World report on promoting the health of refugees and migrants

Monitoring progress on the WHO global action plan

World Health Organization

Advancing refugee and migrant health: from commitment to action

World Health Organization

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Contents

Foreword

Around the world, more than one billion people are on the move, seeking safety, opportunity and dignity. Refugees and migrants are not just recipients of health care: they are essential contributors to health systems and society as health care professionals, caregivers and community leaders. Supporting their health and inclusion strengthens health systems and benefits everyone.

Recognizing this, WHO has made migration and health a strategic priority. In 2019 Member States adopted the *Global action plan on promoting the health of refugees and migrants, 2019–2030* (GAP). This is the first comprehensive framework to address migration and health through coordinated, multisectoral action. The GAP emphasizes that the health of refugees and migrants is inseparable from that of host populations and that inclusion is central to building stronger and more equitable health systems.

Building on the foundation of the first *World report on the health of refugees and migrants*, this report tracks progress in translating the GAP vision into practice. Using data from the Global Survey on Health and Migration provided by participating Member States, it provides a baseline of achievements, persistent challenges and emerging opportunities.

Encouragingly, many countries have begun integrating refugee and migrant health into national strategies, establishing coordination mechanisms, and promoting equity and inclusion. Yet gaps remain, particularly in collecting and using migration-related health data, ensuring participation of refugees and migrants in decision-making, and guaranteeing access to care for all, regardless of legal status.

The evidence demonstrates a powerful truth: investing in refugee and migrant health is both ethically essential and strategically beneficial. Inclusive health systems are stronger, enhance social cohesion, foster economic productivity and improve preparedness for public health emergencies.

This report is both a milestone and a call to action. Sustained political commitment, robust evidence and meaningful engagement of refugees and migrants are essential to realizing the GAP's vision. The WHO Special Initiative on Health and Migration continues to play a significant role in advancing this agenda and working with countries to make inclusion a reality. I invite Member States, agencies, donors and civil society partners to act with vision and compassion to advance the health of people on the move and, through that shared commitment, build a healthier, fairer and more resilient world for all.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

Evidence must inspire action. This report brings together important input from Member States and partners, offering the first comprehensive overview of progress, challenges and opportunities in promoting the health of refugees and migrants. Drawing on data from the Global Survey on Health and Migration, it provides the strategic insights and evidence needed to move from advocacy to impact, helping to ensure that the health of refugees and migrants is integrated into public health planning and implementation at every level.

Dr Jeremy Farrar, Assistant Director-General for Health Promotion and Disease Prevention and Care, WHO

Migration and health are inseparable in advancing equity, resilience and sustainable development. As the world faces concurrent health and humanitarian crises, including refugees and migrants in preparedness and response is essential to protecting everyone's health. The evidence in this report points the way towards stronger and more inclusive health systems and greater readiness for future public health emergencies.

Dr Chikwe Ihekweazu, Executive Director, WHO Health Emergencies Programme

Climate change is transforming patterns of displacement and migration and amplifying risks to health and wellbeing. Displaced and migrant populations are often among those most affected, yet they often remain excluded from national health and climate strategies. Guided by the WHO *Global action plan on promoting the health of refugees and migrants*, this report calls for long-term transformation by building sustainable, migrant-inclusive and climate-resilient health systems to ensure that the right to health is realized for all.

Dr Rüdiger Krech, Director a.i., WHO Environment, Climate Change and Migration, Division of Health Promotion, Disease Prevention and Care

Preface

With four years remaining until the 2030 deadline for achieving the Sustainable Development Goals, this second World Report on Promoting the Health of Refugees and Migrants comes at a pivotal moment. Migration and displacement continue to shape our world – economically, socially, demographically and politically – with today an account of about 304 million international migrants and 120 million displaced people. The health and well-being of refugees and migrants remain unevenly addressed across countries and systems, despite mounting evidence that inclusive and equitable health responses are fundamental to achieving health for all.

This report builds on the foundation laid by the first 2022 *World report on the health of refugees and migrants*, which offered a comprehensive overview of migration health globally and highlighted the urgent need for stronger data systems and more coordinated action. It also marks a major milestone in the implementation of the WHO *Global action plan on promoting the health of refugees and migrants, 2019–2030* (GAP), providing the first in-depth analysis of global progress through the lens of the GAP Monitoring Framework.

Grounded in the results of the first global survey to track GAP implementation, the report draws on data and examples from countries across all WHO regions. It assesses the extent to which national health systems are responsive to the needs of refugees and migrants and provides evidence of where progress is being made and where major gaps persist. A key focus is the patchy global data landscape, which continues to hinder informed policy-making, strategic planning and monitoring of migration health outcomes. This report takes a critical step forward by mapping out the status of migration health data systems and calling for urgent investment in data infrastructure, capacity-building and coordination mechanisms to improve data disaggregation by migratory status.

Importantly, the report is forward-looking. It not only presents the current state of implementation but also identifies strategic priorities and actions to accelerate progress in the remaining years of the GAP. It highlights emerging opportunities, including the growing political momentum around universal health coverage, and outlines what is required to leverage these at the national, regional and global levels.

The value of this report lies not only in what it reveals but also in what it enables. Through detailed country-level insights, thematic analysis and clear guidance, it offers a roadmap for actors across sectors – governments, United Nations agencies, civil society, academia and migrant communities themselves – to work in coordinated ways to meet shared goals. The report also makes clear that promoting the health of refugees and migrants is not a parallel endeavour – rather, it is central to the pursuit of public health, equity and resilience.

The health of refugees and migrants is not a marginal concern: it is a defining issue of our time. As the global health and migration landscape grows increasingly complex, this report urges a collective recommitment to the principles of inclusion, solidarity and evidence-informed action. By acting now, countries can ensure that refugees and migrants are not left behind – and that health systems are stronger, fairer and more prepared for the future.

Dr Santino Severoni
Head of Special Initiative on Health and Migration
Division of Health Promotion, Disease Prevention and Care

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Leadership and coordination

This report was developed under the overall strategic lead and technical direction of Santino Severoni (Head, WHO Special Initiative on Health and Migration, Switzerland) in conceptualizing the report, in alignment with the priorities of the *WHO Global action plan on promoting the health of refugees and migrants, 2019–2030* and the WHO Fourteenth General Programme of Work, 2025–2028. Saverio Bellizzi (Technical Officer, WHO Special Initiative on Health and Migration, Switzerland) coordinated the development and production of the report, leading the analytical and drafting process and managing inputs from contributors across WHO headquarters, regional offices and external partners. He played a central role in drafting and translating the monitoring framework into the report's analytical structure. Soorej Puthoopparambil (Head of the WHO Collaborating Centre on Migration and Health Data and Evidence, Uppsala University, Sweden) provided methodological and technical advice throughout all stages of the report's development. Staff from the Centre also contributed to data validation, evidence synthesis and conceptual alignment between the report's analytical framework and global monitoring efforts. Eva Brocard Paine and Khawla Nasser AlDeen (Technical Officers, WHO Special Initiative on Health and Migration, Switzerland) provided support to report coordination and technical and analytical contribution on data interpretation, infographics and design of the report. Elisa Mosler Vidal and Nurtaç Kavukcu (Consultants, WHO Special Initiative on Health and Migration, Switzerland) provided methodological and technical guidance on the overall content of the report.

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Santino Severoni, Saverio Bellizzi, Soorej Puthoopparambil, Eva Brocard Paine, Elisa Mosler Vidal, Khawla Nasser AlDeen and Nurtaç Kavukcu reviewed evidence and drafted the sections of the report. Gary Humphreys (Writer, Switzerland) made significant contributions to the technical writing and drafting of chapters.

WHO contributors and reviewers

WHO gratefully acknowledges contributions from colleagues from all departments within WHO headquarters and WHO regional and country offices who provided technical input, data and guidance throughout the development of the report.

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The following staff of the WHO Special Initiative on Health and Migration reviewed the report, checking data and evidence and/or providing technical support: Candelaria Araoz, Mohammad Darwish, Cetin Dikmen, Sylvia Garry, Claudia Marotta, Daniel Míč and Miriam Orcutt. Hong Chu Ann from WHO Health Data Strengthening and Olivier Le Polain from the WHO Emergency Programme also contributed throughout the development of the report with input to multiple review stages.

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Abbreviations

COVID-19	coronavirus disease
EU	European Union
GAP	Global action plan on promoting the health of refugees and migrants, 2019–2030
GCM	Global Compact for Safe, Orderly and Regular Migration
GCR	Global Compact on Refugees
GMF	GAP Monitoring Framework
IDP	internally displaced person
IOM	International Organization for Migration
LFPR	labour force participation rate
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, intersex, asexual and other
NGO	nongovernmental organization
PAHO	Pan American Health Organization
SDG	Sustainable Development Goal
TB	tuberculosis
UHC	universal health coverage
UNHCR	United Nations High Commissioner for Refugees
WASH	water, sanitation and hygiene

Glossary

Asylum seeker. An individual who seeks international protection. In countries where asylum cases are judged on a case-by-case basis using specific eligibility criteria, asylum seekers are people whose claim has not been finally decided on by the country in which they have submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker *(1)*.

Internally displaced people. Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border *(2)*.

International migrant. Any person who changes his or her country of usual residence *(3)*. Unless otherwise identified, the migrants discussed in this report are international migrants.

International migrant worker. This report uses the International Labour Organization's definition of "all international migrants who are currently employed or unemployed and seeking employment in their present country of residence" *(4)*.

Internal migrant. Any person who is moving or has moved within a State for the purpose of establishing a new temporary or permanent residence or because of displacement *(5)*.

Migrant. A person who moves from one place to another, whether across or within international boundaries. Despite the absence of a universally accepted definition of "migrant", this definition is widely used *(5)*.

Migrant in an irregular situation (also irregular migrant, undocumented migrant). A person who moves or has moved across an international border and is not authorized to enter or stay in a State pursuant to the law of that State and to international agreements to which that State is a party *(5)*.

Refugee. Any person who meets the eligibility criteria under an applicable definition of refugee, as provided for in international or regional refugee instruments, under the mandate of the Office of the United Nations High Commissioner for Refugees (UNHCR), or in national legislation. Under international law and the UNHCR's mandate, refugees are people outside their country of origin who need international protection because they fear persecution or a serious threat to their life, physical integrity or freedom in their country of origin as a result of persecution, armed conflict, violence or serious public disorder *(1,6)*.

Stateless person. The United Nations Convention Relating to the Status of Stateless People defines stateless people as people who are not considered to be nationals by any State under the operation of its law *(7)*. Most live in their own country and may have never crossed an international border *(5,8)*. However, many are migrants or refugees or have a history of migration and forced displacement *(8)*. Statelessness can both cause and be caused by migration. Moreover, displaced people are at a higher risk of becoming stateless due to increased difficulties in proving their nationality, including as a result of conflicting nationality laws, the loss or destruction of important documents, and lack of access to civil documentation or registration in their country of refuge *(8)*.

For full sets of definitions related to refugees and migrants, see the UNHCR master glossary of terms *(1)* and the International Organization for Migration glossary on migration *(5)*.

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A refugee from Ukraine showcases artwork created during therapeutic art classes in Hungary, 2024
© WHO/Laszlo Vegh

1. Introduction

Population mobility has been a defining feature of humanity's shared history, driving social, political and economic development and shaping cultures worldwide. In the 21st century, migration and displacement continue, presenting public health challenges and opportunities both for people on the move and for those living in their countries of origin, transit and destination.

According to the United Nations Department of Economic and Social Affairs International Migrant Stock 2024 dataset *(1)*, the number of international migrants worldwide reached 304 million in 2024, a figure that has nearly doubled since 1990, when there were an estimated 154 million. If internal migrants are included, the total number of people on the move is around 1 billion *(2,3)*.

Ensuring the health of refugees, migrants and host populations alike has emerged as a critical policy challenge and opportunity, requiring coordinated, evidence-informed action. Migration affects not only the health of people on the move but also the health of the communities with whom they live and interact. Far from being a side issue to public health, migration is firmly a core area of interest. Recognizing this, WHO has identified migration and health as a priority area of action.

In collaboration with Member States worldwide, WHO works to support and promote initiatives that address the health needs of refugees and migrants in both short- and long-term perspectives and across emergency and non-emergency contexts, including through close collaboration between the WHO Special Initiative on Health and Migration and Health Emergencies Programme.

This report is part of that work and builds on the foundation laid by the first *World report on the health of refugees and migrants (2)*, published in 2022. That report provided critical evidence, data and analysis on the health status of refugees and migrants globally. By consolidating the available knowledge and identifying significant data gaps, it also highlighted the urgent need for stronger monitoring and improved data systems, while underscoring the importance of systematically including refugees and migrants in health and social care planning and implementation.

The report also represented a significant milestone in supporting Member States in their implementation of the WHO *Global action plan on promoting the health of refugees and migrants, 2019–2023* (GAP), extended to 2030 *(4)*. As noted by the Seventy-second World Health Assembly in 2019, the GAP constitutes a strategic framework to guide coordinated action among Member States and WHO and its partners. This report presents a baseline of GAP implementation to advance the refugee and migrant health agenda.

At its core, the GAP is a response to the growing global recognition that there is no public or global health without refugee and migrant health and that refugees and migrants often face significant barriers to accessing the health and social services they need. Such barriers are rooted in legal, structural and social inequities. By outlining six key priorities, from strengthening health systems and health information systems to promoting governance and tackling the social determinants of health, the GAP provides a clear roadmap for addressing these challenges in a comprehensive, rights-based manner. This report also presents the GAP Monitoring Framework (GMF), the first global framework designed to measure the progress of GAP achievement, and outlines its development and contributions from WHO regions and key stakeholders.

These efforts culminated in the launch of the first WHO global survey to track GAP implementation. Its findings are presented in detail here, offering insights into the key challenges faced and opportunities presented.

Lastly, the report reviews its key findings and their implications within the wider global migration and health space, and considers what can be done going forward to strengthen health information systems and sustain momentum in the GAP's implementation.

The report is designed for policy-makers, researchers, public health experts, and health and migration stakeholders, including refugees and migrants themselves. It is intended to offer insights into current global efforts to promote the health of refugees and migrants beyond emergency contexts, how progress is being measured and the critical role that data and evidence will play in guiding future action and monitoring progress at Member State level.

Rohingya communities collecting water in Bangladesh, 2024
© WHO/Walter Owens

2. The intersection of health and migration

Migration and health interconnect in complex and dynamic ways, with migration affecting health outcomes – both positively and negatively – across all phases of the mobility continuum, from predeparture to return or resettlement.

People move for many reasons and in a wide range of circumstances *(2,5–6)*. Some may be particularly vulnerable to negative mental health impacts due to the conditions that forced their departure, whereas others may experience violence, trafficking or exploitation en route to their destination. Many refugees and migrants face obstacles that include financial, legal, language and cultural barriers in transit and destination countries that impact their health *(7–11)*.

Additionally, many refugees and migrants may enjoy better health after migration as a result of improved living or working conditions, better access to health services in destination communities or other benefits (*12).* Health also influences decisions around migration. For example, it is often healthy individuals who migrate and – in the context of displacement – the desire to preserve health and life may be the sole reason for moving from one place to another *(2,13)*.

2.1 Global displacement and migration trends

As of 2024 there were an estimated 304 million international migrants worldwide *(1)*. At mid-year 2025, there were an estimated 36.8 million refugees and 8.4 million asylum seekers *(14)*.

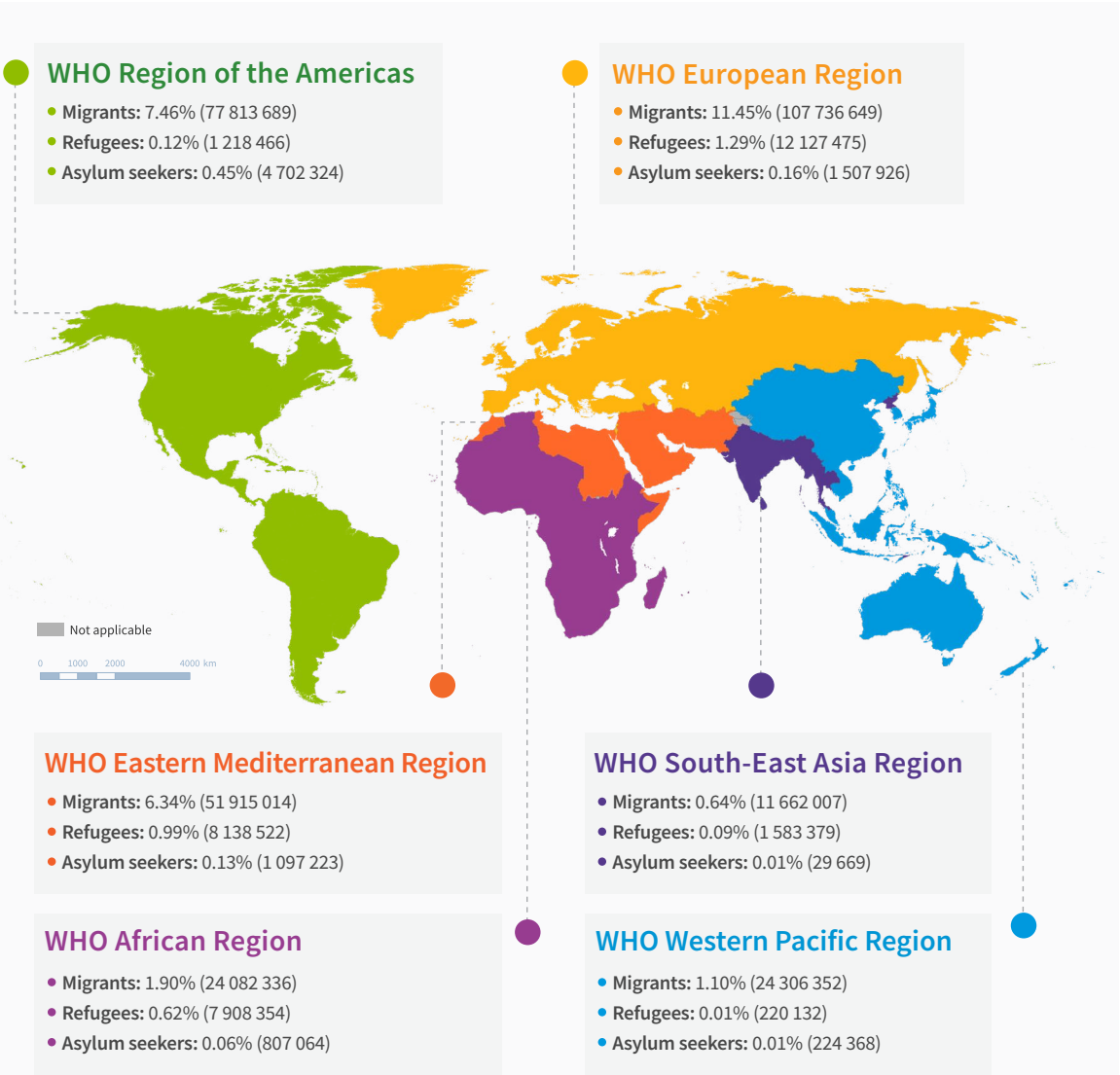
Reasons for migration are diverse. In 2022 there were an estimated 167.7 million international migrant workers *(13)*, including many essential health workers. Many international migrants include the family members of migrant workers who migrate alongside them *(15)* and 6.9 million international students *(16)*.

