The global migration & health ... - Soorej Jose Puthoopparambil

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Migration health, global health, public health, equity in health, intersectoral approach, multidisciplinary approach, health determinants, forced migration, labor migration, remittances, health status, communicable diseases, non-communicable diseases, occupational injuries, mental health.

SPEAKERS

Tanatswa Chineka, Speaker 2, Speaker 1, Soorej Jose Puthoopparambil, Wellington Mvundura, Jo Vearey

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S Soorej Jose Puthoopparambil 00:00

Yeah, but I very much like what Jo was introducing before about what is actually migration and what's actually health, or public health on that matter. And I'll try to discuss bit more. What I'll try to do is that sort of explain the concepts a bit more, because you all have from different backgrounds, as we heard during the introduction, and then also try to provide sort of an overview of the current state of evidence. Border, is there or not there, actually? So this, I think it's an obvious question, and usually I do this interactive way, but I try to keep it Not this time, because we have a discussion later on. Somehow, even if you just just give an example, if you just Google the word health, on your mobile phones or laptops. What do you often see is doctors and nurses or people in white clocks or hospitals? And for me, somebody who has been working global health, that's exactly the opposite of health. See who defines health as a complete state of well being, not just physical, mental, social, well being, but a lot of other factors as well. For me, working global health, health is even important, because it looks into equity in health. That is the difference in health between various groups, be it migrants versus horse population, be it male versus female and so on and so on. And this has to go across the board, not just within a country. If you see health from a larger perspective, any public health or global health system, the aim is to keep people healthy and to promote health. And think, what do you guys need to be healthy? Probably good house, good education, a good job and a good work, insurance. None of this is actually about health sector. It's actually everything outside the health sector, and that's actually where health is created. And I think that's a common issue when we work in global health or migration health, we always tend to focus on hospitals and the buildings and so on and so on and so on. But actually, therefore it has to be done somewhere outside the system, and that's with inter sectoral and the multidisciplinary approach comes into play. So for me, health is everything that where it is being created, which is often at the house, a workplace or the schools and other places. It's when those systems don't work you go and seek health care. So remember, the difference between health care services and health services. Health Service is not actually giving vaccine. Health Service actually giving the school meals. Could also be as a health service could be, depending on how

you define health now this, I guess most of you familiar with what it is. This is one of the I wouldn't call as a definition, because this is not necessarily officially endorsed, but this is one of the widely used descriptions of migration. This is the latest one I am so if you looked at the year before, say, from 2018 they had bit more elaborate with lot more sub clauses, because, as you guys know there is less agreement on what migration and migrants are. They went for a more, broader description. So pretty much anybody moving within our outside state, regardless of the time, regardless of the reason, and so on and so on. So just this is where my migration hell comes into play. I'm just gonna keep an eye on the time part. So the size wise, I guess this is all something quite familiar to you guys. So if you add both internal migrants, so the ones who are moving within a country, regardless of the reason, be it force or not force, and if you take the international migrants, the the ones who are moving across the national border, there are more than a billion migrants globally. And this is an underestimate, because, for example, the number I quote in then 763 internal migrants, that's from 2013 and nobody since then bothered to do another estimate. And as you know, internal migration is the largest countries with like South Africa, Russia, India, Brazil, and so on, China and so on and so on. So more than a billion, I would say it's unrest. It's probably more than a billion and a half or more than that. And among international migrants, the ones who are moving across the board, more than 60 personal labor migrants, the ones who are moving, moving for the reasons to work and money, and depending on the context, send it back home, remittances. So to say this, I would like to emphasize bit more, because there is a lot of discussion, and often it's politically charged. I don't know how often you guys are, how long you have been working on migration health. So if you take prior to 2016 2015 we often spoke out migrants as general, the number and so on. Since 2015 since 2016 we started talking refugees and migrants. And I don't know how far you discuss this topic, for me as a researcher, shouldn't be the case. It's sort of saying as roses and flowers, because both are flowers. But due to various reasons, hopefully we can get into that later on. There is a political movement to say, No, these are refugees and migrants, and that's why I want to show this figure. So this is the latest figures actually come from UNHCR on 12th or 20th of June. So this is the, I mean, the thing in the parenthesis, highest ever recorded number that I've been putting on since 2015 because it's just been going up and up and up. And so this is the number of forced migrants who are forced to leave from the place of their habitual residence, either within a country, then they become IDPs, internally displaced persons, sorry for the abbreviation, or across a country. So you become either a Fiji asylum seeker. And this is a new term UNHCR coined two years ago. So, for example, people in need of international production. So these are, for example, Venezuelans in Colombia. They are not necessarily sought protection because they are afraid they might get rejection. But UNHCR considers them as individuals who need protection but have not applied. So these are people in need of protection, but have no protection status yet. So if you take the first three figures, 31 8.4 and 5.9 these are the international I'm using the word migrants among the forced migrants, the ones who have been forced to move across the country. And that's only 15 percentage of the total international migrants. And I'll come back to why I'm showing that number. So just keep that in mind, among the totally forcibly displaced population, only 15 percentage are across their own country of residence, or country hubs of residence. So at least now we know what is sort of the definition of health migration, and the size the normal migration, and then the forced migration part. So ideally, the evidence, the research we do, should be reflective of that population, right? One more thing else, forgot to mention that most of the migration actually happens within the region. So within the region. So within Africa, most of migrants are actually within the region. Be it force, be it for labor reasons, it's within the region. Same in Europe, same in Southeast Asia and so on and so on. And when it comes to forced migrants, I think now it's like 73 or 74 percentage are hosted within low and middle income countries, not in us, not in Europe, Northern Australia and so on, and now probably this makes more sense. This is a map done in 2016 by colleagues from various places, but also led by IAM. This is a

