

Promoting Health among Migrants in the U.S. and Russia through a Public Health Approach

A White Paper produced by the Public Health Working Group of the US-Russia Social Expertise Exchange

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About this Report

The project was implemented by the UIC Center for Global Health, Chicago, Illinois, USA (<https://globalhealth.uic.edu/>) and the Russian Public Health Association, Moscow, Russia (www.rpha.ru). The preparation of this white paper was led by Stevan M. Weine, MD, Professor of Psychiatry, University of Illinois at Chicago, Chicago, Illinois, USA and Andrey Konstantinovich Demin, MD, PhD, MPH, Doctor of Political Science, Professor, Counsellor of the Russian Federation of the 1st Class, President of Russian Public Health Association, Moscow, Russia.

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About US-Russia Social Expertise Exchange

The US-Russia Social Expertise Exchange (SEE) (<http://www.usrussiasocialexpertise.org>) is a diverse network of Russian and US civil society experts and socially involved individuals engaged in a meaningful exchange of ideas and best practices to produce positive change in the lives of citizens in both countries. This paper was prepared by members of the Public Health Working Group (co-chairs Judyth Twigg, Professor, L. Douglas Wilder School of Government and Public Affairs, Virginia Commonwealth University, Richmond, Virginia, USA and Elena Viktorovna Dmitrieva, Doctor of Sociological Sciences, Director of Health and Development Fund, Moscow, Russia).

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EXECUTIVE SUMMARY

According to expert assessments, the United States and the Russian Federation are the two largest recipients of migrants globally, with 45.8 million and 11 million migrants respectively. Migration has significant health implications both for migrants themselves and for the native-born population of the country that receives them.

Using a population-based public health approach, this white paper provides an overview of the health issues associated with migration and makes recommendations for future research and programming to improve the health of migrants in the United States and Russia.

US and Russian experts collaborated to review fifty articles on migrant farmworkers in the United States and forty-two articles on economic migrants in Russia to develop strategies and practical recommendations focusing on the social determinants of migrants' health, health issues and behaviors, and health systems.

The most frequently identified social determinants in the U.S. were discrimination and social exclusion, difficult living and working conditions, low language competency, and low income or poverty. In Russia, where it was predominantly migrants from Central Asia that were studied, the social determinants of health that were identified included difficult living and working conditions, poor social support, low language competency and education, low income or poverty, and family separation.

The most frequently identified health problems in the U.S. were mental health problems, occupational health problems, communicable diseases, and substance abuse. In Russia the most frequently identified health problems were communicable diseases.

It should be taken into account that studies of labor migrants in Russia covered predominantly those originating in Central Asia (Uzbeks, Kyrgyz, and Tajiks), and did not focus either on Slavic migrants, originating in Ukraine, Moldova, Belarus, and Slavic countries, or on the large number of Korean migrants, who also do not originate in Central Asia. Research evidence on Caucasian, Moldovan, Gagauz, and Kazakh migrants, among others, is also scarce.

The most frequently identified health systems problems in the U.S. were deficiencies in access to healthcare, insurance status, and legal status. In Russia they were deficiencies in access to healthcare, insurance status, availability of health care services, and legal status.

Despite historical, political, and social-cultural distinctions between the U.S. and Russia, migrant workers in the two countries face comparable barriers to good health. These barriers are apparent in the poor health outcomes of migrant farmworkers in the U.S. and of economic migrants in Russia relative to those of the general populations in their respective countries. Social determinants of health contribute to problematic health issues and health behaviors, and this poor prognosis is compounded by migrants' difficulty accessing high-quality healthcare in both countries.

There is a need for further research to overcome prior methodological limitations, to identify new, more culturally appropriate interventions, and to provide more inclusive policies to benefit migrants. With these limitations in mind, however we have identified several practical

strategies for improving the health of migrants in both countries, which we recommend for use and dissemination by policymakers, educators, researchers, and other stake-holder groups in the U.S. and Russia.

1. Use as much potential as possible from international intergovernmental organizations, including the World Health Organization (WHO) and the International Organization of Migration (IOM), and from bilateral and multi-lateral cooperation among governmental agencies, business associations, and civil societies for resolving migrants' health issues;
2. Establish and sustain working relationships between the sending countries' ministries of health, the diaspora communities themselves, and the health organizations in the receiving countries in order to implement collaborative projects and programs for improving the social determinants of health, optimizing the migration processes from the point of view of migrant health, and ensuring that labor migrants have access to health care services and health information. These relationships should include health care organizations and non-commercial organizations working with migrants, diaspora organizations, and religious confessions, with due consideration of the real influence and potential of civil society;
3. Develop World Wide Web portals that can function as global and regional resource centers on migrant health issues and for the accumulation of statistics, research evidence, best practices, and other relevant data;
4. Promote the development of centers that provide relatively inexpensive legal services to undocumented migrants seeking to legally immigrate or to otherwise stay in the country in accordance with legal admission criteria, and support development of specialized non-commercial organizations to provide such services;
5. Enforce labor-protection laws and other norms and rules of occupational safety to protect migrant workers from environmental and occupational health hazards;
6. Provide occupational safety education in either the language spoken in the country (i.e., Russian or English), or in the migrants' languages;
7. Promote legal employment and encourage migrant workers to become involved in trade unions, which should ensure higher standards of living;
8. Promote media outreach and encourage more widespread education on the health issues facing migrants in order to personalize these issues for others and improve the host country's attitude towards migrant workers and their families;
9. Provide migrant workers and their families with resources giving them access to legal, medical, and social services. This might include free help hotlines, free legal aid organizations, and migrant-friendly primary care clinics;
10. Improve migrant workers' access to health information, partly through cooperation with specialized non-commercial organizations, to help them learn more about nutrition, reproductive health, sexually transmitted diseases (STDs), alcoholism, tobacco use, and drug use;

11. Provide culturally competent health information services in the migrant workers' native languages;
12. Provide comprehensive health education training to community health workers and laypeople in diaspora and religious communities;
13. Improve migrant workers' access to health care services in their host countries;
14. Develop disease prevention and health promotion among migrant workers;
15. Include sections on migrant health issues and possible solutions to them in the training programs for civil service, health work, and social service, including corresponding teaching and methodological kits.
16. It should be noted that such activities, according to expert opinion, would be more efficient if they were aimed at prevention of diseases, particularly infectious diseases, among migrant workers and members of their families.

BACKGROUND

According to the International Organization on Migration (IOM), foreign and domestic migration have increased significantly over the past two decades, from a total 154 million migrants worldwide in 1990 to 175 million in 2000. Approximately 230 million people, 3.2% of the world's population now live outside the borders of the countries where they were born.¹ The US is the largest receiver of migrants internationally, with 45.8 million.² Russia has the second-largest number of migrants in the world, with over 11 million, according to the assessments of a number of experts.³ It should be kept in mind that this number is explained in part by the dissolution of the USSR, when considerable numbers of people found themselves suddenly in the territories of newly established states.

Migration can adversely affect an individual's health before, during, and after the migration process. Physical and psychological stress is a common experience for migrants during relocation, although it is not universally shared and does vary with country of origin, legal status, and mode of transportation. Migrants can also suffer from low wages, poor housing quality, unsafe work conditions, low educational attainment, and poor language skills, rendering them vulnerable to various communicable and non-communicable diseases, psychosocial stresses, and other health problems.

While migrants in the United States and Russia fill a variety of professions, our research focuses on migrant farmworkers in the U.S. and migrant workers in Russia. These are the two comparable populations with the largest base of research evidence. Experts believe that there is still insufficient research on these issues in the Russian Federation.

The IOM's *Handbook on Migration Terminology* defines temporary migrant workers as "semi-skilled or untrained workers who remain in the receiving country for definite periods as determined in a work contract with an individual worker or a service contract concluded with an enterprise."⁴ The definition varies slightly between the US and Russia.⁵

Not only have migrant workers historically been underrepresented and marginalized, but the literature on these migrants in the U.S. and Russia points to similarities between them that are proving valuable in the search for solutions to the problems that migrants face in both countries. Migrants in both groups are victims of discrimination and face substantial barriers to good health, including barriers to health care access, low financial status, language and cultural barriers, low education levels, fears about contacting a physician in a country with a different culture, and undocumented legal statuses. These factors can lead to significantly poorer health outcomes compared to the native population.

Increasingly, national governments and international organizations are coming to recognize the health of migrants as a key factor in the health outcome of the entire migrant-receiving country.

The international literature on migrant health has grown significantly in recent years, with special attention being given to areas of conflict, and with the largest body of evidence focused on migration to Western Europe and the United States. Peer-reviewed studies on the health of migrants have covered HIV/AIDS, tuberculosis, reproductive health, access to primary care, mental health, families and children of migrants, and drug use. Due to the longer history of migration to the U.S., and also to the more considerable attention paid to the

problem there, the body of literature on migrants in the US is substantially more extensive than in the Russian Federation.

Recent Russian research in the field of migrant health has focused on policy, monitoring, and evaluation of the basic statistics and demographics of migration. Comprehensive surveys of the health and risk factors of migrant communities have not been conducted in Russia. Single studies have focused on policy and on access to healthcare, with notably few studies analyzing high-risk behavior among migrants in Russia, in particular illicit drug use and prostitution in Moscow, St. Petersburg, and Kazan.

When it was established in 1951, the International Organization for Migration made the health of migrants one of its leading initiatives and it has since developed numerous reports pertaining specifically to migrant health. The U.S. is a member of IOM and Russia is an observer state.

This scoping review relies extensively on the IOM for terminology and operational definitions related to migration and the health of migrants. Additionally, this white paper operates based on the World Health Organization's (WHO) documents. In particular the *Report by the WHA Secretariat (A61/12 7 April 2008)* puts forward "basic principles of a public health approach to the health of migrants."⁶ It says: A population health approach is necessary in order to align strategies, policy options and interventions for improving health outcomes among particular subgroups of migrants. Several basic principles influence the development of a public health approach for migrants.

