Migrant health: a global responsibility

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December 18 marks the 22nd International Migrants Day and more people than ever are living in a country outside of their country of birth. According to The International Organisation for Migration (IOM) 2022 report, close to 4% of the world's population in 2020 were migrants, three times the estimated number in 1970. Although moving out of necessity or for opportunity has been a longstanding practice, health and general wellbeing are topics frequently overlooked among other geopolitical migration issues. However, with controversy over deaths of migrant workers in Qatar since it won the right to stage the World Cup, questions over migrant rights and access to health care have once again been raised.

Migrants are often described as facing a triple burden of infectious diseases, mental health issues, and non-communicable diseases (NCDs). Chronic cardiometabolic conditions make up a substantial portion of the NCD burden and one cause could be the large numbers of migrants coming from ethnic backgrounds associated with increased cardiovascular risk factors. In 2020, more than 40% of all international migrants were born in Asia, with India being the largest country of origin. A review of NCD burden among migrant groups in Europe, North America, and Australia found that type 2 diabetes was the only condition that is more common in nearly all migrant groups compared with the host populations. Although the right to health should apply to everyone regardless of immigration status, global NCD policies often neglect refugees and migrants. Primary care is the cornerstone for screening, identifying, and managing diabetes but migrant engagement and utilisation with these services is often poor. Barriers to accessing appropriate health care often include difficulties in navigating which medical subsidies and services are available to them, language difficulties, cultural differences, and despite legal rights, a lack of trust in authorities.

Research and statistics on migrant health is scarce and the term migrant remains largely undefined, covering a range of individuals regardless of length of stay, legal status, or cause for movement. Subsequently, their health needs are diverse and wide ranging. A qualitative study exploring migrant experiences of living with type 2 diabetes in Sydney, Australia, found that those who spoke Arabic reported a decline in their self-management due to difficulties in affording a healthy diet, feeling homesick, and the trauma of migration itself. In those who spoke Chinese, stress also impeded their ability to manage their condition and led to them not prioritising their health; however, their stress was largely caused by financial worries and losing their support network. This variation of cultural habits and attitudes towards health within migrant groups can be amplified when compared with those in host countries; therefore, it is essential that we fully understand migrant lived experiences if we are to optimise access to appropriate health resources.

Relocating to a different residence can often improve the socioeconomic status of migrants and their access to health-care; however, moving from an area of poor resources could also lead to a deterioration in their wellbeing. The healthy migrant effect suggests that migrants have a better health status than natives of the host country, which worsens with increased length of residency. One influential factor could be the major transitions in diet and lifestyle. Diets in many high-income countries, which can be low in fruits and vegetables and high in fat, sodium, and sugar, can lead to weight gain and serious health consequences. In the RODAM study, the prevalence of obesity among Ghanaian migrant men in Europe was up to three times higher than those living in Ghana, which correlated with a higher prevalence of type 2 diabetes in the migrant population. With national health-care systems pushed to their limits and expanding and ageing populations, an increasing burden of potentially avoidable obesity-related conditions will inevitably lead to difficulties in resource management and access to medications and health-care services.

Migration is a global reality and the consequences are multifaceted. In addition to the more commonly discussed problems of infectious diseases, poor mental health, and maternal and child health issues, the cardiometabolic health burden in this population is large and growing. Managing and preventing chronic conditions such as diabetes involves adequate screening and regular health-care visits that cannot be fulfilled if the barriers for migrant participation are not overcome and policies are not considerate of the individual migrant experience. The responsibility does not lie with one nation or government body and, as such, a collective global effort is needed to ensure the most vulnerable are not left behind.

■ *The Lancet Diabetes & Endocrinology*

For more on **International Migrants Day** see https://www.un.org/en/observances/migrants-day

For more on the **2022 World Migration Report** see https://publications.iom.int/books/world-migration-report-2022

For more on **migrant deaths in Qatar** see https://www.amnesty.org/en/latest/news/2022/11/qatar-ongoing-debate-over-migrant-worker-deaths-exposes-need-for-truth-and-compensation

For more on **non-communicable diseases in migrants** see *Travel Med* 2019; **26:** tay107

For more on **migrant experiences in Sydney** see *Public Health Res Pract* 2021; **31:** 3122109

For more on the **RODAM study** see *BMC Med* 2016; **14:** 166