bibliometric analysis. What this does is that it looks into where evidence on migration is being produced. So the purple, blue, the red and so on. These are the countries with the highest proportion of literacy is produced. So remember what I said before? Most of the migrants migrated within the region, when it comes to forced migrants, they are in low and middle income countries. None of the colored countries are actually LMICs, low and middle income countries. And then it also means that who produces the evidence, who gets the voice and who it is being said linked to what Jo was saying before? Quite a lot of might be actually on refugees who actually arrive in these countries, or labor markets in these countries, whereas you still have a lot of labor markets in South Africa and other parts of Africa and so on. But this is the evidence what we're working on. So also keep in mind when we talk about evidence informed policies, this is the evidence that has informed the policy. And then you can imagine how skewed the policies might be. Another way of looking at it. This is a pie chart from a recent who report we produced in 2022 this was the first ever who Global Report. We led it from Uppsala. So what we did that, we did a large literature review, and we looked into which populations were covered in this literature, this globally. So as you can see, that refugees actually cover 31% of the global literature on migration health, and these only international migrants. Remember, as I said before, around 11% or so, only among the force migrants. Only 11% are international migrants as refugees, 11% of the population group, 31% of the literature. And then I said more than 60% labor migrants, international migrants, are labor migrants, and that's covered around 17 percentage.

S Soorej Jose Puthoopparambil 09:29

Who gets to speak, who gets chosen to be research upon, and what is evidence we get? And then, are we using the research from refugees who are forced migrants for various reasons to generalize and make policies on labor migrants or vice versa. How do we work? How is how are textbooks formed? How are policies from just so just keep in mind the layout of the literature. And this is a quote from the WHO report more than half of the literature actually focused on health, state. Status, and more often, on how sick or not sick you are. And imagine, as I said before, where is health created? Is it the hospital? Probably not. But the literature is still talking about the health status of, are you malnourished? Are you standard? Do you have HIV? Do you have TB, and so on, not necessarily understanding why and how it is being caused, rather than the outcome. What is your health status, and that's what the Treasury is showing about. And then in that around a quarter actually looking just on communicable diseases, and this is something we see across the globe. The reason being simple, because I cannot infect you with my PTSD or with my depression, but I can infect you with my TB also. Then imagine where is the funding going? Who decides what gets to be funded? You know, I'm sure you have heard from Trump, a lot of others. You know, these people are coming with diseases. So then let's do for communicable diseases. And actually, in many countries and few countries in Europe, actually, people are being detained for TB screening. They get screened for TB and ensure that you're not there, then only you're even allowed to apply for asylum, for example, in Malta. So lot of research being done on communicable diseases, and few on mental health, even much less on NCDs, non communicable diseases. As you know, the health systems and health status across the globe is improving, and actually we were in global health and public health we call as the disease transition. People are moving away from having a higher burden of communicable diseases to a higher burden of NCDs because living standards increase. But that is known as living focus. For example, in Europe, traditionally, we always looked into communicable diseases, HIV, TB and so on and so on. But for example, within the Syrian crisis, we see that there's actually much more prudence of non communicable diseases. Because Syria was a well functioning country until the war broke out. They had a much advanced health