- The main public health goal is to avoid disparities in health status and access to health services between migrants and the host population.
- The second, closely associated, principle is to ensure migrants' health rights. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions, which are the basic health entitlements of the host population.
- The third principle, associated with migrations resulting from disaster or conflict, is to put in place lifesaving interventions so as to reduce excess mortality and morbidity.
- The fourth principle is to minimize the negative impact of the migration process on migrants' health outcomes. Together, these four principles may be taken as the basis for a policy framework for defining public health strategies for migrants.⁷

In this light, the *WHA Resolution on migrant health (WHA 61.17)* places the following demands on its member states:

1. To promote migrant-sensitive health policies;
2. To promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;
3. To establish health information systems in order to assess and analyze trends in migrants' health, disaggregating health information by relevant categories;
4. To devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
5. To gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;

6. To raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
7. To train health professionals to deal with the health issues associated with population movements;
8. To promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;
9. To contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals.⁸

KEY CONCEPTS AND TERMS

Public Health Approach

The key concepts for this research on migrant health are based on and to be understood in accord with WHO documents.⁹ Addressing the health of migrants and their host communities, the public health approach consists of adherence to the following principles:

1. To avoid disparities in health status and access to health services between migrants and host populations;
2. To ensure migrants' health rights. This entails limiting discrimination and stigmatization and removing impediments to migrants' access to the preventive and curative interventions that are the basic health entitlements of the host population;
3. To put in place lifesaving interventions so as to reduce excess mortality and morbidity among migrant populations. This is of particular importance in situations of forced migration resulting from disasters or conflict;
4. To minimize the negative impact of the migration process on migrants' health outcomes. Migration is considered a risk factor to health due to the hazards of displacement, stress, and adaptation.

Human Rights Approach

Health is considered a universal human right. A human rights approach to migration holds that the migrant should be at the center of migration policies and management; such an approach is also focused on marginalized and disadvantaged groups of migrants. According to this framework, migrants should be included in relevant national action plans and strategies, for example on public housing provision or on proposals for combating racism and xenophobia.

When health care is understood as a right, on this kind of approach, the major concept to point out is the fact that, though all countries have a sovereign right to determine the conditions of entry and stay in their territories, they are obliged to respect, protect, and fulfill the human rights of all individuals under their jurisdiction, regardless of their nationality, origin, or immigration status. This approach is grounded on the understanding that exclusion from social protection policies, such as pensions, unemployment benefits, health insurance programs, and social safety nets, can lead to marginalization and social insecurity. All of these factors can impede the productive integration of migrants into society, amplifying the negative impact on their health.

Social Determinants of Health

According to WHO's approach, the social determinants of health are the "conditions in which people are born, grow, live, work, and age."¹⁰ These circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels. The social determinants of health are mostly responsible for health inequities, the unfair and avoidable differences in health status visible within and between countries. Social determinants of health may include educational opportunities, economic opportunities, employment, access to health care services, quality of educational job training, transportation options, public safety, social support, exposure to crime and violence, residential segregation, language skills, and literacy. Physical determinants include natural environments and built

environments. Examples of these are green spaces, buildings, sidewalks, worksites, schools, housing, and community design.

Health Care Access

Health care access is the ability of a person to obtain health care services, which is a function of: the availability of health care personnel and supplies, and the ability of the person to pay for those services.¹¹

One area of debate on this subject is whether countries should consider the right to health to be a basic one irrespective of a person's status. There is also considerable debate over whether migrants should have limited health care access or the same access as everyone else in the country.

Healthy Migrant Effect

Migration, due to its peculiarities, always poses a threat to the health of migrants themselves and the people around them, even in normal circumstances. Some research suggests that immigrants to the United States and Western Europe are often healthier than the native-born residents of their host countries. It may be that a self-selection process operates among potential immigrants in favor of those who are physically or financially better able to migrate. On the other hand, the incidence of health problems may be under-reported among migrants due to their low healthcare usage compared to the general population.

Nonetheless, some protective factors carry over from countries of origin that can insulate migrants and immigrants from the least-healthy lifestyle habits prevalent in their host country. These factors include traditional culinary practices, use of alternative medicine, and abstention from alcohol, tobacco and drugs. For example, Hispanic and Asian immigrants to the U.S. have better health outcomes than the greater U.S. population despite lower rates of health insurance and lower rates of healthcare utilization. This phenomenon is termed the "healthy migrant effect."

Over several generations, the health outcomes of immigrant populations converge with those of native-born population for reasons that are not fully known and require further study. In the U.S. and Western Europe, immigrants may adopt the least-healthy lifestyle habits of their host countries, including alcohol, tobacco, and drug use. Their culinary habits may change due to the unavailability of traditional foods or to the overabundance of cheaper food options that may be less healthy overall.¹² The loss of the healthy migrant effect may result in elevated rates of chronic disease or disability in immigrant populations.

Types of Migration

Migration is defined as a "process of moving, either across an international border, or within a state. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes."¹³ Migration can be short-term or long-term, and it can result in permanent settlement. Additionally, migrants can have various legal statuses in their host countries. Documented migrants are those who entered the country lawfully and remain in the country in accordance with their admission criteria.¹⁴ Undocumented migrants either migrated across the national borders of the host country in

violation of its immigration laws or remained in the host country after their legally-permitted work or visitation period had ended.

Although various factors can motivate people to become migrants, including serious political or economic pressures, any given migration is generally categorized as either *voluntary* or *forced*. Voluntary migration involves those who made their own decision to migrate, whereas forced migration is migratory movement under an element of coercion. This includes the situation of people forced to move because of persecution, conflict, or natural disasters.¹⁵

Specific types of voluntary migrants can include intersecting categories of migrant workers and their families, economic migrants, seasonal migrants, temporary contract workers, international students, and returnees.^{16,17} Although immigrants are a type of migrant who are non-nationals and who move into a country for the purpose of settlement,¹⁸ it is often difficult to differentiate between immigrants and other migrants because many people cross borders without the intention of permanent settlement, but stay as a result of better economic and social opportunities or due to the force of other circumstances—in particular, establishing a family and buying a home. The purpose of this paper, however, is to focus on the more mobile populations, including economic migrants, migrant workers, and seasonal workers.

The majority of migrants are economic migrants, those who have left their homes in search of work or better economic and social opportunities than could be found in their countries of origin. This group of migrants is the world's fastest growing migrant population.¹⁹ A sub-category of economic migrants are seasonal migrants, those who move with each season in response to labor demands and climate conditions, and who include farm workers who follow crop harvests.²⁰

Although forced migrants are not the focus of this white paper, they include refugees: individuals “persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion” who are thus unable or “unwilling to avail [themselves] of the protection” of their country of origin.²¹ Other forced migrants are asylum seekers, those who seek safety from persecution or serious harm in a country other than their own and await a decision on their application for refugee status under relevant international and national instruments. Another group is internally displaced people. These are people who have been forced to flee their homes in order to avoid the effects of armed conflict, generalized violence, human rights violations, or natural disasters, and who have not crossed an internationally recognized state border.²²

Process of Migration

Migration is a process that usually includes four phases: pre-departure, travel, arrival at destination, and return. *Pre-departure* takes place in the time before the migrants leave their home. The *travel* phase is the period when individuals are between their place of origin and their destination. The *destination* phase begins when individuals arrive at their destination and settle there in either the short or the long term. The majority of migrant research has focused on this phase, specifically in looking at the health of migrants in their host country, in areas such as communicable and chronic diseases, social determinants of health, and the healthy migrant effect.²³ The last phase of migration is the *return* phase, where migrants return to their place of origin, either temporarily or permanently. Although immigrants have traditionally moved for the purpose of permanent settlement, shifting patterns of migration

and globalization have resulted in an increase in “circular” migration. Circular migration, or repeat migration, involves an established pattern of population mobility through the repetitive, regular movement of migrant workers between their home and host countries. Economic migrants in these situations often travel as individuals and leave their families behind.

CONTEXT OF MIGRATION IN THE UNITED STATES AND RUSSIA

Migrants in the United States

Though migrant farmworkers make up only a small portion of the total (documented and undocumented) immigrant population there, the US literature focuses primarily on the health of seasonal farmworkers. A migrant farmworker is an “individual whose principal employment is in agricultural labor on a seasonal basis,” and who “establishes a temporary abode” for the purposes of seasonal employment.²⁴ The vast majority (95%) of seasonal farmworkers in the U.S. are Mexican-born Hispanics, and about half of these (52%) are undocumented.²⁵ The population of seasonal farm workers is estimated to be between 1.4 million and 12 million, depending on whether dependents (husbands, wives, children, and other family members) are counted.²⁶ The majority (79%) of migrant farmworkers are male. Migrant farmworkers earn an average salary of \$10,000 to \$12,499 per year, placing them below the US poverty line.^{27,28} In addition, employers can easily garnish wages or delay payments to their employees, since there are few legal consequences for this type of exploitation, especially against undocumented workers.²⁹ Despite this, seasonal farmworkers can send as much as 40% of their earnings to their families in the form of remittances.³⁰ Remittances thus amount to \$15 billion dollars a year in Mexico, or about 2.4% of Mexico’s gross domestic product (GDP).³¹ Economic opportunity is frequently cited as the primary motivation for migration from Mexico to the U.S.³²

Migrants, including both documented and undocumented farmworkers, contribute to the U.S. economy and tax base by paying payroll, sales, and state and local income taxes in the areas where they live. Even undocumented immigrants can pay federal income taxes by way of Individual Taxpayer Identification Numbers (ITINs) or false Social Security Numbers.³³ Nonetheless, undocumented migrants are ineligible for most social programs in the U.S. Private insurance is not common (only 5 to 11% of migrants are estimated to have private insurance, while 7 to 11% have access to Medicaid).³⁴ Seasonal farmworkers utilize health services at a lower rate than other Hispanics do and at a far lower rate than the general population.³⁵ In part due to low utilization rates, vulnerability, and other factors, seasonal farmworkers have extremely poor health outcomes, including an estimated life expectancy of only 49 years, according to one study.³⁶ Agricultural labor is also the second-most dangerous profession in the United States, after construction. The natural occupational hazards of the field are exacerbated by low rates of compliance with the labor standards outlined by the Occupational Safety and Health Association (OSHA) on the part of agricultural employers.^{37,38,39} Workplace safety training is rare or non-existent, and when provided it is often in a language unfamiliar to the farmworkers.⁴⁰ Day laborers, a subset of seasonal workers who do not work in agriculture, also report facing significant workplace hazards, and they are also less likely to seek care in spite of their significantly elevated risk of workplace injury.⁴¹

The implementation of the North American Free Trade Agreement (NAFTA) in 1994 has had profound effects on seasonal migration patterns between the U.S. and Mexico. As part of a set of broader economic liberalization policies, including the removal of import tariffs between the US and Mexico, NAFTA fostered the privatization of Mexican communal landholdings, many of which had been traditionally used by farming communities. Privatization led to the eviction and forced migration (the “displacement effect”) of millions of poor farmers to larger Mexican cities or the U.S., where they pursued low-wage

agricultural work. Migration to the U.S. in this case was eased by the liberalization of US immigration policies a decade earlier, in 1986.⁴² NAFTA's displacement effect was also exacerbated by a concurrent drop price of coffee, which had been a traditional cash crop for farmers in Mexico. In the 1980s, ten years prior to NAFTA, the Mexican government eliminated the country's state-owned agricultural enterprises along with supports and subsidies for staple goods. NAFTA superseded these policies, and its implementation signified Mexico's near-total transition from subsidized small-scale farming to private large-scale agribusiness. The Congressional Research Service attributes the mass migration of seasonal farmworkers to NAFTA.⁴³ One commentator writes, "there are no jobs [in Mexico], and NAFTA drove the price of corn so low that it's not economically possible to plant a crop anymore. We come to the United States to work because there's no alternative."⁴⁴