Displacement and migration are equally prevalent within country borders, as indicated by the latest available estimate on people living outside of their region of birth in 2005, which put the number of internal migrants worldwide at approximately 763 million *(17)*. There were an estimated 83.4 million internally displaced people (IDPs) worldwide in 2024. Together, these figures indicate that global human mobility affects well over 1 billion people worldwide *(3,18)*.

A closer look at the data reveals a complex and evolving landscape of displacement and migration, encompassing a wide range of motivations and patterns. These continue to evolve in response to global demographic, economic and environmental trends, among others. It is also important to note that while data sources and national legal categories tend to make distinctions between different types of migrants, many move as a result of overlapping factors related to employment, education, family reasons, conflict, climate, disasters and many others.

While the total number of international migrants has nearly doubled since 1990, the share of migrants in the global population has remained relatively constant, at an estimated 3.7% compared with 2.9% in 1990 *(1)*. Notably, nearly half of international migration occurs within the same geographical region, such as within the WHO African, South-East Asia or European region *(1)*. Additionally, WHO European Region Member States hosted more international migrants than any other region in 2024, with 107 million, followed by the WHO Region of the Americas (77 million) and the WHO Eastern Mediterranean Region (51 million) (Fig. 1).

Fig. 1. International migrants, refugees and asylum seekers (percentage of the total population), by WHO region, 2024

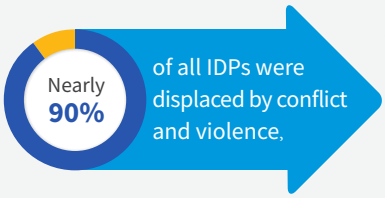


Notes: migrant stock figures include total numbers of refugees and asylum seekers as of 2024. This map shows data only for WHO Member States and excludes data from non-Member States, countries and territories (shown in grey).

Source: based on data provided directly by the United Nations Department of Economic and Social Affairs and UNHCR.

The level of displacement resulting from disasters, persecution, conflict, violence, human rights violations or events that seriously disturb public order has also risen, with two thirds of refugees under United Nations High Commissioner for Refugees (UNHCR) mandate, and others in need of international protection originating from just four countries – Afghanistan, the Syrian Arab Republic, Ukraine and the Bolivarian Republic of Venezuela *(19)*.

Internal displacement has also **doubled** since 2018, with conflicts as a main driver.



with Sudan alone reporting 11.6 million displaced people as of the end of 2024, the highest number ever recorded in a single country.

Furthermore, nearly the entire population of the Gaza Strip, approximately 2.1 million people, remains displaced as of the end of 2024 *(18)*.

The evidence base on displacement and migration is constrained by several factors, with statistics remaining highly imperfect, and sometimes outdated. For example, there are no regular global estimates relating to internal migrants, and many key statistics may be underestimates.

Furthermore, irregular migrants and migrants working in the informal economy tend not to be captured in official data. In addition to this, countries themselves may use different definitions and methodologies to monitor migration, making any comparative analysis of statistics challenging.

While the International Migrant Stock database *(1)* provides the most comprehensive global count of people living outside their country of birth, drawing primarily on national population censuses and administrative data, it does not provide data by reason for migration, as countries rarely collect or report on this in a comparable fashion. Further, the International Labour Organization's migrant worker estimates *(13)*, also based on country-level labour force surveys, offer valuable insight into migrants' labour market participation but exclude both non-working migrants and the dependents of registered migrant workers.

Countries collect data on different migration-related variables, using varying definitions and methodologies which results in inconclusive and noncomparable data. Better-standardized data are essential to produce a clearer and more policy-relevant global picture of migration.

Around the world, migrants play essential roles in sustaining and growing economies, with the number of international migrants in the labour force continuing to rise (Table 1) *(13)*. Student migration is also increasing, and has risen by 176% over the past 2 decades, with students choosing an increasingly wide range of destinations *(16)*.

Table 1. International Labour Organization estimates on number of international migrants in the labour force by WHO region, 2022

WHO region	International migrant labour force (millions)	Non-international migrant labour force (millions)	Total labour force (millions)[a]
WHO African Region	13.2	452.2	465.4
WHO Region of the Americas	45.7	461.9	507.6
WHO Eastern Mediterranean Region	26.2	217.9	244.1
WHO European Region	57.7	389.6	447.3
WHO South-East Asia Region	7.6	856.3	863.9
WHO Western Pacific Region	14.6	1 032.4	1 047.0
Global (180 countries)	**165.0**	**3 410.3**	**3 575.3**

Notes: international migrants in the labour force are international migrants who are in the labour force in their country of residence; that is to say, are employed or unemployed. Estimates are based on 180 countries.

[a] Some estimates differ from those published in the fourth *ILO global estimates of international migrant workers (13)*, which are based on 189 countries and territories, with a total of 167 689 million migrants in the labour force.

Source: based on data directly provided by the International Labour Organization.

It is important to note that the impact of migration on health goes beyond the health of migrants themselves. For example, it can impact members of destination communities that benefit from the active participation of migrants in the labour market, where they often play a crucial role *(20)*. The majority of the 304 million international migrants are labour migrants, and this mirrors the fact that many migrants move for reasons related to livelihoods and economic opportunities *(13)*. Across all WHO regions, labour force participation rates (LFPRs) for migrants[2] are consistently higher than those for the host population (Table 2).

[2] International Labour Organization estimates cover all international migrants including refugees; however, separate estimates of the LFPR for the refugee population are not provided.

Table 2. LFPR of international migrants by WHO region, 2022

WHO region	LFPR for migrants (%)	LFPR for nonmigrants (%)
WHO African Region	70.1	66.5
WHO Region of the Americas	66.5	61.9
WHO Eastern Mediterranean Region	68.8	45.7
WHO European Region	61.7	58.1
WHO South-East Asia Region	69.9	55.5
WHO Western Pacific Region	71.6	66.3
Global (180 countries)	**65.9**	**60.1**

Notes: the LFPR is the proportion of international migrants of working-age who are currently in the labour force (whether employed or unemployed) of their country of residence. Estimates are based on 180 countries. They differ from those published in the fourth *ILO global estimates on international migrant workers (13)*, which are based on 189 countries and territories, resulting in a global LFPR of 65.8% for migrants.

Source: based on data directly provided by the International Labour Organization.

The contribution of migrants is particularly significant in the health sector, where they constitute a substantial proportion of the employed population in many destination countries, providing health care to refugees, migrants and host populations alike *(21,22)*. Migration also influences the health of those who are connected to migrants, for example, their family and friends who did not move but may benefit through receiving different types of remittance, which can in turn support their health care access, nutrition and other factors (Box 1).

The impact of migration on health goes beyond the health of migrants themselves

Box 1. Migration, health and remittances

Refugees and migrants often send money, goods and ideas back to their communities of origin, thereby contributing to those communities in different ways – including in terms of health and well-being. There is also evidence that financial transfers increase health-related household expenditure and improve health outcomes in the origin community *(23–29)*. Money sent back in this way can directly and indirectly affect the health of recipients' households by enabling improvements in living standards or education. Both of these are significant social determinants of health *(30,31)*.

Moreover, refugees and migrants may also share newly acquired knowledge, norms, attitudes, practices or behaviours relating to health with their loved ones through social remittances. Social remittances concerning health have been shown to positively affect behaviours and/or outcomes related to contraception, female genital mutilation and other aspects of migrant networks *(32–35)*.

While not enough is yet known about social remittances and health, it is an area of emerging and promising evidence *(36)*.

The interplay between health and migration cannot be fully appreciated without due consideration of the broader determinants of health before departure, during transit and after arrival. These can include conditions experienced in countries of origin, such as those related to poverty or conflict; the often-precarious conditions experienced during transit, which can range from overcrowded shelters to exposure to violence and exploitation; and substandard work and living conditions in the destination country.

Together, these determinants operate at various levels across phases of migration, influencing not only the health of refugees and migrants but also the well-being of their families and host community. It is, therefore, important that efforts to promote refugee and migrant health explicitly address these determinants. It is also imperative that the health of refugees and migrants is addressed as part of broader efforts to ensure population health, recognizing that public health goals cannot be achieved without addressing the needs of all groups within a population.

Recent global health crises – most notably the COVID-19 pandemic – have underscored the reality that unless everyone, including those in vulnerable situations, is protected, society as a whole remains at risk. Inclusive health systems that proactively include refugees and migrants are not only more equitable but also better placed to deliver health security and cost–effectiveness *(37,38)*.

Lastly, ensuring the health of refugees and migrants is both fundamental to upholding their rights, dignity and well-being and essential to fostering inclusive, equitable and cohesive communities. Studies have shown that excluding or creating barriers for refugees and migrants in seeking health care often results in more cost for refugees and migrants as well as for host countries *(39–42)*. Health is central to the successful integration of refugees and migrants into host communities and key to optimizing the social, cultural and economic contributions they can make. When refugees and migrants have access to timely, culturally sensitive and affordable health care, they are empowered to manage their health and well-being, support their families, and contribute meaningfully to the communities in which they live.

Migrants play vital roles in sustaining and growing economies

2.2 Determinants of refugee and migrant health

The conditions in which people are born, grow, live, work and age have a profound impact on their health *(43–45)*. In the context of displacement and migration, these conditions are expressed in distinctive ways that shape health outcomes before departure, during transit and after arrival, to the extent that migration itself is widely recognized as a social determinant of health *(46)*. As shaped by a range of individual, social, economic, environmental and other factors, the migration experience can either heighten health risks or present opportunities for health improvement *(47,48)*.

The determinants of health can be broadly grouped into four categories: individual characteristics and behaviours, social and economic environment, physical environment and others *(49)*.

2.2.1 Individual characteristics and behaviours

Individual determinants of health encompass personal characteristics, including biological factors such as age, genetic heritage and biological sex; demographic attributes; and behavioural or lifestyle factors such as diet, physical activity, harmful substance use and health-related practices *(50)*. Sex and gender shape the health-related challenges and opportunities of refugees and migrants in several ways, for example, by influencing access to health services and health-seeking behaviours in many settings. Many women and girls on the move encounter particular challenges, including exposure to gender-based violence and restricted access to reproductive health services, whereas lesbian, gay, bisexual, transgender, queer, intersex, asexual and other (LGBTQIA+) refugees and migrants face particular risks, notably in regard to stigmatization and discrimination. Older age, low health literacy and other individual-level characteristic have also been shown to determine health outcomes *(51)*. Behavioural determinants also play an important role, including those related to harmful use of alcohol, physical activity, tobacco consumption and nutrition *(52)*.

2.2.2 Social and economic environment

Inadequate housing and income, limited educational opportunities, and unemployment are well-documented contributors to adverse health outcomes and have been identified as primary drivers of health inequities. They have also been shown to play a critical role in shaping migrants' health outcomes *(46)*.

On arrival in destination countries, refugees and migrants may encounter barriers to accessing decent accommodation, work and education *(2,53)*. The negative health impacts of these may be exacerbated by lack of access to health services, particularly in contexts where there are legal, policy, linguistic or other barriers *(54)*.

Migrant workers are often concentrated in informal and precarious sectors, where there is a lack of labour protections, occupational safety measures and access to health care, including mental health services *(55)*. Exposure to unsafe conditions in construction, agricultural or domestic workplaces increases the risk of injury or illness *(2)*. Refugees and migrants also often face discrimination or abuse, leading to psychosocial distress *(56,57)*. Income, social support and many other related factors also shape refugees' and migrants' health outcomes *(2)*.

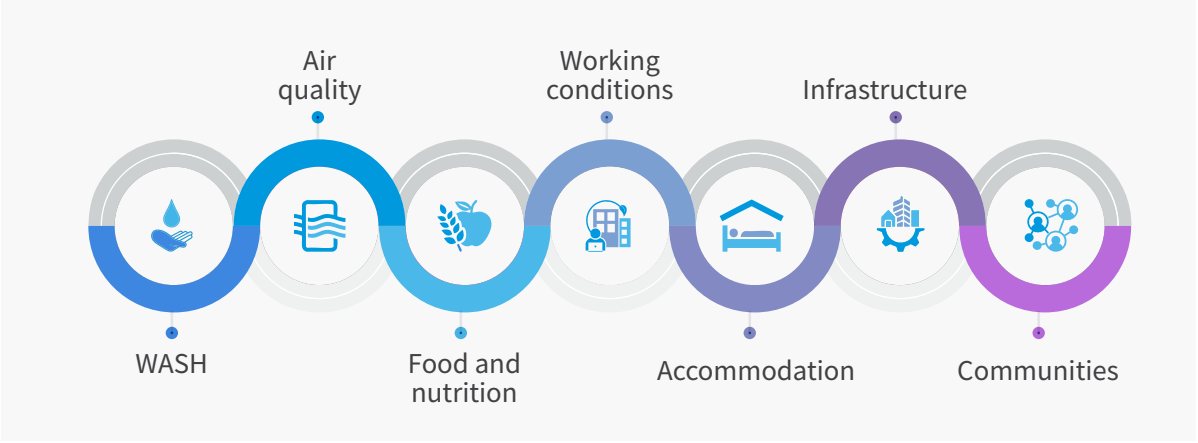
The legal status accorded to refugees and migrants very often determines their eligibility for health care, housing, employment and social services and is shaped by the national legal, policy and human rights frameworks under which they reside. Migrants in irregular situations may be at particular risk as irregular status can exclude migrants from potential employment, housing and social support opportunities *(58,59)*, further impacting health. Meanwhile, limited legal protection can expose individuals to exploitation, which can negatively impact their health *(45)*.

Lack of legal protections exacerbates health vulnerabilities

2.2.3 Physical environment

Environmental conditions – including those related to water, sanitation and hygiene (WASH), air quality, food and nutrition, the working environment, accommodation, communities, and infrastructure – are fundamental determinants of health that intersect in distinctive ways with displacement and migration (Fig. 2).

Fig. 2. The physical environment and fundamental determinants of health



For example, displaced populations may live in camps, shelters or informal housing where there is limited access to clean water, sanitation and ventilation, whereas many migrants live in overcrowded households or in insanitary housing *(60–63)*. Frequent displacement or eviction increases exposure to cold, heat and violence and heightens stress and mental health risks. Poor living conditions are particularly harmful to children's growth, nutrition and development. Environmental exposures due to hazardous work and air pollution further compound health risks, as does exposure to extreme weather events driven by climate change *(64)*. Climate change itself is increasingly influencing migration trends and exposing refugees and migrants to environmental hazards that can impact health. It also interacts with many determinants of health to influence their health outcomes.

2.2.4 Other determinants

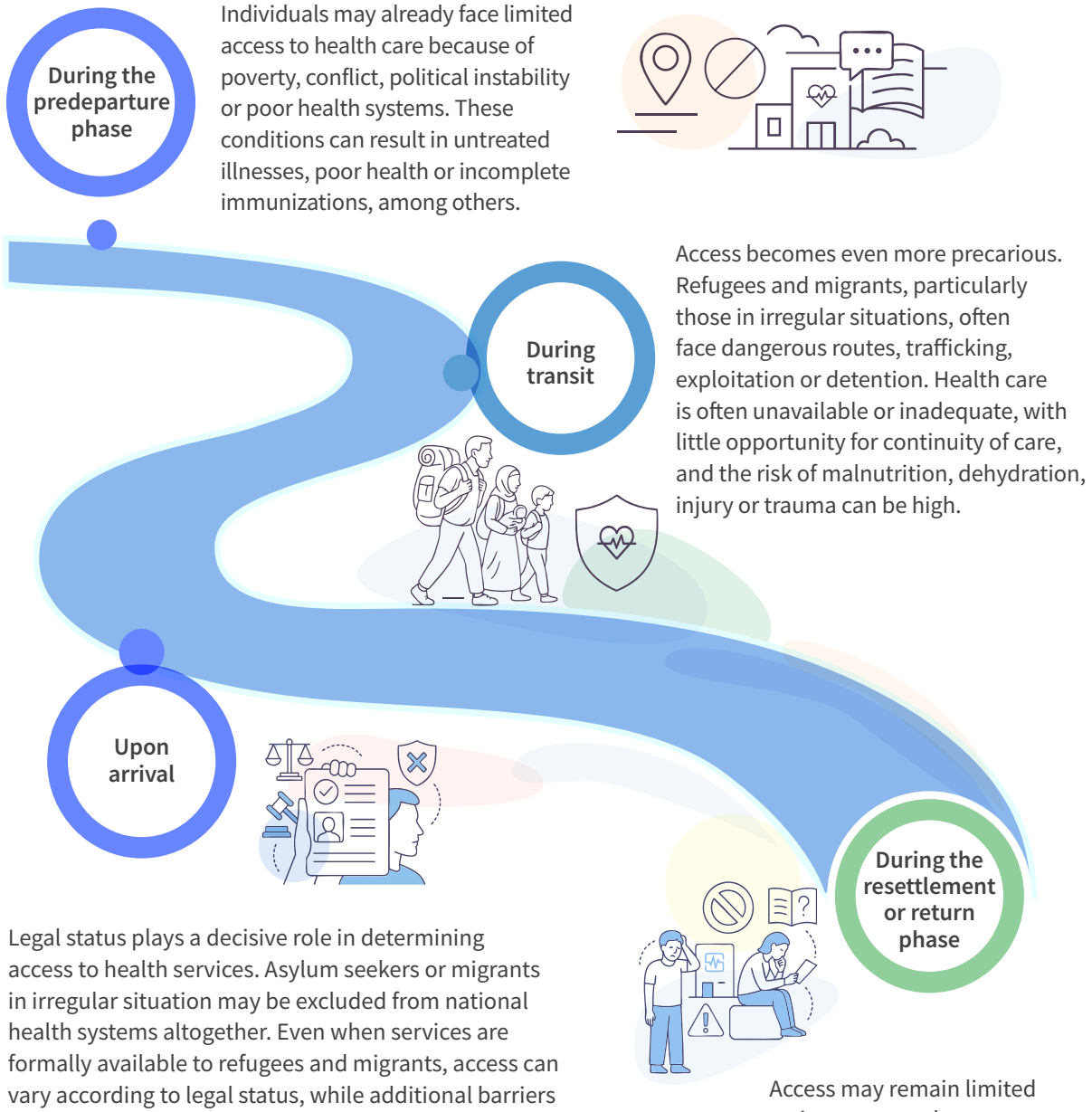
Many other factors also influence the health of refugees and migrants. Political determinants, which are closely related to many of the determinants discussed in sections 2.2.1–2.2.3, include governance structures and policies. Additional factors may include marketing practices, inadequate labour protections and excessive medicine pricing, of which the latter is often reinforced by pharmaceutical monopolies *(65–67)*. Digital determinants include the spread of online misinformation and social-media-driven discrimination and isolation, algorithmic bias in service delivery, and health risks associated with data surveillance *(68,69)*. For young refugees and migrants, these factors are especially important as they shape their access to trustworthy health information, influence their mental well-being and social inclusion, and determine how equitably digital health services respond to their needs *(70)*. Geopolitical factors related to conflict and border militarization profoundly affect mobility, health and well-being *(71)*. Trade agreements *(72–74)* and global supply chain dynamics can create new layers of vulnerability that remain largely invisible in conventional public health models *(75)*.