system. They actually are more issues of high blood pressure, NCS and so on and so on, which is not reflected in the literature. So now we know the concepts and the lay of the land in terms of where and how research is being produced. Now, just to give some stats and numbers on health status, this is a box plot. This is bit old, from 2018 the categories you see on your which studies now left hand side, this is known as ICD 10 international class for diseases. So basically, how we classify diseases in different ways? And what this does is that it compares the health status of international migrants versus the health of the host population. Any dots you see onto your left hand side means that migrants have a mortar advantage, or in simple sense, they have a lesser risk of dying. Any dots you see onto your right hand side, it shows that migrants have a higher risk for dying for those particular disease categories. So left hand side, less risk of dying for migrants, higher risk for dying. So if you look the graph bit more closely, you can see that for most of the disease categories, you actually have a more tart advantage for migrants, international migrants. In this case, what they say is that migrants are healthy or healthier, not healthy, healthier, I would say, which, to me, is not a surprise. So I don't know how many of you guys have tried to maybe apply for a visa or a pyramid to Canada or UK or Australia. I'm sure you always had to answer questions on health in some cases, even have to do a health checkup and submit it. So this is not rocket science. They pick the healthy ones, so then they're healthier. But again, understand the difference between what is being discussed in terms of data, I said these are international migrants. What I didn't say was that most of the international migrants in this was labor migrants, not refugees or asylum seekers. So if you add them to this box plot, I would say it will look more or less the same, but the dots will be bit more closer to the dotted line, because they would probably have bit more health challenge because of the reasons why they had to migrate. But still, traditionally, they'll be more healthier because it's young and the healthy who can move. Migration is an easy thing. It costs, costs in terms of money, but also health wise. So the ones who are weaker, elderly or other kind of people with vulnerabilities, they often don't migrate. Still, it's the healthier one who gets to move, who can afford to move. So this is sort of also known as healthy migraine effect, which, in the due course, change to unhealthy migraine effect due to living conditions, which I get back later. So just want you to keep in mind, migrants tend to be healthier when they move, when at least when they move. This is a map of the WHO European region. I did not have an equivalent of that for the global region. This is something we produced in 2018 when I was at who the trends and patterns are not different. There are various colors. So if you look at the I don't know how. What do you see? Like peach, pink watercolor, that is, it shows that around 58 to 85 or 90 percentage of all newly diagnosed cases of HIV are amongst peoples of migrant origin in the WH European region, the ones with yellow, that's Central Europe, and they have less proportion, maybe around 10 to 20 and so on. You see the numbers over here, and this is confirmed by the number from ECDC, European Center for decision control. It says in I guess you know, eu is not same as Europe and bigger one, right? EU is a smaller it's only 27 member states. Europe is much bigger, with Russia and other parts of the world. So within EU around 50% of the newly diagnosed case are among migrants, which, well, in a sense, make sense of what you know. Some political leaders say, you know they bring disease. You know they bring HIV. But what this figure doesn't say something known as the post migration acquisition of HIV, meaning you got HIV after you migrated. This is not a big data set, as I showed in the bigger one, but it gives indication. So what this chart on your left hand side shows is that migrants from Europe within Europe, migrants from SSA, Sub Saharan Africa to Europe, migrants from Latin American, Caribbean to Europe and so on. That many percentage of them, they got HIV after coming to Europe. In Latin America, Caribbean and SSA, HIV is a challenge. It's highly prevalent. And these are the healthy individuals who managed not to have HIV come to Europe, then get HIV from there. And we could actually look back, because we had the data on when they came back, when they arrived in Europe, we could actually do a simulation based on CD for cell count and so on. So they actually got infected after coming it's

not that they got tested after coming to Europe, but they actually got infected. And this is the and this you wouldn't necessarily see, I'm trying to go back, yeah, you wouldn't necessarily see over here. Just see how 50% of migrants actually have HIV, but not necessarily where they got it. And this is where a lot of the policies we need to discuss come in. Why do they get that? Is it because they have less access to healthcare? Are they in an exploited context? Because, you know, if you are an irregular status, underground status, men and women can be exploited. Are they abused along their route? Or is it because in the language barrier, where they know what their rights are, where they can seek health care, where they can ask, Where can I get condom and other kind of things? So this a missed opportunity in the host country's health system. I'm not sure what the slides are actually doing. Okay, yeah, so this is communicable disease that was HIV. This is TB. Shows along the same picture, the dark blue colors are the countries where migrants have a higher proportion among TB cases, and the other shades a bit lesser. This, again, is sort of simple mathematics. If you go to a country where there is low prevalence of TB, let's say it's a country with five people having TB, and there comes 100 migrants. Of them have two have TB. So of the five, two are migrants, all of 50 percentage. If you go to a country where there 10 individuals with TB and the same group of migrants goes there, then it's two out of 10. That's 20 percentage. So what this says is more about the host country's health system. That's why, for example, Russia up there is light and green, because Russia and parts of Central Europe, this is part of the world where TB is actually on rise, similar to South Africa. So South Africa is a country where TB is a challenge, but if you look at the difference between migrants, they work in the mining industry and rest of South Africa, you can see three to four to five times higher prevalence of TB among migrant workers in the mining industry who are migrants, basically within public health and epidemiology, we also Call TB as a disease of poor man, poor man's disease. It's the living conditions that make them more susceptible and more risk of getting TB. This sort of pattern you can observe for many of the communicable diseases, non communicable diseases, meaning the disease you can honestly transmit.