Despite their contributions to the U.S. economy and tax base being quite high relative to their low utilization of social services, undocumented immigrants are routinely scapegoated as being responsible for both high unemployment and crime rates, and for taking jobs away from U.S. citizens. This discrimination is sometimes euphemized as a "concern with national security, crisis of moral turpitude, an issue of criminality, and threats to national cultural cohesion."⁴⁵ In reality, undocumented immigrants have no negative effect on general employment and low rates of crime compared to the general population, although they do compete with non-college educated, non-Hispanic white males in the labor market.⁴⁶ Labor migrants and undocumented immigrants more broadly can be victims of discrimination, which compounds their vulnerability and contributes to their poor health outcomes.^{47,48,49} Discrimination takes the form of wage theft, based on perceived linguistic barriers, or relegation to substandard housing, when quality of housing is dispersed based on legal status, country of origin, or indigenous status.^{50,51}

Fear of job loss and fear of deportation are frequently cited as concerns among undocumented migrants, though discrimination is not limited to those with undocumented legal status.⁵² While some American policymakers view low-skill, seasonal migration work as less desirable than high-skill, legal immigration work, agricultural employers rely on low-cost labor to lower the cost of produce in the United States. Seasonal farmworkers are necessary for American farms because traditional unpaid family labor has become insufficient to meet the needs of the U.S. population.⁵³ Additionally, migrants are generally younger than the average of the U.S. population and provide an important labor and tax base at a time when an increasing proportion of Americans are opting out of the labor market due to age.⁵⁴

Agricultural workers are exempt from federal minimum wage laws, and this fact combined with their employers' low compliance to occupational health and safety standards, the inadequate housing they are provided with, and the discrimination they experience, perpetuates a "low-income, disadvantaged, farm labor force," but allows the low cost of American food. Arguably, this policy was designed in part to "assist farm employers by keeping them free of legislatively imposed, labor-connected costs."⁵⁵ In the U.S., migration is a "product" of policies that have been supported and exacerbated by the implementation of NAFTA, and the environmental and occupational health hazards associated with low-wage migrant labor will continue until these policies are rectified or new workplace protection laws are put in place.^{56,57}

Migrants in Russia

Since the Soviet Union dissolved in 1991, Russia has become a leading recipient of immigrants and migrants due to Russia's relatively successful economic development compared to neighboring former Soviet Union countries.⁵⁸ Russia ranks second after the United States among countries receiving immigrants, based on the gross number of immigrants to each.⁵⁹ In 2010 the World Bank reported the arrival of 12.3 million immigrants to the Russian Federation.⁶⁰ The majority (88%) of these migrants and immigrants come from countries in the Commonwealth of Independent States (CIS).⁶¹ The countries sending the most immigrants to Russia include Ukraine, Kazakhstan, Belarus, and Uzbekistan.⁶² The numbers of migrants arriving from Tajikistan, Kyrgyzstan, Armenia, Azerbaijan, Georgia, and Moldova are also considerable.

Following the *Handbook on Migration Terminology*,⁶³ a long-term migrant is a "person who moves to a country other than that of his or her usual residence for a period of at least a year, so that the country of destination effectively becomes his or her new country of residence. From the perspective of the country of departure, the person will be a long-term emigrant and from that of the country of arrival, the person will be a long-term immigrant."⁶⁴ This definition most closely aligns with our understanding of an *immigrant* in Russia. A migrant worker is defined as "a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a state of which he or she is not a national."⁶⁵

In the Russian context, *immigrant* will refer to people who most closely meet the definition of *long-term migrant*, whereas we will use *migrant* to refer to short-term migrant workers. Specifically, we focus on migrant workers in Russia who labor in construction, retail trade, the service sector, housing and utility services, and other parts of the economy that employ relatively low-skill professions. The literature tends to refer to "migration policy" and "immigration policy" interchangeably, so in reference to legislation we will use both terms to apply to both immigrants and migrants unless otherwise specified.

In addition to these general definitions, defining a *migrant* or an *immigrant* in Russia requires addressing an issue that is unique in the global context. Russia classifies all migrants from post-Soviet countries as international immigrants, even though a considerable portion of these migrants are Russian.

Between 2002 and 2010 the percentage of migrants declined from all countries except those of Central Asia—Uzbekistan, Kyrgyzstan, and Tajikistan—which increased. For example, in 2002 22.5% of migrants came from Ukraine, compared to 13.6% in 2010. By contrast, the percentage of migrants from Uzbekistan increased from 6.9% to 19.1% over the same time period.⁶⁶ It should also be noted that currently, due to crisis in Ukraine, there is again a considerable flow of migrants from this country to the Russian Federation, including refugees and forced migrants.

Central Asians constitute the majority of the labor migrant population that we focus on in this paper. Compared to the ethnic Russians, other Slavic groups, Moldovans, and Gagauzes arriving in the country, Central Asian migrants face significant cultural and linguistic barriers to accessing health care and other social services.

The regulation of entry along the borders that Russia shares with fourteen countries has

presented significant challenges to policy makers, especially in the decade following the collapse of the Soviet Union, when the country was in the midst of transitioning to a market economy.⁶⁷ The emergence of this market economy substantially increased income inequality in Russia.⁶⁸ Frequently working in unskilled professions and having little upward social mobility, partly due to a lack of access to higher education, migrant workers suffer the most from these disparities in income. Migrant laborers commonly take jobs with construction companies, restaurants, and hotels, in cleaning industries, and as hospital attendants, sitters, and domestic servants. These positions are less popular with locals. Many employers find migrant workers attractive because they are willing to work for lower wages.⁶⁹ Furthermore, migrant workers are often temporary and willing to work without a work permit, which leads to tax breaks for employers.⁷⁰ Unlike the migrant farmworkers in the United States, migrant workers in Russia tend to be concentrated in large megalopolises. The two largest metropolitan areas of Russia, Moscow and Saint-Petersburg, also have the largest numbers of migrants. For example, the Moscow region hosts more than a third of the foreigners staying in the Russian Federation.

Despite the low wages and often difficult working conditions facing them in Russia, economic pressure is a significant motivation for incoming migrants, although we acknowledge that the decision to migrate is made on the basis numerous complex factors. Likewise, Russia's immigration policies are greatly influenced by a need to replenish the work force. While remittances benefit the development of CIS countries, Russia's economy relies on foreign workers. Recent demographic reports from the government indicate that Russia's population is showing a trend toward stabilization after a period of decline; however, aging is something to consider. An estimated "million working age migrants" are needed to replenish Russia's workforce.⁷¹

Unskilled laborers from Central Asia come to Russia, usually to large cities, for higher wages. Migrants from Tajikistan, in particular, have received attention for their country's dependence on remittances. According to the World Bank, approximately half of Tajikistan's male working-age population works abroad, mostly in Russia.⁷² A similar situation describes migration to Russia from Kyrgyzstan.

Migrants coming to Russia from Central Asia may often face marginalization, since they are both minorities and non-nationals. Migrants from Central Asia often lack basic health education, have no access to public services, and have inadequate housing resources. Due to the physical nature of their work, these low-skilled migrants also encounter greater health risks.⁷³ Urban migrant groups, most prominently in Moscow, are at a higher risk for contracting HIV due to drug injections and low condom usage. Besides that, the risk of infections like hepatitis spreading among migrants' compatriots is rather high. The marginalization of HIV-positive, drug-using migrants can hinder their effective treatment.⁷⁴

Russian immigration policy has developed unevenly between simultaneous anti-migrant rhetoric and economic incentives that promote migration. In the 2000s, when the Ministry of the Interior took control of migration policy, the relevant laws became less transparent.⁷⁵ This period witnessed an increased flow of migrants into the Russian Federation from Central Asia, which met a negative response from Russian society. At the same time, in the mass media, hostile rhetoric aimed at migrants increased.⁷⁶ Much of this rhetoric targeted illegal migrants. An estimated three million people work illegally in Russia, according to the country's Federal Migration Service.⁷⁷ Migrants are defined as illegal by their having either

entered illegally or remained illegally. Migrants frequently arrive in the country legally but then work without the proper registrations or permits. The exact number of such migrants is unknown. For example, the Russian Ministry of Internal Affairs estimates that there are 10 million illegal migrant workers in the country, with 70% of those coming from CIS countries.⁷⁸

The *Concept of the State Migration Policy of the Russian Federation for the Period to 2025* was enacted in June 2012.⁷⁹ Among the aims of the *Concept* is a “differentiated approach to [the] regulation of migratory flows depending on aims and terms of stay, social – demographic and professional qualification characteristics of migrants.”⁸⁰ The *Concept* responds to the needs of both the Russian economy and the potential job-seeking migrants.

Specific points in the *Concept of the State Migration* envision benefits for highly skilled immigrants, for example, entrepreneurs, scientists, physicians, and journalists, who for the most part officially earn over 2 million rubles per year, while for low-skilled migrants benefits are not foreseen.⁸¹ Of the one million people who left Russia in the past decade, the World Economic Forum estimates that 80% were highly qualified specialists,⁸² though experts believe that these figures might have been overestimated. Thus, as some experts point out, Russian policymakers have incentives to encourage the entry of highly skilled immigrants to Russia.⁸³

In 2010, Russia enacted a bill that “grants special three-year visas to ‘highly qualified specialists’ (those who earn more than \$66,000 USD a year).”⁸⁴ This provision excludes low-skilled workers and those without advanced degrees. Highly skilled specialists receive further benefits from the *Russian Law on Entry and Exit from the Russian Federation*, which states that “a worker’s visa is extended to family members of the applicant only if the migrant is qualified as a highly skilled specialist. Such provision is not envisaged for low-skilled migrant laborers.”⁸⁵

It should also be pointed out that the Ministry of Economic Development of the Russian Federation, in collaboration with the Ministry of Labor and Social Development, is producing special lists of professions that are not included in the system of quotas related to migration.

Studies on migration in countries around the world have demonstrated that separation from social networks, particularly from family ties, undermines the migrant’s ability to adjust to their new culture. This separation tends to have negative impacts on their mental and physical health.