2.3 Effect of the determinants of health on access to health services

One of the central findings of the first *World report on the health of refugees and migrants (2)* was the degree to which health services for refugees and migrants are fragmented, often resulting in uneven service coverage and quality. In addition, refugees' and migrants' access to health services is directly and indirectly influenced by the determinants outlined in section 2.2. Migration policies linked to legal status, in particular, directly affect access to health services *(76)*. In some instances, access is formally restricted in destination countries, particularly for migrants lacking the required documents. In others, administrative requirements such as proof of legal identity or residence documents can create practical obstacles for migrants *(77,78)*. Language, cultural barriers and health literacy may also hinder communication or limit access to health information, while transport barriers and poor infrastructure can make it difficult to access health systems *(79)*. Lastly, experiences of discrimination by health care providers, often linked to migratory status, may further discourage individuals from seeking help.

Access to health services for refugees and migrants is influenced by the interactions of determinants across all phases of displacement and migration. It is important to note that such phases are not always part of a linear sequence and may be cyclical, as in the case of seasonal labour migrants or migrants who are turned back by law enforcement only to attempt their journey again. Additionally, what might have been considered a destination can become a transit location if conditions force refugees and migrants to keep moving. For example, individuals who are displaced by conflict can be displaced again if their temporary destinations are impacted by disasters such as flooding or earthquakes (Fig. 3).

Fig. 3. Phases of migration and their risks



Across all phases, these determinants create obstacles to equitable health care access *(80)*.

2.4 Meeting the health needs of refugees and migrants

As this chapter has outlined, migration health is a complex, multidimensional, cross-sectoral issue. Therefore, meeting the health needs of refugees and migrants and addressing the inequities they face requires a multisectoral, rights-based approach. The systematic, proactive inclusion of migrant health considerations in the development of universal health coverage (UHC) and initiatives related to the 2030 Agenda for Sustainable Development *(81)* are key to supporting such an approach. This includes the development and implementation of inclusive policies, investment in cross-cultural competencies among health workers, and tailored interventions to address structural, legal, linguistic and financial barriers to accessing health services. Crucially, inclusive legal frameworks are needed that ensure equitable access to health care and prevent discrimination against refugees and migrants. Ensuring that refugees and migrants are meaningfully involved in decision-making processes that affect their health and well-being is key. Equally important is the implementation of policies and practices that combat discrimination and promote social inclusion. Such inclusive approaches not only uphold human rights and foster equity but can also enhance the effectiveness and sustainability of health interventions *(45,82)*.

According to WHO, health services include all services dealing with the promotion, maintenance and restoration of health. They include both personal and population-based health services. Health care services focus more narrowly on diagnosing, treating and managing illness. Thus, health care is a component of the broader health services system (83)

By embedding refugee and migrant health services within existing health and social structures, countries can promote inclusivity, strengthen health system resilience and ensure that refugees and migrants receive the same standard of care as the host population. This integrated approach also facilitates data collection, monitoring and coordination across sectors, ultimately contributing to better health outcomes for all *(84)*.

The underrepresentation of refugees and migrants in national health data and research *(85–87)* contributes to their exclusion from policy agendas and resource allocation decisions. In order to understand and address the intersection between migration and health, it is important that quality, disaggregated data are collected frequently. These data should monitor the health outcomes and services that are available and accessible for refugee and migrant populations.

Despite challenges, many countries have launched initiatives that are beginning to yield valuable lessons on effective ways to address migration health *(88–90)*. Specific policies have delivered tangible benefits across a range of sectors in various countries. For example, in Canada, a points-based immigration system has allowed for the strategic selection of skilled workers to meet labour market demands, thus contributing to sustained economic growth and increased innovation *(91)*. While this benefits the health care sector in host countries, it can also negatively impact health care systems in countries of origin due to the migration of skilled workers *(2)*.

While investing in the health and well-being of refugees and migrants is important from a rights-based perspective and to improve health equity, it can also yield significant benefits *(39)*. By providing refugees and migrants with accessible health care and social services, destination communities can support their integration *(92)*.

In Italy, the Italian National Institute for Health, Migration and Poverty, a public body supervised by the Ministry of Health, delivers medical courses on migration health and continuing medical education for health care workers and, as the National Reference Centre for Transcultural Mediation in Healthcare, trains transcultural mediators in Italy according to a core curriculum specifically developed by the Institute *(38)*.

Healthy refugees and migrants are better able to learn new languages, participate in education, enter the workforce and engage in civic life. This means they are more able to contribute to economic productivity, less likely to strain emergency health care services and better positioned to thrive and prosper.

Refugees and migrants bring skills, diversity and innovation and contribute not only by forming a significant proportion of the critical workforce in areas such as health care and education but also by creating job opportunities through entrepreneurial activity. When host countries ensure equitable access to health services for all – including refugees and migrants – they create more just, inclusive and economically vibrant societies.

Significant progress has been made in the field of refugee and migrant health in recent years. However, more action is needed to sustain and accelerate this progress, particularly in the light of recent reductions in public spending and humanitarian aid that affect interventions for refugees and migrants around the world *(93–95)*. Against this backdrop, the integration of refugee and migrant health into national public health and broader development strategies is emerging as a clear public health imperative focused not only on protecting and promoting the health of the populations concerned but also on maximizing the benefits of migration for host communities.

The GAP provides a strategic foundation for countries to do just this. Chapter 3 introduces and sets out the GAP in detail.

Displaced communities affected by the fuel depot explosion receive essential rehabilitation support, Armenia, 2024
© WHO

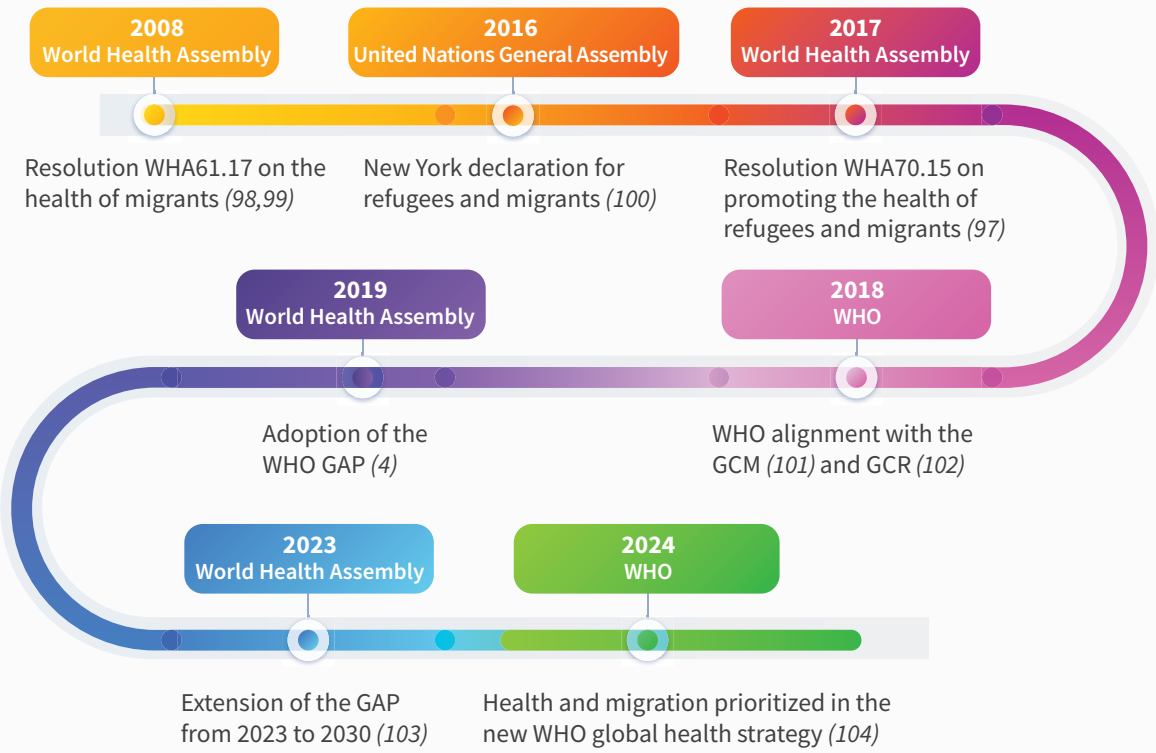
3. The GAP and the GMF

The GAP aims to support efforts to promote the health and well-being of refugees and migrants through inclusive, integrated and comprehensive action, in recognition that the health of refugees and migrants should not be considered separately from the health of the overall population *(96)*.

3.1 Progress towards a new global plan of action

Resolution WHA70.15 on promoting the health of refugees and migrants was endorsed by the Seventieth World Health Assembly in 2017 *(97)*. It represents a landmark political commitment that affirms the rights of refugees and migrants and marks a turning point for the promotion of inclusive health systems. Fig. 4 shows how the health and migration landscape is being redefined by the approach outlined in the Resolution.

Fig. 4. Health and migration policy landscape, progress towards action: redefining the narrative



GCM: Global Compact for Safe, Orderly and Regular Migration; GCR: Global Compact on Refugees.

The Resolution outlined a stepwise approach to align the GAP with the GCM *(101)* and GCR *(102)*. It included a request for the WHO Director-General to increase WHO's advocacy to promote refugee and migrant health and to support WHO Member States in collaboration with the International Organization for Migration (IOM) and UNHCR in promoting the health of refugees and migrants.

The resolution also called on WHO to identify promising practices and to highlight experiences and lessons learned in order to guide the development of a global action plan on the health of refugees and migrants for consideration at the Seventy-second World Health Assembly in May 2019. Additionally, the resolution urged Member States to strengthen international cooperation on the health of refugees and migrants. It also expressed Member States' appreciation for the framework of priorities and guiding principles to promote the health of refugees and migrants that the WHO Secretariat had prepared in response to the request by the WHO Executive Board in decision EB140(9).

In response to requests from the World Health Assembly, the WHO Secretariat launched an online call for contributions from Member States and partners to share promising practices and lessons learned in meeting the health needs of refugees and migrants at the local, regional, national and global levels. Between August 2017 and January 2018, 199 submissions were received, highlighting practices implemented in 90 Member States across all six WHO regions. Based on the evidence gathered, a draft of the GAP 2019–2023 was developed and formally noted with appreciation; the GAP was agreed to be a WHO document that was not binding on Member States by the World Health Assembly in 2019 *(96)*.

Both the GAP and the framework of priorities and guiding principles were developed by WHO in consultation with the IOM, the UNHCR and other relevant stakeholders. The GAP is fully aligned with existing framework of priorities and guiding principles, such as the United Nations' Sustainable Development Goals (SDGs), the GCR and the GCM *(100,101–105)*.

The WHO Health and Migration Programme was established in 2020 to support the implementation of the GAP, and in 2022 published the first *World report on the health of refugees and migrants (2)*. The report was the first global synthesis of evidence on the health status and access to care for refugees and migrants, and presents a data-driven, policy-relevant baseline analysis across all WHO regions. By highlighting the ways in which social determinants, including legal status and structural barriers, drive health inequities, the baseline provides Member States with essential evidence to guide action and advance the GAP priorities. In 2023 at the Seventy-sixth World Health Assembly, Member States adopted resolution WHA76/2023/REC/1, extending the duration of the GAP from its original 2019–2023 time frame to 2030 *(106)*, and requested WHO to report on implementation progress in 2025, 2027 and 2029.

The GAP sets out six priority areas of action and several objectives for WHO's work with Member States and partners. Salient considerations include the multisectoral nature of migration health. The GAP advocates for a holistic approach to promoting the health and well-being of refugees and migrants by underlining the importance of extending efforts beyond the health sector.

The GAP also encourages coordinated action among international organizations and non-State actors, with a view to leveraging their comparative advantages across sectors. Additionally, it fosters multisectoral coordination by promoting collaboration across health, social protection, labour, education and migration governance sectors and encourages countries to align their national health and migration strategies with key international frameworks and agreements.

Although several international and regional frameworks and processes make reference to the health of refugees and migrants, the GAP is the first framework to address these issues comprehensively, thereby providing a roadmap for concrete action. The priorities of the WHO GAP are shown in Box 2.

Box 2. Priorities of the WHO GAP

Priority 1

Promote the health of refugees and migrants through a mix of short- and long-term public health interventions

Priority 2

Promote the continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures

Priority 3

Advocate for the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of refugee- and migrant-sensitive health policies and legal and social protections

Priority 4

Enhance the capacity to tackle the social determinants of health and to accelerate progress towards achieving the SDGs *(105)*, including UHC Target 3.8[3]

Priority 5

Strengthen health monitoring and health information systems

Priority 6

Support measures to improve evidence-informed health communication and to counter misperceptions about refugee and migrant health

[3] Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

In parallel to the governing bodies' processes, WHO collaborated with IOM, UNHCR and other partners to hold global consultations on refugee and migrant health in 2010, 2017 and 2023. The consultations brought together participants representing various sectors within governments from all geographical regions. Representatives from civil society organizations also participated, along with academics, experts, and representatives of international organizations, regional institutions and professional and migrant associations.

The three events provided a platform for in-depth discussion on refugee and migrant health and allowed for the exploration of different ways to strengthen high-level political commitment, with the aim of improving, protecting and preserving the health and well-being of refugees, migrants and host communities. The events also highlighted the need to collect, analyse and share comprehensive, comparable and standardized data to support evidence-informed decision-making on refugee and migrant health, as also set out in the political outcome document of the third global consultation – the Rabat Declaration *(107)*.

3.2 Alignment of the GAP with other key frameworks

The GAP aligns with multiple international frameworks in both the global health and international development domains, thus contributing to a coherent global health agenda for refugees and migrants *(2)*. It not only reinforces the global consensus that UHC cannot be achieved without inclusive health systems that serve all population groups, including refugees and migrants, but also provides guidance to Member States seeking to operationalize the right to health. Notable in this regard is the GAP's promotion of nondiscriminatory service delivery, regardless of refugees' and migrants' legal status.

The GAP also supports the objectives of the International Health Regulations (2005) *(108)*, which require countries to develop and maintain core capacities to prevent, protect against, control and provide a public health response to the international spread of disease *(2)*. In addition, it draws from and contributes to the implementation of the 2030 Agenda for Sustainable Development *(81)* by reflecting the interconnected nature of health, human mobility and sustainable development (Box 3). Lastly, the GAP operationalizes the core commitments of the GCM and the GCR, both of which emphasize ensuring access to health services for refugees and migrants without discrimination, as well as the continuity of those services, as part of broader efforts to safeguard dignity, human rights and well-being *(101,102)*.

Box 3. The GAP and the SDGs

While SDG 3 (ensure healthy lives and promote well-being for all at all ages) – with its targets for UHC (Target 3.8)[4] and health security (Target 3.d)[5] – is the SDG most directly relevant to refugee and migrant health, other SDGs also shape the social, economic, environmental and political determinants of migrant health, all of which are addressed in the GAP *(4,105)*.

For example, SDG 1 (end poverty in all its forms everywhere) and SDG 2 (end hunger, achieve food security and improved nutrition and promote sustainable agriculture) are relevant, as refugees and migrants are disproportionately exposed to economic hardship and food insecurity, both of which adversely affect their health status. SDG 5 (achieve gender equality and empower all women and girls) is of particular significance for migrant women, who often face gender-based violence and unequal access to reproductive health services.

SDG 6 (ensure availability and sustainable management of water and sanitation for all) is critical in contexts where refugees and migrants lack access to basic WASH, which increases their risk of exposure to communicable diseases. Employment conditions covered under SDG 8 (promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all) have direct implications for occupational health and social protection of migrant workers.

SDG 10 (reduce inequality within and among countries), particularly Target 10.7,[6] underscores the need for orderly, safe, regular and responsible migration and mobility of people, which should include equitable access to health services. Urbanization, covered under SDG 11 (make cities and human settlements inclusive, safe, resilient and sustainable) has implications for the health of urban refugees and migrants, for example, those living in informal settlements.

Climate change and its intersections with health and migration are relevant to SDG 13 (take urgent action to combat climate change and its impacts), while strong governance and the protection of rights under SDG 16 (promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels) are essential to removing legal and institutional barriers to health services. Lastly, SDG 17 (strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development) highlights the importance of cross-sectoral and international collaboration to address refugee and migrant health in a coordinated and evidence-informed manner.

[4] Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

[5] Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

[6] Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies.

3.2.1 The GAP's alignment with recent regional initiatives

The priorities of the GAP are aligned with and reflected in several regional frameworks; notable among these are the WHO *Action plan for refugee and migrant health in the WHO European Region 2023–2030 (109)* and the framework set out by the Pan American Health Organization (PAHO) in the *Guidance document on migration and health* (Table 3) *(110)*. Both align with the GAP's priorities by addressing specific regional dynamics, such as migration flows, health system capacities, cross-border mobility and sociopolitical contexts. For example, the European framework builds upon lessons from refugee arrivals from 2015 onwards by emphasizing mental health, continuity of care and legal access to health services for undocumented migrants. PAHO's guidance calls for the integration of migrant health into broader UHC efforts in response to large-scale displacement from countries such as Haiti and the Bolivarian Republic of Venezuela. Vision 2023, which outlines the strategic direction for WHO's work in the Eastern Mediterranean Region is also of note. Acknowledging the Region's socioeconomic diversity, along with the unique opportunities and challenges it presents *(111,112)*, Vision 2023 emphasizes the need for solidarity and collective action to achieve the goal of "Health for All by All" and prioritizes UHC as a key regional objective – and one that explicitly includes refugees and migrants, regardless of their legal or migratory status.

