made available free to all, regardless of residence status and nationality, in accordance with the WHO 'leave no-one behind' approach to public health (c.f. IOM, 2021)	Short	MS
• Information campaigns about vaccination programmes should be made available in other languages	Short	MS

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## Annex I: Infographic sources

*To obtain the numbers cited, the respective country needs to be selected.*

### General Information

<b>Population</b>	- (CIA, 2020; UN DESA, 2019b)
<b>GDP</b>	- (World Bank, 2019a)
<b>Human Development Index</b>	- (UNDP, 2019a)
<b>UHC service coverage</b>	- (World Bank, 2017b)
<b>Migrant population data</b>	- (UNHCR, 2019f)
<b>Hospital beds</b>	- (WHO, 2020f)
<b>Physicians</b>	- (World Bank, 2018b)
<b>AIDS / HIV prevalence</b>	- (UNAIDS, 2019)
<b>Malaria prevalence</b>	- (World Bank, 2019b)
<b>Typhoid prevalence</b>	- (Kim et al., 2017)
<b>COVID-19 prevalence</b>	- (Johns Hopkins University & Medicine, 2021b)
<b>Ebola outbreak data</b>	- (CDC, 2021)
<b>Health care priorities data</b>	- (IHME, 2018a; Roser & Ritchie, 2016)

### Country specific information

#### **DRC:**

Hospital infrastructure data - (Sion et al., 2015)

#### **Morocco:**

Migrant health priorities and refugee health care provision

- (UNHCR, 2019g)

Regional hospital bed coverage data - (Dr. H. Semlali, 2010)

#### **Kenya:**

Migrant and refugee health care provision

- (Odipo, 2018; WHO, 2018c)

#### **Nigeria:**

Regional hospital data - (WHO, 2012)

#### **South Africa:**

Regional hospital data - (Life Health care, 2021)

AHP refugee doctor's placement project

- (WHO, 2018c)

## Annex II: Good Practice Examples

Good practice examples concerning migration and health policies and programmes identified in the course of this study include the following:

### Data collection and information sharing

New Partnership for Africa Development - Southern Africa Tuberculosis and Health Systems Support Project - Lesotho, Malawi, Eastern, Central and Southern Africa Health Community, and Africa Union Development Agency (World Bank 2020e). Project aims to: (i) improve coverage and quality of tuberculosis (TB) control and occupational lung diseases (OLD) services in targeted geographic areas of the participating countries; (ii) strengthen regional capacity to manage the burden of TB and OLD; and (iii) strengthen country-level and cross-border preparedness and response to disease outbreaks (ibid.)

IOM Displacement Tracking Matrix- Programming in the East and Horn of Africa - Burundi, Ethiopia, Kenya, Somalia, South Sudan, Uganda

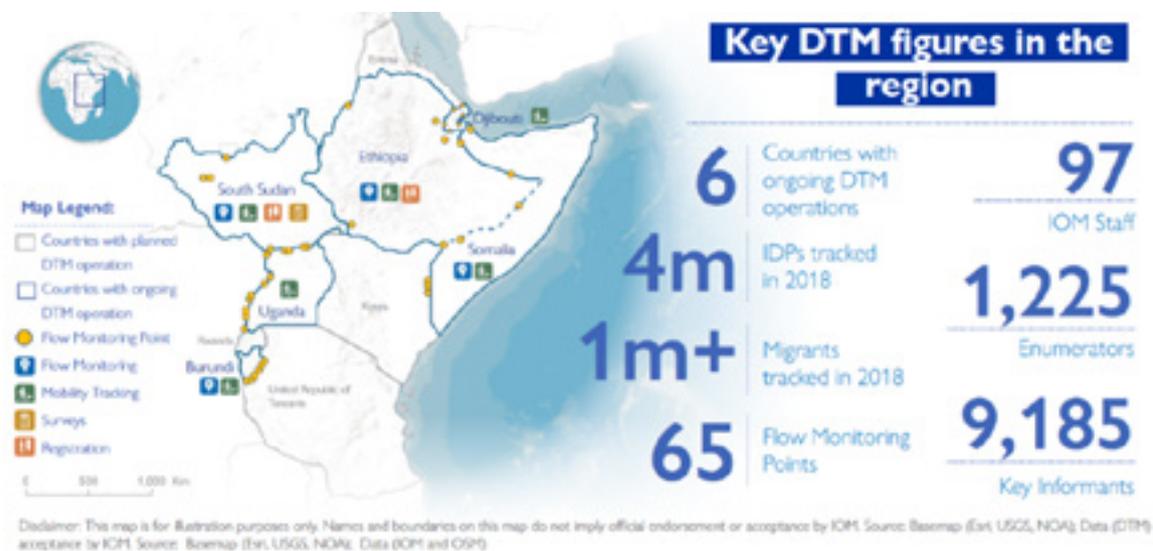


Figure 22: IOM Displacement Tracking Matrix- Programming in the East and Horn of Africa (Source: IOM, 2021a)

The Displacement Tracking Matrix (DTM) is a system to track and monitor displacement and population mobility, provide critical information to decision-makers and responders during crises, and better understand migration flows (IOM, 2021a). Migrant data is collected on population, location, conditions, needs and vulnerabilities, and flows.

### Health screening

Enhanced health screening at airports and border crossing points - Nigeria

Nigeria Centre for Disease Control (NCDC), Nigerian Civil Aviation Authority (NCAA), Federal Airports Authority of Nigeria, Source: Adepoju (2020)

Nigeria's rapid mobilisation of resources and manpower to combat the Ebola virus disease in 2014, led by the NCDC, received praise from the international community and the World Health Organization. The outbreak in Nigeria was controlled in just 92 days a "piece of world-class epidemiological detective work," the WHO stated at the time. In addition, Nigeria was an early adopter of enhanced health screening at airports, with NCAA and FAAN establishing temperature checks and health screening early on. NCDC, NCAA, and FAAN likewise introduced health screening for COVID-19 in January 2020.

IOM Migration Health Assessments and Travel Health Assistance for regular migrants in African states.

Pre-migration health activities (PMHAs) are one of the longest-standing services offered by IOM, delivered through the IOM Global Migration Health Assessment Programme (HAP) at the request of receiving country governments (IOM, 2020i). In 2019, IOM completed just over 140,000 PMHAs in sub-Saharan Africa and 57,000 in the MENA region for migrants and refugees (ibid).

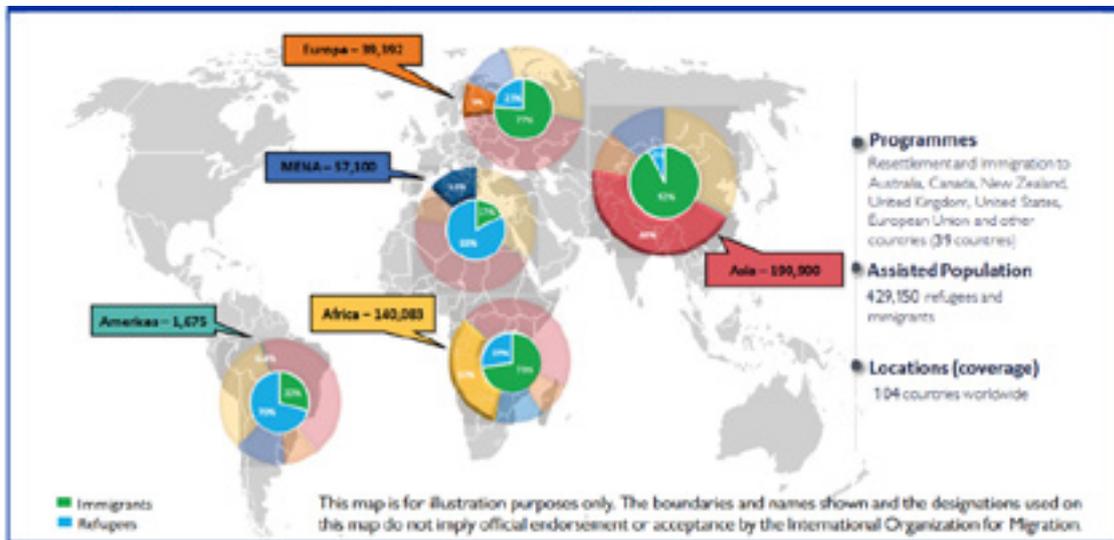


Figure 23: IOM Global Health Assessments 2019  
Source: (IOM, 2020i)

## Cross border Infectious disease surveillance

Southern African Centre for Infectious Disease Surveillance (SACIDS), East Africa Infectious Disease Surveillance Network (EAIDSNET) - Southern and Eastern Africa

SACIDS, based at Sokoine University in Tanzania, and EAIDSNET, based at the University of Entebbe in Uganda, have developed innovative models of infectious disease areas working with local farmers and herders and mobile apps to and animal vectors, such as nomads and their flocks, or refugees and SACIDS and EAIDSNET have lent their expertise to other regions, in surveillance of the Ebola Virus and other infectious disease netw



[www.sacids.org](http://www.sacids.org)

**10-years of developing SACIDS**

**Towards a Sustainable Structure for Supporting Disease Surveillance and Risk Management of Epidemics in Africa**

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Figure 24: Maasai woman in Tanzania working to identify disease outbreaks in remote and cross-border areas for SACIDS using mobile technology. (Source: SACIDS, 2021)

## Pandemic preparedness planning - Africa CDC

Africa CDC provides regular, up to date guidance to African governments, health workers, and citizens on (inter alia) the importance of including migrants in pandemic preparedness plans and effective local contact tracing system protocols.

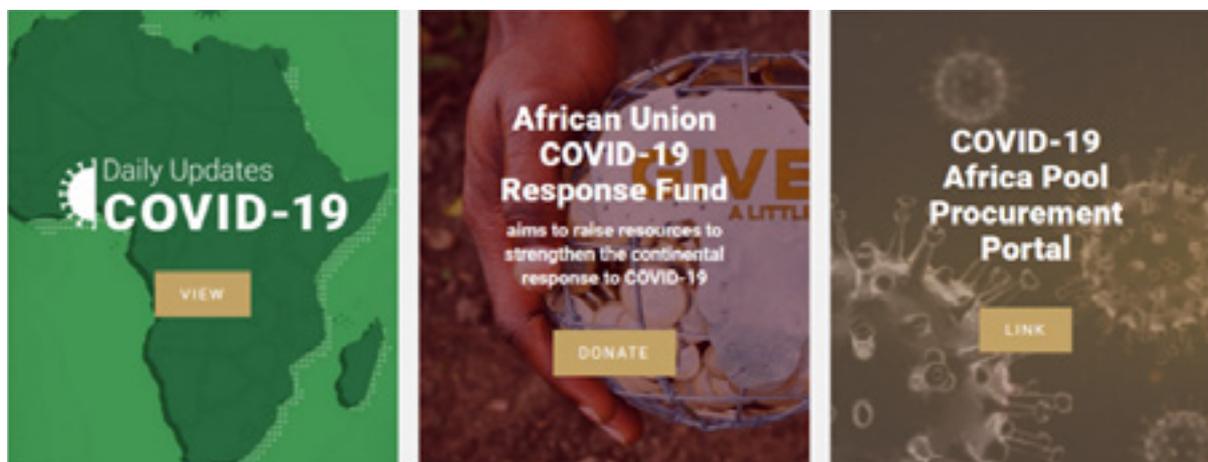


Figure 25: Africa CDC COVID-19 Responses  
(Source: Africa CDC 2020)

## Social coverage

Extension of primary health services to all population groups (S Africa)

Since 1994, South Africa has phased free access to emergency health care for all population groups, including migrants, regardless of their status (Leatt et al., 2006). This enables migrants to access emergency health care free of charge, leading to better health outcomes and earlier identification of illness.