Without the governmental support that is available to highly skilled immigrants, low-skilled labor migrants have to seek out legal and medical services from non-profit, non-governmental organizations (NGOs). Some of these organizations receive government funding and support, but many are severely underfunded and have difficulties providing their services. Currently, measures are being taken to mandate the purchase of medical insurance policies by everyone working in the Russian Federation.

In light of the recent trends in migration policies and the challenges that NGOs face in Russia, the need for advocacy for migrant workers’ rights is becoming more pressing there. Russia may continue to break down barriers for migrants in order to sustain its workforce; however, it is unlikely that its new policies will be inclusive for all labor migrants.⁸⁶

METHODS

Search Methods

In order to assess the relevant literature, PubMed, eLibrary, EBSCO, JSTOR, and Google Scholar were searched for English- and Russian-language articles using the following keywords in various combinations: *migrant, migrants, economic migrants, labor migrants, seasonal farmworker, mobility and migration, health, public health, mental health, social determinants of health*. The reference sections of the reviewed articles were also examined to identify additional articles. The Moscow State University Library was also searched, and relevant articles found there were included. Regarding Russian migrants, the authors chose to include media reports because of the low number of research articles identified. For U.S. migrants, the number of articles exceeded the scope of this review and was pre-systematic.

Given Dr. Stevan M. Weine's extensive work on this topic, files and relevant articles from past searches were examined.

The authors acknowledge that despite extensive literature searches, some relevant articles may have been omitted, especially regarding US migrants. Overall, the white paper review should be regarded as scoping. A total of 148 articles or chapters were reviewed for possible inclusion.

Inclusion and Exclusion Criteria

The articles included examined economic or labor migrants, defined as individuals who leave their place of usual residence and move temporarily to a different locale (either in-country or abroad) to engage in remunerated activity with the intention of returning to their prior place of residence.

Several mobile populations were excluded from this review for the following reasons. First, permanent immigrants were excluded because they have no intention to return to their places of origin and thus could not serve as a bridge population for transmission. Second, border workers, defined as those who commute from their place of usual residence to their place of employment abroad, were excluded. Even though these individuals work across national borders, they have the ability to return home nightly and thus lack many of the characteristics of other migrant workers. Refugees and asylum seekers were excluded, both because forced migration may produce distinct risks and because they are not likely to return to their country of origin. Articles that focused on the children of migrants were also not included.

Only articles directly examining health and migration were included. This included articles concerning:

1. The social determinants of health;
2. The health issues facing migrants;
3. Health systems as they pertain to migrants; and
4. Strategies for addressing social determinants of the health of migrants.

The articles included were published in peer-reviewed journals or books from 1989 to 2014 and were consisted of original empirical research. This included literature reviews, editorials, newsprint, proposals, conference abstracts, and other types of grey literature provided by practitioners and policymakers in the U.S. and Russia. Only English- and Russian-language literature was included. Using these criteria, two independent reviewers validated the selection of articles. Disagreements were resolved by consensus.

RESULTS

Study Designs

United States

Fifty articles were reviewed on migrants in the U.S. Forty-one of these were original empirical research articles and nine were either literature reviews or summary reports.

The forty-one research articles represented a variety of study designs, including quantitative (n=24, 59%), qualitative (n=13, 32%), and mixed methods (n=4, 10%).

The articles focused on adult migrants, rather than their children or families left behind in their country of origin; data was collected from both male and female migrants (n=23, 56%), from male migrants only (n=10, 24%), from female migrants only (n=4, 10%), from migrant families (n=2, 5%), from migrants and clinicians together (n=1, 3%), and from providers only (n=1, 3%).

Most of these articles were cross-sectional or used data from previous large-scale surveys. Only one study was longitudinal; it collected data from migrants up to four times at monthly intervals.⁸⁷

Russia

About one hundred articles describing issues related to migrants' health in Russia were reviewed and forty-two were selected based on the inclusion criteria. These articles consisted of original empirical research articles (n= 17, 40%), mass media reports (n=8, 19%), and "miscellaneous" (n=17, 40%), the last of which included case studies, discussions, presentations, and other materials from conferences and roundtables.

The seventeen research articles represented a variety of study designs, including quantitative (n=5, 29%), qualitative (n=7, 41%), and mixed methods (n=5, 29%).

The "miscellaneous" group contained articles that could be described as case studies (n=5, 29%), materials of conferences and roundtables (n=7, 41%), and discussions (n=5, 29%).

All the articles focused on adult migrants, predominantly males, although there were not always clear specifications of gender (n=35, 83%). Only three articles (7%) focused exclusively on male migrants and four (10%) on females. Only one article that mentioned issues involving the families or children of migrants in Russia was found.⁸⁸

The vast majority of the articles reflected "secondary" data derived from other sources.

Data from Studies Reviewed

Social Determinants of Health

Low Income and Poverty

United States. Poverty is an epidemic among U.S. migrant populations. There is a broad consensus that relative poverty and low-income status are linked to poor health outcomes.^{89,90}

Most migrant farmworkers live at or below the poverty line. At least half of these workers send remittances to their country of origin, which may account for 40% of their gross income, and much of that income is further subject to sales taxes, payroll taxes, and income taxes. Migrant workers are often victims of wage theft or delays in payment. Poverty may contribute to increased stress levels and is associated with other psychological risks, as well as with an increased risk for HIV/AIDS and other STIs.⁹¹ Similarly, poverty may increase alcohol and drug abuse, which can contribute to migrants' risks for workplace injury.⁹²

Russia. Poverty is a social determinant of health and lifestyle habits for Central Asian migrant workers in Russia.⁹³ The vulnerability of migrants is rooted in their low income, as most migrants work in low-skill positions for low wages.^{94,95} The low-income status of migrants can prevent them from purchasing health insurance.⁹⁶ Up to 48% of businesses in Russia hire migrants without proper documents, thereby increasing the size of the cheap labor force.⁹⁷

Difficult Living and Working Conditions

United States. Poor quality of housing, environmental hazards, and occupational health hazards are frequently cited in studies examining health risks for migrant workers in the US. Agricultural work is an extremely dangerous profession, second only to construction, and usually employs Hispanic immigrant laborers. An increased risk of injury for migrant workers is cited in at least four studies,^{98,99,100,101} while migrants are less likely to seek care than are other laborers in spite of these elevated rates of workplace injury.^{102,103} This is consistent, however, with other studies that have looked at barriers to care. Environmental hazards contribute to mental health risks for the migrant populations surveyed.¹⁰⁴ A study on quality of housing found that migrants are less likely to be homeowners and are more likely to face hazards (e.g., exposed electrical wires, asbestos) in their homes.¹⁰⁵

Russia. Crowded and unsafe housing conditions contribute to the vulnerability of Central Asian migrants.¹⁰⁶ Migrant workers live in crowded conditions, with multiple migrants or migrant families often sharing the same apartment.¹⁰⁷ Multiple-occupancy homes are typical for migrants regardless of their job type or gender.^{108,109} Approximately 68% of female migrants in Russia live in multiple-occupancy homes.¹¹⁰ Migrant women live together, on average, with five women to a room.¹¹¹ Environmental hazards and poor housing conditions are two contributing factors to the threefold-elevated threefold miscarriage rate of migrant women over that of the host population.¹¹²

Lack of Access to Food

United States. Several studies point to the lack of access to culturally appropriate and healthy food options as a matter of particular concern for the health of migrants. Lack of access to healthy food, due to isolation and transportation difficulties, is mentioned in at least two studies.¹¹³ Higher rates of food insecurity in migrant populations are observed in three studies.^{114,115,116} Chronic food insecurity may contribute to obesity and weight gain in certain migrant subpopulations.^{117,118} Malnutrition is another issue noted in at least one study.¹¹⁹

Russia. Due to low wages and high rates of remittances, migrant workers cannot afford balanced and healthy food options, leading to observed nutritional deficiencies in comparison with the host population.¹²⁰

Limited Transportation

United States. Transient lifestyles, relative isolation, and limited transportation options together significantly reduce migrants' access to care.¹²¹ This barrier to even seeking care contributes to migrants' low utilization rates and their poor health outcomes by way of delays in diagnosis and treatment.¹²² Their limited transportation options also increase migrants' risk for food insecurity.^{123,124}

Russia. Migrants do not have the income to facilitate easy transportation between Russia and their countries of origin.¹²⁵

Discrimination and Social Exclusion

United States. Discrimination is frequently cited as a contributing factor to poor health for migrant populations.¹²⁶ Three studies indicate that discrimination creates social isolation and associated conditions that lead to high-risk sexual behavior, which increases vulnerability to HIV/AIDS.^{127,128,129} At least two studies suggest that discrimination in health care delivery due to perceived cultural barriers can lead to delayed treatment.^{130,131} Discrimination is apparent in housing arrangements and quality of housing, with indigenous groups receiving poorer-quality housing than documented and undocumented Mexicans, who in turn receive poorer-quality housing than native-born Americans.¹³² Discrimination reduces self-worth and leads to the mental-health risks associated with low self-esteem, such as depression and alcohol and drug abuse.^{133,134} Discrimination thus leads to "othering" and to feelings of marginalization that can contribute to poor health outcomes in Mexican migrant communities.

Russia. Social exclusion and discrimination occur frequently to migrants in Russia and can pose significant barriers to good health.¹³⁵ Discrimination is both institutionalized through the political and legal system and personalized through nationalism and xenophobia. Female migrants often experience additional discrimination in pregnancy.¹³⁶ Social exclusion can result from the difficulties involved in acquiring legal status, or in acquiring documentation if the migrant is undocumented.¹³⁷

Family Separation

United States. Separation from one's family can lead to poor health, delayed diagnoses, and low-quality treatment in comparison with migrants who have family support systems.^{138,139,140} Migrants who are separated from their families are also more likely to engage in high-risk behavior, such as prostitution and drug abuse, than migrants with traditional support systems.^{141,142}

Russia. Families are an important support structure in migrant populations and form the basis of social networks among migrants in Russia.¹⁴³ Migrant women more often than men still have families in their countries of origin.¹⁴⁴ Due to the labor migration process, migrants may not see their children for months or years.¹⁴⁵ Lack of family support increases the vulnerability of migrant workers who do not have access to other social networks.¹⁴⁶ In at least one study of Tajik migrants in Russia, family separation led to high-risk sexual behavior, exposing migrants and their families in Tajikistan to HIV/AIDS and other communicable diseases.¹⁴⁷

Poor Social Support

United States. Relative isolation and limited social support increase the likelihood of

engaging in high-risk behavior such as prostitution, alcohol abuse, and drug abuse. At least three studies cite a lack of social support as a predictor for anxiety and depression.^{148,149,150} Poor social support also increases the risk of suicide for migrants.¹⁵¹