S Soorej Jose Puthoopparambil 19:19

If I'm going to put all those in nutshell, On arrival, they seem to be healthy. The longer you stay, you become less healthy. You get sort of diabetes, high blood pressure and those kind of diseases, NCDs, that's the pattern we see. But there are also some genetic makeup that makes things bit different. For example, individuals from Southeast Asia tend to have a higher risk of having diabetes compared to Europeans and other parts of the world. For example, females from north part of Africa tend to have higher risk of overweight. And these are studies, what we have shown. So there is gender difference, there is regional difference, and so on. But the bigger thing, what we need to look into is also the occupational. Injuries, because injuries and non communicable diseases, and there have been recent systematic studies showing that being an international migrant, international labor migrant, increases the risk of having occupational injury by 50 percentage. So being a national migrant, every day morning, you get up and get out as a 50, 50% chance, I may or may not get injured compared to a non international migrant. It's because they work in so called 3d jobs, not the three dimensional but dirty, demeaning and dangerous construction, driving, mining, House made and so on. It's that makes the higher risk of occupation injury, not any other genetical makeup, so to say, mental health. I have a colleague still at IOM. He used to say that many times the mental health challenges the migrants face, these are normal reactions to abnormal situations. So the challenges they face, the depression, anxiety and so on, it's not, I mean, it's not abnormal, because that's the challenges they face through. And as we all know, it's the living conditions that's what makes us at all on the mental health but for refugees, asylum seekers and others who might have experienced violence and torture, those kind of events, they have a higher risk

of developing depression, PTSD and all those kind of things because of the experience they went through. Other than that, migrants generally don't necessarily have a higher bad mental health considering situation they are in. But of course, if you compare a migrant with a host population who have insurance and everything, of course, the higher risk of mental health issues, be it depression, be it anxiety, but it's the living conditions that matter. I'm going to soon finish with two or three more slides. I want you guys to keep in mind two things, the difference between migrant health and migration health sounds, display of words, but it's much bigger than that. Migrant health. It's actually the health of the migrant, the individual who have migrated, whereas migration health is how the process of migration impacts the health of migrants, the people they interact, say, the whole society, and also the people they are left behind, say a lot of labor migrants who migrate and send money back home or friends and families there. So what we deal often deal with something or migration health, not necessarily migrant health, because if you're looking at migrant health, you're not understanding the context. Let's say a labor migrant who comes to our say, in Malaysia or in Dubai, for that matter, and you do everything for migrant health. But the reason why he's cutting shot on his food or have a poor living conditions because he want to save money and send back home is to family and kids. We have to understand that context. Doesn't matter how much you're going to do for that individual. So the focus has to migration health, rather than migrant health. I'll show a few examples. So how does migrant health impact host population? So this is a chart showing the proportion of migrants in so called Essential workforce. This from Europe. Essential workforce means teachers, nurses, firefighters and those kind of things. So as you can see, in countries like Ireland or Sweden, around 1/4 of the essential workforce are migrants. So them being there, it keeps them healthy, but also it keeps the host population healthy. Imagine like in the UK or in Ireland, where it's like anybody with a migrant origin in the NHS or health service, no, we are not going to work, or everybody's going to be deported. A quarter of the workforce is gone. So this one example how they impact the host population's health. This shows how they impact health of the people left behind or in the home country. Remittance is the process of sending money, basically international labor migrants sending money back home. So this is a chart from the World Bank. What it shows is that the red line that's remittance has been increasing from 2000 under 2025, it's around 650, 6 billion US dollars. You compare that to FDI. FDI is the orange dotted line. That's foreign direct investment. So like say, I don't know, UK comes to South Africa. Invest money in XY said, or, I'm sure you're familiar, China coming investing something that's foreign direct investment. In that sense, Oda, overseas development assistance, aid money, that's the aid money given to various countries. So if you look at, if you take any country, this is general estimation, the remittance is 40% higher than the direct money given by the foreign government 60 times higher than the aid given. So imagine if anybody actually wants to help another country. It's enough to allow people to come legally and work and send money. If I as a father want to send back $10 to my wife and kids back in country X, probably the wife is going to get $9 off my two. Dollar because I need to pay fees and everything. If I'm going to give that $10 by eight, imagine the bureaucracy goes through, and the mother and the child might get $1 or 50 cents. It's actually more effective. They come here, they actually contribute to the economy. I saw showed you the graph before they work in essential workforce, and so on and so on. So it's actually a way to work on and it actually helps the home country, because many countries around 41 to 30% of the GDP is just based on remittance. In Nepal, for example, I think it's around 24 35% of GDP is actually just remittance. And it's the GDP is the total amount of money the country has to build roads, schools, hospital and so on. So this is how migrants also impact the health of the people back home, so it's migration health, not migrant health. I'm just going to finish here, just showing what is determinant of health. Determinants of Health is basically the conditions you leave, age and work. And when we did the WHO report, we create a diagram like this. What shows is that you have the various phases. The green one you start there before you migrate,