Table 3. Illustration of GAP alignment with selected global and regional migration frameworks

Framework		African Union, 2018 *(113)*	African Union, 2021 *(114)*	WHO, 2023 *(115)*	ASEAN, 2023 *(116)*	European Union, 2020 *(117)*	PAHO, 2019 *(110)*
Priority	Survey item						
1	Health policy/legislation/strategy/plan includes any component on refugees and migrants	✓	✓	✓	–	✓	–
	Disaster risk reduction plan has at least one component on the health of refugees and migrants	✓	✓	–	✓	–	–
	Emergency preparedness and response plan has at least one explicit component on the health of refugees and migrants	✓	✓	–	✓	–	✓

Table 3 continued

Framework		African Union, 2018 *(113)*	African Union, 2021 *(114)*	WHO, 2023 *(115)*	ASEAN, 2023 *(116)*	European Union, 2020 *(117)*	PAHO, 2019 *(110)*
Priority	Survey item						
2	At least one assessment of the health system conducted to assess quality, acceptability, availability or accessibility of health services for refugees and migrants	✓	–	✓	✓	✓	✓
	Refugees and migrants included in occupational health and safety policy/legislation/strategy/plan	✓	✓	✓	✓	–	–
3	Refugees and migrants included in the governance, including planning, of health care service delivery	✓	✓	✓	✓	✓	✓
4	Government-led multisectoral coordination mechanisms to promote the health of refugees and migrants by addressing social determinants of health	✓	✓	✓	✓	✓	✓
5	Data on migratory status and/or other related variables are routinely collected, analysed and disseminated as part of the health information system	✓	✓	–	✓	✓	✓
	Safeguards in place to prevent misuse of refugee/migrant health data	–	✓	–	✓	–	–
6	Health care providers receive training on culturally responsive care for refugees and migrants	✓	✓	✓	–	–	✓
	Communication or information campaigns to counter misperceptions about refugee and migrant health	✓	–	✓	–	✓	✓
	Refugees and migrants included in community engagement strategies and plans	✓	–	✓	✓	–	–

ASEAN: Association of Southeast Asian Nations.

Note: this table reflects the 12 areas of the GAP Monitoring Framework, which are presented below.

Both the GAP and the regional frameworks cited are grounded in the principles of equity, nondiscrimination and a human-rights-based approach to health. They collectively seek to dismantle barriers that prevent refugees and migrants from accessing health and social services – such as legal status, language, stigma and cultural differences – and to promote inclusive policies that enhance resilience and social cohesion. It is also important to note that these regional frameworks go beyond generalized recommendations by supporting the operationalization of relevant principles through country-specific action plans, stakeholder coordination and technical guidance. This represents a tangible shift from aspirational global commitments to actionable regional strategies.

The GAP also emphasizes the importance of improving health information systems – a goal reflected in regional plans that promote standardized metrics and shared indicators across borders. The disaggregation of data by migratory status is a key objective, allowing for more effective monitoring of health outcomes.

Many regional frameworks leverage the technical assistance and advocacy mechanisms established by the GAP. For example, intercountry collaborations in the WHO Eastern Mediterranean Region are using the GAP's guidelines to shape coordinated responses for Syrian and Palestinian refugees, while in the WHO South-East Asia Region, efforts are under way to integrate migrant health into national disaster preparedness plans *(118)*.

3.3 Monitoring progress in the implementation of the GAP

A major obstacle to developing evidence-informed policies and programmes for refugees and migrants is the lack of routinely collected high-quality data.

Because the dynamics and contexts of displacement and migration are so diverse, and national health systems vary in their capacities, there is a pressing need for a robust monitoring and evaluation framework. Such a framework is critical, not only for tracking progress and identifying gaps but also for enabling the exchange of good practices across settings. In recognition of this need, a dedicated monitoring framework has been developed by the WHO Special Initiative on Health and Migration *(119)*.

3.3.1 Developing the GMF methodology

The GMF is designed to systematically track progress towards stated goals of the GAP *(4)*, identify challenges and guide evidence-informed policy and programme implementation to improve health outcomes for refugees and migrants worldwide.

Building on lessons learned by the WHO regional offices and in collaboration with the WHO Collaborating Centre on Migration and Health Data and Evidence at Uppsala University, in 2024 the WHO Special Initiative on Health and Migration developed a standardized global survey instrument – the Global Survey on Health and Migration.

To inform and validate the GMF, the WHO Special Initiative on Health and Migration convened a virtual consultation on the monitoring framework of the GAP in 2024. Held in two separate sessions on 12 and 13 September, the consultation aimed to review and validate the content of the preliminary GMF. This is essential for tracking progress in implementation of the GAP, particularly in preparation for the 2025 World Health Assembly *(120)*.

The consultation also provided a platform to gather input from Member States and specialists from key United Nations agencies and international organizations, including the International Federation of Red Cross and Red Crescent Societies, IOM and UNHCR, along with WHO regional and country offices. Member States from the WHO Region of the Americas, WHO European Region and WHO Eastern Mediterranean Region participated on 12 September 2024, and those from the WHO African Region, WHO South-East Asia Region and WHO Western Pacific Region contributed on 13 September 2024.

Following the consultation, the survey was pilot tested with a selected Member State (Chile) and WHO regional offices (for Europe and the Eastern Mediterranean) to ensure reliability, validity and coherence with the GAP. The objectives of the consultation were to validate the content and feasibility of the framework, assess the clarity of the questions, and confirm their applicability to ministries of health.

The Global Survey on Health and Migration takes the form of a standardized questionnaire to be completed by Member States and was developed through several iterations incorporating feedback from all six WHO regional offices and relevant partners, including Member States and representatives of key United Nations agencies. It is the primary monitoring instrument of the GMF.

The survey includes 12 core questions that are designed to elicit reliable responses and based on key areas for action within each of the six GAP priorities, while also ensuring alignment with global frameworks and supporting the monitoring of meaningful progress. The questions focus on documenting, rather than assessing, Member States' interventions. Box 4 provides more information on how the survey relates to other initiatives that monitor aspects of migration health policy.

Box 4. Monitoring migration health policy and related efforts

There have been several recent initiatives to better understand programmes, policies and other activities relating to the health of refugees and migrants. Designed and implemented by a range of actors, often with different objectives, these initiatives have varying strengths and limitations.

Notable examples include the Migrant Integration Policy Index, which assesses countries' policies on migration health, explores them in relation to countries' gross domestic product and other characteristics, and offers different analyses to inform policy *(121)*. Another example is IOM's Migration Governance Indicators, which offer insights regarding the different policy inputs that countries use *(122)*. The tool, which does not rank countries on their migration policies but rather helps to assess their comprehensiveness and identify gaps, includes two questions on migrants' health care access. Other indicators and tools also exist to measure selected dimensions relevant to health care access.

Unlike these and other initiatives, the GMF focuses not on measuring migrant health care access but rather on monitoring the implementation of the GAP. As outlined above, monitoring is based on the six GAP priorities developed in collaboration with Member States.

The GMF is comprised of questions refined in consultation with Member States, WHO regional and country offices, and other development and humanitarian organizations. While it does contain one question on refugees' and migrants' access to health care compared with that of host populations, most questions focus on other dimensions of migration health.[7] Importantly, the GMF is action oriented: rather than ranking countries on their progress in implementing the GAP, it seeks to shed light on implementation at the global and regional levels and to identify ways in which key gaps can be addressed going forward.

[7] Note that answers to health care access questions included in the GMF cannot be compared with other findings from different tools because the participating countries and coverage differ.

3.4 GAP priorities – key areas for action

The development of the GAP priorities and their corresponding action areas followed a structured, multilayered approach that integrated core public health functions, governance benchmarks and operational mapping. Each priority was anchored within the framework of essential health system and public health functions, spanning leadership and governance, health financing, health information systems, health promotion, occupational health and safety, and health workforce. The systems-based framing ensured that all core components of health service delivery and policy infrastructure were addressed in a holistic manner.

For each priority, a detailed mapping exercise was carried out to connect high-level objectives with specific operational benchmarks. For example, under Priority 1 (short- and long-term public health interventions), benchmarks on access to diagnostics, immunization, emergency preparedness and inclusion in national health strategies were identified and translated into concrete subpriorities. These key areas for action were grounded in actual practices and policies that had already been implemented or piloted at country level to ensure that they were both measurable and action oriented.

The approach also integrated cross-cutting considerations such as the social determinants of health, legal protections, gender equity and intersectoral collaboration. For example, Priority 3 emphasizes the mainstreaming of migrant-sensitive policies and coordination mechanisms, whereas Priority 4 addresses the social determinants and aligns closely with the SDGs *(105)*.

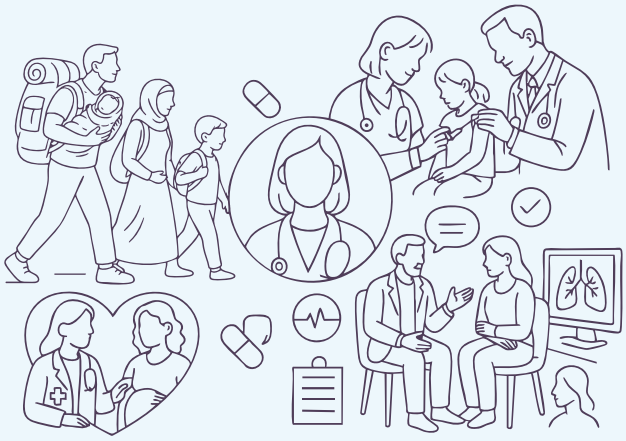
Lastly, indicators and benchmarks from international frameworks, including the GCM, the GCR and the 2030 Agenda *(80,100,101)*, were incorporated to ensure alignment with global standards and to facilitate the monitoring of progress across national contexts.

Communities displaced by drought receive essential health services from WHO mobile clinic teams in Marsabit, Kenya, 2022
© WHO

3.4.1 Priority 1

Promote the health of refugees and migrants through a mix of short- and long-term public health interventions

Objectives



To promote the physical and mental health of refugees and migrants by strengthening health care services, as appropriate and acceptable to country contexts and financial situations and in line with their national priorities and legal frameworks and competence, to ensure that essential components are addressed such as vaccination of children and adults and the provision of health promotion; disease prevention; timely diagnosis and treatment; rehabilitation and palliative services for acute, chronic and infectious diseases; injuries, mental and behavioural disorders; and sexual and reproductive health care services for women

Key action areas

1. Inclusive public health strategies and programmes
2. Funding for health needs during the influx of refugees and migrants
3. Access to diagnostics and screenings
4. Availability and affordability of health services
5. Sustainable funding for UHC
6. Emergency and disaster risk reduction preparedness
7. Healthy environment: WASH, decent living conditions, healthy air quality

The case studies in this chapter (case studies 1–6) are drawn from the WHO dashboard on Global Experiences in Promoting Refugee and Migrant Health *(123)*, which serves as a repository of diverse strategies and interventions implemented worldwide for integrating refugee and migrant health into national policies and systems.

Case study 1
Meeting migrant health needs in Sri Lanka

Sri Lanka's 2013 National Migration Health Policy guarantees essential health services for all migrants. The Inbound Health Assessment Programme, introduced in 2019, requires health screenings for long-term visa applicants at entry and renewal. Screenings cover tuberculosis (TB), HIV infection, malaria and lymphatic filariasis, with positive cases referred for treatment and follow-up care. Migrants completing the assessments join the National Health Protection Plan, thereby gaining free access to public health services. The Programme reflects a multisectoral effort by the Ministry of Health and partners *(124)*.

A refugee from Sudan receives medical care for her pregnancy at the Médecins Sans Frontières Switzerland hospital upon her arrival in Adré, Chad, 2024
© WHO/Nicolò Filippo Rosso

3.4.2 Priority 2

Promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures

Objectives

To improve the quality, acceptability, availability and accessibility of health care services, for example, by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the displacement and migration process, and by working to prevent occupational and work-related diseases and injuries among refugees and migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems, in accordance with Member States' national contexts, priorities and legal frameworks

Key action areas

1. Continued cross-border health care and treatment
2. Safe health data sharing
3. Inclusive vaccination campaigns and access to vaccination
4. Detention only as a last resort, with no detention of children, and dignified living and health access conditions in detention
5. Access of labour migrants to health care, and inclusive labour safety and security protocols
6. Health information systems inclusive of refugee and migrant workers (death, accident, injury, occupational risks)

Case study 2
Addressing health risks for Mozambican migrant workers

Each year, thousands of Mozambicans migrate to South Africa for farm and mining work, with many facing occupational and public health risks. In 2020 Mozambique's ministries of health and labour launched a cross-border initiative targeting TB, HIV infection, silicosis and hearing loss. Services include screenings, facilitating early disease detection and management. The project also facilitates health service access for eligible mineworkers through direct referrals between Mozambican and South African health centres *(125)*.

Migrants from the Bolivarian Republic of Venezuela in Colombia take part in community health promotion efforts, 2024
© PAHO/Karen González Abril

3.4.3 Priority 3

Advocate for the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of refugee-sensitive and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms

Objectives

To help to meet the health needs of refugees and migrants by preventing and mitigating the impact of gender-based inequality in health and access to health services throughout the displacement and migration process. Achieve this by advocating for refugees' and migrants' right to the highest attainable standard of physical and mental health, in accordance with international human rights obligations and corresponding relevant international and regional instruments and by working to lower or remove physical, financial, information and discrimination barriers to accessing health care services in synergy with WHO's partners, including non-State actors

Key action areas

1. Inclusive UHC strategies
2. Access to social protection
3. Local functions within national and local government for refugees and migrants
4. Cross-border human mobility and health in frameworks and agreements
5. Quality, equity, dignified, safe maternal, newborn and child health services, sexual and reproductive health services
6. Childhood development programmes and health care
7. Equitable inclusive and tailored health promotion campaigns
8. Protection of women and children from domestic violence and abuses; safe reporting mechanisms
9. Competency and capacity-building for trauma-informed care and treatment

Case study 3
Viet Nam forges a multisectoral alliance for migrant health

The Ministry of Health of Viet Nam conducted a migrant health situation analysis in 2019 that identified gaps in communication and cooperation across ministries. In 2021 the Ministry established the Migration Health Working Group, which serves as an interministerial technical coordination mechanism that brings together representatives from various government agencies and United Nations organizations. The group focuses on developing policies, raising awareness and implementing coordinated action plans to address migration health *(126)*.

A cardiologist and general practitioner in Armenia takes part in mobile clinics to provide health care for newly arrived refugees, 2023
© WHO/Marta Soszynska

3.4.4 Priority 4

Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the SDGs, including UHC

Objectives

To ensure that the social determinants of refugees' and migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses based on all relevant SDGs *(105)*, particularly SDG 3 (ensure healthy lives and promote well-being for all at all ages) and SDG 10 (reduce inequality within and among countries), Target 10.7 (facilitate orderly, safe and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies)

Key action areas

1. Protection measures for people with disability and other vulnerabilities
2. Social support mechanisms and financial aid schemes
3. Firewalls between health and other services
4. Protection against discrimination
5. Research on the social determinants of health
6. Interventions for the social determinants of health

Case study 4
Inclusive policies for social and economic benefits in Colombia

Colombia's strategy for integrating migrants into its health system demonstrates how inclusive policies can generate social and economic benefits for both migrants and host communities. By providing health insurance cards to 1.5 million migrants – 500 000 of whom actively contribute – Colombia has enhanced its national health system while promoting equitable access to care. Through a blend of contributory and subsidized schemes, the model ensures financial sustainability: employed migrants support the system while vulnerable groups receive protection. This approach not only strengthens public health outcomes but also promotes social cohesion and system resilience, thus offering a replicable model for countries addressing similar migration challenges *(127)*.

Displaced persons in the Gaza Strip face uncertainty and limited access to essential services, 2023
© WHO

3.4.5 Priority 5

Strengthen health monitoring and health information systems

Objectives

To ensure that information and disaggregated data at the global, regional and country levels are generated and that adequate, standardized, comparable records on the health of refugees and migrants are available to support policy-makers and decision-makers to develop more evidence-informed policies, plans and interventions

Key action areas

1. Migratory status included in routine health data collection
2. Ethical standards and guidelines for sensitive data
3. Migrant health variables included in emergency surveillance systems
4. Ethical, safe cross-border surveillance and data sharing
5. Coordinated health data-sharing mechanisms
6. Frameworks and toolkits on ethical research and data collection
7. Coordinated efforts on missing migrants and those who die during migration

Case study 5
Mapping migrant health in the United Kingdom

In 2021, 9.6 million residents of the United Kingdom were born abroad, yet little is known about refugees' and migrants' use of health services or health outcomes. To address this, the Million Migrant Study was launched in 2019 by University College London (United Kingdom), with partners including the UK Health Security Agency. The study analyses hospital care and mortality among 1.7 million non-European Union (EU) refugees and migrants by linking TB screening, refugee health assessments, hospital statistics and death records *(128)*.

Mobile health teams in Somalia deliver COVID-19 vaccinations to communities displaced by drought and conflict, 2022
© WHO/Arete/Ismail Taxta

3.4.6 Priority 6

Support measures to improve evidence-informed health communication and to counter misperceptions about refugee and migrant health

Objectives

To provide accurate information and dispel fears and misperceptions among refugee, migrant and host populations about the health impacts of displacement and migration on refugee and migrant populations, the health of local communities, and health systems

Key action areas

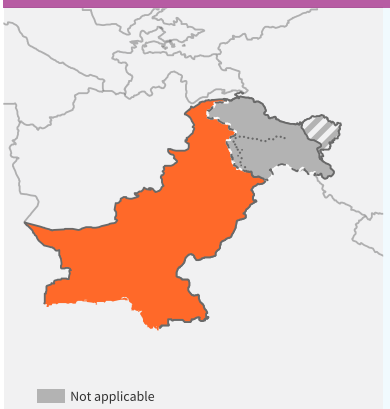
1. Responsible, sensible communication protocols and capacity-building

2. Capacity-building in human rights and migration laws among law enforcement cadres

3. Participatory governance in health and migration, inclusive of refugees and migrants

4. Inclusive health communication, health information sharing and emergency communication strategies

Case study 6
Strengthening community engagement and accountability in Pakistan's humanitarian response



Pakistan's 2021 Humanitarian Response Plan targeted 4.3 million vulnerable people, including 1.4 million registered Afghan refugees, 840 000 Afghan Citizen Card holders, and up to 500 000 undocumented Afghans. The plan emphasized dignity, equity and strengthened coordination among humanitarian and government actors while promoting inclusive community engagement and accountability to affected populations. An Accountability to Affected Populations Working Group was established to ensure that communities were informed about available services and could voice their needs and concerns, and to actively guide operational decision-making processes *(129)*.

Mental health and psychosocial support programmes for refugees in Poland, 2024
© WHO/Michał Dyjuk

3.4.7 Components of the GMF

The questionnaire's 12 questions are grouped by the six GAP priorities (Table 4). A set of follow-up questions were included to provide an opportunity for respondents to expand on their answers. In addition, Member States were given the option to submit supporting documents to provide further information.