## Addressing emigration of skilled health professionals

Bilateral health workforce agreements to promote retention and/or circular return of trained medical staff

More sustainable bilateral training and exchange programmes for health professionals that promote retention and/or circular return of skilled health workers promise to help address this trend for African states.

For example, Sudan has also negotiated bilateral health worker agreements with Ireland, Qatar, Saudi Arabia with the aim of managing migratory flows and addressing brain-drain by providing training placements for Sudanese residents and short locum modalities for Sudanese specialists in addition to bilateral institutional links between countries (Abdalla et al., 2016). Furthermore, some health and other workforce mobility agreements between France and Benin and Senegal, and between Spain and Morocco and other West African states, also seek to embed circular return and capacity-building for health workers (Khadria, 2010).

Diaspora health system strengthening, humanitarian response, and public health promotion

African diaspora health professionals' networks are active in providing skills exchange and technical assistance to strengthen health systems in origin countries and diaspora humanitarian response to health crises. For example, Sudanese diaspora health professionals' networks based in Europe, North America, and the Middle East, such as the Sudan Doctors' Union (SDU), have mobilised to support the country's health system during the Coronavirus pandemic and recent flooding (Sudan Doctors Union UK, 2020).

Similarly, the Somali diaspora organisation Himiilo Relief and Development Association Netherlands (HIRDA NL) works with sister organisation Hirda Somalia to deliver Maternal and Child Health (MCH) services in the Gedo region in Somalia and has provided relief supplies and WASH provision to IDPs displaced by drought and other natural disasters in Somalia ([www.hirda.org](http://www.hirda.org)).

## Annex III: Migration, pandemic preparedness, and COVID-19

As noted in Chapter 3, disease surveillance - and indeed public health awareness – is arguably stronger in many African states due to their previous experience of managing disease outbreaks and other public health issues. While many poor communities in Africa may lack access to running water and detergent, they also have experience with public health campaigns and living with disease outbreaks. This previous experience may help serve as a protective factor in relation to the current COVID-19 pandemic. As noted by an interviewee from UNICEF,

“The COVID pandemic has shown weaknesses in surveillance [in Africa] [...] Diseases do not know boundaries. The last time I checked, disease never asked for a visa to be able to cross from one country to another! [...] we have seen this with COVID”

Therefore, the Africa Centres for Disease Control (Africa CDC) is a key stakeholder in the development of migration and health policy and guidance and in strengthening disease surveillance. Its network of Regional Coordination Centres (RCCs) in Egypt, Gabon, Kenya, Nigeria and Zambia are charged with overseeing public health and infectious disease surveillance efforts and response. Indeed, the Africa CDC Strategic Plan 2017-2021 (2017) designates migrants and refugees as “key populations” in risk management (Africa CDC, 2017).

While pandemic preparedness in many African states has improved, especially after the Ebola Virus outbreaks in West Africa and DR Congo, many member states surveyed in the scoping study did not consider migrant groups in their pandemic preparedness plans as a matter of course. This is, therefore, a key area to address to improve migrants’ health and health security more broadly.

Moreover, there are already existing models of good practice in relation to disease surveillance in remote and cross-border areas (Wickramage et al., 2018). The Southern African Infectious Disease Surveillance network (SACIDS) in Tanzania and the East African Infectious Disease Surveillance network (EAIDSNET) in Uganda have developed innovative approaches to cross-border disease surveillance, working with local communities and mobile phone applications to identify and monitor disease outbreaks in mobile populations and their animals (Danquah et al., 2019). They have also seconded scientists and medics to help improve disease surveillance of the Ebola Virus outbreaks in DR Congo and West Africa (Ibid.).

### Impact of COVID-19 on migration and mobility in Africa



Figure 26: Map of Cumulative COVID-19 cases in Africa, 28 January 2021. (Source: Africa CDC, 2021)

The COVID-19 pandemic has already had significant impacts on economies and mobility in Africa. Travel restrictions, border closures, and economic lockdown measures (however lightly implemented) have affected mobility between AU MS and the lives of migrants of all types living in particular African states.

Part of this impact stems from severe disruption to livelihoods. Irregular migrants reliant on finding work in the informal sector day-to-day to meet their needs face considerable challenges in this regard. Many, if not most, irregular migrants risk being forced to choose between protecting themselves from COVID-19 or from starvation. Similarly, refugees and IDPs in overcrowded camps and settlements will struggle to protect themselves from infection (Mixed Migration Centre, 2021).

Regular migrants are also affected, both by economic slowdowns and by restrictions on movement and income-generating activities in some countries.

For both regular and irregular migrants, there has also been a double economic shock, as remittance sending and receiving is affected. The World Bank has warned that remittance flows to Africa will drop significantly by as much as 23 % in 2020 and 2021 to \$445 billion (World Bank, 2020a, 2020h). This is likely to place increasing pressure on migrants' and their dependants' ability to pay for health care.

health care This decline in remittance flows has macroeconomic implications for African states, such as Somalia or Cap Verde, where remittances make up a large share of GDP, as well as microeconomic effects on individuals and families who rely on remittance flows to help meet basic subsistence needs, as well as the Small and Medium Enterprises (SMEs) and jobs that remittances support (KNOMAD, 2021).

Consequently, it will be important for international institutions, especially multilateral development banks, to help the most vulnerable countries to cope with the effects of these shocks. For example, the African Development Bank (AfDB) has put in place a USD 10 billion COVID-19 Crisis Response Facility (CRF), dedicated to public sector operations through budget support or investments projects to support AU MS in this regard (AfDB, 2020b). This includes support to private sector operations, WHO regional operations, and emergency grants comprising projects and operations targeting vulnerable communities, including IDPs (ibid).

Africa CDC continues to provide regular updates and guidance for AU MS on the COVID-19 situation, including daily surveillance and real-time reports on the pandemic. The data to date shows a deteriorating situation in Africa as countries report increases in infection and mortality rates (African Union, 2020d). Africa CDC has also noted the impact of travel restrictions on mobility and migration (ibid). The development of the AU's Migration and Health Programme announced in July 2020, will also be an important step to improve the health outcomes of migrants, especially in the context of the current pandemic (Africa CDC, 2021).

## Potential interventions to reduce infection and transmission of COVID-19 among migrant groups

This section presents potential interventions to protect migrants from the risk of infection and transmission of COVID-19. Some of these are already being implemented by AU MS for their own populations. All migrants (whether international or internal) are potential vectors of COVID-19 transmission, although their migration journeys and their legal status may create specific issues or challenges in managing and reducing transmission.

A non-exhaustive list of issues identified and potential mitigations are presented below. Across all groups of migrants (as with the broader population), the most effective and scalable interventions are likely to focus on:

### 1. Basic Mitigation Measures

- Health promotion campaigns to encourage behaviour change (e.g., raising awareness of the importance of social distancing, not touching your face, regular handwashing where possible, avoiding unnecessary social gatherings),
- Improving access to, and promoting the use of, facemasks (African Union, 2020f)

#### Screening

- Enhanced health screening at borders and crossing points, such as the use of temperature checks and other measures, can help identify cases and reduce transmission for regular migrants in transit.
- For people in refugee-like situations and the forcibly displaced, enhanced health screening at camps and settlements as well as refugee reception centres and clinics can help identify cases and reduce transmission in this group.
- Where practical/feasible, workplace health screening would also help reduce transmission of cases

## Cross-border infectious disease surveillance

- Effective infectious disease surveillance, including in remote cross-border areas, is crucial to help identify and monitor disease outbreaks and the spread of pathogens via human and animal vectors.
- Existing models of good practice in cross-border disease surveillance in East and Southern Africa should be enhanced and replicated in other regions of the continent (see Annex 1, also (Wickramage et al., 2018).

## 2. Regular migrants

Although regular / labour migrants in Member States may in principle be able to access health services like national citizens, in practice, they may not have the same equality/equity of access to health services as other groups. Potential measures to help address this include:

- Public and private social insurance providers should consider lowering eligibility criteria (e.g., duration of residence, minimum amounts to be paid in) to enable more regular migrants to access social insurance and health care
- Health authorities should produce guidance for businesses and employers on how to protect their workforce as much as possible from COVID-19
- Where practical/feasible, businesses and employers who employ migrants should implement measures – such as the use of distancing and screens - to reduce the risks of transmission to employees and workplaces.

## 3. People in refugee-like situations

Refugees, asylum-seekers, and IDPs in camps are likely to have access to some basic health services, but with a lack of adequate hygiene facilities and a high population density making self-isolation and distancing extremely difficult, if not impossible in some contexts.

Refugee camps and settlements in Africa already require increased additional financial and technical support, as well as protective equipment and other medical supplies to cope with increasing numbers of suspected cases.

Forcibly displaced people, IDPs, and other people in refugee-like situations living outside of camps and settlements are particularly vulnerable as they can lack any access to health care. If they have access to accommodation, this is more likely to be substandard with high population density with extremely limited WASH facilities.

Like irregular migrants (see below), they are also more likely to be dependent on a precarious day to day informal employment, as well as limited public and charity provision, to meet their basic needs. Potential measures to help address these challenges include:

- Governments and humanitarian partners should allocate increased resources to enhance the capacity of health services in camps and provision of medical supplies and protective equipment
- Health authorities and humanitarian agencies should invest in health screening capacity in camps and settlements
- Targeted health promotion campaigns with practical advice on minimising risks of infection and transmission

## 4. Irregular migrants

Irregular migrants – including some people living in refugee-like situations – arguably present one of the biggest challenges in identifying and isolating cases or implementing preventive measures. By virtue of their lack of legal status, they are more likely to be living precariously and more likely to be dependent on finding work in the informal economy, where there will likely be fewer protective measures in place compared to those in formal employment.

This lack of status also makes them less likely to access health services and make them less willing to engage with services for fear of coming to the attention of the authorities. Potential solutions to help overcome these challenges include:

- Governments should consider temporary registration schemes and amnesties for irregular migrants at high risk of transmission to increase access to health services and screening
- Governments should work with the private sector to reduce eligibility criteria for social insurance or social coverage (e.g., duration of residence, minimum amounts to be paid in) to enable more migrants to access social insurance and health care, at least on a temporary basis
- Governments should consider developing health policies that move beyond social coverage to providing minimum 'social floors' to the population as a whole
- Targeted health promotion campaigns with practical advice on minimising risks of infection and transmission and sources of medical assistance
- Governments should work with the private sector to invest in the development of relatively low-cost, effective testing kits to target vulnerable population groups, including irregular migrants, refugees, and IDPs. The low-cost test developed by the Institute Pasteur in Senegal is extremely promising in this regard, but investment in similar innovations in Africa should be encouraged (Yeung, 2020).
- Governments should consider building more effective local-level contact tracing systems, as have been used in some Asian countries, drawing on African experience and expertise in contact tracing developed in response to earlier disease outbreaks (African Union, 2020c; Juneau et al., 2020).