the transit phase, it depending on what kind of migrant you are and your route, your arrival and maybe the return. In all these phases, you need to look at the age, the sex of the individual migrant. How that impact health. In some context, female migrants are much preferred as nurses housemate. In some context, male migrants are preferred as drivers, as construction workers. Then in other contexts, being a female migrant, you're much at risk being exploited. There are a lot of stories being people from Southeast Asia, women being abused in Saudi in Israel and so on and so on in other places or the other way around, individual life, size factors, society commit, networks, living, working conditions. Do migrant workers get insurance? Is it a language they can understand? Do the same level of protection? Recently, there was this big battery company in Sweden called North world. It's supposed to resolve all battery cuts across the world. It went bankrupt within one year of establishment, the people who are impacted most were migrant workers. They came to work in northold. Once they lost the job, they had three months to find a new job or leave the country. So how are systems being created on that part? So it's that's what I said. Health is actually created outside the health care system. And this is sort of, at least to me, driving the point home. I finish here. I'm sure I went beyond my 2025 minutes, but I stop here. Thank you.

Jo Vearey 27:39

I think what we should do is in shifting the program a little bit is, I think let's take questions, comments, thoughts, points of clarification for Suresh, then we'll have a break and come back afterwards. Yeah, so over to the floor. I've got the Zoom open here for anyone online? Are we able to show the just the Zoom screen with online, the people who are online?

Jo Vearey 28:18

Do we stop sharing from this one?

S

Soorej Jose Puthoopparambil 28:21

I think it's already stopped. Okay,

Jo Vearey 28:28

great, yeah, on my screen, I can see, like everybody, I think

28:36

that's fine.

Jo Vearey 28:38

Okay. Would anybody like to kick us off with any thoughts, reflections, questions and online colleagues, please feel free to pop questions in the chat box if that's easier.

S Speaker 1 28:55

Good afternoon colleagues season to here. Mine is just a comment, really, I don't know if you can hear me.

S Soorej Jose Puthoopparambil 29:02

Yes, we can hear you loud and clear.

S Speaker 1 29:06

Yes. Thank you so much for the very informative presentation. And when I saw the sort of the stats as to where the migration research is produced, sort of like confirmed what I've always suspected in terms of how the migration policies are being politicized. And today, when you showed that research, you know the research, most of the research is coming from the north, but most migrants and immigrants and asylum seekers are coming from the Global South. And I think that was just a mind opening for me. Thank you.

S Soorej Jose Puthoopparambil 29:47

Thank you. Just to clarify asylum seeker and refugees, they come, but also they stay, also many parts in global south. So yeah,

29:59

thank you so much. For

T Tanatswa Chineka 30:07

that. Thank you very much for that well rounded presentation. I have a sense which I wanted your input on, that the real framing of migration policy, migration discourse, especially at a political level, is around not shifting power across states and nations. Because, if it makes sense, that the way to if you look at the Global Compact, let migration be orderly. Let it be safe. Let it be regulated. Also looking at the the evidence from the remittances, allowing people to move in a regulated and orderly and safe manner helps both the host countries as well as largely the community. Communities where they've come from. But that argument and evidence, for me, is not taken on board by the global power drivers, because it shifts power and helps communities really develop, because the money actually gets to the communities in that way. And also the reason, if you look at forced migration, is there's a lot of almost even when you look at climate induced displacement, most of the forced discipline displacement based on conflict around the world, there's also that instigation and input and interference by the same powers that refuse these people to move whom they have disturbed. So does that assessment

capture the real organization around why migration discourse and policy is structured the way it is that because if this evidence is used appropriately and correctly, it shifts power and responsibility in ways that disturbs those that hold the power that has to be shifted in That way,