Table 4. Questionnaire relating to the six GAP priorities

GAP priority	Questions included in the questionnaire
1	Does the national health policy/legislation/strategy/plan include any component on refugees and migrants? Does the national disaster risk reduction plan have at least one component on the health of refugees and migrants? Does the national emergency preparedness and response plan have at least one explicit component on the health of refugees and migrants?
2	Since 2019, has at least one assessment of the national health system been conducted to assess the quality, acceptability, availability or accessibility of health services for refugees and migrants? Are refugees and migrants included in the national occupational health and safety policy/ legislation/strategy/plan?
3	Are refugees and migrants included in the governance, including planning, of health care service delivery?
4	Are there government-led, multisectoral coordination mechanisms to promote the health of refugees and migrants by addressing social determinants of health?
5	Are data on migratory status and/or other related variables routinely collected, analysed and disseminated as part of the national health information system? Are there safeguards in place to prevent misuse of refugee/migrant health data?
6	Do health care providers receive training on culturally responsive care for refugees and migrants? Have there been communication or information campaignsa to counter misperceptions about refugee and migrant health? Are refugees and migrants included in community engagement strategies and plans?

These questions were intended to elicit responses by ministries of health to provide an initial snapshot of the status and progress of the GAP in promoting the health of refugees and migrants. It should be taken into account that while this measures GAP implementation, it also captures all and any related progress that may have been conducted in the context of other frameworks and policy initiatives related to the health of refugees and migrants.

3.4.8 Launch of the first Global Survey on Health and Migration

The online Global Survey on Health and Migration was launched in October 2024, with invitations sent to the 111 WHO Member States (out of 194) that had nominated a focal point. By the closing date of 14 February 2025, 93 of the 111 Member States had completed the survey, establishing a robust dataset for the monitoring of GAP implementation. Responses were received from 30 Member States in the WHO European Region, 21 Member States in the WHO African Region, 16 Member States in the WHO Region of the Americas, 12 Member States in the WHO Western Pacific Region, eight Member States in the WHO Eastern Mediterranean Region and six Member States in the WHO South-East Asian Region.

The survey yielded valuable insights regarding both the health needs of refugee and migrant populations and the responsiveness of national health systems. As a snapshot of the current state of affairs of migration and health policies globally – as reported by the participating Member States – the results highlight promising practices while also identifying areas where additional support may be needed for GAP implementation.

An expert review group was consulted to build consensus on the analysis undertaken in the *World report on the health of refugees and migrants (2)* concerning policy and governance on refugee and migrant health at country level and to gather expert guidance on its strategic direction. The consultation brought together around 30 specialists in health and migration from all six WHO regions, representing ministries of health, academia, international organizations and nongovernmental organizations (NGOs).

It is important to bear in mind that not all Member States responded to the survey and that the findings rely on self-reporting. It is also important to note that some initiatives may not have been captured in the responses, particularly if they were conducted at subnational levels and/or by actors outside the health sector, because the respondents may have had limited information. As with other policy input surveys, the purpose was not to capture implementation or outcome data, nor to rank or compare different countries' progress, but simply to report on the information provided by Member States. Lastly, not all refugees and migrant subgroups were explicitly referred to in the questions. Therefore, "internal migrants", "family migrants" and "student migrants" were not among the listed answer options. However, Member States could indicate any additional refugee and migrant subgroups relevant to their context that were not listed among the answer options.
Chapter 4 presents the results from the first iteration of the survey to showcase the available information on GAP implementation around the world.

4. GMF survey results

In Islamabad, Pakistan, women and children survivors of gender-based violence, including Afghan refugees, receive mental health and psychosocial support at the Family Protection and Rehabilitation Centre, 2025
© WHO

The first Global Survey on Health and Migration was administered by the WHO Special Initiative on Health and Migration in 2024 and garnered responses from 93 of the total 194 WHO Member States. This chapter presents the results of the survey with a short overview of the results, followed by a detailed breakdown of responses to the survey's 12 questions.

The survey findings clearly indicate that several strategic areas of GAP implementation are relatively advanced. This is true, for example, of steps taken towards ensuring some degree of inclusion for refugees and migrants in national health policies, legislation, strategies and plans.

An encouraging finding is that GAP implementation is also relatively advanced in relation to the building blocks of effective policy-making. For example, in most responding Member States, government-led multisectoral coordination mechanisms promoting the health of refugees and migrants are in place. However, GAP implementation appears to be less advanced in other areas. For example, the survey results suggest that refugees and migrants are still not adequately included in emergency-related policies: few national disaster risk reduction or emergency preparedness and response plans contain explicit components addressing their needs.

The evidence base for migration health policies and interventions also appears to be weak. Most responding Member States do not systematically assess how their national health systems and services address the needs of refugees and migrants. Nor do they collect, analyse or disseminate data on migratory status or related variables through their health information systems or have safeguards to prevent the misuse of relevant data.

The results also show that refugees' and migrants' involvement in decision-making and the implementation of health interventions is low, which may limit the responsiveness of such interventions. Only a minority of Member States include refugees and migrants in the governance of health services or in the drafting and implementation of community engagement strategies and plans.

Additionally, in most of the responding Member States, health care professionals do not receive training on culturally responsive care for refugees and migrants. Similarly, there is a lack of communication or information campaigns designed to counter misperceptions about refugee and migrant health. Although more action is needed in these areas, several cross-cutting issues merit particular attention.

4.1 Cross-cutting issues identified in the survey

4.1.1 Refugee and migrant subgroups are not evenly included across GAP implementation efforts

The survey results suggest that different refugee and migrant subgroups have varying levels of access to health services. While some responding Member States reported providing access to specific subgroups not listed in the survey – such as beneficiaries of temporary protection schemes and IDPs – access still varied across groups, with refugees more likely than migrants in irregular situations to be granted access. Member States' responses also indicate that national disaster risk reduction plans tend to include refugees more often than several migrant subgroups. It is also worth noting that a few Member States mentioned IDPs as a target group for interventions, despite not being explicitly asked about IDPs in the survey.

The indications of uneven attention to refugee and migrant subgroups across GAP implementation priorities reflect an overall piecemeal approach to refugee and migrant inclusion. This may have negative public health consequences in several areas. For example, the neglect of some hard-to-reach migrant populations *(130)* may hamper disease elimination campaigns. It is, therefore, essential to prioritize the inclusion of diverse subgroups across programmes and policies. Additionally, specific barriers to access faced by these subgroups must be addressed, since migrant-responsive health policies do not necessarily guarantee their access to health services *(131)*.

4.1.2 Interventions are often not tailored to refugee and migrant subgroups

Member States often seem to adopt a one-size-fits-all approach to interventions, rather than tailoring their approach to the various subgroups of refugees and migrants. The survey results suggest that refugees and migrants are frequently included under general policies, plans or programmes designed for the broader population, without specific adaptations to address their particular needs. For example, in some cases, refugees and migrants are classified as

being part of a broader vulnerable group. Several responding Member States have disaster risk management plans that target all populations assessed to be highly vulnerable to risks of emergencies and disasters, which include migrants. Similarly, some Member States indicated that migrant workers are covered under general policies for vulnerable workers, although they are not explicitly mentioned. While such generalized approaches can help to address the health needs of many refugees and migrants, the lack of targeted approaches may limit the effectiveness of interventions or have other negative impacts.

4.1.3 Multisectoral coordination on migration health is not always reflected in policies and interventions

Many Member States have established mechanisms for multisectoral coordination on migration health, but this approach is not always reflected in policies and interventions. The survey results suggest that while responding Member States recognize the need for multisectoral collaboration to address the specific health needs of refugees and migrants, such collaboration is often limited to dialogue. The engagement of key ministries and sectors – including those of education, labour and social protection – in shaping comprehensive migration health policies must extend to implementation and continuous monitoring and evaluation. To strengthen implementation of the GAP, it is essential that a broad range of actors is actively and meaningfully involved in coordinated, country-level efforts.

4.1.4 Political priorities impact the ability to advance refugee and migrant health

Shifting political priorities often dictate Member States' abilities to advance the health of refugees and migrants. The results serve as a reminder that the ability to act on migration and health is often a function of politics, with policies and programmes reflecting shifting priorities. For example, when asked about future plans in relation to areas of GAP implementation, several responding Member States cited uncertainty about the way forward, given their changing political leadership and agendas. One way to address such uncertainty is to establish robust, evidence-informed migration health policies developed through inclusive stakeholder engagement and cemented in formal adoption. Such an approach reduces vulnerability to politically driven fluctuations and strengthens the foundations for long-term planning.

4.1.5 Country-level efforts offer a strong foundation for advancing GAP priorities

Because the survey did not assess the level of implementation or impact of any given initiative, the outcomes achieved by Member States cannot be evaluated. However, the findings suggest that the participating Member States are undertaking substantial initiatives across multiple GAP areas that can be built upon with the support of actors such as WHO. Data collection and dissemination is a

case in point. While only about a third of the Member States routinely collect and disseminate data on migratory status and related variables, more than half reported having measures in place to safeguard against the misuse of such data. This suggests that more than the reported one third of Member States collect data on migration-related variables, but that not all do so in a systematic or routine way. There may, therefore, be opportunities for Member States and other stakeholders to strengthen existing systems rather than having to start from scratch.

The results also highlight the diversity of Member States' migration health dynamics, the differing approaches adopted to address the challenges faced and the broad flexibility afforded by the GAP. The variety of national initiatives reported indicates that valuable insights and innovations are emerging at country level. Sustaining momentum is critical, since many Member States are at pivotal stages in developing inclusive and forward-looking migration health frameworks. It is, therefore, essential that they are supported. There is also an urgent need to strengthen inter- and cross-regional knowledge exchange to facilitate the sharing of lessons learned and the comparison of approaches taken, particularly among regions with similar migration health dynamics and trends.

4.1.6 Technical assistance and capacity development are needed across many areas

In order to build on existing country efforts, there is a need for targeted interventions that tackle areas where GAP implementation lags behind. The specific characteristics of national health systems and contexts demand that responses should be carefully tailored. Involving refugees and migrants in the development and implementation of interventions is key to achieving this. Because the way forward will be different for each national context, Member States should play a key role in conducting priority-setting exercises to structure action that is inclusive of national and local actors, including refugee and migrant populations *(132)*. That said, some requirements, such as the need for routine collection, analysis and dissemination of high-quality migration health data, are common to all Member States. Potential synergies are available and capacity development interventions can simultaneously respond to several gaps across GAP priorities. For example, improvements to migration health data can also support the development of inclusive and accessible communication/information campaigns to counter misperceptions about refugee and migrant health – in this way responding to two GAP implementation areas at once.

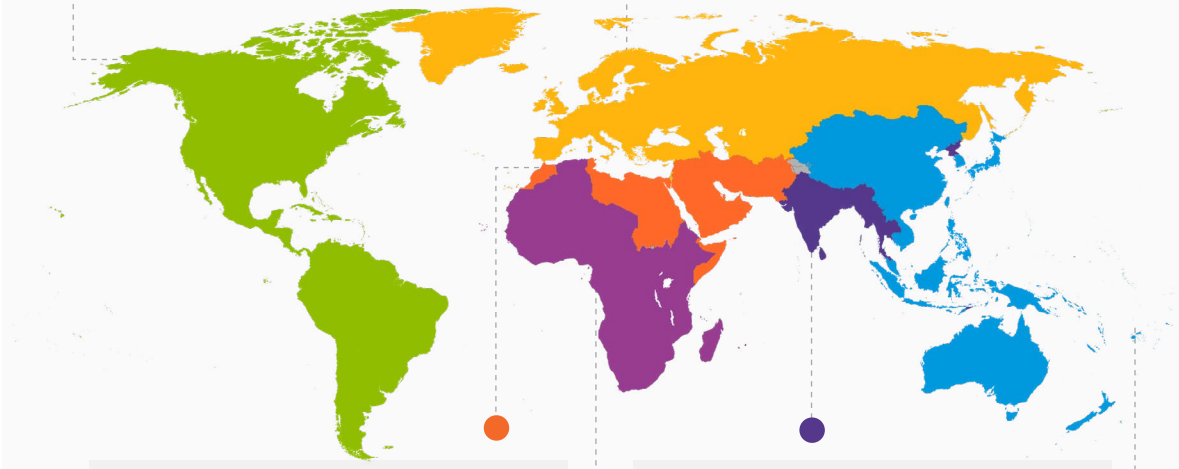
4.2 Detailed results for the questionnaire

Detailed results for the areas covered by each of the 12 questions are set out below.

4.2.1 Inclusion of refugees and migrants in the national health policy/legislation/strategy/plan

The majority of responding Member States (62/93, 67%) indicated that their national health policy/legislation/strategy/plan includes components relating to refugees and migrants (Fig. 5).

Fig. 5. Inclusion of refugee and migrant health aspects in national policies, legislation strategies or plans across thematic areas, by WHO region

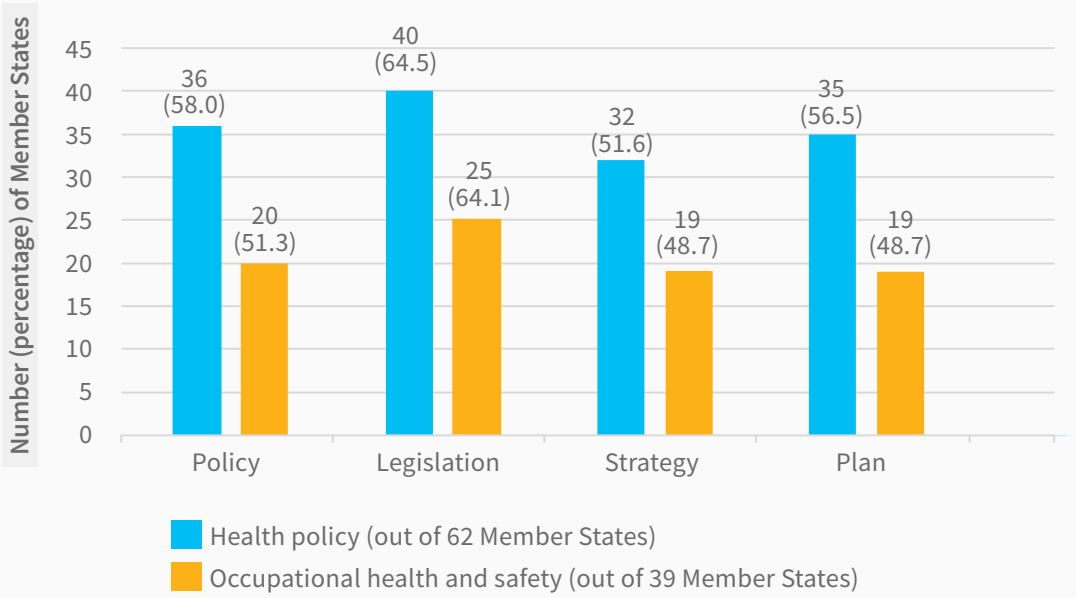


Source: first GAP survey results.

Note: data reflect only those Member States that responded to the survey. Results are categorized by WHO region and and exclude data from non-Member States, countries and territories (shown in grey).

Fig. 6 illustrates which types of instruments include components relating to refugees and migrants.

Fig. 6. Inclusion of refugee and migrant health components in national policies, strategies and plans, by type of instrument



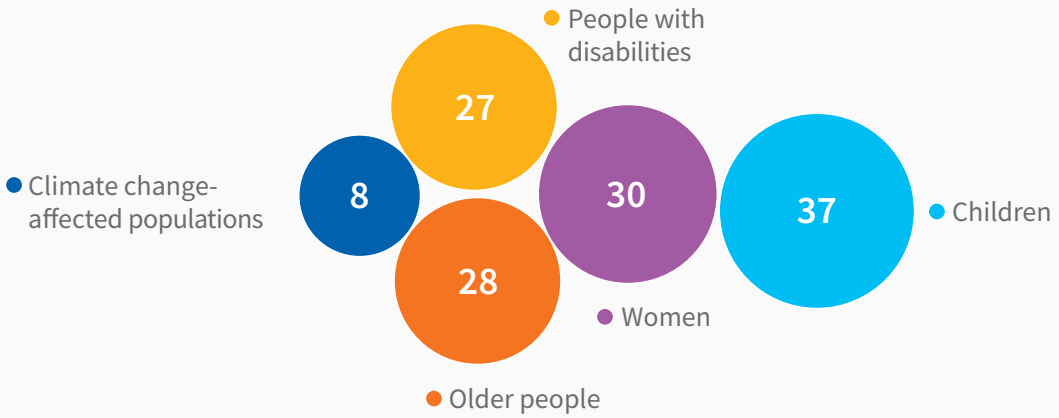
Source: first GAP survey results.

Note: more than one instrument could be selected. Data reflect only those Member States that responded to the survey. Results are categorized by WHO region and do not represent all countries in each region.

Nine Member States answered that other instruments contained references to refugees and migrants, such as including standard operating procedures and a framework of guiding actions for the right to health of migrants from the Ministry of Health.

Of the 93 Member States that reported including refugee and migrants in their national health policy/legislation/strategy/plan, 62 further elaborated on which vulnerable group(s) were explicitly represented (Fig. 7). Children had the most representation, with 37 out of 62 Member States reporting adequate coverage in national policies and plans. However, none of the Member States covered all vulnerable groups, although three Member States covered all vulnerable groups except for climate change-affected populations.

Fig. 7. Population groups among refugees and migrants included in national health policies, legislation, strategies or plans



Source: first GAP survey results.
Note: multiple groups could be selected.

Member States that responded that "other" vulnerable groups are mentioned in their national documents stated that they specifically refer to those living with HIV/AIDS, TB/multidrug-resistant TB or victims of human trafficking.

Out of the 62 Member States that reported including refugee and migrants in their national health policy/legislation/strategy/plans, 30 reported that all migrant subgroups listed have access to health services[8] equal to that of the host populations. Nine responded "other", indicating that migrants have equal access to emergency health care only or that only certain groups, such as migrant workers, have equal access to health services.

Of the 23 Member States indicating that access to health services for all migrant subgroups referenced in the survey is not equal to that of the host populations, 16 indicated that equal access is provided to refugees for all services (with the exception of one Member State that provides equal access to all services excepting those related to noncommunicable diseases), 14 indicated that equal access is provided to international migrant workers for all services and 11 indicated that equal access is

[8] The health services listed were sexual and reproductive health; maternal, newborn, child and adolescent health (including emergency obstetric services, pre and postnatal care); infectious diseases, noncommunicable diseases and mental health services; emergency health care services; and access to vaccination programmes.

provided to asylum seekers for all services. None of the 23 Member States reported providing equal access to migrants in irregular situations. Other countries reported providing access to health services to specific subgroups on a par with the host population. These included Ukrainian civilians, beneficiaries of temporary protection, foreign retirees and some asylum seekers.