Russia. Institutionalized discrimination at all levels hinders social support within the migrant population.¹⁵² Due to the location-specific registration system in Russia, which is based on place of residence, educational and health-care services are inaccessible to mobile populations like migrants.¹⁵³ Surveyed migrants from Kyrgyzstan report a significant lack of social and medical support in at least one study.¹⁵⁴ In a study of Central Asian migrants in Saint Petersburg, low social support was found to be a factor in the high depression rates among those who had been separated in their families and support networks.¹⁵⁵

Low Language Competency

United States. Low language competency is considered a serious barrier to receiving timely, comprehensive care.¹⁵⁶ Linguistic barriers increase the risk of injury on the worksite, while simultaneously making it more likely that diagnosis and treatment will be delayed.¹⁵⁷ Linguistic barriers elevate stress levels in migrant populations, which contribute to further psychological risk.¹⁵⁸ Low language competency is also a substantial barrier to education, for both migrants and their dependents, reducing upward social mobility.¹⁵⁹ Cultural and linguistic barriers make it less likely that Spanish-speaking migrants will seek care in the United States, and many return to their other countries of origin for culturally competent care.¹⁶⁰ Even clinics that provide services to migrant populations are often ill-equipped to care for Spanish-speaking migrants or for indigenous people who speak languages other than Spanish.¹⁶¹ Folk traditions such as vitamin injections are common in migrant communities, and this can pose problems for migrants receiving medical treatment. Likewise, members of many migrant communities believe that is a holistic rather than a symptomatic phenomenon, a belief that the volunteer physicians and nurses serving these communities may not be trained to address.¹⁶²

Russia. Language competency is frequently cited as the most challenging problem that migrants face in their host country. All legal information is presented in Russian, leaving them with difficulty in understanding the laws or their rights as non-nationals.^{163,164,165} The language competency of migrant women from Central Asia is lower than that of migrant women from other CIS countries.¹⁶⁶ Language and cultural barriers are among the top challenges of Kyrgyz migrant workers, according to one study,¹⁶⁷ and can lead to increased risk for psychological disorders.¹⁶⁸

Change of Social Role or Status

United States. Male workers who migrate to the United States to provide for their families find themselves experience changes in their social roles as the patriarch of the family. Among Latino day laborers, the patriarchal masculine identity as the “provider” and as working “tough” jobs is compromised if the man is injured and can no longer support his family.¹⁶⁹

Russia. Migrants may have high levels of education in their countries but still work low-skilled jobs in Russia. In one study of Kyrgyz migrants, 51.7% had high-school degrees and 22.6% had advanced degrees but did not hold jobs related to their occupations at home. Migrants may need to acquire new skills that are substantially below their level of education.¹⁷⁰ This can lead to a sudden drop in social status, putting the recent migrants at increased psychological risk if they are unable to cope.¹⁷¹ One study describes a case in

which urban families from Central Asia had to adjust to farm labor in an unfamiliar environment in Russia.¹⁷² It should also be noted that quite often, after migrant workers have familiarized themselves with their new work by acquiring skills and social links, they start working in the professions that they used to have in their home countries.

Low Education

United States. Among 150 migrant and seasonal farmworkers living in residential camps in northern Michigan, 55% had less than a high school education and 20% had not completed elementary school.¹⁷³ Low levels of education can influence migrants' abilities to understand safety warnings and risks, such as those involving pesticide.

Russia. Low language competency among Central Asian migrants is a significant barrier to obtaining education in Russia.¹⁷⁴ Professional education is not common among migrants in Russia.¹⁷⁵ A limited education can also leave one more susceptible to misinformation about risks and preventative measures for HIV/AIDS and other communicable diseases.¹⁷⁶ Education is crucial for the adaptation and assimilation of migrants to their host country.¹⁷⁷ One study reported that more than half of Kyrgyz migrant workers had a high school education;¹⁷⁸ nonetheless, education is difficult for non-Russian speaking migrants to access, even though the relatively high quality of education in Russia is cited as a primary motivation for families who migrate to Russia. One study found that 94% of migrant parents living in Stavropol had sought higher education for their children, compared to less than 80% in Moscow.¹⁷⁹

Patterns of Migration

United States. The choice to migrate is itself a factor predicting psychological risks in migrant populations: those who migrated willingly have more self-esteem and less anxiety and depression than those who were forced to migrate.¹⁸⁰ Mobile lifestyles are also thought to be a significant contributor to stress and related psychological risks.¹⁸¹ Migration already makes it difficult to acculturate oneself to the host country, creating substantial barriers to education, documentation, and upward social movement;¹⁸² continued mobility adds to this an inconsistent access to care, as mobile populations are less likely to see the same health care providers over any given period of time.¹⁸³

Russia. Though single men are the largest group of migrants in Russia, the percentage of migrant women and migrant families with children has been increasing in recent years.¹⁸⁴ Of the migrants surveyed, 40% had settled permanently in Russia, 25% still returned home for one to three months each year, 15% were seasonal workers, 11% were contract workers, and 6% worked for less than one season.¹⁸⁵ Some migrants prefer to return to their country of origin to find jobs that match their level of education or to apply the skills they learned abroad. Migrant workers from more remote areas of Central Asia tend to leave for Russia without returning home.¹⁸⁶ Remittances and resettling may be major motivating factors for these migrants.¹⁸⁷

Health Issues and Behaviors

Communicable Diseases

United States. Several of the studies dealt with communicable diseases among migrants, and with HIV/AIDS in particular. A few studies reported that homosexual relationships and the use of prostitutes and homosexual were common among male migrants, and that an increased

involvement with prostitutes was related to being separated from their wives.^{188,189,190} In one study of twenty-three male Mexican migrants in South Carolina and Arizona, the migrants knew that condoms could protect them from STIs, including HIV, but nonetheless made limited use of them due to disliking condoms, believing that they themselves were not at risk, or holding the misconception that HIV could spread only through homosexual behavior and that only gay men needed to use condoms.¹⁹¹ In another study of Mexican and Central American migrants in North Carolina, only men who made more frequent visits to prostitutes had elevated risks for HIV because they reported less condom use with sex workers they knew well.¹⁹²

Russia. Most of the Russian literature on migrant health issues emphasizes that migrants in Russia are exposed to specific communicable diseases (e.g., HIV and TB) and describes the factors that increase the risks migrants have of contracting them. An increased risk of HIV is attributed to limited knowledge of the communicability of HIV and to risky behavior enabled by ignorance of the available methods of prevention.¹⁹³

Recent studies indicate that migrant workers are at a higher risk for contracting HIV than members of the broader population due to risky sexual behaviors. These include having multiple sex partners, engaging in unprotected sex with prostitutes, and using condoms less frequently when drinking alcohol.¹⁹⁴ Thirty percent of migrants reported having had multiple female partners in the preceding three months. Rates of condom use were also low, ranging from 35% with long-term partners to 52% with casual partners.¹⁹⁵ In 2013, a report was released stating that in Moscow the rate of HIV infection was approximately 48 per 100,000 people tested, while the tuberculosis (TB) and syphilis rates were 48 and 53 per 100,000, respectively.¹⁹⁶ Moscow receives more migrant workers than any other city in Russia. Only 62% of the migrants in Moscow had the medical certificate (*spravka*) that Russian law requires them to have to cross the border; only 13% had health insurance; and only 3% of employers had provided their employees with insurance in Moscow.¹⁹⁷

One study of female migrants who performed sexual services with male migrants for money found that they engaged in behaviors that put them at greater risk for HIV and practiced inadequate HIV protection with their clients. Overall, they did not have access to women's healthcare or to information on HIV prevention.¹⁹⁸

Labor migration increases the prevalence of tuberculosis as well as of HIV/AIDS.¹⁹⁹ The rate of TB in Moscow has been increasing steadily: it rose from 20,000 cases in 1999 to 100,000 in 2000.²⁰⁰ Some surveys show still-higher figures for TB infection rates in the migrant population in Moscow. According to these surveys, the TB rate is 8.3 per 1000, which would be seventeen times as high as that of the non-migrant population of Moscow. Furthermore, the lethal cases of TB in the migrant population make up 44.5% of the recorded lethal cases in Moscow.²⁰¹ According to WHO experts, the rate of newly reported TB cases among migrants continued to increase in 2008 and made up 25.6% of all newly registered cases of TB in Russia.²⁰² According to this data, the total number of newly registered TB cases among migrants is 500 per 100,000.²⁰³

According to data provided by Rospotrebnadzor in 2011, less than half of the migrants coming to Russia, only 1.07 million of 2.6 million, were examined for TB.²⁰⁴ At the same time, the media reported that the Russian government planned to require employers to purchase health insurance for their employees to increase their motivation and change their

behavior regarding testing, prevention and treatment.²⁰⁵

Mitigating communicable diseases remains one of the most serious challenges in public health and it requires cross-sectional and multidisciplinary approaches, including counseling, testing for HIV, TB, and HPT in migrants and their family members, routing of patients to special services, and diligent monitoring programs. Some models have already been developed and piloted.²⁰⁶ Data from WHO shows that thirty-one intervention initiatives and programs were conducted in 2007 aimed at HIV prevention in migrant populations in Russia.²⁰⁷ Some of these pilot interventions took innovative approaches. For example, HIV-educational programming for Tajik male migrant workers that was provided in transit during the five-day train ride between Dushanbe and Moscow yielded a significant increase in knowledge and preventive skills in its audience.²⁰⁸

Mental Health

United States. Migrants in the United States have high rates of mental illness. In one study, 25% of migrant farm workers from Mexico reported high levels of anxiety and depression.²⁰⁹ The migrant farmworker lifestyle itself results in psychological risk, and specific risks for anxiety and depression among migrants included low social support, social marginalization, and low income.^{210,211,212} Loss of or separation from one's family structure, which is important in Mexican culture, was also a risk factor for depression and anxiety.^{213,214} According to one study, 51% of participants perceived themselves as having high levels of stress, which were often caused by their mobile lifestyle, job insecurity, and lack of legal status.²¹⁵ Other studies of migrants and day laborers reported that their social isolation and poor working conditions caused feelings of sadness, loneliness, and hopelessness.^{216,217,218}

Russia. The psychological health of migrants in Russia requires further exploration. Only a few articles have addressed the topic, despite mental health being a significant concern for migrant populations. Migration is associated with stress both prior to departure and after arrival. The difficult lifestyle many migrants lead, compounded with their "acculturation stress," can lead to unwanted emotional reactions and can cause depression, anxiety, drug and alcohol addiction, and suicidal behavior.²¹⁹ Recent studies of married male seasonal migrant workers from Tajikistan who were living in Moscow have demonstrated the roles played by trauma and post-traumatic stress disorder (PTSD) in the development of migration-associated HIV-risk behaviors. Some studies associated sexual behaviors that increased risk for HIV with higher exposure to indirect trauma.