## Annex IV: Tables

Annex IV: Table 1: Descriptive statistics about the survey sample for: Gender, urbanity of residence, residence status, educational level, occupation status

Table with descriptive statistics for all 3 country cohorts (1)

	#Total																					
	Kenya			Nigeria			South Africa			Female			Male			Prefer not to say						
	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%				
<b>gender</b>																						
Female	20469.4	123.35.6	160	31.9	204	100.0	0	0.0	0	0	123	100.0	0	0.0	0	0	100	100.0	0	0.0	0	0
Male	9036.8	223.65.9	148	48.1	0	0.0	90	100.0	0	0	0	0.0	223	100.0	0	0	0	0.0	148	100.0	0	0
Prefer not to say	0	0.0	1	0.3	0	0.0	0	0.0	0	0	0	0.0	0	0.0	1	100	0	0.0	0	0.0	0	0
#Total cases	294	294	349	349	308	308	204	204	90	90	0	0	123	123	223	223	1	1	100	100	148	148
<b>rural_urban</b>																						
Prefer not to say	0	0.0	0	0.0	2	0.6	0	0.0	0	0.0	0	0.0	0	0.0	0	0	2	1.2	0	0.0	0	0
Rural (village)	2	0.7	97	27.6	39	3.2	2	1.0	0	0.0	0	0	18	14.5	77	34.5	1	100	5	3.1	5	3.4
Urban-rural mix	3	1.0	118	33.6	2	0.6	3	1.5	0	0.0	0	0	44	35.5	74	33.2	0	0	1	0.6	1	0.7
Urban-city	201	98.3	136	39.7	296	95.5	197	97.5	89	100.0	0	0	62	98.0	72	32.3	0	0	152	95.9	142	95.9
#Total cases	293	293	338	338	310	310	202	202	89	89	0	0	124	124	223	223	1	1	100	100	148	148
<b>residence_status</b>																						
Citizen	32	11.1	35	9.9	2	0.6	17	8.7	13	16.9	0	0	13	10.4	21	9.4	0	0	0	0.0	2	1.4
No documents	7	2.4	80	23.0	284	65.8	7	3.6	0	0.0	0	0	20	16.0	80	36.9	0	0	106	66.2	97	65.5
Permanent documents(work)	2	0.7	60	17.3	20	6.5	2	1.0	0	0.0	0	0	20	16.0	41	18.4	0	0	9	5.6	11	7.4
Prefer not to say	3	1.0	21	6.0	2	0.6	1	0.5	2	2.2	0	0	6	4.8	15	6.7	0	0	1	0.6	1	0.7
Temporary documents (Asylum)	21	7.3	49	14.4	60	19.4	14	7.1	6	6.7	0	0	11	8.8	29	13.0	0	0	33	20.6	27	18.2
Temporary documents (Refugee)	21	7.6	38	10.8	15	4.2	155	79.1	62	69.7	0	0	12	9.6	24	10.8	1	100	7	4.4	5	3.4
Temporary documents(Educational)	4	1.4	79	21.6	9	2.9	0	0.0	4	4.3	0	0	43	34.4	33	14.8	0	0	4	2.5	5	3.4
#Total cases	287	287	352	352	310	310	196	196	89	89	0	0	125	125	223	223	1	1	100	100	148	148
<b>education</b>																						
No formal schooling	80	27.2	53	15.1	3	1.0	55	27.2	25	27.3	0	0	9	7.2	43	19.3	1	100	2	1.3	1	0.7
Other (please specify)	0	0.0	1	0.3	6	1.9	0	0.0	0	0.0	0	0	1	0.8	9	4.0	0	0	4	2.5	2	1.4
Prefer not to say	0	0.0	7	2.0	1	0.3	0	0.0	0	0.0	0	0	1	0.8	6	2.7	0	0	0	0.0	1	0.7
Primary school	113	38.4	37	10.5	22	7.1	81	40.1	32	35.6	0	0	10	8.0	27	12.1	0	0	10	6.3	32	21.8
Secondary school	75	25.5	30	8.2	216	69.9	52	25.7	21	23.1	0	0	21	16.8	13	5.8	0	0	123	77.4	91	61.5
University (post graduate)	4	1.4	56	15.9	19	6.1	1	0.5	3	3.3	0	0	25	20.0	30	13.5	0	0	7	4.4	32	21.8
University (undergraduate)	20	6.8	100	29.3	21	10.0	11	5.4	9	10.0	0	0	35	28.0	48	21.5	0	0	7	4.4	24	16.2
Vocational training	2	0.7	39	11.1	11	3.6	2	1.0	0	0.0	0	0	23	18.4	36	16.1	0	0	6	3.8	5	3.4
#Total cases	294	294	352	352	310	310	202	202	90	90	0	0	125	125	223	223	1	1	159	159	148	148
<b>occupation</b>																						
I am a student	12	4.1	63	17.9	4	1.3	3	1.5	7	7.8	0	0	34	27.2	29	13.0	0	0	1	0.6	3	2.0
I am self-employed	152	51.7	125	35.5	117	37.7	104	51.5	47	52.2	0	0	36	28.8	88	39.5	0	0	49	30.6	46	31.1
I am unemployed	83	28.2	34	9.7	39	12.6	94	47.1	19	21.1	0	0	12	9.6	41	18.4	1	100	28	17.5	11	7.4
I work full-time	12	4.1	52	14.8	70	22.6	7	3.5	3	3.6	0	0	15	12.0	36	16.1	0	0	38	23.8	32	21.6
I work part-time	25	8.5	45	12.8	65	21.0	17	8.4	8	8.9	0	0	23	18.4	22	9.9	0	0	36	22.5	27	18.2
I work without a contract	6	2.0	11	3.1	15	4.8	4	2.0	2	2.2	0	0	3	2.4	3	1.3	0	0	8	5.0	7	4.7
Other (please specify)	4	1.4	1	0.3	0	0.0	1	0.5	2	2.2	0	0	0	0.0	1	0.4	0	0	0	0.0	0	0.0
I am retired	0	0.0	1	0.3	0	0.0	0	0.0	0	0.0	0	0	0	0.0	1	0.4	0	0	0	0.0	0	0.0
#Total cases	294	294	352	352	310	310	202	202	90	90	0	0	125	125	223	223	1	1	100	100	148	148

## Annex IV: Table 2: Descriptive statistics about the survey sample for: Type of Apartment, Size of the Household, Length of stay in the country

Table with descriptive statistics for all 3 country cohorts (2)

	#Total																							
	Kenya			Nigeria			South Africa			Female			Male			Prefer not to say								
	cases	%		cases	%		cases	%		cases	%		cases	%		cases	%							
<b>type_of_appt</b>																								
I have no permanent place to stay	8	2.7	29	8.3	9	2.9	4	2.0	4	4.4	0	0	9	7.2	19	8.6	0	0	7	4.4	2	1.4	0	0
In a camp/ refugee settlement	0	0.0	88	25.1	4	1.3	0	0.0	0	0.0	0	0	18	14.4	68	30.6	1	0.9	3	1.9	1	0.7	0	0
In a private Apartment/ house	218	74.1	231	65.8	290	91.5	159	74.3	68	75.6	0	0	87	77.6	133	59.9	0	0	143	90.9	141	95.3	0	0
Prefer not to say	0	0.0	0	0.0	7	2.3	0	0.0	0	0.0	0	0	0	0.0	0	0.0	0	0	3	1.9	4	2.7	0	0
Other (please specify)	68	23.1	3	0.9	0	0.0	48	23.8	18	20.0	0	0	1	0.8	2	0.9	0	0	0	0.0	0	0.0	0	0
#Total cases	294	294	351	351	310	310	202	202	90	90	0	0	125	125	222	222	1	1	166	166	148	148	0	0
<b>household_size</b>																								
0	0	0.0	4	1.2	2	0.7	0	0.0	0	0.0	0	0	1	0.9	3	1.4	0	0	2	1.4	0	0.0	0	0
1	6	2.1	9	2.7	39	13.5	2	1.0	4	4.5	0	0	4	3.5	5	2.3	0	0	12	8.1	27	19.4	0	0
2	11	3.8	16	4.8	62	21.5	8	4.0	3	3.4	0	0	7	6.1	9	4.1	0	0	27	18.2	39	28.7	0	0
3	36	12.5	18	5.4	67	23.2	24	12.1	12	13.6	0	0	9	7.9	8	3.7	0	0	43	29.1	28	17.3	0	0
4	43	14.9	22	6.6	66	22.8	31	15.6	12	13.6	0	0	10	8.8	12	5.5	0	0	39	26.4	27	19.4	0	0
5	34	11.7	61	18.2	30	10.4	35	17.6	18	20.5	0	0	21	18.4	46	21.4	0	0	15	10.1	85	60.8	0	0
6 or more	129	48.1	205	61.2	23	8.0	99	49.7	29	34.3	0	0	62	54.4	146	64.5	1	0.9	10	6.8	13	9.4	0	0
#Total cases	289	289	335	335	239	239	199	199	88	88	0	0	114	114	217	217	1	1	148	148	139	139	0	0
<b>language_spoken</b>																								
0	175	59.7	40	11.8	158	51.8	124	61.4	49	55.1	0	0	15	12.5	25	11.6	0	0	82	51.6	75	52.1	0	0
1	6	2.1	62	18.2	65	21.3	42	21.3	22	24.7	0	0	19	15.8	43	19.9	0	0	30	23.9	27	18.8	0	0
2	22	7.5	101	29.7	15	4.9	16	7.9	6	6.7	0	0	32	26.7	67	31.0	1	0.9	8	5.0	7	4.9	0	0
3	13	4.4	77	22.6	18	5.9	8	4.0	5	5.6	0	0	27	22.5	36	16.3	0	0	6	3.8	11	7.6	0	0
4	0	0.0	32	9.4	16	5.2	0	0.0	0	0.0	0	0	15	12.5	16	7.4	0	0	9	5.7	7	4.9	0	0
5	18	6.1	28	8.2	33	10.8	11	5.4	7	7.9	0	0	12	10.0	15	6.9	0	0	16	10.1	17	11.8	0	0
#Total cases	293	293	340	340	305	305	202	202	89	89	0	0	120	120	216	216	1	1	159	159	144	144	0	0
<b>length_of_stay</b>																								
1-2 years	31	10.5	91	26.1	37	12.1	16	7.9	14	15.6	0	0	33	26.6	57	25.9	0	0	18	11.2	11	7.4	0	0
2-5 years	104	35.3	114	32.8	114	37.1	79	34.5	33	36.7	0	0	33	26.6	79	35.9	1	0.9	76	47.5	36	26.2	0	0
3-6 months	1	0.3	10	4.0	10	3.3	1	0.5	0	0.0	0	0	7	5.8	9	4.1	0	0	5	3.0	2	1.4	0	0
6-12 months	1	0.3	45	12.9	7	2.3	1	0.5	0	0.0	0	0	22	17.7	23	10.5	0	0	5	3.1	2	1.4	0	0
more than 5 years	177	59.2	78	22.4	138	43.6	114	56.2	41	47.8	0	0	28	22.6	49	22.3	0	0	53	33.1	85	60.6	0	0
up to 3 months	0	0.0	2	0.6	1	0.3	0	0.0	0	0.0	0	0	0	0.0	2	0.9	0	0	6	3.8	0	0.0	0	0
Prefer not to say	1	0.3	2	0.6	0	0.0	1	0.5	0	0.0	0	0	1	0.8	1	0.5	0	0	0	0.0	0	0.0	0	0
#Total cases	295	295	341	341	307	307	202	202	90	90	0	0	124	124	220	220	1	1	160	160	145	145	0	0

## Annex IV: Table 3: Descriptive statistics grouped in country and gender cohort and for gender cohorts in different countries about Rating of health access, rated quality of health system, rated own health status (1): before migration, (2): upon arrival in residence country, (3): at time of survey

Table with health status rating statistics for all 3 country cohorts grouped by gender