S Soorej Jose Puthoopparambil 32:19

it's a good question and a complicated question. Just to give the answer to I don't know how much of the power play will be in there, but of course, there is lot of self interest to be observed there. But I don't know if it's power or not. These days, actually, countries, regardless of where you are from, they would like to use the benefit. If I have a need for healthcare workers, then I'm going to promote that. If I don't, I don't need to promote that part so I can pick and choose. But also the key part is that now, for example, the Swedish government, like in many parts of Europe, the narrative is changing. So previously, within the aid budget, they had around, I don't know, 100 million, 100 million, 100 and 50 million Swedish kronor for three years to work on migration. Last year on race, they have a billion Swedish kroner to spend in three years time on migration. But two, this is what, how it is, sort of address the root cause of migration in major countries of origin. So basically, try to stop migration. So there they're okay to invest the money in that. I think in term comes to migration, it's less of money, it's more of the narrative part. You know, I don't think any of the Europeans or anybody for them will actually care. I mean, mind actually people who are educated, people coming there to work in old age homes and drivers and all those kind of things. But it's the the sort of the mistrust and the narrative within the context that actually makes a difference. I can give an example. I have worked, and I still work a lot with immigration detention, where people are being locked up before being deported, and that's a very costly endeavor. In Swedish context, it would take, say, around 600 euros per day per person to detain a person, and now we are reaching around 1000 places altogether, right? And I can show through my evidence that a lot of places where actually I saw that we can actually achieve the aim of reporting a person without detaining but that doesn't fly there, because the aim is not saving money. The aim is actually politics and symbol, sort of showing that, you know, this is how we treat people are not belong to so their money is not a part in other contexts, money make makes sense. You know, I know, for example, Norway has an agreement with one particular state in Kerala, Finland had an agreement with Ethiopia, where they actually pay the tuition fees for nursing students in a particular school. For all of them, the agreement is that half of them, I don't exact number would actually then end up working in Finland or in Norway for that part. So this also they try to address the brain drain. I don't know how much of addressing is that, but one point you mentioned is also interesting. I think we as researchers, we as practitioners, we also need to take the responsibility to see data. Is not evidence, and evidence is not information. A glass is half empty, is half full, both. Both are honest facts in that right? But what is it you want to hear see if I'm going to work on, say, human rights and if I want to work with the government, while it is true that that glass is half empty, maybe that's not where I'm going to start, I will say that the glass is awful. See, you already done this kind of thing. You already signed it's good. So how can you make it better? But if you want to work with UN agents and others, you might see so we also need to know that it's not enough to produce good evidence or good data. You need to know how to present and that's one thing we as the core try to do it like training and workshops and so on. How to help you guys to work with it. And this is something I do with who a lot of governments on regular basis, I can give another example. When immigrants are being put in detention, they do not go any health screening in Sweden, and I ask the question, why are we not doing it? It costs money. Of course, it costs money. But imagine if some of them actually have TB, and then you're putting your employees at higher risk. The labor law in Sweden is quite high. That rang a bell. It's the same thing. It's not, I'm not saying anything different, but it's about we need to

know who our audience and how we present. For some, it's the systematic review, the meta analysis, the big article that makes sense for some, it's the 10, top 10 Tips for policy makers. For some, it's a training workshop. So yes, power is involved. There is self interest. I think we all as human beings, we have and I'm sure you see that color in South Africa, with migrants from other parts of Africa. And one more thing to remember, most often, when we talk about migration, we are actually talking about immigration, because that's where the evidence is. We don't talk much about immigration, as with an E, people moving out. If the global south there's more research, I'm sure that'll be more of the research will be on immigration, because that's where people move out. Again, another bias in evidence. I don't know if answered question, but you know around that, yes, please, couldn't I if that's right?

S Speaker 2 37:00

Yeah. Yeah. Okay. So mine is just a comment on what you have presented your presentation. Jo, it was just eye opening. I just want to form in on what you said about like when you migrate, your your healthy deteriorates your health. You're healthy. It deteriorates like when you're migrating, you're looking for greener pastures. You're looking for employment. You want to improve your healthy you're going to improve yourself. But like, when you say about, like when you migrate, actually, your health can actually deteriorate, like your health is compromised and stuff like that because of different issues. It links to my PhD I did up about female migrants in precarious occupations, like there's a lot of pressure and stuff like that. The work is unpredictable. It contributes their mental health and stuff like that. So their health is like, it deteriorates, rather than like. You improve your healthy you improve your well being and stuff like that. Yeah, it was just eye opening, right?