Reproductive Health

United States. Few the studies focused on female migrants and their reproductive health. Lack of access to health care has been found to result in delayed confirmation of pregnancy, resulting in pregnant women working under dangerous conditions and being unable to take time off for prenatal care.²²⁰

Russia. The birth rate among foreign citizens in Moscow remained constant from 2010 to 2013 and accounted for about 7% of the births in Moscow during that time period. These statistics include foreigners from all countries, not only Central Asia.

Substance Use

United States. Many studies reported that migrant workers are at significant risk for developing substance abuse problems due to their lifestyles and working conditions. A few

studies reported significant variance in alcohol use among migrants, where some migrants would abstain from alcohol entirely while a large portion of others would drink heavily.^{221,222,223} In a study of Latino day laborers in the Southwest, binge drinking was reported as a way to unwind after challenging work days, to reduce pain from injuries, and to cope with discrimination and social isolation.²²⁴ Another study, of 102 migrant day laborers in Northern California, found that they did not drink frequently, but that when they did drink, the average number of drinks was seven, indicating that the drinking that did occur tended to be binge drinking.²²⁵

Russia. Although migrants in Russia are exposed to injection drug use, only a few reports have presented regional models or approaches to addressing issues of drug use among migrants. Not only are there very few centers addressing the issues of injection drug use among migrants, but the services they provide are also limited and focus mostly on drug testing.²²⁶ The existing surveys on drug use among migrant workers are also insufficient, although some recent surveys have suggested that male Tajik migrants who inject drugs experience double jeopardy for social marginalization, both from Russian society as migrants and from the community in generally, Russian and Tajik, as injection drug users (IDUs).²²⁷ A lack of ready access to clean needles and syringes further contributes to Tajik IDUs' risk of contracting HIV.²²⁸ Furthermore, in the absence of familiarity with the risk of needle-borne HIV infection, migrant IDUs continue forging close social alliances with their drug-using peers due to a sense of community that arises from sharing drugs and syringes. Sexual contact with Russian prostitutes, many of whom use drugs, further contributes to HIV vulnerability and forms a potential bridge for the transmission of the virus.²²⁹

Non-Communicable Diseases

United States. Few studies have focused on non-communicable diseases among migrant populations in the United States. Two articles reported that obesity was a health problem among migrants due to a lack of nutritious food and insufficient time to cook meals.^{230,231} A study of food insecurity among one hundred U.S.-Mexico border-migrant and seasonal-farmworker households found that the most common physician-diagnosed conditions included hypertension (30%) and diabetes (28%).²³² Migrants also have a higher risk for certain kinds of cancer than the general population. An analysis of Mexican migrant workers in California found high rates of lymphatic and hematopoietic cancers. Specifically, the prevalence of non-Hodgkin's lymphoma more than tripled, and leukemia rates doubled, in areas where certain pesticides were used heavily.²³³

Russia. No relevant studies were found in the accessible literature.

Occupational Health

United States. Most health problems among migrants involved injuries or illnesses directly related to their working conditions. Agricultural work is labor intensive with its long hours, and causes skin rashes from pesticides and chemical exposure, musculoskeletal injuries, and lesions.^{234,235,236,237} In one study of 150 Hispanic migrant seasonal farmworkers, 185 injuries were reported by 109 of the participants. Musculoskeletal injuries were the most common of these and including backaches, shoulder pains, sprains, and fractures, due to long hours, repetitive motions, uncomfortable positions, and heavy loads to carry.²³⁸

Russia. No relevant studies were found in the accessible literature.

Domestic Violence

United States. Few studies of migrants in the United States reported domestic violence. Due to the gendered power difference within the family, women who migrate with their male partners are vulnerable to violence.²³⁹ In one study of migrant and seasonal farm-working women who reported to migrant-care clinics, 19% were found to have been physically or sexually abused by their partner. Predictors of abuse included the partner's drug and alcohol abuse and migrant status.²⁴⁰

Russia. No relevant studies were found in the accessible literature.

Oral Health

United States. Among migrant workers, ignorance of and lack of access to care resulted in poor oral health. In one study of 119 migrant farmworkers in southern Illinois, half showed signs of periodontal disease and nearly half had not received oral health care in the preceding year.²⁴¹ A study of 151 male farmworkers in North Carolina found that only 21% had received oral health care in the past year, most of whom received it in Mexico rather than the United States, and that 52% reported dental caries and 33% reported missing teeth.^{242,243}

Russia. No relevant studies were found in the accessible literature

Health Systems

Health Care Services Available

United States. Housing and working conditions have can have serious effects on the health of migrant farmworkers.²⁴⁴ Such workers lack the normal support networks to rely on in case of an emergency as well as the resources to monitor chronic health conditions.²⁴⁵ Those health conditions are further exacerbated by the worker's inability to pay, their lack of insurance, and other barriers to care.²⁴⁶ This conglomeration of factors indicates the need for health clinics with services tailored to the needs of migrant farmworkers. However, one study found that there are only fifteen clinics specifically targeted at migrant farmworkers.²⁴⁷ Migrant health centers are needed which can provide culturally sensitive, cost-effective services, based on a voucher or sliding scale, in the native languages of the migrant workers.

Russia. For labor migrants, the only free healthcare services provided by the Russian government are emergency-room services, including childbirth. The government provides medical examinations, but only as part of the border-control and deportation processes. The surveillance and monitoring of communicable diseases among migrants places a significant financial burden on the Russian healthcare system.^{248,249,250}

Employers of legal migrants are required to provide health insurance to their employees, as per recent government policy. The migrants may then receive treatment for infectious diseases such as TB, provided that the disease is not acute enough to require immediate deportation.²⁵¹ Some NGOs provide preventative and educational health-care services in order to decrease the social exclusion of underserved labor migrants.²⁵² Since 2011, the Red Cross of Saint Petersburg has provided healthcare to underserved migrant workers and advocated for health rights for migrants.²⁵³

Access and Barriers to Care

United States. Numerous studies have researched the barriers to care that migrant workers

encounter. The most significant barriers include cost, transportation, language, insurance, legal status, knowledge of services, clinic hours, and fear of discrimination.^{254,255,256,257,258,259,260} Institutional violence and the disenfranchisement of migrant and Latino communities exacerbate these obstacles, while the migrants simultaneously have a higher risk of injury and illness.^{261,262} Due to these barriers to care, many migrants use emergency services almost exclusively and do not have access to preventative care.²⁶³ Three studies have proposed ways to increase the use of medical services by migrants. These include collaboration on outreach and data collection and the use of mHealth technologies, including the provision of transportation services, mobile clinics, bilingual staff, and childcare services.^{264,265}

Russia. Obtaining access to services for the treatment of TB and other infectious diseases, for pregnancy, and for other non-primary health needs is difficult for migrant workers.^{266,267,268,269,270} Though migrants are legally able to access free emergency care services, even if they are undocumented, individual urgent-care centers may turn them away. Migrants can also utilize social networks, doctors from their diaspora communities, and migrant-friendly private clinics to get care.^{271,272,273,274,275} Only three NGOs in Moscow provide services to migrants with children in need, which suggests a dearth of services for this community.²⁷⁶ Additional barriers to care face men who have sex with men (MSM), who may have to evade HIV testing or purchase false test results, since Russia deports HIV-positive individuals.^{277,278}

Insurance Status

United States. One study found that health insurance is an important indicator of consistent use of health-care services, including prenatal care.²⁷⁹ Migrant farmworker families are disproportionately uninsured even as compared with other low-income families.^{280,281,282} Unlike low-income, non-migrant families, migrant farmworkers are frequently banned from Medicaid and other publicly funded healthcare because of their movement from location to location. Another problem is because yearly income is generally determined from one's most recent pay stubs, but this does not work with seasonal or part-time employment.²⁸³ Additionally, Pransky's study found that 56% of non-agricultural Latino workers were told they would not be covered by worker's compensation insurance if they became sick or were injured at work, which indicates that even when certain jobs appear to have insurance, it may not be effective.²⁸⁴ Without services specific to migrants, particularly to migrant farm workers, the situation is unlikely to improve, because migrant workers are also likely to be unable to enroll in the Affordable Care Act.

Russia. Health insurance is not mandatory for migrants in Russia, although employers do have the option of offering health insurance plans.²⁸⁵ Less than 20% of migrant workers have health insurance, and those that do often do not take full advantage of their plans.^{286,287,288} Providing supplemental health insurance is inadequate as a means to integrating migrant workers into the Russian healthcare system, according to three Russian health officials.²⁸⁹ It should be noted that in Russia the general public, mass media, and leading political forces are demanding that compulsory medical insurance be introduced for foreigners working in the country. According to some sources, such compulsory medical insurance will be implemented shortly.

Legal Status

United States. Legal status has a significant effect on migrants' health, their access to

healthcare, and the quality of the care they receive.^{290,291,292,293,294,295} The stress of migration itself, including the fear of deportation, increases migrants' risks of developing mental and physical health issues.^{296,297} Indeed, one study found that 51% of respondents faced stressors that they felt had led to psychological difficulties.²⁹⁸ Despite their increased need for health services, however, migrant workers are less likely to seek out medical care, especially preventive care that would decrease their numbers of emergency room visits and their overall costs.^{299,300} While cultural and financial barriers do also contribute to the difficulty of their integration into the healthcare system, undocumented and green-card holding migrants in particular make fewer physician visits than their U.S.-born counterparts.³⁰¹

Russia. Undocumented status is a significant barrier to basic health care, including preventative services and routine medical examinations. If migrant receive test results that bar them from employment in Russia, such as a positive HIV status, they will most often seek illegal employment and become undocumented.^{302,303,304} Migrants who work in Russia illegally will receive medical care only at pay-care clinics, from NGOs such as the Red Cross, or at urgent-care centers.³⁰⁵

Migrant Specialty Services

United States. Health centers and services specializing in migrant health address the linguistic, cultural, and financial barriers that inhibit migrant workers' access to healthcare.^{306,307} The majority of such healthcare centers receive "mixed grant" funding and also serve other marginalized communities than migrant workers.³⁰⁸ Migrant health centers can provide high-quality care to migrant workers regardless of their ability to pay using voucher systems or a sliding cost scale. These centers can also frequently provide care in the native language of the patient, and some offer transportation services.

Russia. Specialty care services, including gynecology, maternity services, and dentistry, are rarely available to labor migrants.^{309,310,311} Female migrants may receive emergency childbirth services at urgent-care centers, but they are discharged immediately after birth, with no prolonged treatment or follow-up,³¹² if they do not pay the prescribed fee for the service. Even if a migrant is insured, their basic health insurance may not cover specialty services.³¹³

Medical Exams to Receive Work Permit

United States. No relevant studies were found in the accessible literature.