	#Total																						
	Kenya			Nigeria			South Africa			Female			Male			Prefer not to say							
	cases	%		cases	%		cases	%		cases	%		cases	%		cases	%						
<b>rating_quality</b>																							
Mean	5.3	8.5	5.6	8.4	8.5	0	8.3	8.3	0	8.4	8.6	0	8.5	8.6	0	8.5	8.6	0	8.5	8.6	0	0	
Std. dev.	1.6	1.2	1.5	1.5	1.5	0	1.5	1.8	0	1.4	1.2	0	1.6	1.5	0	1.6	1.5	0	1.6	1.5	0	0	
Use. valid N	293.0	293.0	308.0	475.0	411.0	0	204.0	89.0	0	113.0	174.0	0	158.0	148.0	0	158.0	148.0	0	158.0	148.0	0	0	
<b>rating_access</b>																							
Mean	5.1	8.5	7.8	8.1	8.2	0	8.0	8.1	0	8.4	8.6	0	7.9	7.8	0	7.9	7.8	0	7.9	7.8	0	0	
Std. dev.	1.7	1.5	2.0	1.8	1.7	0	1.7	1.8	0	1.7	1.3	0	2.1	2.0	0	2.1	2.0	0	2.1	2.0	0	0	
Use. valid N	289.0	290.0	308.0	466.0	405.0	0	200.0	87.0	0	108.0	170.0	0	158.0	148.0	0	158.0	148.0	0	158.0	148.0	0	0	
<b>health_status_bef</b>																							
Mean	7.9	7.4	8.9	8.1	8.0	8	8.0	7.6	0	7.3	7.5	8	8.8	9.0	0	8.8	9.0	0	8.8	9.0	0	0	
Std. dev.	2.0	1.3	1.6	1.9	1.6	0	2.0	2.1	0	1.5	1.1	0	1.7	1.5	0	1.7	1.5	0	1.7	1.5	0	0	
Use. valid N	292.0	349.0	316.0	484.0	458.0	1	200.0	90.0	0	124.0	220.0	1	160.0	148.0	0	160.0	148.0	0	160.0	148.0	0	0	
<b>health_status_upon</b>																							
Mean	7.9	8.4	8.8	8.3	8.5	9	8.1	7.7	0	8.2	8.6	9	8.7	8.9	0	8.7	8.9	0	8.7	8.9	0	0	
Std. dev.	2.0	1.3	1.4	1.8	1.4	0	1.9	2.1	0	1.7	1.1	0	1.6	1.2	0	1.6	1.2	0	1.6	1.2	0	0	
Use. valid N	292.0	350.0	309.0	485.0	458.0	1	201.0	90.0	0	124.0	221.0	1	160.0	147.0	0	160.0	147.0	0	160.0	147.0	0	0	
<b>health_status_now</b>																							
Mean	8.4	8.7	8.9	8.6	8.8	10	8.4	8.4	0	8.5	8.9	10	8.8	8.9	0	8.8	8.9	0	8.8	8.9	0	0	
Std. dev.	1.9	1.3	1.3	1.6	1.3	0	1.8	2.0	0	1.7	1.0	0	1.8	1.2	0	1.8	1.2	0	1.8	1.2	0	0	
Use. valid N	283.0	339.0	303.0	473.0	408.0	1	196.0	87.0	0	119.0	216.0	1	158.0	145.0	0	158.0	145.0	0	158.0	145.0	0	0	

## Annex IV: Table 4: Descriptive Statistics about all 3 countries, grouped in gender about: where respondents seek help if they have issues and where they found information on the local health system (both multiple select)

Table with statistics where to get help if needed and where find information regarding health care needs, grouped by gender

	#Total			Kenya						Nigeria			South Africa												
	Kenya		Nigeria	Female		Male		Prefer not to say	Female		Male	Prefer not to say		Female		Male	Prefer not to say								
	A	B	C	A	B	C		A	B	C	A	B	C	A	B	C									
cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%								
<b>where_help_public_health_center</b>																									
0	83	28.3	171	49.0	119	33.5	A	54	26.9	29	32.2	0	0	55	44.4	112	50.7	1	100	67	49.6	53	36.1	0	0
1	210	71.7	178	51.0	190	61.5	B	147	73.1	61	67.8	0	0	89	55.6	109	49.3	0	0	95	59.4	94	63.9	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_private_doctor</b>																									
0	148	37.3	193	35.3	190	61.5		122	60.7	43	50.0	0	0	91	49.2	129	58.4	1	100	97	60.6	93	61.9	0	0
1	125	42.7	156	44.7	119	38.5		79	39.3	43	50.0	0	0	63	30.8	92	41.6	0	0	63	39.4	56	38.1	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_NGO</b>																									
0	197	67.2	342	98.0	309	100.0	A,B	132	65.7	64	71.1	0	0	123	99.2	215	97.3	1	100	100	100.0	147	100.0	0	0
1	96	32.8	7	2.0	0	0.0		69	34.3	26	28.9	0	0	1	0.8	6	2.7	0	0	0	0.0	0	0.0	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_emergency_room</b>																									
0	293	100.0	348	99.7	309	100.0		201	100.0	90	100.0	0	0	123	99.2	221	100.0	1	100	100	100.0	147	100.0	0	0
1	0	0.0	1	0.3	0	0.0		0	0.0	0	0.0	0	0	1	0.8	0	0.0	0	0	0	0.0	0	0.0	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_pharmacy</b>																									
0	261	89.0	268	76.8	270	87.4	A,B	149	74.1	60	66.7	0	0	90	72.6	174	78.7	1	100	144	90.0	133	90.5	0	0
1	32	11.0	81	23.2	41	13.0		52	25.9	30	33.3	0	0	34	27.4	47	21.3	0	0	16	10.0	14	9.5	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_friends</b>																									
0	290	98.6	196	56.7	306	99.0	A,B	109	54.0	89	98.9	0	0	87	70.2	109	49.3	0	0	100	100.0	146	99.3	0	0
1	13	4.4	151	43.3	1	0.3		12	6.0	1	1.1	0	0	37	29.8	112	50.7	1	100	0	0.0	1	0.7	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_non_conventional</b>																									
0	293	100.0	247	70.8	304	98.4	B	201	100.0	90	100.0	0	0	102	82.3	143	64.7	0	0	100	100.0	142	96.6	0	0
1	0	0.0	102	29.2	5	1.6		0	0.0	0	0.0	0	0	22	17.7	78	35.3	1	100	0	0.0	5	3.4	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_internet</b>																									
0	293	100.0	318	91.1	309	100.0	B	201	100.0	90	100.0	0	0	119	83.7	205	92.8	1	100	100	100.0	147	100.0	0	0
1	0	0.0	31	8.9	0	0.0		0	0.0	0	0.0	0	0	14	11.3	16	7.2	0	0	0	0.0	0	0.0	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_other</b>																									
0	282	96.2	349	100.0	306	99.0	A	191	95.0	89	98.9	0	0	124	100.0	221	100.0	1	100	158	96.8	146	99.3	0	0
1	11	3.8	0	0.0	3	1.0		10	5.0	1	1.1	0	0	0	0.0	0	0.0	0	0	2	1.2	1	0.7	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_help_dont_know</b>																									
0	292	99.7	333	95.4	303	98.1		200	99.5	90	100.0	0	0	129	96.8	209	94.6	1	100	156	97.5	129	98.6	0	0
1	1	0.3	16	4.6	6	1.9		1	0.5	0	0.0	0	0	4	3.2	12	5.4	0	0	4	2.5	2	1.4	0	0
#Total cases	293	293	349	349	309	309		201	201	90	90	0	0	124	124	221	221	1	1	100	100	147	147	0	0
<b>where_info_family</b>																									
0	32	10.9	91	26.1	41	13.4		19	9.4	13	14.6	0	0	24	19.4	46	20.9	1	100	24	15.2	17	11.6	0	0
1	261	89.1	258	73.9	268	86.6	B	182	90.6	76	85.4	0	0	100	80.6	155	70.1	0	0	134	84.8	130	88.4	0	0
#Total cases	293	293	349	349	307	307		202	202	89	89	0	0	124	124	221	221	1	1	158	158	147	147	0	0
<b>where_info_NGO</b>																									
0	240	81.9	323	92.6	306	99.0	A,B	145	71.7	79	88.3	0	0	116	91.9	205	92.8	1	100	159	100.0	146	99.3	0	0
1	47	16.0	26	7.4	3	0.9		57	28.3	10	11.2	0	0	10	8.1	16	7.2	0	0	0	0.0	1	0.7	0	0
#Total cases	293	293	349	349	307	307		202	202	89	89	0	0	124	124	221	221	1	1	159	159	147	147	0	0
<b>where_info_public_system_professionals</b>																									
0	200	68.3	203	58.2	277	90.2	B	182	90.1	54	64.4	0	0	89	55.6	130	58.8	1	100	141	90.5	132	89.8	0	0
1	25	8.5	146	41.8	30	9.8		20	9.9	5	5.6	0	0	55	44.4	91	41.2	0	0	35	9.5	15	10.2	0	0
#Total cases	293	293	349	349	307	307		202	202	89	89	0	0	124	124	221	221	1	1	158	158	147	147	0	0
<b>where_info_dont_know</b>																									
0	253	86.6	260	74.5	296	96.4	B	196	96.0	83	93.3	0	0	106	85.0	152	68.8	0	0	152	96.2	142	96.6	0	0
1	10	3.4	89	25.5	11	3.6		4	2.0	6	6.7	0	0	18	14.5	69	31.2	1	100	6	3.8	5	3.4	0	0
#Total cases	293	293	349	349	307	307		202	202	89	89	0	0	124	124	221	221	1	1	158	158	147	147	0	0
<b>where_info_internet</b>																									
0	286	97.6	274	78.5	270	88.3	B	199	98.5	85	95.5	0	0	106	85.0	164	74.2	1	100	138	87.3	131	89.1	0	0
1	7	2.4	75	21.5	30	11.7		3	1.5	4	4.3	0	0	18	14.5	57	25.8	0	0	20	12.7	16	10.9	0	0
#Total cases	293	293	349	349	307	307																			

## Annex IV: Table 5: Health disease people are most worried about

Table with statistics health complications the people are most worried about, grouped by gender