The 62 Member States that responded that their national health policy/legislation/strategy/plan includes components on refugees and migrants reported that these groups have access to different types of health service.

Overall, the responses to this question suggest that steps have been taken to integrate the consideration of refugees and migrants into many national health policies, legislation, strategies and plans. This is consistent with other indications that refugee and migrant inclusion in health systems has steadily progressed at the national and subnational levels *(133)*. Nevertheless, the variability across subgroups and health services provided indicates that their inclusion is far from uniform.

The case studies in this chapter (case studies 7–20) give more detail about the national health policies/legislation/strategies/plans in some of the responding Member States.

Of the 22 Member States that reported that their national health policy/legislation/strategy/plan does not include components on refugees and migrants, eight responded that there are plans to address this in the next 2 years and five responded that there are no such plans. Nine responded "other".

Case study 7
Mental health strategy in Spain

Spain's Mental Health Strategy 2022–2026 identifies migrants as a vulnerable group at higher risk of mental health issues due to structural and individual factors; highlights the need for inclusive health promotion, early detection and prevention efforts; and mentions migrant groups throughout *(134)*. Similarly, the country's Action Plan on Addiction 2017–2024 acknowledges the importance of addressing the needs of those at risk of marginalization, including migrants *(135)*. Additionally, the Ministry of Interior has worked together with Government representatives on national drug policies to address addiction issues in detention centres for foreigners, and is developing recommendations to improve related care.

Case study 8
Health financing integration in Thailand

Thailand has made significant strides in integrating migrants into its national health system. Migrants may enrol in the Migrant Health Insurance or Social Security Scheme *(136)*, both of which provide access to essential services. Since 2019, the Migrant Health Insurance Scheme has been extended to undocumented migrants on a voluntary basis, while remaining compulsory for documented workers. To ensure access to care, the scheme allows the Ministry of Public Health to provide health services for migrants not covered by the Social Security Scheme, including undocumented migrants. The Ministry of Public Health uses the Country Cooperation Strategy and Joint Assessment Missions to promote migrant inclusion in UHC, policy planning, health literacy and governance frameworks *(137–139)*.

4.2.2 Inclusion of the health of refugees and migrants in the national disaster risk reduction plan

A total of 39 of the 93 responding Member States (42%) reported having at least one component on the health of refugees and migrants in their national disaster risk reduction plan (Fig. 5). Of these, 32 said that refugees are included in plans and 18 that all migrant subgroups listed are included in plans.

Only 22 of the 39 Member States reporting that refugees and migrants are included in their disaster risk reduction plan stated that the plan addresses challenges for refugees and migrants related to climate change.

Case study 9
Disaster risk reduction in Papua New Guinea

The Papua New Guinea National Disaster Risk Reduction Framework 2017–2030 explicitly refers to migrants as stakeholders in disaster resilience, calling for efforts to empower local authorities through regulatory and financial means "to work and coordinate with civil society, local communities, vulnerable, internally displaced people and migrants in disaster risk reduction at the local level". By embedding migrants in preparedness, response and recovery, the framework promotes community-based disaster resilience that is inclusive of migrant groups *(140,141)*. Additionally, the framework reiterates an inclusive national disaster risk governance approach by highlighting the importance of supporting "policies and programmes addressing disaster-induced human mobility/displacement to strengthen the resilience of affected people and that of host communities, in accordance with national laws and circumstances".

Thirty-eight of the 93 Member States (41%) responded that their national disaster risk reduction plans have no component relating to the health of refugees and migrants, while 16 (17%) responded "other".

Of the 38 Member States that answered "no", nine plan to include component(s) on the health of refugees and migrants in the national disaster risk reduction plan in the next 2 years, while 17 do not. Ten Member States responded "other", with the reasons most often given being "not known" or "not yet decided".

4.2.3 Inclusion of the health of refugees and migrant in the national emergency preparedness and response plan

A total of 39 of the 93 responding Member States (42%) reported having at least one component on the health of refugees and migrants in their national emergency preparedness and response plan (Fig. 5).

Of these 39 Member States, 13 include all listed refugee and migrant groups in their national emergency preparedness and response plan. One Member State explicitly references the inclusion of IDPs in their plan.

Of the total 93 Member States, 32 responded that they do not have any component on the health of refugees and migrants in their national emergency preparedness and response plan, while 22 Member States responded "other". Of these 22, one Member State said that refugee and migrant populations are provided with the same benefits in this context as nationals, without distinction, and two indicated that refugees and migrants are not directly referred to in their plans but are included in the plan as part of the vulnerable populations. Two others responded that emergency preparedness and response plans do not exist at national levels but that refugees and migrants might be included in subnational level plans at the discretion of each region or state.

While these approaches can help to address the health needs of many refugees and migrants, the lack of special consideration towards them in emergency planning could pose risks. Refugees and migrants frequently face specific risks during emergencies and disasters *(142)* and plans to protect them need to reflect this.

When asked whether there is a plan to include refugees and migrants in their national emergency preparedness and response plan within the next 2 years, eight of the 32 Member States that did not already include these groups responded "yes", 12 responded "no", 10 responded "other" and two did not respond.

Case study 10
Crisis response in Libya

The Libya Crisis Response Plan 2024 explicitly mentions migrants alongside IDPs, returnees, refugees and host communities. The Plan commits to "assist in meeting the growing challenges linked to migration governance" and to "provide protection and humanitarian assistance and support to migrants and IDPs". Planned interventions address migrants' urgent health, protection, shelter and basic needs, in recognition of their vulnerabilities in Libya's evolving humanitarian context *(143)*.

4.2.4 Assessment of the national health system regarding quality, acceptability, availability or accessibility of health services for refugees and migrants

Of 93 responding Member States, 34 (37%) report having conducted at least one assessment of the national health system and health services for refugees and migrants since 2019. Twenty-one of the 34 reported including refugees, which comprise the most commonly included subgroup. Only six Member States responded that they cover all listed refugee and migrant groups in such assessments.

Case study 11
The health system in Jordan

Jordan's Ministry of Health assessed how the health system has adapted to its large refugee population. The published review of the assessment highlights financial constraints, workforce shortages and service delivery gaps, while identifying opportunities to strengthen resilience and integration. The review also emphasizes the need for sustainable financing, inclusive health policies and improved health information systems to ensure equitable access to care, support data-driven planning and advance broader health system strengthening to benefit host and refugee populations *(144)*.

In response to a request for a brief summary of the key findings from the assessments conducted, participants highlighted gaps in service availability and readiness in refugee-hosting districts. They cited inadequate human resources, infrastructure, medicines and other supplies as the main challenges faced. Respondents also noted multidimensional barriers to access, ranging from financial hardship to limited health literacy, poor support for system navigation, and language or cultural mismatches.

Of the 18 Member States that responded "other", most indicated that no comprehensive assessment has been undertaken, only targeted reports. Thirteen Member States reported having plans to carry out a health system review in the next 2 years, and an additional seven Member States responded that they would consider conducting one, if given the necessary support from international organizations.

The relative scarcity of recent assessments by Member States of the national health system and health services for refugees and migrants suggests that data needed to establish an evidence base may be lacking. Such assessments are not only critical to inform policy and programmes to address refugees' and migrants' health but also important to measure progress over time.

4.2.5 Inclusion of refugees and migrants in the national occupational health and safety policy/legislation/strategy/plan

Of the 93 responding Member States, 39 (42%) reported that refugees and migrants are included in the national occupational health and safety policy/legislation/strategy/plan. These 39 were asked to list documents that include at least one component on refugees and migrants (Fig. 5). Nine of the Member States included components relating to refugees and migrants in all documents.

Case study 12
At-risk groups in Liberia

Liberia's National occupational health and safety guidelines include a reference to migrants and displaced populations in the context of addressing the needs of at-risk groups, and note that many face exploitative working conditions. The guidelines state that language barriers, family disruption, poor access to health care, stress, and violence are some of the specific problems faced by migrant workers that make them particularly vulnerable to health and safety risks in the workplace *(145)*.

Member States that answered "other" mentioned a requirement for any person staying legally in the country and wishing to start a job to undergo a medical examination, and a reference in existing plans to vulnerable workers, including foreign workers.

Of the 39 Member States that included refugees and migrants in the national occupational health and safety policy/legislation/strategy/plan, 10 included all listed subgroups. Other population groups referenced included IDPs and culturally and linguistically diverse workers.

Twenty-two Member States responded "other" to the question of whether refugees and migrants are included in their national occupational health and safety policies, legislation, strategies and/or plans. Some of these stated that the national constitution guarantees equal rights and benefits for all individuals within the territory, regardless of nationality, and that the labour code makes no distinction between nationals and foreigners, regardless of migratory status or category. Other Member States stated that while there was no explicit mention of migratory status in relevant documents, permanent residents share the same occupational health rights as the rest of the population. One Member State noted that, while refugees and migrants are not specifically referenced in occupational health and safety policies, they are covered under general labour and safety regulations, in accordance with international conventions and EU directives.

Regarding other areas, this one-size-fits-all approach may not be enough to meet the occupational health needs of refugees and migrants, who often have different profiles and needs to other population groups. For example, some migrant workers enjoy fewer workers' rights to safe and healthy working conditions than others *(2)*. Relevant occupational health plans may require migrant-responsive adjustments to take this into consideration.

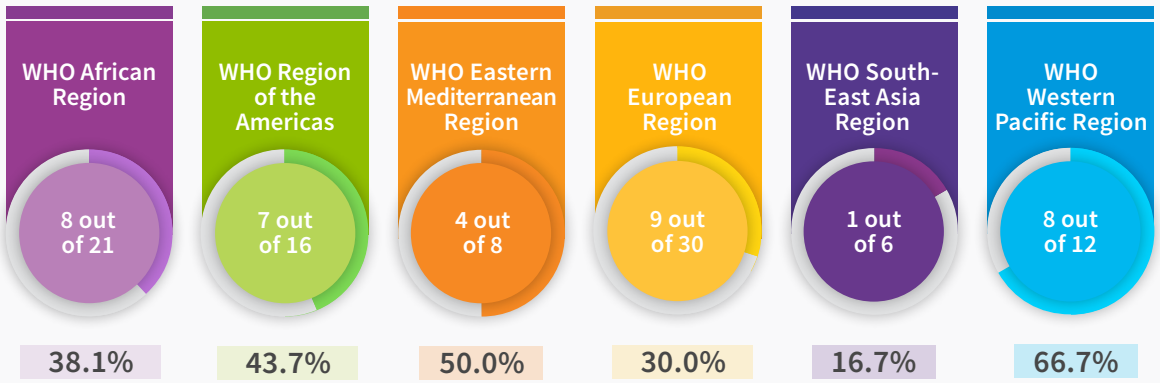
Thirty-two of the responding 93 Member States (34%) did not include refugees and migrants in the national occupational health and safety policy/legislation/strategy/plan. Eight of the 32 stated that there are plans to address this within the next 2 years, while 16 reported that there are no such plans.

4.2.6 Inclusion of refugees and migrants in the governance, including planning, of health care service delivery

Of the 93 responding Member States, 37 (40%) reported that they include refugees and migrants in the governance of health service delivery, including planning (Fig. 8).

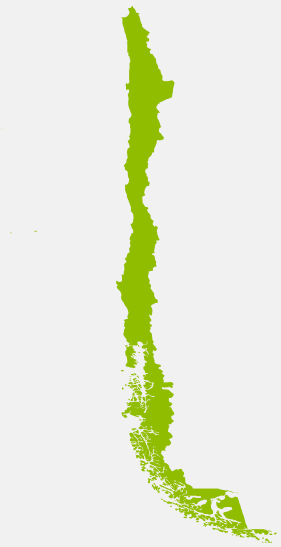
Of the 37, 14 reported including all listed refugee and migrant groups in the governance, including planning, of health service delivery.

Fig. 8. The inclusion of refugees and migrants in health service delivery governance of Member States, by WHO region



Source: first GAP survey results.

Case study 13
Refugee and migrant inclusion in Chile



Chile has advanced refugee and migrant inclusion in health governance by integrating these groups into national and local health planning frameworks. The Ministry of Health established intercultural health units and consultative bodies that include migrant community representatives in decision-making on primary care delivery. Municipal health councils in high-migration areas, such as Santiago and Antofagasta, engage migrants in setting priorities for maternal health, communicable disease prevention, and mental health services. Partnerships with NGOs and United Nations agencies have further supported participatory planning, ensuring culturally sensitive care models. This approach improves accountability, service responsiveness and equity, while strengthening trust between migrant communities and health authorities *(146)*.

The area of health service delivery governance where refugees and migrants are most commonly involved is planning, and seven Member States reported that refugees and migrants are included in all listed components.

Case study 14
Equitable access to health in Morocco

Morocco's National Strategic Plan for Health and Immigration 2021–2025 ensures equitable access to primary, sexual, reproductive and psychosocial health care for all migrants, regardless of legal status. It emphasizes regional action plans, capacity-building of culturally sensitive health care providers, community "field agents", integrated surveillance and alignment with national UHC goals. The Plan advances intersectoral coordination and data integration to bridge health gaps and enhance migrant well-being across Morocco *(147)*.

Of the 93 Member States, 41 (44%) reported not including refugees and migrants in the governance of health service delivery, while 15 responded "other". "Other" responses included statements to the effect that refugees and migrants are included in the governance regarding certain areas, including the response to HIV/AIDS, communicable diseases and emergency situations.

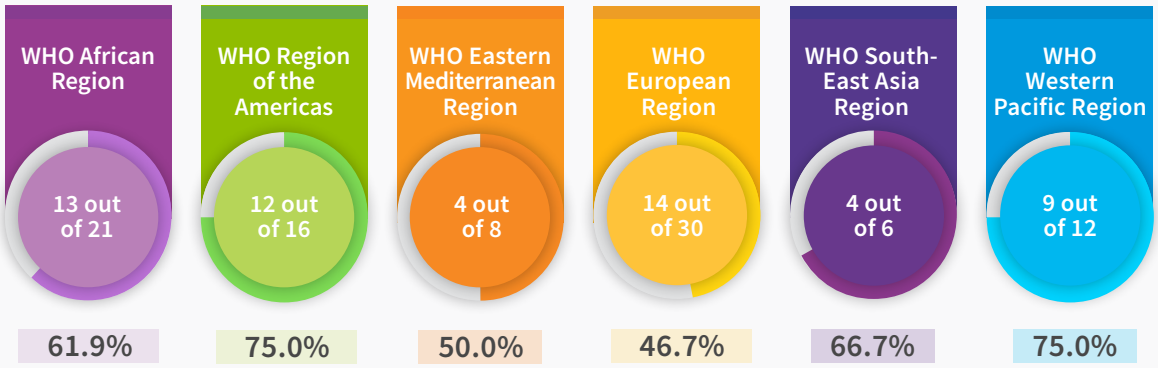
Of the 41 Member States that reported not including refugees and migrants in health service delivery governance, 11 responded that they have plans to address this within the next 2 years, 20 responded that they have no such plans and eight responded "other". One Member State that responded "other" indicated that work was under way in this area, with the creation of coordination and participation spaces.

The low inclusion rates for refugees and migrants in the governance of health service delivery is a matter of concern. When refugees and migrants are not included in decisions about how health services are delivered, health systems are less able to respond to their needs. Involving refugees and migrants more meaningfully could also help in other GAP areas by unlocking new strategies and approaches to effectively target refugees and migrants. For example, while access to services may be granted, understanding and addressing the many barriers to their practical uptake requires the perspectives of refugees and migrants.

4.2.7 Government-led multisectoral coordination mechanisms to promote the health of refugees and migrants

Of the 93 responding Member States, 56 (60%) reported that there are government-led multisectoral coordination mechanisms in place to promote the health of refugees and migrants that address the social determinants of health (Fig. 9).

Fig. 9. Member States that reported having government-led multisectoral mechanisms addressing refugee and migrant health and its social determinants, by WHO region



Source: first GAP survey results.

Of these 56, 20 responded that all refugees and migrants listed are covered by the mechanism. Of those that responded "other", one stated that the mechanism covers refugees from Ukraine.

Of the same 56 Member States that responded "yes", 51 reported that such mechanisms exist at national level and 21 that they exist at regional level. "Other" responses included statements indicating that they exist at district, local or provincial level or at refugee sites.

Case study 15
Migration as part of the national agenda in Kenya

Kenya developed the National Implementation Plan of the Global Compact for Safe, Orderly and Regular Migration 2023–2027 to integrate migration into its national development agenda, improve migration governance and provide a clear roadmap towards safer, more orderly migration. The Plan is intended to establish a coordinated policy framework for unifying efforts across all levels of government, civil society and international partners. Public health with a focus on migration health is a priority within this framework and the Plan includes considerations to facilitate migrants' access to WASH and health services *(148)*.

The health sector is engaged in 52 of the 56 Member States, while private sector engagement was reported in 22 of the Member States. Sixteen of the 56 Member States reported that all sectors listed are involved in partnerships.

Case study 16
Protection for people of concern in the Philippines

Philippine Executive Order No. 163 (2022) entitled Institutionalizing Access to Protection Services for Refugees, Stateless Persons and Asylum Seekers formally establishes a legal framework to ensure access to protection services for these people of concern. The order reiterates the Refugees and Stateless Persons Protection Unit in the Department of Justice, and creates the Inter-Agency Committee on the Protection of Refugees, Stateless Persons and Asylum Seekers to coordinate rights-based services and assistance on health, education, social welfare, labour and employment, among others. The Department of Health is included in this inter-agency group *(149)*.

Member States that answered "other" mentioned the involvement of other sectors: water and sanitation (one Member State), gender (two Member States), the Ministry of Culture (one Member State), the Department of Internal Affairs (five Member States), the Ministry of Labour (three Member States), the Ministry of Youth and Sport (one Member State) and social services (five Member States).

In most Member States, existing government-led multisectoral coordination mechanisms are related to policy (38 Member States) and practice (40 Member States) on migrant health, with research being the focus of fewer mechanisms (17 Member States). In nine Member States, the mechanisms are related to climate change. Three Member States responded "yes" to all listed areas.

Brief summaries of the coordination mechanisms included ministries of health establishing a migration health working group to coordinate all related sectors to implement the health of migrants, including internal and international migrants. Several Member States reported that regular meetings are held between ministries and directorates or that regional ministerial health secretariats participate in formalized and active regional intersectoral councils. Another Member State mentioned a national refugee health and nutrition steering committee and a refugee health and nutrition technical working group.

One Member State in the WHO European Region said that its Migrant Health Liaison Office (primary health care) had participated in EU-funded projects focused on building the capacity of government service providers in the areas of migration and health, including the social determinants of health. The Office offers training for cultural mediators in health care aimed at equipping interested refugees and migrants to support the effective engagement of these groups with health systems. The Office also coordinates a working group on improving the integration of migrant workers into the health care sector.