Russia. The Russian government considers labor migration to be a threat to public health due to the perceived higher prevalence of communicable diseases among Central Asian labor migrants. Medical examinations are required of all foreigners in order to receive work permits, and they must pay for these at their own expense. Deportation is required in the case of specific communicable diseases, such as HIV/AIDS and TB.³¹⁴ Some studies have shown higher TB rates in migrant populations in Moscow, but there is no publicly available epidemiological data from governmental sources on the basis of which these findings could be generalized to the greater migrant population.³¹⁵

Table 1. Summary of US and Russia Results

		<i>USA</i> (<i>n</i> = 50)	<i>Russia</i> (<i>n</i> = 42)
<i>Social Determinants of Health</i>	Discrimination/social isolation	12 (24%)	3 (7%)
	Difficult living and working conditions	11 (22%)	7 (17%)
	Low language competency	9 (18%)	6 (14%)
	Low income/poverty	5 (10%)	5 (12%)
	Lack of access to food/nutrition	4 (8%)	1 (2%)
	Limited transportation	4 (8%)	1 (2%)
	Family separation	4 (8%)	5 (12%)
	Low social support	4 (8%)	7 (17%)
	Patterns of migration/mobility	4 (8%)	4 (10%)
	Low education	1 (2%)	6 (14%)
	Change of social role/status	1 (2%)	4 (10%)
<i>Health Issues and Health Behaviors</i>	Mental health	14 (28%)	2 (5%)
	Occupational health	8 (16%)	0 (0%)
	Communicable diseases	8 (16%)	15 (36%)
	Substance use	6 (12%)	2 (5%)
	Domestic violence	5 (10%)	0 (0%)
	Non-communicable diseases	5 (10%)	0 (0%)
	Reproductive health	1 (2%)	1 (2%)
	Oral health	3 (6%)	0 (0%)
<i>Health Systems</i>	Access and barriers to care	10 (20%)	12 (29%)
	Insurance status	7 (14%)	7 (17%)
	Legal status	6 (12%)	6 (14%)
	Health care services available	3 (6%)	7 (17%)
	Migrant specialty services	3 (6%)	5 (12%)
	Medical exams for work permit	0 (0%)	4 (10%)

Comparing the US and Russia

Despite the historical, political, and social-cultural differences between the U.S. and Russia, our white paper shows that migrant workers in the two countries face comparable barriers to good health. These barriers are apparent in the poor health outcomes of migrant farmworkers in the U.S. and of economic migrants in Russia relative to the general populations in their respective countries. Social determinants of health contribute to problematic health issues and health behaviors, and this poor disposition is compounded by the difficulty that migrants have gaining access to health systems of both countries.

Our analysis of the studies included in this white paper has shown the following:

	<i>USA, Migrant farmworkers</i>	<i>Russia, Economic migrants</i>
<i>Most frequently identified social determinants of health</i>	1) discrimination/social exclusion 2) difficult living and working conditions 3) low language competency 4) low income/poverty	1) difficult living and working conditions 2) low social support, 3) low language competency 4) low education
<i>Most frequently identified health and health behavior issues</i>	1) mental health 2) occupational health 3) communicable diseases 4) substance use	1) communicable diseases 2) mental health 3) substance abuse 4) reproductive health (2-4 notably less attention compared to #1)
<i>Most frequently identified health-systems factors</i>	1) access and barriers to care 2) insurance status 3) legal status	1) access and barriers to care 2) insurance status 3) health care services available 4) legal status

DISCUSSION

Policymakers and practitioners should note the similarities of these findings across the U.S. and Russia. For example, “access and barriers to care” and “insurance status” are identified as among the key factors to the health of migrants in the health-systems literature of both countries. This result is unsurprising given the similarities between the U.S. and Russia’s private health insurance systems and their treatment of non-nationals who seek care. In Russia, the primary barrier is monetary: economic migrants can rarely afford supplemental health insurance, and employer-provided healthcare plans are very rare. In the US, the primary barriers are both monetary and legal, because undocumented immigrants are barred from participating in the Patient Protection and Affordable Care Act (PPACA), but cannot afford either private insurance or the out-of-pocket costs of medical services. In both cases, migrants are less likely than the general population to have either insurance or regular access to health care services.

Similarly, the literature for both the U.S. and Russia identifies “difficult living and working conditions” as the primary social determinant of health for migrants, although in the US “discrimination/social exclusion” is given particular notice, while it is not identified in the Russian literature. This is likely to be due to the particular history and socio-cultural context of each country.

While discrimination against individual Central Asian migrants in Russia has been documented, the poor housing, segregation, and low wages that can be observed on a population-wide level are more likely to be attributed to solely economic factors than to institutional discrimination or social exclusion as in the US. Latinos in the US, who constitute the majority of migrant farmworkers, are treated as a distinct ethnic and cultural group there, whereas Central Asians have a shared cultural history with Russians, mainly through the former Soviet Union period, and are less likely to be identified as minorities. However, according to a number of experts, this will change as immigration increases and these nationalities gain sizable diaspora communities. Most importantly, however, there is simply more sociological and ethnographic data on discrimination available in the U.S. than in Russia, and this is due to the particular emphasis placed on anthropology in the U.S. and the consequent availability of such studies in peer-reviewed journals.

Mental health was the most commonly identified health issue on the US side, while the Russian literature focused primarily on communicable diseases. This can be attributed to the different health needs of the two countries. Russia has a higher prevalence of TB than the U.S., and TB and HIV/AIDS remain priorities for the Russian immigration and security systems.

The US also has a stronger health-screening infrastructure in place for work visa applicants, whereas Russia allows free entry between the Russian Federation and its Central Asian neighbors in spite of the risk of worker overstay, falsification of health certification documents, and regional disease outbreaks.

Notably, though, the U.S. cannot medically screen undocumented migrants, and they have a prevalence of TB nine times that of the general U.S. population, where TB is very rare.

While the US has high rates of HIV/AIDS in certain populations, this is related more to social

marginalization (among African-American communities), intravenous drug use, and men having sex with men than to migration or border issues as in Russia.

Furthermore, mental health research has a more extensive history in the U.S. than in Russia, and in spite the lack of peer-reviewed studies in Russia, there is no reason to suspect that Central Asian migrants have fewer mental health issues than their U.S. counterparts. Isolation, family separation, and multiple sex partners are commonly recognized as prevalent within both migrant populations, and these conditions can increase risk for depression, anxiety, and other mental health issues.

Drug use is commonly identified in both the U.S. and Russia, although the usage patterns and the substances involved vary based on location and drug availability.

Similarly, though domestic violence was only identified on the U.S. side, there is no evidence that this issue does not exist among economic migrants in Russia. Women are increasingly becoming migrants in both countries, both as individuals and in migrant families, due to economic opportunities and the relatively higher-quality medical care they can receive there than in their countries of origin, especially for reproductive issues. More research needs to be done on mental health in the U.S. and Russia before substantive comparisons between the two countries.

Some Models Used to Improve Migrant Health

Community Health Worker Model

Community health workers (CHWs), also known as lay health advocates, outreach educators, and peer health promoters, are members of the community who work with the local health care system. CHWs generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve.³¹⁶ Community health worker models aim to improve access to care, increase knowledge, prevent disease, and improve health outcomes. CHWs can serve as a bridge between the communities they serve and the health care system by building trust within the underserved population, by providing interpretation services, culturally appropriate education and information, and informal guidance on health behavior, and by advocating for community health needs.³¹⁷ A community health worker model applied in migrant communities can increase community capacity building and ensure the provision of culturally competent care.

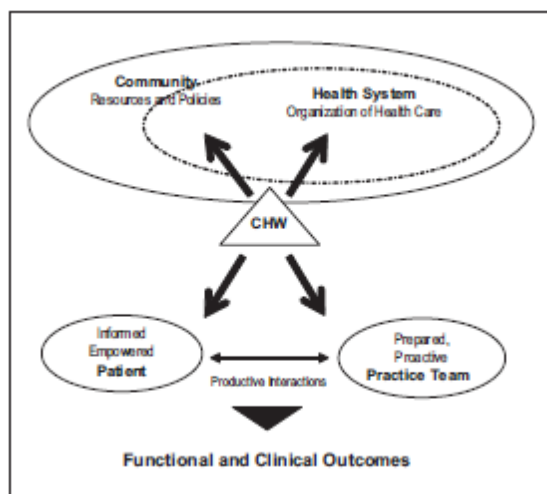


Figure 1. Integration of the Community Health Worker Model into the Chronic Care Model. Adapted from Wagner et al.³¹⁸

Migrant Health Promotion Program. Migrant Health Promotion (MHP) is an organization that has developed adaptable outreach programs to build healthier migrant communities from within.³¹⁹ Their Capacity Building Program provides assistance to migrant and community health centers, community-based organizations, health departments, and community stakeholders in the planning and implementation of community health worker programs. Three of MHP's programs also use community health worker (promotora) models to address particular health issues: the Colonia Outreach Program uses promotores(as) to provide culturally and linguistically appropriate assistance in filling out applications for benefits, including those of the Temporary Assistance for Needy Families (TANF) and Supplemental Nutritional Assistance Program (SNAP) programs; the Health Relationships Program uses the Promotor(a) de Salud model to promote healthy relationships, prevent intimate-partner violence and sexual assault, and provide support for survivors of abuse; and the Amor de Madre Program uses promotoras who are trained as doulas, women who help other women through pregnancy, and as peer counselors, who educate and support new mothers on breastfeeding throughout the postpartum period.³²⁰ The models are used to guide the development of programs and can be adapted to local communities.

Collaborative Partnership Model

Providing effective health care services that address the multidimensional needs of migrant populations requires more than just a health outreach approach. A collaborative partnership between universities, migrant health clinics, and migrant workers themselves will bring diverse training, knowledge, and expertise to the problems.³²¹

Community-Academic Partnership. One example of a growing community-academic partnership began as a collaboration to improve health issues related to breast cancer among migrant and seasonal farmworker women. The Lee Moffitt Cancer Center and Research Institute at the University of South Florida at Tampa became aware of the need to reach the nearby migrant community, who faced numerous barriers to mammography due to insurance problems, limited access to health care, low education and literacy levels, and cultural differences.³²² The research institute partnered with the Suncoast Health Center, a health center that serves migrant populations in rural Florida. The partnership began as the

Suncoast/farmworker community-Moffitt Cancer Center partnership and was built on Minkler and Wallerstein's community organization principles of empowerment, community competence, relevancy, participation, issue selection, and creation of critical consciousness.³²³ The partnership model has been used to develop collaborations among many other organizations.