	# Total																									
	Kenya			Nigeria			South Africa			Female			Male			Nigeria			South Africa							
	A		B		C		A		B		C		A		B		C		A		B		C			
	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%		
<b>most_worried_mental</b>																										
#	217	97.3	216	91.7	173	55.8	199	93.0	30	95.0	0	0	70	61.3	139	62.0	0	0	39	55.0	82	55.4	0	0		
1	5	2.7	134	38.3	A	137	44.2	A	4	2.0	4	4.4	0	0	40	38.7	83	37.4	1	100	71	64.4	66	64.0		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_children</b>																										
#	204	88.5	302	86.3	257	82.9	177	87.2	82	91.1	0	0	102	82.3	197	88.7	1	100	123	76.9	132	89.2	A	0	0	
1	34	11.5	48	13.7	53	17.1	26	12.8	8	8.9	0	0	22	17.7	25	11.3	0	0	37	23.1	38	18.8	0	0		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_infectious</b>																										
#	192	65.1	328	93.7	A	267	86.1	A	134	86.0	56	62.2	0	0	115	92.7	211	95.0	1	100	141	83.1	124	83.8		
1	109	34.9	B	22	6.3	42	13.9	B	69	34.0	34	37.8	0	0	9	7.3	11	3.0	0	0	39	11.9	24	16.2		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_sexually</b>																										
#	224	75.9	C	333	95.1	A	184	99.4	164	80.8	B	58	64.4	0	0	114	93.9	215	96.8	A	1	100	92	61.5		
1	71	24.1	B	17	4.9	126	40.6	A	39	19.2	32	35.6	A	0	0	10	8.1	B	7	3.2	0	0	68	42.5		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_chronic</b>																										
#	187	63.4	323	92.3	A	188	60.0	123	61.6	69	66.7	0	0	111	89.5	200	93.7	1	100	96	66.0	99	68.3			
1	106	36.0	B	27	7.7	122	39.4	B	78	38.4	30	33.3	0	0	13	10.5	14	6.3	0	0	64	40.0	38	26.2		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_physical</b>																										
#	205	90.6	C	327	93.4	C	273	88.1	197	97.6	30	95.6	0	0	115	92.7	200	93.7	1	100	148	92.5	B	123	83.1	
1	39	13.4	23	6.6	37	11.9	A	6	3.0	4	4.4	0	0	9	7.3	14	6.3	0	0	32	7.5	25	16.9	A	0	0
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_dental</b>																										
#	291	98.6	B	333	95.7	C	253	81.6	202	99.5	87	96.7	0	0	117	94.4	214	96.4	1	100	132	82.5	129	81.1		
1	4	1.4	15	4.3	A	57	18.4	A	1	0.5	3	3.3	0	0	7	5.0	8	3.6	0	0	20	17.5	28	18.9		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_dermatological</b>																										
#	205	100.0	B	291	83.1	300	97.7	B	203	100.0	90	100.0	0	0	109	87.9	176	88.2	1	100	155	96.9	146	96.6		
1	0	0.0	39	10.9	C	7	2.3	0	0.0	0	0.0	0	0.0	15	12.1	44	19.8	0	0	5	3.3	2	1.4			
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_eye</b>																										
#	200	94.9	C	319	91.1	268	86.5	194	95.6	84	93.3	0	0	109	87.9	207	93.2	1	100	143	89.4	123	83.1			
1	15	5.1	31	8.9	42	13.5	A	9	4.4	6	6.7	0	0	15	12.1	15	6.8	0	0	37	16.0	25	16.9			
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_reproductive</b>																										
#	203	99.3	C	341	97.4	294	94.8	201	99.0	90	100.0	0	0	115	92.7	222	100.0	A	1	100	144	96.0	148	100.0		
1	2	0.7	9	2.6	16	5.2	A	2	1.0	0	0.0	0	0	9	7.3	0	0.0	0	0	36	18.0	0	0.0			
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_cancer</b>																										
#	72	24.4	295	76.6	A	105	33.9	A	48	22.2	27	30.0	0	0	96	77.4	175	78.8	1	100	63	39.4	41	27.7		
1	223	75.6	B	75	21.4	200	66.1	B	139	77.8	63	70.0	0	0	28	22.6	47	21.2	0	0	97	66.6	107	72.3		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_ohla</b>																										
#	295	100.0	C	350	100.0	C	303	98.4	203	100.0	90	100.0	0	0	124	100.0	222	100.0	1	100	137	98.1	146	98.6		
1	0	0.0	0	0.0	3	1.0	0	0.0	0	0.0	0	0.0	0	0	0	0.0	0	0.0	0	0	3	1.9	2	1.4		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_nutrition</b>																										
#	203	97.6	B	290	82.9	300	97.1	B	200	98.5	30	95.6	0	0	110	88.7	176	88.2	0	0	154	96.2	145	98.0		
1	7	2.4	60	17.1	A	9	2.9	3	1.5	4	4.4	0	0	14	11.3	44	19.8	1	100	6	3.3	3	2.0			
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_other</b>																										
#	205	100.0	C	347	99.1	C	308	98.3	203	100.0	90	100.0	0	0	123	99.2	220	99.1	1	100	153	96.9	143	96.6		
1	0	0.0	3	0.9	18	5.2	B	0	0.0	0	0.0	0	0	1	0.8	2	0.9	0	0	5	3.3	5	3.4			
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_anae</b>																										
#	295	100.0	B	350	85.7	304	98.1	B	203	100.0	90	100.0	0	0	89	71.8	137	60.7	1	100	153	98.1	143	98.0		
1	0	0.0	120	34.3	C	6	1.9	0	0.0	0	0.0	0	0	35	28.2	85	38.3	0	0	2	1.2	3	2.0			
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		
<b>most_worried_no_say</b>																										
#	295	100.0	B	341	97.4	308	99.4	203	100.0	90	100.0	0	0	120	96.8	217	97.7	1	100	158	98.8	143	100.0			
1	0	0.0	9	2.6	2	0.6	0	0.0	0	0.0	0	0.0	0	0	4	3.2	5	2.3	0	0	2	1.2	0	0.0		
#Total cases	295	295	350	350	310	310	203	203	90	90	0	0	124	124	222	222	1	1	100	100	148	148	148	148		

## Annex IV: Table 6: Rating of health access, quality in respective country and health status for three points in time: before migrating, upon arrival and now

Table with health status rating statistics for all 3 country cohorts grouped by gender

	#Total						Kenya			Nigeria			South Africa			
	Kenya	Nigeria	South Africa	Female	Male	Prefer not to say	Female	Male	Prefer not to say	Female	Male	Prefer not to say	Female	Male	Prefer not to say	
	cases	cases	cases	cases	cases	cases	cases	cases	cases	cases	cases	cases	cases	cases	cases	
<b>rating_quality</b>																
Mean	8.3	8.5	8.6	8.4	8.5	0	8.3	8.3	0	8.4	8.6	0	8.5	8.6	0	0
Std. dev.	1.0	1.2	1.2	1.2	1.2	0	1.5	1.8	0	1.4	1.2	0	1.6	1.5	0	0
Uns. valid N	295.0	289.0	308.0	475.0	418.0	0	204.0	89.0	0	113.0	174.0	0	158.0	148.0	0	0
<b>rating_access</b>																
Mean	8.1	8.5	7.8	8.1	8.2	0	8.0	8.1	0	8.4	8.6	0	7.9	7.8	0	0
Std. dev.	1.7	1.5	2.0	1.8	1.7	0	1.7	1.8	0	1.7	1.3	0	2.1	2.0	0	0
Uns. valid N	209.0	200.0	306.0	466.0	405.0	0	200.0	87.0	0	160.0	170.0	0	158.0	148.0	0	0
<b>health_status_bef</b>																
Mean	7.9	7.4	8.9	8.1	8.0	8	8.0	7.6	0	7.3	7.5	8	8.8	9.0	0	0
Std. dev.	2.0	1.3	1.6	1.9	1.6	0	2.0	2.1	0	1.5	1.1	0	1.7	1.5	0	0
Uns. valid N	292.0	349.0	388.0	484.0	458.0	1	200.0	90.0	0	124.0	220.0	1	160.0	148.0	0	0
<b>health_status_upon</b>																
Mean	7.9	8.4	8.3	8.3	8.5	9	8.1	7.7	0	8.2	8.6	9	8.7	8.9	0	0
Std. dev.	2.0	1.3	1.4	1.8	1.4	0	1.9	2.1	0	1.7	1.1	0	1.6	1.2	0	0
Uns. valid N	293.0	350.0	309.0	485.0	458.0	1	201.0	90.0	0	124.0	221.0	1	160.0	147.0	0	0
<b>health_status_now</b>																
Mean	8.4	8.7	8.9	8.6	8.8	10	8.4	8.4	0	8.5	8.9	10	8.8	8.9	0	0
Std. dev.	1.9	1.3	1.3	1.6	1.3	0	1.8	2.0	0	1.7	1.6	0	1.8	1.2	0	0
Uns. valid N	285.0	339.0	305.0	473.0	448.0	1	190.0	87.0	0	119.0	206.0	1	158.0	145.0	0	0

## Annex IV: Table 7: Experienced restrictions

Table with statistics what restrictions they have experienced, grouped by gender

	#Total																												
	Kenya			Nigeria			South Africa			Female			Male			Prefer not to say													
	cases	%		cases	%		cases	%		cases	%		cases	%		cases	%												
<b>restrictions</b>																													
Have not tried so far	22	7.5	C	94	26.9	A,C	8	2.6	11	5.4	31	12.4	A	0	0	27	21.6	16	29.9	0	0	5	3.1	3	2.0	0	0		
No	227	77.2	B,C	232	66.3		189	68.2	139	70.3	87	75.3		0	0	83	70.4	142	84.3	0	0	161	63.1	83	56.5	0	0		
Yes	45	15.3	B	24	6.9		115	37.2	A,B	33	16.3	31	12.4		0	0	10	8.0	13	5.9	1	100	54	33.8	81	41.5	0	0	
#Total cases	294	294		350	350		309	309		203	203		89	89		0	0	123	123	221	221	1	1	160	160	147	147	0	0
<b>restrictions_language</b>																													
0	7	15.6		15	62.5	A	60	54.8	A	5	15.2	2	18.2		0	0	3	30.0	9	69.2	1	100	28	31.9	35	37.4	0	0	
1	38	14.4	B,C	9	37.5		32	45.2		28	84.8	9	81.8		0	0	3	30.0	4	30.0	0	0	26	48.1	26	42.0	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_religious</b>																													
0	43	95.0		23	95.8		115	99.0	A,B	31	93.9	31	100.0		0	0	9	90.0	13	100.0	1	100	54	100.0	61	100.0	0	0	
1	2	4.4		1	4.2		0	0.0		2	6.1	0	0.0		0	0	1	10.0	0	0.0	0	0	0	0.0	0	0.0	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_admin</b>																													
0	33	73.3		12	50.0		78	67.8		25	75.8	7	63.6		0	0	4	40.0	7	53.8	1	100	36	66.7	42	68.9	0	0	
1	12	26.7		12	50.0		37	32.2		8	24.2	4	36.4		0	0	6	60.0	6	46.2	0	0	18	33.3	19	31.1	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_occupational</b>																													
0	43	95.0	C	20	83.3		90	79.1		31	93.9	31	100.0		0	0	9	90.0	11	84.6	0	0	43	76.6	48	78.7	0	0	
1	2	4.4		4	16.7		24	20.9	A	2	6.1	0	0.0		0	0	1	10.0	2	15.4	1	100	31	54.4	13	21.3	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_family</b>																													
0	45	100.0		24	100.0		115	96.5		33	100.0	31	100.0		0	0	10	100.0	13	100.0	1	100	50	92.6	61	100.0	A	0	0
1	0	0.0		0	0.0		4	3.5		0	0.0	0	0.0		0	0	0	0.0	0	0.0	0	0	4	7.4	0	0.0	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_geographical</b>																													
0	45	100.0	B,C	17	70.8		102	88.7	B	33	100.0	31	100.0		0	0	1	10.0	3	61.5	1	100	49	90.7	53	86.9	0	0	
1	0	0.0		7	29.2	C	13	11.3		0	0.0	0	0.0		0	0	2	20.0	5	38.5	0	0	5	9.3	3	13.1	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_undocumented</b>																													
0	41	91.1		23	95.8		90	79.1		31	93.9	9	81.8		0	0	9	90.0	13	100.0	1	100	44	81.3	47	77.0	0	0	
1	4	8.9		1	4.2		24	20.9		2	6.1	2	18.2		0	0	1	10.0	0	0.0	0	0	10	18.5	14	23.0	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_gender</b>																													
0	45	100.0		23	95.8		119	95.7		33	100.0	31	100.0		0	0	10	100.0	12	92.3	1	100	53	98.1	57	93.4	0	0	
1	0	0.0		1	4.2		5	4.3		0	0.0	0	0.0		0	0	0	0.0	1	7.7	0	0	1	1.9	4	6.6	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_prejudice</b>																													
0	37	82.2		21	87.5		90	79.1		27	81.8	9	81.8		0	0	1	10.0	13	100.0	0	0	43	76.6	50	82.0	0	0	
1	8	17.8		3	12.5		22	19.1		6	18.2	2	18.2		0	0	2	20.0	0	0.0	1	100	31	54.4	13	21.3	0	0	
#Total cases	45	45		24	24		115	115		33	33		31	31		0	0	10	10	13	13	1	1	54	54	61	61	0	0
<b>restrictions_cultural</b>																													
0	44	97.8	C	24	100.0	C	90	79.																					