Member States in the WHO African Region stated that their Ministry of Health has established a coordination team composed of senior officials from the Ministry and a technical group. The team is responsible for monitoring and resolving any issues related to the delivery of health services for refugees and asylum seekers. Such teams work in close collaboration with other ministries, including the ministries of education, the interior, social affairs, and human rights and foreign relations, as well as with UNHCR.

One Member State in the WHO South-East Asia Region reported that their Public Health Service Act has a provision for a National Public Health Committee, which incorporates members of all sectors.

Twenty-seven of the 93 Member States (29%) responded "no" to there being government-led multisectoral coordination mechanisms in place to promote the health of refugees and migrants and address the social determinants of health, while 10 responded "other". Member States that responded "other" reported that a plan is being developed and that other interinstitutional collaborations are in place.

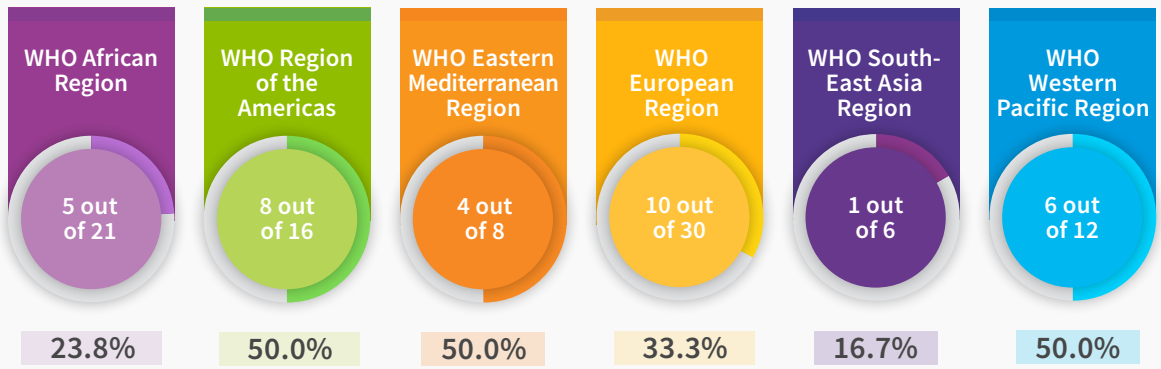
Of the 27 Member States that reported not having a government-led multisectoral coordination mechanism, six plan to establish one within the next 2 years. Several Member States reported that a coordination mechanism is being established under new migrant health policies.

It is encouraging that the majority of responding Member States reported having a government-led multisectoral coordination mechanism in place to promote the health of refugees and migrants: this provides an excellent basis for action across GAP areas. Multisectoral coordination mechanisms related to research appear to be less common than those related to policy and practice and should be strengthened to support the development of evidence-informed interventions. Responses to this question also highlighted the active roles played by NGOs and academia, as well as international organizations that are involved across multiple operational and policy areas.

4.2.8 Routine collection, analysis and dissemination of data on migratory status and/or other related variables as part of the national health information system

Of the 93 responding Member States, 34 (37%) reported collecting, analysing and disseminating data on migratory status or other related variables as part of the national health information system (Fig. 10). Examples of the variables collected and analysed include data on country of birth, country of citizenship (nationality), date of arrival, reason for migration and parent's country of birth. Several migration variables were said to be recorded as part of data collection across health through specialized health surveys, national health information management systems, national electronic medical records and other mechanisms. In one Member State, data on migratory status are included in the national register, which is partially linked to the health information management system.

Fig. 10. Routine collection, analysis and dissemination of data on migratory status, as part of the national health information system, by WHO region



Source: first GAP survey results.

The 34 Member States that responded "yes" to this question were asked whether evidence and/or research on the health of refugees and migrants is routinely produced by the Ministry of Health to inform the planning and policy-making process: 19 Member States said "yes", eight said "no" and five responded "other".

Case study 17
Data on migration in Australia

Australia captures data on visas, health, demographics, education, employment and other topics through its census and various other sources, including administrative reporting. Through a partnership between relevant agencies, much of these data are linked through the Person Level Integrated Data Asset, which provides insights on particular population groups, including refugees and migrants. Its microdata help to inform research, for example, through the Refugee and Humanitarian Entrant Health Project, which analyses chronic illness, service use and mortality. Complementary sources of information include the Settlement and Integration Outcomes Framework and the longitudinal Building a New Life in Australia study, which provide structured, multidomain data on a range of settlement outcomes for humanitarian migrants, including health and social outcomes. Indicators for the Refugee and Humanitarian Settlement and Integration Outcomes Framework are being developed that will draw on data sources to track the settlement of humanitarian entrants *(150–154)*.

Of the 93 Member States, 49 (53%) do not collect/analyse/disseminate data on migratory status or other related variables as part of the national health information system. Ten Member States responded "other", with stated reasons including that such data are being collected by migration and asylum authorities or through the social system or other sectors.

Of the 49 Member States that do not collect/analyse/disseminate data, 17 reported having plans to do so using variables systematically within the next 2 years, while 19 stated that they do not. Three did not respond.

Ten Member States responded "other": their answers included that efforts are ongoing to improve data collection and integration, but are not yet fully implemented nationwide. Other Member States reported that they have no specific plans at present and that decisions will depend on the priorities set by elected officials.

The low proportion of Member States collecting, analysing and disseminating relevant data as part of the national health information system reflects major data gaps and other well-documented challenges *(85)*. Without a foundation of reliable, accurate and timely data, refugee and migrant health needs will remain unaddressed.

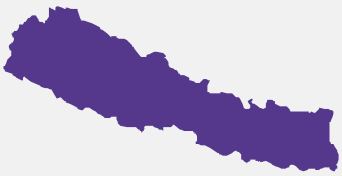
4.2.9 Safeguards in place to prevent misuse of refugee/migrant health data

Of the 93 responding Member States, 53 (57%) reported having safeguards in place to prevent the misuse of refugee and migrant health data. Respondents reported using different kinds of safeguards, including legislative instruments, policies and frameworks that involve data sharing and restricting which data can be accessed and by whom. Respondents also cited having secure information technology systems, conducting security audits, training in handling and storing personal data, and ensuring that data-processing and antivirus software is up to date, among other measures. Data encryption and secure data transmission, data anonymization, and the use of firewalls were also cited.

Some respondents detailed data protection frameworks that are used for personal data in general in the country. For example, one Member State mentioned legislation that establishes the protection of personal data as a fundamental right and applies to data recorded on any medium. Several Member States mentioned that all data are handled in accordance with the General Data Protection Regulation *(155)* – an EU legal framework that sets strict guidelines on how personal data must be collected, stored, processed and shared. Many Member States said that regulations or safeguards for the general population are being applied to refugees and migrants as well. For example, in many Member States, patient confidentiality in registered health care facilities and safeguards around national electronic patient records are the same for all patients, including refugees and migrants.

Migration health data are often governed by broader data protection frameworks that apply to all personal data, reflecting a one-size-fits-all approach. Under such frameworks, refugees and migrants are included under interventions designed for the broader population, without specific adaptations. This presents several challenges, notably because migration health data can be particularly sensitive *(156)*. Tailored data protection measures are, therefore, recommended.

Case study 18
Migration data in Nepal



Between 2019 and 2022, Nepal's Ministry of Health and Population developed a Migration Health Management Information System with United Nations support. By incorporating data protection measures aligned with international standards, including safeguards to ensure confidentiality and prevent misuse, the system enhances the collection, analysis and use of migration health data across the country. In this way, it strengthens the capacity for evidence-informed policy and planning and helps to integrate migration into national health strategies *(157)*.

Other Member States detailed frameworks relating to health data. One of these described the personal data-processing policy used by its health ministry. Another described using high-level safeguard systems for all health data processed in its health information system. This included applying data anonymization procedures, storage in secure servers managed by the Ministry of Health, the use of a health intranet and limiting access to data to authorized personnel. Other examples were related to organizations and agencies.

Case study 19
Data safeguards in Mexico

Mexico's pilot project on mobility, environment and climate-change data is advancing the ethical collection and protection of migration data relevant to health. The project captures migration history, health status and environmental impacts using anonymized, secure data protocols. Privacy safeguards are aligned with Mexico's Federal Data Protection Law *(158)*. The project aims to inform rights-based migration and health policies while upholding data confidentiality and integrity *(159,160)*.

Twenty-one of the 93 Member States (23%) reported not having safeguards in place to prevent the misuse of refugee and migrant health data, while 19 answered "other". "Other" responses included a statement explaining that although some measures exist to protect the privacy and security of health data for refugees and migrants, safeguards to prevent misuse are still being developed. One Member State noted that the legal framework provided by wider national data protection legislation offers relevant protections, but that full implementation of these safeguards in the context of refugee and migrant health data remains a work in progress.

Of the 21 Member States that reported not having safeguards in place, seven stated that they have plans to establish safeguards within the next 2 years, 10 stated that they have no such plans, two responded "other" and two did not respond.

4.2.10 Training for health care providers on culturally responsive care for refugees and migrants

Of the 93 responding Member States, 36 (39%) reported that health care providers receive training on culturally responsive care for refugees and migrants.

When asked how the training was structured, 17 of the 36 Member States stated that training is provided as part of the continuous education programme, while four stated that it is incorporated into the national preservice curricula. Fifteen of the 36 replied "other", with three of these stating that both options applied. "Other" responses also included reports that there is no systematic training for all, but that individual training is organized, including targeted training for staff in health facilities that work with refugees and migrants.

Examples of the training offered included courses run by national health care programmes at universities. For example, health care providers receive some training on culturally responsive care to ensure that they can meet the needs of diverse populations. However, the extent and comprehensiveness of this training varies by institution and region. Some medical and nursing schools include modules on cultural competency and people-centred care, with a focus on understanding diverse populations such as refugees, migrants and cross-border communities. Another Member State reported that this issue is included in the national curriculum or integrated into population and health training curricula. Another Member State reported that many health care providers receive some training on culturally responsive care at university.

Case study 20
Refugee and migrant health in Belgium

Belgium's intercultural mediation programme, launched nationally in 1999, strengthens refugee and migrant health by equipping health care providers with tools to navigate cultural and linguistic diversity. As of October 2024, 113 mediators, trained in both health systems and cross-cultural communication, were working in 40 general and eight psychiatric hospitals and 28 community health centres. Providers also make use of multilingual videoconferencing, which is now available in over 250 facilities. This kind of training and support serves to enhance culturally sensitive care and has been particularly helpful for migrants and asylum seekers managing trauma *(161)*.

NGO-led training initiatives conducted through regular workshops were also mentioned, as were on-the-ground training for health care workers in selected areas with large migrant populations. Topics covered include understanding the trauma of displacement, managing language barriers and ensuring confidentiality. In another example, a Member State working in collaboration with an international NGO developed a guide to assist survivors of violence with a culturally sensitive approach.

Digital courses were also mentioned, with examples including an intercultural awareness e-learning programme for staff as well as a virtual course on sexual and reproductive health in emergency contexts that was developed in coordination between multiple actors including IOM and the United Nations Population Fund. Other courses mentioned include a health and migration course designed to guide public authorities within the health sector and beyond in the development of inclusive and evidence-informed policies and strategies.

Of the 93 Member States, 36 (39%) responded that health care providers do not receive training on culturally responsive care for refugees and migrants. The 21 Member States that responded "other" provided a range of information, including that such training is provided for those working in refugee camps; that it is not being conducted systematically, but rather for selected health care providers; and that although health care providers may receive some form of training or sensitization to the specific health needs of refugees and migrants, particularly in regions with a higher degree of refugee and migrant populations, there is no comprehensive or nationwide policy to ensure systematic and ongoing training.

Of the 36 Member States that responded "no", 12 stated that there are plans to introduce such training within the next 2 years, while 15 stated that there are no such plans. Seven responded "other", with responses indicating this could be possible if funding were made available and prioritization given to migrant health. Two did not respond.

The overall proportion of health care providers receiving official training on culturally responsive care for refugees and migrants may be low in many countries, particularly as part of pre-service curricula. However, the plurality of training approaches in this area suggests that many of those working with refugees and migrants have received such training. Nevertheless, there is a clear opportunity to expand the reach of such training to enable more health care providers to respond to refugees' and migrant's specific health needs.

4.2.11 Communication or information campaigns to counter misperceptions about refugee and migrant health

Of the 93 responding Member States, 28 (30%) reported having run communication/information campaigns to counter misperceptions about refugee and migrant health. The aspects of refugee and migrant health addressed by these campaigns ranged from the right to health (25 Member States) to the impacts of migration on health (14 Member States) and of climate change on migration and health (seven Member States). Six Member States reported covering all listed aspects.

Member States that responded "other" reported running campaigns focused on xenophobia, the impact of racism on refugees' and migrants' health, vaccination, and reproductive health (sexually transmitted diseases, female genital mutilation). They also reported that there are campaigns directed towards minors and that there is cooperation with NGOs in this area.

Case study 21
Resources for refugees and migrants in Poland

Since 2022, the Government of Poland has anchored public information in official, bilingual (Polish/Ukrainian) channels that explain entitlements and how to navigate care, thus reducing the possibility of misperceptions. Core assets include the gov.pl portals for refugees (with health sections) *(162)*, the *Narodowy Fundusz Zdrowia* (National Health Fund) 24/7 patient helpline (with Ukrainian support) *(163)* and Ministry of Health digital tools such as LikarPL for clinical guidance and communication with providers *(164)*. In parallel, national statistical and health authorities have used the Refugee Health in Poland dashboard *(165)* to publish survey-based evidence on access, needs and service use to support fact-checking and media briefings. The Chief Sanitary Inspectorate and voivodeship (provincial) services received training in infodemic management and social listening, strengthening routine risk communication during outbreaks, and immunization campaigns. Together, these measures represent a State-led, evidence-informed approach to correcting myths, improving health literacy and sustaining equitable access for displaced populations.

The 28 Member States that responded "yes" indicated that the target audience of their campaigns is the general population (21 Member States) or health care workers (21 Member States). Fifteen Member States responded that both groups are the intended audience.

Of the 93 Member States, 56 (60%) reported that they have not run communication/information campaigns to counter misperceptions about refugee and migrant health. Nine Member States answered "other", with responses including the following: the Ministry of Health, along with the national institution focusing on AIDS, has conducted campaigns related to migrant health; and their

campaign primarily targeted labour migrants, with a focus on HIV/AIDS prevention and treatment and raising awareness about health vulnerabilities among migrants returning from other countries. Of the 56 Member States that reported that they have not run communications or information campaigns, 10 reported planning to conduct such campaigns within the next 2 years, 28 reported having no such plans and 16 responded "other".

"Other" responses indicated that this would depend on any forthcoming leadership changes. One Member State responded that while there had not been any nationwide campaigns, some local or regional initiatives might address related issues by focusing on raising awareness and combating stigma associated with the health of refugees and migrants.

The relative scarcity of Member States that have run these kinds of communication or information campaigns suggests that much can still be conducted to help to counter misperceptions about refugee and migrant health. Factors contributing to the lack of such campaigns may include the limited assessments of health care services (section 4.2.4), as well as patchy data on migration health.

4.2.12 Inclusion of refugees and migrants in community engagement strategies and plans

Of the 93 responding Member States, 45 (48%) reported including refugees and migrants in community engagement strategies and plans (Fig. 5).

Among the 45 Member States, several shared examples of different community engagement initiatives. These include projects in which migrant health volunteers receive training with a curriculum developed by the Ministry of Health and are involved in communicating health information within their communities, with access to essential health services being a core topic. Other initiatives include community-based projects led by refugee and migrant populations. One Member State reported that interested refugees and migrants are trained to act as cultural mediators in clinical encounters for refugees and migrants.

Another Member State mentioned that most of its ministerial health secretariats at regional level include at least one migrant or pro-migrant organization in community engagement mechanism(s). Other examples include refugees being involved in risk-communication strategies as part of broader efforts to promote the participation of refugees and migrants in different areas of society, under wider national integration plans.

Case study 22
Active involvement for refugees and migrants in Brazil

Brazil actively involves refugees and migrants in national policy and local decision-making. Through a process within the National Conference on Migration, Refuge and Statelessness, held 8–10 November 2024, over 14 000 participants including displaced people generated community proposals for a federal migration policy. The Conference included a significant focus on health, with various health authorities participating, and the resulting policy proposals included solutions to ensure universal access to the Unified Health System regardless of documentation status *(166)*. As of mid-2025 the policy had not been enacted by presidential decree, but related interministerial negotiations and drafting were reported to be ongoing *(167)*.

The 45 Member States that responded "yes" were asked to indicate to which migrant/displaced population the community engagement strategies and plans apply. Nine Member States include all listed groups.

Of the 93 Member States, 28 do not include refugees and migrants in community engagement strategies and plans and 20 Member States responded "other". "Other" responses included a statement indicating that this was often conducted at local level in selected municipalities with large diaspora populations.

Six of the 28 Member States that responded "no" reported having plans to include component(s) of migration and health in community engagement strategies and plans within the next 2 years, while 16 stated that they have no such plans. Five Member States responded "other", with one noting that inclusion would be possible if trained personnel or a dedicated team were available. One did not respond.

The results suggest that while there have been a number of valuable initiatives, the inclusion of refugees and migrants in community engagement strategies and plans is for the most part lacking. This is despite emerging evidence that meaningfully including refugees and migrants in community initiatives not only is critical to ensuring that the initiatives are responsive to mobile populations but also helps to empower these groups in relation to their own health trajectories *(168)*.

4.3 Summary of findings

These combined results indicate that progress is being made in promoting refugee and migrant health despite the challenges faced by many Member States. They also highlight areas requiring urgent attention, including the assessment of national health system responsiveness to refugees and migrants, the inclusion of refugees and migrants in health governance and communication strategies, the routine collection and dissemination of migration health data and the training of health service providers. Chapter 5 provides suggestions as to how Member States working in collaboration with WHO and other partners can move forward in these areas.