S Soorej Jose Puthoopparambil 37:56

Just to add it can, it doesn't have to deteriorate again, it's the living conditions that matter, right? So I mean, if you migrate, and then if you're in a well to do situation, you do exercise regulator, you get good food, and then it's fine. But I'm sure, I don't know how excited I was in South Africa, but usually it's cheaper to buy junk food than good and healthy food. So if it's a migrant who want to save money to send home water, of course, he might eat more of junk food because he want to send want to send money back home. But also the conditions you mentioned, the precarious situation. So, you know, like, if you're a legal migrant, then many countries you have health insurance, meaning, even if you're sick, you get still the payment. You can still pay money, or you don't. It's okay to seek healthcare in other places, if you're sick, you're sick, you don't get the payment, then you don't get to seek health care. It's those conditions that make you more unhealthy. So it doesn't have to be that you will be, but the conditions that can make you more less healthier.

S Soorej Jose Puthoopparambil 38:58

I can't see your name, sorry.

 Wellington Mvundura 39:01

Okay. Thank you very much for the insightful presentation and your presentation of statistical

Okay. Thank you very much for the insightful presentation and your presentation of statistical evidence relating migrant health, or migration and health. So mine is, is just a reflection and maybe somehow related to what tanatswa And the earlier respondent have said. We ask you, as senior researchers of migration and health and other budding researchers, I think there's also need to take a critical perspective where we think beyond the statistics, because first, the statistics can be part of a global agenda, in terms of bio politics, power dynamics, controlling nations who has the power, where should? Certain bodies be in terms of migration and what is their health at a particular time that could be used to push certain agendas. Secondly, given the evidence, it might be credible if the evidence like the one you presented, but who has control the outlet, control over that evidence behind the laptop, who makes the final decisions relating to that critical data collected within communities in certain fields so they they could be a certain war. Which is a mainly epistemological right, which is the who is the where is the biography of knowledge? Who is producing that knowledge, on migration and health right, and why is that knowledge being produced? So it's just food for thought. For instance, we have the idea of Fortress Europe, where it is easier for those from the global north to migrate to the south, and the nomenclature used, for instance, could say these are expertise, but when you migrate to the Fortress Europe, where it is increasingly difficult for those from the global south to migrate, you could be called something else, maybe migrant workers. So that dynamic, it's also very important for us, from a critical perspective, to think through as we go through this, this workshop. Thank you.

S Soorej Jose Puthoopparambil 41:38

I fully agree that is something I work quite heavily with lot of countries, and I do actually training, actually, on how to collect, what to collect data. And this is not the research data, but rather routine data. Yes, you're right. There is also this still the notion of global not deciding, but when it comes to the stats, I'm not sure if that is always the case. So I've been in several meetings where, actually, I don't like to use the term global north and south, but for the purpose of this, let me use that those terms, there are actually countries from the Global South. Saying, No, we don't want to use it. And they're also actually countries from the Global South. You are actually championing. For example, I didn't even get into like, who is actually a migrant. How you define them, right? Is it your country of birth? What if I moved to Country X when I was one year old? Is it still my country of birth that is relevant, or is it my country of birth of my parents? Then you come to Oh, then you are second generation migrant. But no, because I did not migrate the How am I a second generation migrant? If you want to extrapolate it, like my kids, they look like me because they are Indian, because I'm married to an Indian woman, and they are small. They're like, six and four. I'm sure they're going to be 13, and they're like, where do you come from? I'm from Uppsala, but where do you really come from? That's a simple question, right? But that could actually long going consequence for the child, because for her, Sweden is a country. But why am I being asked that question? It can lead to an identity crisis. But then, is that person a migrant or not? Or for epidemiology purpose, like the one I showed at HIV, we could the researchers could make that assessment, because they are the date on country of date of arrival. I could count back. And then this is not just a matter of so called rich countries and doing something. It's also a lot of politics in that. When we published the first who region report, I wrote one line there, saying that in the European region, we have internally displaced persons. I'm not going to say the country name, because we are quoting it in countries x and y, but this report will not discuss those population. We will only discuss international migrants. That's only one line I wrote we published the day after this country callback say, No, we don't have any internally displaced persons. Of course, you do. There is data from the UN agency showing that, no, we don't. And lot of these UN

agencies, we think they are technical agencies, yes, but they are more of a political agencies as well. We are forced to take the report back, remove that one line, upload it back. And these are not necessarily countries from the global north, so to say. And there another example we when we develop policies on migration health, for example, when we write the terms sexual and repertory health certain countries from the so called Global South. No, we don't want that in there. So while there is still the former colonial sort of power structure still influencing us, it's not all that like you see how what's happening in South Africa with migrants from Malawi, Mozambique and so on and so on. It's nothing to do with Global South. It's basically a difference in power, and that acts as a global level, regional level, national level, municipal level, in the village level. So I think power, yes, but not necessarily always. Who does. And what decides nowadays, global powers interest investing global south so that people don't migrate. The reason is different. They're happy to invest. But the migration strategy is not as simple as