## Annex IV: Table 8: Descriptive statistics table focused on undocumented migrants - South Africa only (1)

Table with descriptive statistics for South Africa for experienced health complications and diseases people are most worried about

	#Total		gender				residence <sup>3</sup>					
	cases	%	Female		Male		No documents		some documents		excluded	
			cases	%	cases	%	cases	%	cases	%	cases	%
<b>health_complication_any</b>												
No	169	54.9	89	55.6	78	53.4	113	55.7	55	54.5	1	25.0
Prefer not to say	1	0.3	1	0.6	0	0.0	1	0.5	0	0.0	0	0.0
Yes (please specify)	138	44.8	70	43.8	68	46.6	89	43.8	46	45.5	3	75.0
#Total cases	308	308	160	160	146	146	203	203	101	101	4	4
<b>health_complication_chronic</b>												
0	125	90.6	63	90.0	62	91.2	82	92.1	41	89.1	2	66.7
1	13	9.4	7	10.0	6	8.8	7	7.9	5	10.9	1	33.3
#Total cases	138	138	70	70	68	68	89	89	46	46	3	3
<b>health_complication_dental</b>												
0	110	79.7	56	80.0	54	79.4	73	82.0	34	73.9	3	100.0
1	28	20.3	14	20.0	14	20.6	16	18.0	12	26.1	0	0.0
#Total cases	138	138	70	70	68	68	89	89	46	46	3	3
<b>health_complication_dermatological</b>												
0	135	97.8	69	98.6	66	97.1	86	96.6	46	100.0	3	100.0
1	3	2.2	1	1.4	2	2.9	3	3.4	0	0.0	0	0.0
#Total cases	138	138	70	70	68	68	89	89	46	46	3	3
<b>health_complication_eye</b>												
0	123	89.1	63	90.0	60	88.2	80	89.9	40	87.0	3	100.0
1	15	10.9	7	10.0	8	11.8	9	10.1	6	13.0	0	0.0
#Total cases	138	138	70	70	68	68	89	89	46	46	3	3
<b>health_complication_other</b>												
0	113	81.9	59	84.3	54	79.4	74	83.1	38	82.6	1	33.3
1	25	18.1	11	15.7	14	20.6	15	16.9	8	17.4	2	66.7
#Total cases	138	138	70	70	68	68	89	89	46	46	3	3
<b>health_complication_physical</b>												
0	110	79.7	62	88.6	48	70.6	68	76.4	39	84.8	3	100.0
1	28	20.3	8	11.4	20	29.4	21	23.6	7	15.2	0	0.0
#Total cases	138	138	70	70	68	68	89	89	46	46	3	3
<b>health_complication_dental</b>												
0	110	79.7	56	80.0	54	79.4	73	82.0	34	73.9	3	100.0
1	28	20.3	14	20.0	14	20.6	16	18.0	12	26.1	0	0.0
#Total cases	138	138	70	70	68	68	89	89	46	46	3	3
<b>health_complication_reproductive</b>												
0	114	82.6	46	65.7	68	100.0	73	82.0	38	82.6	3	100.0
1	24	17.4	24	34.3	0	0.0	16	18.0	8	17.4	0	0.0
#Total cases	138	138	70	70	68	68	89	89	46	46	3	3
<b>most_worried_mental</b>												
0	173	55.8	89	55.6	82	55.4	107	52.5	62	60.8	4	100.0
1	137	44.2	71	44.4	66	44.6	97	47.5	40	39.2	0	0.0
#Total cases	310	310	160	160	148	148	204	204	102	102	4	4
<b>most_worried_sexuality</b>												
0	184	59.4	92	57.5	91	61.5	121	59.3	60	58.8	3	75.0
1	126	40.6	68	42.5	57	38.5	83	40.7	42	41.2	1	25.0
#Total cases	310	310	160	160	148	148	204	204	102	102	4	4
<b>most_worried_chronic</b>												
0	188	60.6	96	60.0	90	60.8	118	57.8	68	66.7	2	50.0
1	122	39.4	64	40.0	58	39.2	86	42.2	34	33.3	2	50.0
#Total cases	310	310	160	160	148	148	204	204	102	102	4	4
<b>most_worried_corona</b>												
0	105	33.9	63	39.4	41	27.7	75	36.8	27	26.5	3	75.0
1	205	66.1	97	60.6	107	72.3	129	63.2	75	73.5	1	25.0
#Total cases	310	310	160	160	148	148	204	204	102	102	4	4
<b>most_worried_children</b>												
0	257	82.9	123	76.9	132	89.2	170	83.3	83	81.4	4	100.0
1	53	17.1	37	23.1	16	10.8	34	16.7	19	18.6	0	0.0
#Total cases	310	310	160	160	148	148	204	204	102	102	4	4
<b>most_worried_nutrition</b>												
0	301	97.1	154	96.2	145	98.0	199	97.5	98	96.1	4	100.0
1	9	2.9	6	3.8	3	2.0	5	2.5	4	3.9	0	0.0
#Total cases	310	310	160	160	148	148	204	204	102	102	4	4
<b>most_worried_infectious</b>												
0	267	86.1	141	88.1	124	83.8	172	84.3	93	91.2	2	50.0
1	43	13.9	19	11.9	24	16.2	32	15.7	9	8.8	2	50.0
#Total cases	310	310	160	160	148	148	204	204	102	102	4	4

## Annex IV: Table 9: Descriptive statistics table for South Africa (2)

Table with descriptive statistics for South Africa for experienced restrictions payment methods

	#Total		gender				residence3					
	cases	%	Female		Male		No documents		some documents		excluded	
	cases	%	cases	%	cases	%	cases	%	cases	%	cases	%
<b>restrictions</b>												
Have not tried so far	8	2.6	5	3.1	3	2.0	7	3.4	1	1.0	0	0
No	186	60.2	101	63.1	83	56.5	119	58.6	65	63.7	2	50
Yes	115	37.2	54	33.8	61	41.5	77	37.9	36	35.3	2	50
#Total cases	309	309	160	160	147	147	203	203	102	102	4	4
<b>restrictions_language</b>												
0	63	54.8	28	51.9	35	57.4	46	59.7	15	41.7	2	100
1	52	45.2	26	48.1	26	42.6	31	40.3	21	58.3	0	0
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_religious</b>												
0	115	100.0	54	100.0	61	100.0	77	100.0	36	100.0	2	100
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_admin</b>												
0	78	67.8	36	66.7	42	68.9	44	57.1	33	91.7	1	50
1	37	32.2	18	33.3	19	31.1	33	42.9	3	8.3	1	50
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_occupational</b>												
0	91	79.1	43	79.6	48	78.7	59	76.6	30	83.3	2	100
1	24	20.9	11	20.4	13	21.3	18	23.4	6	16.7	0	0
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_family</b>												
0	111	96.5	50	92.6	61	100.0	73	94.8	36	100.0	2	100
1	4	3.5	4	7.4	0	0.0	4	5.2	0	0.0	0	0
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_geographical</b>												
0	102	88.7	49	90.7	53	86.9	65	84.4	35	97.2	2	100
1	13	11.3	5	9.3	8	13.1	12	15.6	1	2.8	0	0
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_undocumented</b>												
0	91	79.1	44	81.5	47	77.0	59	76.6	31	86.1	1	50
1	24	20.9	10	18.5	14	23.0	18	23.4	5	13.9	1	50
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_gender</b>												
0	110	95.7	53	98.1	57	93.4	72	93.5	36	100.0	2	100
1	5	4.3	1	1.9	4	6.6	5	6.5	0	0.0	0	0
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_prejudices</b>												
0	93	80.9	43	79.6	50	82.0	64	83.1	27	75.0	2	100
1	22	19.1	11	20.4	11	18.0	13	16.9	9	25.0	0	0
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_cultural</b>												
0	93	80.9	42	77.8	51	83.6	60	77.9	31	86.1	2	100
1	22	19.1	12	22.2	10	16.4	17	22.1	5	13.9	0	0
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>restrictions_other</b>												
0	92	80.0	41	75.9	51	83.6	62	80.5	28	77.8	2	100
1	23	20.0	13	24.1	10	16.4	15	19.5	8	22.2	0	0
#Total cases	115	115	54	54	61	61	77	77	36	36	2	2
<b>payment_myself</b>												
0	45	40.2	23	43.4	22	37.3	34	44.7	10	29.4	1	50
1	67	59.8	30	56.6	37	62.7	42	55.3	24	70.6	1	50
#Total cases	112	112	53	53	59	59	76	76	34	34	2	2
<b>payment_insurance</b>												
0	111	99.1	53	100.0	58	98.3	76	100.0	33	97.1	2	100
1	1	0.9	0	0.0	1	1.7	0	0.0	1	2.9	0	0
#Total cases	112	112	53	53	59	59	76	76	34	34	2	2
<b>payment_government</b>												
0	30	26.8	12	22.6	18	30.5	15	19.7	15	44.1	0	0
1	82	73.2	41	77.4	41	69.5	61	80.3	19	55.9	2	100
#Total cases	112	112	53	53	59	59	76	76	34	34	2	2
<b>payment_NGO</b>												
0	112	100.0	53	100.0	59	100.0	76	100.0	34	100.0	2	100
#Total cases	112	112	53	53	59	59	76	76	34	34	2	2
<b>payment_other</b>												
0	112	100.0	53	100.0	59	100.0	76	100.0	34	100.0	2	100
#Total cases	112	112	53	53	59	59	76	76	34	34	2	2
<b>payment_dont_know</b>												
0	112	100.0	53	100.0	59	100.0	76	100.0	34	100.0	2	100
#Total cases	112	112	53	53	59	59	76	76	34	34	2	2

**Annex IV: Table 10: Descriptive statistics about South African sample, grouped in gender and residence cohorts about Rating of health access, rated quality of health system, rated own health status (1): before migration, (2): upon arrival in residence country, (3): at time of survey**

South Africa: Rating of health care access, quality of the system and own health status

	#Total	residence3			gender	
		No documents	some documents	excluded	Female	Male
		A	B	C	A	B
<b>rating_access</b>						
Mean	7.8	7.6	8.3 A	6.5	7.9	7.8
Std. dev.	2.0	2.1	1.7	3.3	2.1	2.0
Unw. valid N	308.0	202.0	102.0	4.0	158.0	148.0
<b>rating_quality</b>						
Mean	8.0	8.5	8.8 A	7.5	8.5	8.0
Std. dev.	1.5	1.6	1.4	1.7	1.6	1.5
Unw. valid N	308.0	202.0	102.0	4.0	158.0	148.0
<b>health_status_bef</b>						
Mean	8.9	8.8	9.0	9.5	8.8	9.0
Std. dev.	1.6	1.6	1.6	1.0	1.7	1.5
Unw. valid N	310.0	204.0	102.0	4.0	160.0	148.0
<b>health_status_upon</b>						
Mean	8.8	8.8	9.0	7.5	8.7	8.9
Std. dev.	1.4	1.4	1.3	3.1	1.6	1.2
Unw. valid N	309.0	203.0	102.0	4.0	160.0	147.0
<b>health_status_now</b>						
Mean	8.9	8.8	8.9	9.2	8.8	8.9
Std. dev.	1.3	1.3	1.3	1.0	1.3	1.2
Unw. valid N	305.0	201.0	100.0	4.0	158.0	145.0

## Annex V: Survey questionnaire

Please note following characteristics of the survey: for single answers are represented by a circle, for multiple selection questions by a square.

Questions marked with \* were mandatory, questions slightly shaded only appeared when particular responses were made on previous questions.

9.12.2020

Health and Migration Survey (a)

### Health and Migration Survey (a)

What is your age (in years)?