A laboratory technician examines samples at the Debaga refugee camp's primary health clinic, supported by WHO, 2018
© WHO / Sebastian Meyer

WHO-trained Rapid Responder, provides mental health services to families impacted by the Mai Mahiu flash flood, 2024
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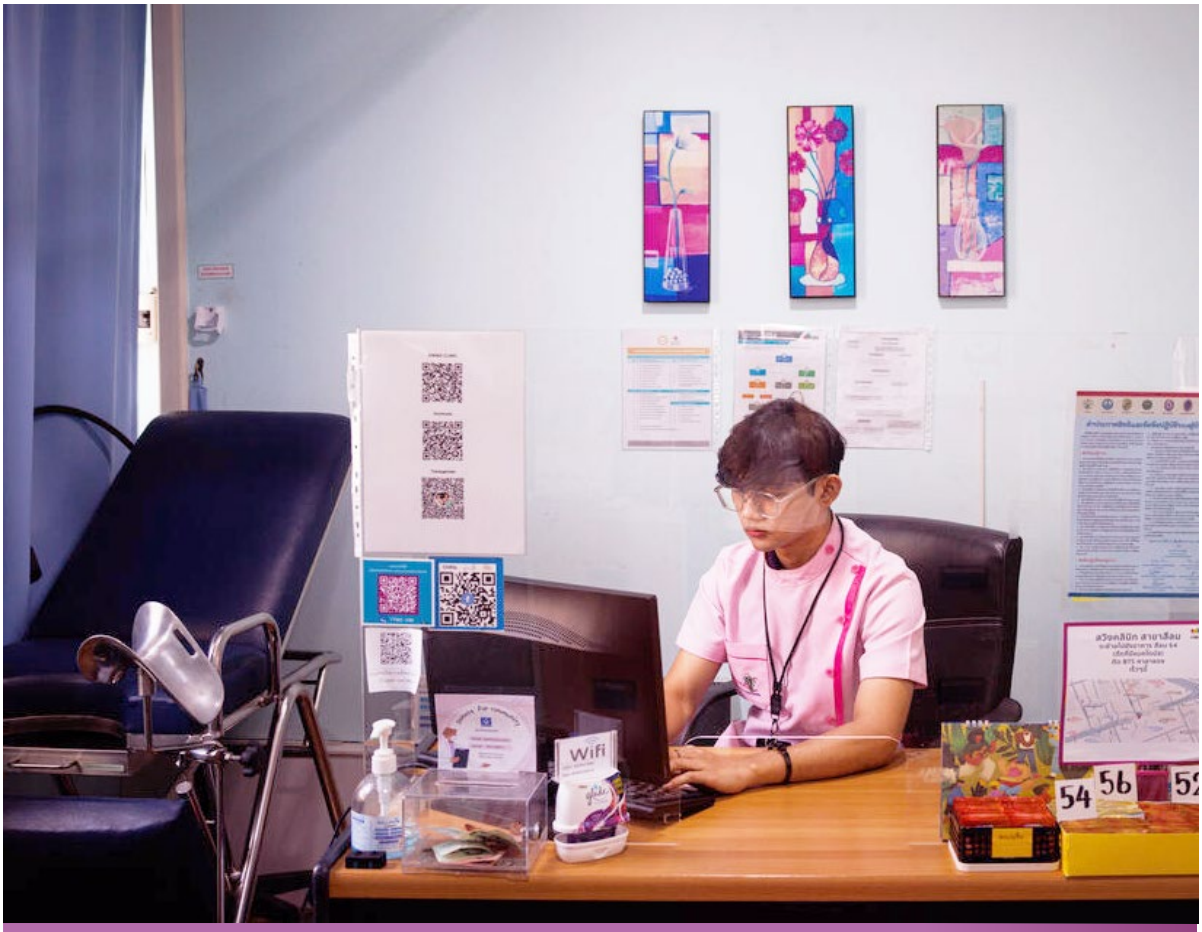
5. The way forward



A health care worker in Thailand provides counselling and education to promote HIV and hepatitis C prevention and care, including for migrant workers, 2024
© WHO/Laureen DeCicca

As this report has shown, significant progress is being made in regard to migration health policies around the world. However, much remains to be done, and, with 4 years remaining until 2030, there is a pressing need to intensify efforts.

The survey results presented in Chapter 4 suggest that more advances are being made in some areas than in others. For example, while most Member States are ensuring some level of inclusion for some refugee and migrant groups in national health policies, legislation, strategies and plans – which is a crucial first step – the needs and rights of those refugees and migrants are still not being fully addressed.

The results also indicate that progress is lacking in several key areas, notably the routine collection, analysis and dissemination of data on migration-related variables as part of national health information systems. Systematic training in culturally responsive care for health professionals is also lacking, as are information campaigns designed to counter misperceptions regarding refugee and migrant health. Lastly, greater efforts are required to integrate refugee and migrant health into UHC programmes and to build collaborative, multisectoral refugee- and migrant-responsive governance.

The needs of refugees and migrants must be fully integrated into existing and emerging initiatives

As the global health and migration landscape continues to evolve, the need to address these challenges will only increase. In a context of increasingly complex global mobility, decisive actions are needed to integrate refugee and migrant health into UHC programmes, build collaborative and fruitful multisectoral governance on the topic and create disaggregated data systems and inclusive health policies. The needs of refugees and migrants must be fully integrated into existing and emerging initiatives to fight noncommunicable diseases, for example, and to address the growing health-related challenges linked to climate change.

The current level of progress is insufficient to meet many of the health and health-related goals and targets set out as part of the 2030 Agenda *(11)*. Countries will not be able to achieve these goals and targets unless refugees and migrants are meaningfully included in their national plans and strategies. Concretely, SDG 3 (ensure healthy lives and promote well-being for all at all ages) cannot be achieved without due consideration of refugees and migrants. The right to health is universal and inalienable: it applies to everyone, everywhere, including refugees and migrants.

As highlighted throughout this report, the health of refugees and migrants is inseparable from that of the general population. Excluding refugees and migrants from national plans and strategies weakens both public and global health, which cannot be meaningfully advanced without addressing the needs of all population groups. On the other hand, their inclusion not only strengthens public health initiatives but also boosts health equity and public health security for all. It also supports their integration into host communities and creates conditions in which their full range of social and economic contributions can be realized. In contrast, neglecting refugee and migrant health carries the associated risk of increasing economic burdens on health systems, weakening global health security and undermining the provision of health care in affected settings *(169–171)*.

Children at an IDP camp in northern Ethiopia face shortages of school supplies and overcrowded classrooms, 2024
© WHO/Nitsebiho Asrat

5.1 Meeting the challenges ahead

Recent financial and political developments make the path ahead increasingly challenging. For example, sharp reductions in global health and development funding are making it harder to respond to many global health challenges, including those faced by refugees and migrants. Such austerity not only exacerbates underinvestment in refugee and migrant health, thus threatening a wide range of migration health interventions, but also increases the risk of fragmentation, service gaps and preventable morbidity in often already marginalized populations. For example, recent reductions in large-scale immunization programmes such as those of the GAVI Alliance, which has played a key role in improving vaccination coverage for refugees and migrants, are likely to impact many people on the move *(172)*. Many existing initiatives specifically designed to reach refugees and migrants may also be constrained or discontinued *(173)*. For example, in Bangladesh, many health interventions in Rohingya refugee camps in Cox's Bazar face disruption following funding suspensions *(174)*. Another pressing issue is increasing negative narratives around migration, which negatively affect refugee, migrant and broader public health *(76,175)*.

The lack of reliable data on refugees and migrants is a core concern

Developments relating to data are a matter of grave concern. At the time of writing, the Demographic and Health Surveys Program the backbone of much health data and SDG-related data, including data on migration – had experienced significant suspensions and disruptions. This further restricts the collection, compilation and dissemination of data on migrant health that are essential for informing effective migrant-responsive policy development *(176)*.

This report has highlighted the fact that migrants are often invisible in national health information systems and that the evidence base regarding health and migration remains limited. This fragmented data landscape stems from several issues, including the inadequate capture of migration-related variables, lack of system interoperability, inadequate data protection measures and inconsistent methodologies *(2)*. In addition, the capacity of health ministries, national statistical offices and other data producers and users is often constrained by limited coordination and insufficient resources.

Without accurate, timely and disaggregated data, health systems cannot adequately identify or address the specific health needs of these populations, nor harness their potential contributions to public health.

This underscores not only the urgency of taking action on migration health but also the imperative need to do so in ways that reflect the evolving complexity of the situation. Cost-effective approaches, such as leveraging migration health partnerships and better utilizing the existing migration health data, will be at a premium in increasingly resource-constrained contexts.

As indicated by the many examples of migrant-responsive initiatives included in this report, a wealth of country-level innovation and lessons learned is being accumulated and can serve as inspiration for further action. While the GAP is a globally applicable framework for action, it is at country level that its application will yield the most results.

It is encouraging that many countries have indicated that they not only intend to advance different aspects of the GAP but are already making plans to do so. To a large extent, it is clear what needs to be done. While solutions must be tailored to country contexts, the broad lines of how to make progress on refugee and migrant health are well defined and fully articulated in the GAP framework.[9] Moreover, the mandate to continue these efforts is strong. In 2023 governments around the world

[9] Given the need to condense the wide-ranging GAP into an agile monitoring framework, the current survey is not sufficiently comprehensive to include every migration health issue that may be relevant in a particular setting. For example, the important topic of migration, health and climate change is not explored in depth. This means that the country action needed will often go beyond aspects covered in the survey.

adopted a political declaration, the Rabat Declaration, to strengthen global commitment to improve the health of refugees and migrants *(107)*. Several regions have indicated their support for migrant health *(112)* and most recently, at the Seventy-eighth World Health Assembly in May 2025, 56 Member States reaffirmed their strong support for implementation of the GAP by supporting work on resolution WHA70.15 on promoting the health of refugees and migrants *(97,120)*. Meanwhile, new opportunities are opening up. For example, increasing digitalization holds potential as an enabler of inclusive health initiatives delivering health for all *(177)*, including refugees and migrants.

Building on the strategic roadmap outlined in the GAP, the following recommended actions are intended to facilitate and strengthen its implementation. These are intended both for national authorities and others working at country and regional levels and for the global community, including United Nations agencies, NGOs, multilateral development banks and other international actors.

5.2 Data and evidence

Strengthen the global evidence base on migration health at all levels. In order to improve the health of refugees and migrants, timely, accurate and accessible information regarding their health needs, access to and use of health services, and other factors is required. Without standardized and comparable records on refugees and migrants, policy-makers cannot develop evidence-informed policies. According to the survey results presented in this report, the evidence base for GAP implementation across different domains remains uneven.

What can be done?

Inclusion of migration variables in routine data collection as part of health information systems is key, notably in regard to the generation of disaggregated prevalence and other essential data. National actors may prioritize secure data sharing and integration to link relevant administrative and other data across policy areas. Such efforts should be underpinned by best practices in regard to data protection and ethics, for example through the use of firewalls. At global level, actors can support national counterparts in standardizing and harmonizing data by increasing the capture of migration variables in global reporting mechanisms and health information systems. They can also support the enhancement of national systems' relevance and responsiveness to refugee and migrant health. Global-level actors can also lead relevant capacity development initiatives, for example, through conducting training workshops, providing targeted guidance and leading efforts to harmonize and compile regional- and global-level data. The WHO Special Initiative on Health and Migration will develop a roadmap to improve data on migration health grounded in broad-based stakeholder consultation to assist countries in strengthening the national evidence base.

5.3 Policy and programme design

Adopt a refugee- and migrant-responsive approach. Programmes and policies that take a one-size-fits-all approach risk overlooking or excluding the specific needs of refugees and migrants. It is, therefore, advisable to adopt an approach that is responsive and sensitive to their diverse circumstances and lived realities.

What can be done?

Proactively considering refugees' and migrants' health-related needs through dedicated needs analysis exercises can help, as can consulting refugee and migrant groups throughout the policy formulation and implementation process. The development of specific migration health policies is also encouraged, as is the mainstreaming of displacement and migration into broader health policies and the inclusion of health considerations in migration policies, plans and strategies.

Proactively include all of the different subgroups in these efforts. This report has shown that certain subgroups are treated differently. Often, those more likely to be at a higher risk of negative health outcomes, such as migrants in irregular situation and IDPs, are also more likely to be excluded from health-related policy and programming across GAP areas. Such exclusion not only impacts the subgroups in question but can also hamper broadly applicable public health interventions – for example, efforts to combat vaccine preventable diseases.

What can be done?

To effectively reach populations on the move, it is important to consider how policies impact different migrant subgroups such as refugees, asylum seekers, migrant workers, student migrants, migrants who moved for family-related reasons, migrants in irregular situations, and others. National actors are encouraged to take a needs-based approach to identify subgroups who may be particularly at risk by working together with them and with civil society groups to create news ways to ensure that no one is left behind.

5.4 Governance and partnerships

Develop tailored roadmaps for national GAP implementation. This report highlights the wide range of migration health interventions initiated by Member States worldwide. However, it also suggests that these efforts are often fragmented – initiated and implemented ad hoc by different government departments. To keep track of related interventions and implement the GAP

systematically, Member States are encouraged to use the GAP as a guiding framework and to assess migration health priorities and existing policy initiatives to inform the development of coordinated, context-specific national strategies or action plans.

What can be done?

Create roadmaps that outline the key activities, timelines, roles and responsibilities of relevant actors and proposed monitoring mechanisms. Building on areas where GAP implementation is already more advanced can enhance efficiency, for example, by channelling action through an existing interministerial working group. Identifying synergies where interventions could respond to several gaps simultaneously can also help, for example, improving secure health data sharing as part of efforts to promote the continuity and quality of essential health care under Priority 2, while supporting action under Priority 5 to strengthen health monitoring and health information systems. Global actors such as WHO are well placed to hold consultations with governments to take stock of GAP implementation and brainstorm tailored approaches to identify and address unmet need, and create country-specific roadmaps.

Boost multisectoral action. To ensure that the social determinants of refugee and migrant health are addressed, joint, coherent multisectoral action is encouraged. This means not only developing migrant response policies in other sectors but also working with those sectors to design policies that actively promote health outcomes for migrants and refugees – from housing and social protection to employment – through close collaboration between the relevant ministries.

What can be done?

Convening dedicated migration health working groups, task forces or committees at different levels can support such collaboration, as can the establishment of dedicated partnership agreements in specific action areas. This will require the inclusion of all relevant stakeholders – including refugee and migrant representatives – to enhance meaningful coordination and collaboration and effective implementation. It is vital that mobile populations are directly involved, for example, by ensuring the participation of refugee and migrant health workers in designing and implementing relevant policy efforts.

5.5 Financing and sustainability

Catalyse investment and coordinate action where GAP implementation lags behind. This report shows that progress is lacking in certain areas, often as a result of inadequate investment. Global actors can play a key role in helping to catalyse resource mobilization and action in these priority areas across countries.

What can be done?

Convening and coordinating cross-sectoral actors to identify ways forward can help, as can supporting global-level advocacy efforts and offering direct assistance to countries. Innovative approaches to financing, for example through pooled funds, diaspora bonds or blended finance, are also worthy of consideration. Global actors are encouraged to strengthen country-level institutional capacities by providing technical assistance and capacity development programming across GAP implementation areas.

Link with existing and new policies, frameworks and processes. Linking efforts to improve refugee and migrant health with other relevant initiatives can help to make efforts more sustainable. Such links serve not only to optimize synergies but also to increase urgency and momentum and, ultimately, the effectiveness of efforts.

What can be done?

Assess the degree to which GAP implementation at country level may align with existing policies and strategies, for example, national health, migration or other plans, as well as regional- and global-level development, humanitarian and emergency processes such as the GCM, the GCR, the Sendai Framework for Disaster Risk Reduction 2015–2030 *(178)*, and others. On the basis of that assessment, explore ways to support joint funding and action.

5.6 Knowledge sharing

Boost inter- and cross-regional knowledge exchange. This report has shown that while countries around the world may face different circumstances, they often share similar migration and health dynamics and can learn from one another's policy responses. Meaningful knowledge exchange can enable Member States to share lessons learned across different GAP domains and those in different regions with similar migration health dynamics or trends to compare notes.

What can be done?

Establishing dedicated forums to facilitate knowledge exchange, such as cross-country networks and regional events, is essential. Global-level actors are well placed to support cross-border dialogue and collaboration, including targeted, bilateral efforts to establish or build on existing coordination mechanisms among countries.

A mother and child sit under a mosquito net at a nutrition centre in Abu Shouk IDP camp, North Darfur, Sudan, where many people remain displaced nearly 2 decades after the conflict began, 2022
© WHO/Lindsay Mackenzie

6. Conclusion

In Cúcuta, Colombia, the Yukpa community is strengthening local health surveillance, 2024
© PAHO/Karen González Abril

This report represents an initial effort to monitor progress towards GAP implementation. Future monitoring efforts can build on it by assessing progress on refugee and migration health over time. As called for in resolution WHA76.14, the next reports on GAP progress are scheduled for 2027 and 2029. In addition to monitoring the 12 questions addressed in the present Survey, future surveys will focus on areas where progress is most lacking *(179)*.

The WHO Special Initiative on Health and Migration will continue its mission by framing migration as a determinant of health, strengthening inclusive governance and supporting Member States in developing refugee- and migrant-responsive health systems. The meaningful participation of young migrants in decision-making and governance processes is essential to ensure that health and social policies reflect their lived experiences, promote inclusion and enhance the effectiveness of interventions that affect their well-being *(180)*. Moving forward, the programme will specifically reinforce technical guidance and leadership, with particular attention paid to irregular migrants, those in protracted displacement, and transit migrants who are overlooked by policies and services *(181)*.

More broadly, WHO is committed to leveraging its global presence by convening and coordinating power and technical expertise to assist Member States in their efforts. It will continue to coordinate with partners such as the International Labour Organization, IOM, United Nations Department of Economic and Social Affairs, UNHCR, World Bank and others to align efforts under frameworks such as the GAP. A key global priority will be improving the availability and quality of data to inform policies, track health outcomes and identify gaps in service delivery.

At regional level, WHO will support the adaptation of global policies to regional migration dynamics. WHO regional offices will also work with countries to enhance data collection systems, promote interoperability across borders and build capacity for surveillance and research. Regional cooperation will also be fostered to ensure consistency and collaboration in addressing cross-border health challenges.

At country level, WHO will continue to support ministries of health in integrating refugees and migrants into national health systems, delivering culturally responsive care, and improving health data disaggregation by migratory status. Strengthening data systems at national level is essential for tracking access to services, monitoring health indicators and supporting targeted interventions that advance health for all, including refugees and migrants.

In a world marked by rapid change and growing mobility, there is an urgent need to advance the health of refugees and migrants through innovative and sustainable approaches. Refugees and migrants are essential contributors to economic prosperity, sustainable development and the cultural fabric of societies. Yet their health needs often remain overlooked.

Advancing the refugee and migrant health agenda is also central to achieving the SDGs *(105)*, including those and their targets relating to UHC, safer cities and preparedness for health emergencies.

Addressing these challenges calls for coordinated, compassionate and systemic responses, underpinned by unwavering political leadership and a readiness to embrace change. The 4 years remaining until 2030 present a crucial window of opportunity to translate commitments into impactful action. This report offers a foundation for that action and a roadmap for building inclusive, responsive health systems that safeguard the rights and dignity of refugees and migrants while strengthening health for all.

Cambodian migrant workers undergo COVID-19 health checks at the Phnom Dey border checkpoint, 2023
© WHO/Roun Ry

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