Jo Vearey 45:17

that it is. There were a couple of comments online that weren't showing here, but I just want to share them, because we're going to be coming back to them throughout the next few days. So huge thanks to edge and I think, some really important questions from the room, which we're going to continue returning to, particularly around issues of like knowledge production, knowledge politics, those sorts of things. Shabby shared a few days back, there was syringe attack panic in France, which disproportionately fueled suspicion towards migrant communities. We often see governments responding with heightened surveillance, border testing and biometric health data collection. How can states ensure that their response to such incidents prioritize public safety without reinforcing xenophobia or compromising the dignity, privacy and rights of migrants. What role should media and public health institutions play in managing narratives to prevent moral panic? You know, I think this is something again we're going to keep returning to, and particularly the session on Thursday, where we're going to be focusing specifically on issues around communicating and narratives and stigma, and we have colleagues from IOM, the International Organization for Migration, running a session in the morning that really is going to help us sort of try and unpack some of these issues, particularly when we're thinking about The media, and the role of different forms of research in the media, and how we need to be be better literate in how to sort of try and navigate that media space. And Sizwe also shared, you know, correctly, that Zama zamas are a prime example of migrants working in dangerous environments. And my question, you know, back is around, what's driving that right? So like thinking about structural factors, as much as direct danger to yourself through injury, not everyone's going to know what Zama zamas are. Does somebody in the room want to explain or seize where can we hear you online and you can just share with us who Zama zamas are? For those who might not be familiar,

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Speaker 1 47:21

okay, thank you so much. Prof Zama. Zama essentially migrant mine workers that are working in the illegal mining sector in South Africa. So me and my friends were discussing this, and she's an occupational therapist, and she was asking me a question about whether occupation is a choice, you know, so the issue of Zama zamas came through to me to say, Do I think that Zama zamas have a choice of going to those dangerous mines and, you know, in those holes to try and make a living? And why is it that it's only migrants who are found to be working in these conditions. So I thought that was interesting for me. Great.

S Soorej Jose Puthoopparambil 48:07

2.1 is actually on the narrative part. I think it's very important we have to be clear on what we present and how we say, again, importance of terminologies. You know, refugees, asylum seekers, labor migrants, irregular migrants, stateless and so on. And so they're not all the same. It's a legal system. So we need to be clear what we talk about which it's one of the ways how can be clear about what is being said in media. But we cannot control all of it. You know, I often have the stupid example of an ax. It doesn't it can be used to chop down a tree or injure a person. The ax doesn't do anything by itself. Let's say we say that the HIV thing 50% of migrants actually among the newly developed HIV. That's a fact. I can say that the prevalence of HIV in these countries increased by 50% by migrants, which is also true. Or say that half of the runs is amongst migrants without saying so, it's about how we present and what we again understand, the difference between data results in your paper and how it is being presented. The other thing also discussion on the because you said the case of sama Sama, we often have this because I think our brains are less developed. We have this dichotomy force and non forced migration. My thesis is that us, all human beings, are kind of lazy. If we get everything, what we need, where we are, we are not going to move. So the ones who are forced to move to work in illegal minds, or the ones who are forced to move to Middle East or to UK to work as a nurse, I'm sure they don't want to, like, say, from India, the part I come from, it's 30 degrees throughout the year. It's Always Sunny. We get tropical fruits. Why should I go to UK when it is cold and rainy and it's 17 and 15 and then still have to work with all those things, leaving my family behind, my parents and others? No, because I want to have a better life. Is that forced? Migration in the literal sense, probably not, but in the philosophy sense, yes, because I was forced to migrate because I couldn't get the income I need to leave with the conditions I have. So also see the larger spectrum, rather than as a box, as a block line, force and unforced, because I often say that I think any form of movement is a force. And then the question is, how pronounced, how strong the force was. Did it cause injury and health? Then it's definitely really forced. The other one is like, have a better life. Thank you. Jo Sure.