---

What is your gender?

- Female
- Male
- Other
- Prefer not to say

Where were you born?

- |  |                                     |  |
|--|-------------------------------------|--|
| <input type="radio"/> Algeria                          | <input type="radio"/> Angola        | <input type="radio"/> Benin                    |
| <input type="radio"/> Botswana                         | <input type="radio"/> Burkina Faso  | <input type="radio"/> Burundi                  |
| <input type="radio"/> Cameroon                         | <input type="radio"/> Cabo Verde    | <input type="radio"/> Central African Republic |
| <input type="radio"/> Chad                             | <input type="radio"/> Comoros       | <input type="radio"/> Congo                    |
| <input type="radio"/> Democratic Republic of the Congo | <input type="radio"/> Côte d'Ivoire | <input type="radio"/> Djibouti                 |
| <input type="radio"/> Equatorial Guinea                | <input type="radio"/> Egypt         | <input type="radio"/> Eritrea                  |
| <input type="radio"/> Ethiopia                         | <input type="radio"/> Gabon         | <input type="radio"/> Gambia                   |
| <input type="radio"/> Ghana                            | <input type="radio"/> Guinea        | <input type="radio"/> Guinea-Bissau            |
| <input type="radio"/> Kenya                            | <input type="radio"/> Lesotho       | <input type="radio"/> Liberia                  |
| <input type="radio"/> Libya                            | <input type="radio"/> Madagascar    | <input type="radio"/> Malawi                   |
| <input type="radio"/> Mali                             | <input type="radio"/> Mauritania    | <input type="radio"/> Mauritius                |
| <input type="radio"/> Morocco                          | <input type="radio"/> Mozambique    | <input type="radio"/> Namibia                  |
| <input type="radio"/> Niger                            | <input type="radio"/> Nigeria       | <input type="radio"/> Rwanda                   |
| <input type="radio"/> Sao Tome and Principe,           | <input type="radio"/> Senegal       | <input type="radio"/> Seychelles               |
| <input type="radio"/> Sierra Leone                     | <input type="radio"/> Somalia       | <input type="radio"/> South Africa             |
| <input type="radio"/> South Sudan                      | <input type="radio"/> Sudan         | <input type="radio"/> Swaziland                |
| <input type="radio"/> Tanzania                         | <input type="radio"/> Togo          | <input type="radio"/> Tunisia                  |
| <input type="radio"/> Uganda                           | <input type="radio"/> Zambia        | <input type="radio"/> Zimbabwe                 |
| <input type="radio"/> Other (Specify):                 |                                     |  |

Please specify where you were born:

---

9.12.2020

Health and Migration Survey (a)

**Where/ what country are you currently living in?**

*\*this question is mandatory to answer*

- Kenya
- Nigeria
- South Africa
- Other (please specify):

Please specify your country:

---

**How long have you been living in this country?**

- up to 3 months
- 3-6 months
- 6-12 months
- 1-2 years
- 2-5 years
- more than 5 years
- Prefer not to say

**At the time you came to the country of residence, how well did you speak the local language?**

5                      4                      3                      2                      1                      0

*(5 = fluent, 4 = very well, 3 = enough for daily life, 2 = basic conversation, 1 = little, 0 = nothing)*

**Please rate your language level:**

- 

**Do you live rural or urban?**

- Urban (city)
- Rural (village)
- Urban- rural mix
- Prefer not to say

**Where are you currently staying?**

- In a private Apartment/ house
- In a camp/ refugee settlement
- I have no permanent place to stay
- Other (please specify):
- Prefer not to say

Please specify your living status:

---

<https://kf.kobotoolbox.org/#/forms/arEkYYFW5A83Yq04-C3VG/summary>

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Health and Migration Survey (a)

**What is your residence status in this country?**

- Citizen
- Permanent documents (e.g. unlimited working permit, etc.)
- Temporary documents (Asylum seeker, e.g. asylum seeker certificate)
- Temporary documents (Recognized refugee, e.g. alien card)
- Temporary documents (Educational stay)
- No documents/ without legal documents (e.g. working permit or refugee status denied)
- Other (please specify):
- Prefer not to say

Please specify your residence status:

---

**How many people live in your household?**

- 0
- 1
- 2
- 3
- 4
- 5
- 6 or more

**What educational qualifications do you have (if any)?**

- No formal schooling
- Primary school
- Secondary school
- Vocational training
- University (undergraduate)
- University (post graduate)
- Other (please specify):
- Prefer not to say

Please specify your educational level:

---

9.12.2020

Health and Migration Survey (a)

**What is your current occupational situation:**

- I work full-time
- I work part-time
- I am self-employed
- I work without a contract
- I am a student
- I am unemployed
- I am retired
- Other (please specify):

Please specify your occupational situation:

---

**What were your main reasons for coming to your current country of residence?**

Please choose up to 3 reasons, from highest to lowest. If only 1-2 reasons select the "..." and "...." options.

---

**Primary reason**

- Improve economic situation (e.g. finding a job)
- Family reunification
- Difficult/ critical situation in previous country (e.g. conflict, violence)
- I prefer not to say
- Health provision
- Education
- Other (please specify):
- ...
- ....

**Secondary reason**

- Improve economic situation (e.g. finding a job)
- Family reunification
- Difficult/ critical situation in previous country (e.g. conflict, violence)
- I prefer not to say
- Health provision
- Education
- Other (please specify):
- ...
- ....

**Tertiary reason**

- Improve economic situation (e.g. finding a job)
- Family reunification
- Difficult/ critical situation in previous country (e.g. conflict, violence)
- I prefer not to say
- Health provision
- Education
- Other (please specify):
- ...
- ....

**If you used "Other" in the previous question, please specify:**

---

<https://kf.kobotoolbox.org/forms/arExYYFW5A83Yq84C3VG/summary>

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Health and Migration Survey (a)

Could you please rate your own health status at the following 3 points in time:

(10 - perfect health, to 1 - heavy limitations)

Before you left your country of origin

Upon arrival in your current country of residence

Now

	10	9	8	7	6	5	4	3	2	1
Before you left your country of origin	<input type="radio"/>									
Upon arrival in your current country of residence	<input type="radio"/>									
Now	<input type="radio"/>									

Have you had any health complications since you left your home country?

- Yes (please specify)
- No
- Prefer not to say

Which health complications have you had since you left your home country?

- Mental health (e.g. Stress, Depression, etc.)
- Infectious diseases (Tuberculosis, Ebola, etc.)
- Sexually transmitted diseases (HIV / AIDS, Hepatitis, Gonorrhoea, etc.)
- Chronic diseases (Obesity, Diabetes, Hypertension, etc.)
- Physical issues (e.g. fracture)
- Nutrition issues
- Dental problems
- Dermatological problems
- Eye problems
- Issues with reproductive health (e.g. during Pregnancy or Menstruation, etc.)
- Other (please specify):
- Prefer not to say

Please specify your health complications:

---

9.12.2020

Health and Migration Survey (a)

**Which health issue are you most worried about in your personal situation?**

Please select up to three health issues.

- Mental health (e.g. Stress, Depression, etc.)
- The health situation of your children
- Infectious diseases (Tuberculosis, Ebola, etc.)
- Sexually transmitted diseases (HIV / AIDS, Hepatitis, Gonorrhoea, etc.)
- Chronic diseases (Obesity, Diabetes, Hypertension, etc.)
- Physical issues (e.g. fracture)
- Dental problems
- Dermatological problems
- Eye problems
- Issues with reproductive health (e.g. during Pregnancy or Menstruation, etc.)
- Corona pandemic
- Ebola
- Nutrition issues
- Other (please specify):
- None
- Prefer not to say

Please specify the health issue you are worried about:

---

**When you have health issues, where do you seek help?**

- Public Health Center/ other primary care
- Private doctor or clinic
- NGO/ Associations
- Emergency Room
- Pharmacy
- Friends/ relatives/ network
- Non-conventional medicine (traditional, religious, etc.)
- Information on the Internet
- Other (please specify):
- Do not know how
- I would/ cannot get help

<https://kf.kobotoolbox.org/forms/arfxYYFW5A93Yq94C3VG/summary>

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Health and Migration Survey (a)

Please specify where you would seek help:

---

**Did you experience restrictions/ difficulties when you needed to access health services provided by the government?**

- Yes
- No
- Have not tried so far

**What restrictions/ difficulties have you had?**

- Language
- Religious
- Administrative
- Occupational obligations
- Family obligations
- Geographical (distance)
- Fear about being undocumented
- For being a man or a woman
- Stigma/ prejudices
- Cultural
- Other (please specify):
- Prefer not to say

**Please specify the difficulty:**

---

**Are there attempts of yourself or other persons/ institutions to overcome these barriers?**

- Yes
- No

**Would you please tell us what is being done?**

---

**Have these services cover all your needs up to this point in time?**

- Yes
- No

9.12.2020

Health and Migration Survey (a)

How is the service provision paid for?

- By myself
- Insurance
- Government
- NGO
- Other (please specify manually)
- I do not know

Please specify who paid for your health condition:

---

Where do you seek medical help if you are not able to access health services?

---

Where did you find information about the local health system regarding your health care needs?

- Family or friends
- NGO
- Public system professionals
- I don't know how the health system works yet
- Internet
- Other (please specify):

Please specify where you find information about the local health system:

---

What is your preferred way of getting information about health services where you currently live?

- Primary Health Centers (e.g. hospitals, doctors)
- Pharmacy
- Religious community
- Government websites
- Friends/ relatives/ network
- Other online sources (please specify):
- Mobile applications (please specify):
- NGO (please specify):
- Other (please specify):
- Do not know

9.12.2020

Health and Migration Survey (a)

Please specify the online sources:

---

Please specify the mobile applications:

---

Please specify the NGO:

---

Please specify other:

---

Please specify where the health care system should be explained:

---

**How do you rate the general quality and access of the health service provision where you currently live?**

*(10=excellent to 1=inexistent)*

	10	9	8	7	6	5	4	3	2	1
Quality:	<input type="radio"/>									
Access:	<input type="radio"/>									

What are strong points about the health care system in your country of residence?

---

In your opinion, what could be done to improve the health of migrants in the country you are currently living in?

---

Thanks you so much to contributing to this research, feel free to forward it to other people of your community! Is there anything else you would like to share with us or inform us of?

---

Do you want to receive updates with the results of the survey?

- Yes  
 No

Please give us your email address, so we can sent you the final report:

---

# Annex VI: Abridged coding relationship matrix of interview groups

	Regional and continental KIs	SA_ Migrants	SA_ GovOff	Nigeria_ Migrants	Nigeria_ GovOff	Nigeria_ ServiceProviders	Kenya_ Migrants	Kenya_ ServiceProviders	Kenya_ GovOff	SUM
Access to HC	9	8	2	1	0	3	3	1	0	27
Access to HC\Barriers to access HC	4	0	0	1	0	0	1	2	0	8
Access to HC\Barriers to access HC\Able / no social coverage	2	0	0	2	1	1	0	0	0	6
Access to HC\Barriers to access HC\Cost / Financial	5	3	0	0	3	2	2	3	0	18
Access to HC\Barriers to access HC\Documentation / Status	9	8	3	1	1	0	0	3	2	27
Access to HC\Barriers to access HC\Language	7	1	0	0	4	4	3	10	4	33
Health issues / HC needs	7	0	0	4	1	4	4	17	0	32
Health issues / HC needs\Environmental factors	0	0	0	0	1	1	0	0	0	2
Health issues / HC needs\Maternal and child health	0	0	0	0	4	0	0	0	0	4
Health issues / HC needs\Tuberculosis	7	0	0	0	0	0	0	0	0	7
Health issues / HC needs\Substance Abuse	1	0	0	0	0	0	0	0	0	1
Social coverage	12	4	0	1	3	0	0	1	2	23
Health workers	1	0	0	0	0	0	0	0	0	1
Health workers\IOM foreign recruitment	6	0	0	0	0	0	0	0	0	6
Health workers\IOM retention	10	0	0	0	0	0	0	0	0	10
Migrants health	0	0	0	0	0	0	0	0	0	0
Migrants health\Migrants health status	0	0	0	0	0	0	0	0	0	0
pandemic preparedness	3	0	0	0	3	3	0	0	0	9
Integrated HC provision	11	0	0	0	0	0	3	12	0	26
Social Security & Insurance	9	0	0	6	5	0	2	0	0	22
Vulnerability (+)	4	3	0	0	3	4	0	0	0	14
<b>SUM</b>	<b>94</b>	<b>27</b>	<b>5</b>	<b>16</b>	<b>29</b>	<b>22</b>	<b>17</b>	<b>33</b>	<b>8</b>	<b>253</b>

Figure 27: Coding relationship matrix of interview groups  
Source: Own Data

## Annex VII: Typology of migrant groups<sup>12</sup>

Migrant category	Definition	Data Source
International migrants	Individuals who remain outside their usual country of residence for at least one year	UNDESA
Internal migrants	Individuals who move within the borders of a country, usually measured across regional, district, or municipal boundaries, resulting in a change in the usual place of residence	UNDPD, UNDESA
Irregular / undocumented migrants  (sometimes also referred to as 'illegal migrants')	Individuals who enter a country, often in search of employment or other opportunities, without the required documents or permits or who overstay the authorised length of stay in the country	N/A / UN Population Division  There are few reliable data sources on numbers of irregular migrant
Regular migrants	Individuals who enter a country, often in search of employment or other opportunities, with the required documents or permits	UNDESA
Trafficked persons	Individuals who are coerced, tricked, or forced into situations in which their bodies or labour may be exploited, which may occur across international borders or within their own country	N/A There are few reliable data sources on numbers of trafficked persons
International labour migrants	Individuals engaged in remunerated activity in a state of which he/she is not a national, including persons legally admitted as a migrant for employment	ILO
Internally displaced persons (IDPs)	Individuals who have been forced to leave their homes or places of habitual residence, in particular as result of / in order to avoid the effects of armed violence, situations of generalised violence, violations of human rights, or natural or man-made disasters, and who have not crossed an international border	UNHCR
People in refugee-like situations	Similar to refugees below, but this category is broader as it includes people who have been forced to leave their country of origin but who lack legal status as refugees and who have not registered claims for asylum. Typically, this latter group are irregular migrants.  In this report, 'people in refugee-like situations' is used as an umbrella term that includes registered/legal refugees, asylum-seekers, and irregular migrants who have been forced to flee their country of origin	N/A / UNHCR  (There are few reliable data sources on this broader category)

12. Adapted from Zimmerman et al. (2011) and Ahmed & Asquith (forthcoming), *Diaspora Humanitarianism*

Migrant category	Definition	Data Source
Refugees	<p>Individuals who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, are outside of the country of their nationality, and are unable to, or owing to such fear are unwilling to, avail themselves of the protection of that country, or return because of fear of persecution.</p> <p>The term refugee is typically used in a precise legal sense – i.e., someone who has been granted legal status as a refugee – as well as in a broader, more abstract sense.</p>	UNHCR
Asylum seekers	Individuals who have sought international protection and whose claims for refugee status have not been determined	UNHCR
Stateless persons	Individuals not considered as citizens of any state under national law. Covers de jure and de facto stateless persons, including persons unable to establish their nationality. Stateless persons may or may not be migrants	UNHCR
Tourists	Individuals travelling to and staying in places outside their usual environment for not more than one consecutive year and whose main purpose of visit is other than work	UN World Tourism Organisation
International students	Individuals admitted to a country other than their own, usually under special permits or visas, for the specific purposes of following a particular course of study for not more than one consecutive year, and whose main purpose of visit is other than work	UNESCO
Diaspora	<p>Migrants or descendants of migrants, whose identity and sense of belonging have been shaped by their migration experience and background (IOM 2018)</p> <p>This report’s working definition of a diaspora will include: those originating from outside of their country of origin or heritage who have resided in their country of residence for one year or more (first-generation); those born to parents of with a nationality or heritage other than their country of residence (second and subsequent generations); Diaspora may be citizens of one or more countries, including their country of origin/heritage</p>	N/A

## Annex VIII: List of KII and FGD interview partners (Berlin team)

Interview partner	Organisation
Edward Addai	UNICEF
Adam Ahmat	WHO, Regional Office of Africa
Judicael Ahouansou	IOM Morocco
(Anonymous)	Manager, Migrant Reception Centre
(Anonymous)	Senior African Public Health Expert
(Anonymous)	UN Agency, DR Congo
Chimwemwe Chamdimba	AUDA / NEPAD
Nkata Chuku	Health Systems Consult Ltd (HSCL)
Ana Fonseca	IOM Morocco
Lotte Kejser	ILO
Gloria Moreno Fontes	ILO
Michela Martini	IOM
Emma Orefuwa	Pan Africa Mosquito Control Alliance (PAMCA)
Francis Tabu	IOM, Special Liaison Office to the African Union

## Annex IX: Inter-State dialogue processes on migration in Africa

Regional Consultative Process (RCP)	Member States	Main areas of discussion
<b>African Union – Horn of Africa Initiative on Human Trafficking and Migrant Smuggling</b>	<p><b>8 Member States:</b></p> <p><b>Core Member States:</b> Egypt, Eritrea, Ethiopia, Sudan</p> <p><b>Neighbouring countries:</b> Djibouti, Kenya, Somalia, South Sudan</p>	<ul style="list-style-type: none"> <li>• Policy coherence on migration</li> <li>• Prevention of human trafficking and migrant smuggling</li> <li>• Strengthening of protection and assistance to victims of human trafficking and smuggled persons</li> <li>• Enhancing rule of law, prosecution and border management</li> </ul>
<b>Intergovernmental Authority on Development Regional Consultative Process on Migration</b> (IGAD-RCP)	<p><b>7 Member States</b></p> <p>Djibouti, Ethiopia, Kenya, Somalia, South Sudan, Sudan, Uganda</p>	<ul style="list-style-type: none"> <li>• Migration and development</li> <li>• Labour Migration</li> <li>• Social integration of migrants</li> <li>• Protection of migrants' rights</li> <li>• Smuggling and trafficking in persons</li> <li>• Migration data and research</li> <li>• Migration and health</li> <li>• Migration and trade</li> <li>• Migration and environment</li> <li>• Migration and security</li> <li>• Voluntary return of migrants</li> <li>• Mixed migratory flows and protection of refugees</li> <li>• Movement of pastoralist communities</li> <li>• Brain Drain and unethical recruitment</li> </ul>
<b>Migration Dialogue for Southern Africa</b> (MIDSA)	<p><b>16 Member States</b></p> <p>Angola, Botswana, Comoros, Democratic Republic of the Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia, Zimbabwe</p>	<ul style="list-style-type: none"> <li>• Labour migration</li> <li>• Irregular and mixed migration</li> <li>• Combatting trafficking in persons and migrant smuggling</li> <li>• Policy development</li> <li>• Disaster risk management</li> <li>• Capacity-building on border management</li> </ul>
<b>Migration Dialogue for West Africa</b> (MIDWA)	<p><b>15 Member States</b></p> <p>Benin, Burkina Faso, Cabo Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo</p>	<ul style="list-style-type: none"> <li>• Labour migration</li> <li>• Combatting trafficking and smuggling</li> <li>• Border management</li> <li>• Return and reintegration</li> <li>• Migration data</li> <li>• Mixed migration</li> </ul>

Regional Consultative Process (RCP)	Member States	Main areas of discussion
<p><b>Migration Dialogue from the Common Market for Eastern and Southern Africa Member States</b> (MIDCOM)</p>	<p><b>19 Member States</b></p> <p>Burundi, Comoros, Democratic Republic of the Congo, Djibouti, Egypt, Eritrea, Eswatini, Ethiopia, Kenya, Libya, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Sudan, Uganda, Zambia, Zimbabwe</p>	<ul style="list-style-type: none"> <li>• Migration and development</li> <li>• Migration and trade</li> <li>• Irregular migration</li> <li>• Combatting trafficking and smuggling</li> <li>• Migration and health</li> <li>• Forced migration</li> <li>• Labour migration</li> <li>• Data collection and inquiries</li> <li>• Free movement of persons</li> <li>• Right of establishment and residence</li> </ul>
<p><b>Migration Dialogue for Central African States</b> (MIDCAS)</p>	<p><b>10 Member States</b></p> <p>Angola, Burundi, Cameroon, Chad, Central African Republic, Congo, Democratic Republic of the Congo, Gabon, Equatorial Guinea, Sao Tome and Principe</p>	<ul style="list-style-type: none"> <li>• Assisted voluntary return and reintegration</li> <li>• Combating human trafficking</li> <li>• Combating migrant smuggling</li> <li>• Irregular migration and mixed migration flows</li> <li>• Labour migration, ethical recruitment, brain drain</li> <li>• Migrant integration</li> <li>• Migration and development</li> <li>• Migration and environment</li> <li>• Migration and security</li> <li>• Migration and trade</li> <li>• Migration data and research</li> <li>• Migration health</li> <li>• Protection of migrants' rights</li> </ul>
<p><b>Khartoum Process</b></p>	<p><b>41 Member States:</b></p> <p>11 African Member States and 30 European Member States</p> <p>Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Djibouti, Egypt, Estonia, Ethiopia, Eritrea, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Kenya, Latvia, Libya, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Somalia, South Sudan, Spain, Sudan, Sweden, Switzerland, Tunisia, Uganda, United Kingdom</p>	<ul style="list-style-type: none"> <li>• Combating human trafficking</li> <li>• Combating migrant smuggling</li> <li>• Development benefits of migration and addressing root causes of irregular migration and forced displacement</li> <li>• Legal migration and mobility</li> <li>• Protection and asylum</li> <li>• Prevention of and fight against irregular migration, migrant smuggling and trafficking in human beings</li> <li>• Return, readmission and reintegration</li> </ul>

Regional Consultative Process (RCP)	Member States	Main areas of discussion
<p><b>Rabat Process</b></p>	<p><b>57 Member States:</b></p> <p>26 African Member States and 31 European Member States</p> <p>Austria, Belgium, Benin, Bulgaria, Burkina Faso, Cameroon, Cabo Verde, Central African Republic, Chad, Congo, Côte d'Ivoire, Croatia, Cyprus, Czechia, Democratic Republic of the Congo, Denmark, Estonia, Finland, France, Gabon, Gambia, Germany, Ghana, Greece, Guinea-Bissau, Guinea, Equatorial Guinea, Hungary, Iceland, Ireland, Italy, Latvia, Liberia, Lithuania, Luxembourg, Mali, Malta, Morocco, Mauritania, Netherlands, Niger, Nigeria, Norway, Poland, Portugal, Romania, Sao Tome and Principe, Senegal, Sierra Leone, Slovakia, Slovenia, Spain, Sweden, Switzerland, Togo, Tunisia, United Kingdom</p>	<ul style="list-style-type: none"> <li>• Development benefits of migration and addressing root causes of irregular migration and forced displacement</li> <li>• Legal migration and mobility</li> <li>• Protection and asylum</li> <li>• Prevention of and fight against irregular migration, migrant smuggling and trafficking in human beings</li> <li>• Return, readmission and reintegration</li> </ul>

Source: IOM (2020)





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