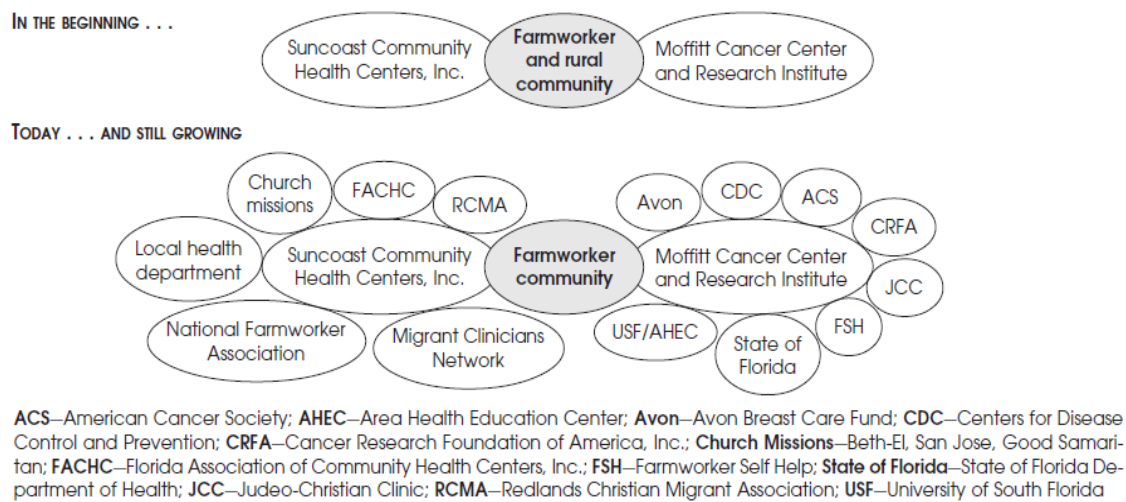


Figure 2. Partnership Evolution

Source: Meade C.D., 3Calvo A. Developing community-academic partnerships to enhance breast health among rural and Hispanic migrant and seasonal farmworker women. *Oncol Nurs Forum*. 2001 Nov-Dec. 28(10):1577-84. <http://www.ncbi.nlm.nih.gov/pubmed/11759305#>

Research Needs and Practical Recommendations

To better inform the development, implementation, and evaluation of multilevel interventions, additional research is needed that overcomes the methodological limitations in the existing literature and focuses on building contextually tailored interventions and policies. The findings of this review reveal several ways in which current knowledge is incomplete because of the methodological limitations of many existing studies and provide insights into how this can be remedied. For example:

1. There are an inadequate number of studies on migrants and health. There is an understandable preponderance of reports on HIV and TB, but there are not enough reports overall that address other infectious diseases, such as hepatitis and STIs, as well as non-communicable diseases, including mental illness and substance abuse.
2. The studies of migrants are for the most part limited to the receiving country, and do not include data from the sending country.
3. Greater methodological rigor is needed in studies of migrants and health. Most of the examined study designs were cross-sectional, which limits their value in that they can provide only a snapshot of a single moment in time. Longitudinally designed studies are necessary to capture time-dependent changes.
4. The studies are mostly quantitative. There is too little use of qualitative methods, let alone mixed methods.
5. The studies done in the U.S. have not looked at anything comparable to the medical exams required for work permits in Russia, because there are no such requirements in the

U.S. However, there are probably comparable medical exams being performed within various industries, which, though relevant here, could not be included because they are not yet addressed in the scientific literature.

6. The existing studies do not adequately address the protective factors and processes that promote better health and mental health outcomes.
7. The studies do not adequately address the comorbidity of conditions, especially conditions involving both physical health and mental health.

This study had several limitations:

1. The review was limited to studies of labor migrants and excluded other types of migrants and refugees.
2. During the electronic search, some relevant literature may have been missed and therefore been excluded from this review.
3. The categorization of information from each article in this review was subjective and based on the authors' own interpretations.

Research Needs

To better understand the health challenges faced by labor migrants, to see how they differ from other vulnerable populations, and to better inform the development, implementation, and evaluation of targeted multilevel interventions, additional research is needed. In particular, this research should address the following questions:

1. What are the social determinants of the highest-priority health problems and behaviors?
2. Which determinants, at which levels, are modifiable under real-world conditions?
3. Which policies and programs are the most potentially effective and the most optimal, feasible, appropriate, and acceptable to migrants and their families and to the organizations and the nation states that work with them?

Practical Recommendations

Based on this review, several priorities were identified and the following actions are proposed:

1. As much as possible, use international intergovernmental organizations, including WHO and IOM, bi- and multilateral cooperation among governmental agencies, and business associations and civil society for resolving migrants health issues.
2. Establish and sustain working relationships among diaspora communities, the ministries of health in their sending countries, and the health organizations in their receiving country, which can implement collaborative projects and programs for improving social determinants of health, optimizing the migration process from the point of view of migrants' health, and ensuring that labor migrants have access to health care services and health information. These relationships should include health care organizations, nonprofit organizations working with migrants, diaspora organizations, and religious communities, with due consideration of the real influence and potential of civil society.
3. Develop internet portals: create global and regional resource centers that can accumulate statistics, research evidence, best practices, and other data on issues pertaining to migrants' health.

4. Promote the development of centers that provide relatively inexpensive legal services to undocumented migrants seeking to apply for legal residency; support the development of specialized nonprofit organizations providing such services.
5. Enforce labor protection laws as well as norms and rules of occupational safety in order to protect labor migrants from environmental and occupational health hazards.
6. Provide occupational safety education in either the common language (i.e., Russian or English), or in the migrants' language.
7. Promote employment through trade unions and more active involvement in them among labor migrants to ensure safer and higher-quality working and living conditions.
8. Promote media outreach and popular education on migrants' health issues in order to personalize labor migration for host country citizens and to improve attitudes within the host country towards labor migrants and their families.
9. Provide labor migrants and their families with resources to help them gain access to legal, medical, and social services, including free help hotlines, legal assistance organizations, and migrant-friendly primary care clinics.
10. Improve labor migrants' access to health information on nutrition, reproductive health, the prevention and treatment of communicable diseases (TB, HIV, other STIs, etc.), drug use (including alcohol and tobacco), and basic health assessment. This should be done in cooperation with nonprofit organizations.
11. Provide culturally appropriate health information services in the labor migrants' native or second languages.
12. Provide comprehensive health education and training to community health workers and members of diasporas and communities sharing common religious confessions.
13. Improve labor migrants' access to primary health care services in their host countries.
14. Develop health promotion and disease prevention strategies among labor migrants, especially regarding infectious diseases.
15. Include sections on migrants' health issues and to them possible solutions in the training programs of government officials and of health and social services professionals, including corresponding teaching and methodological kits.
16. It should be noted that according to expert opinion, such activities would be more efficient if aimed initially at disease prevention, at prevention of infectious diseases in particular, among labor migrants and their families.

APPENDICES

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2. Invited Roundtable Attendees

Experts from Russia who participated in the roundtable “Promoting Health among Migrants in the US and Russia through a Public Health Approach,” UIC, Chicago, Illinois, USA, on 14 March 2014, and reviewed white paper drafts:

Aleksander Tengizovich Gasparishvili, PhD (Philosophy), Associate Professor; Leading Researcher of Analytical Service under Rector, M.V. Lomonosov Moscow State University; Senior Researcher, Institute of Sociology, Russian Academy of Sciences; Managing Director, International League of Non-Governmental Organizations “Dobrososedstvo”; Learned Secretary, Scientific Expert Board of Public Advisory Council, Department of Federal Migration Services of Russia, Moscow.

Oksana Vladimirovna Krivoschekova, head of project activities, direction “Health” of the regional non-governmental organization Baikalskiy regional women’s union “Angara” (<http://womangara.ru>), Director of the autonomous non-commercial organization “Women’s business center “Angara-Plus,” head of group of information support and leadership of automated management system of State health-care institution Irkutsk Oblast Cancer dispensary, expert of Public Chamber of Irkutsk Oblast, specialist in social projecting, Irkutsk.

Yuriy Viktorovich Moskovskiy, historian, sociologist, political scientist, journalist, Director of Project Fund for the Development of International Links “Dobrososedstvo” (<http://dobrososedstvo.com>, <http://dobro-sosedstvo.ru>, <http://dobrososedstvo.info>), Secretary of the Public Consultative Council under the Department of Federal Migration Services of Russia in Moscow, member of the Public Council with ROSSTAT, Central Board of the All-Russia Society for the Protection of Monuments of History and Culture, Board of World Russian Sobor, Union of Writers of Russia, Board of Congress of Ethnic Journalists (responsible for migration issues), Moscow. ksovet@gmail.ru.

Guzel Raisovna Shakirova, Head of the Department of Health Care, Sports and Development of Healthy Lifestyles of Staff of Cabinet of Ministers of Republic of Tatarstan, Kazan.

Liliya Ahatovna Taisheva, Doctor of medical sciences, Director of Autonomous charitable non-commercial organization “Noviy Vek” (<http://newcenturykazan.ru>), Kazan.

Experts from the US who participated in the round table:

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Linda Forst, MD, School of Public Health, Environmental and Occupational Health Sciences, UIC, Chicago, Illinois.

Susan Bauer, MPH, Community Health Partnership of Illinois, Chicago, Illinois.

Ricardo Diaz, Champaign-Urbana Immigration Forum, Champaign, Illinois.

Mildred Hunter, Office of Minority Health, US Department of Health and Human Services.
Jose Alonso, Illinois Migrant Legal Assistance, Chicago, Illinois.



Figure 3. Photo: A group of participants in the expert round table, University of Illinois at Chicago, Chicago, Illinois, USA on 14 March 2014.

3. Practical Recommendations

Promoting Health among Migrants in the US and Russia through a Public Health Approach: Consensus Statement and Practical Recommendations for Migration and Health Policy Makers

Background and Purpose

A working group of U.S. and Russian public health experts reviewed the existing literature, policies, and practices regarding public health issues for labor migrants in both countries. The review focused on the social determinants of health, health problems, and health-systems issues. Health policy makers can use the knowledge they gain from this review to promote health among migrants and improve public health policy in the United States and in the Russian Federation.

This white paper divides migrant health issues into three categories:

Social Determinants: The most frequently identified social determinants in the U.S. were discrimination and social exclusion, difficult living and working conditions, low language competency, and low income or poverty. In Russia, the most frequently identified social determinants among migrants (predominantly those from Central Asia) were difficult living and working conditions, low social support, low language competency, low education, low income or poverty, and family separation.

Health and Health Behavior Problems: The most frequently identified health problems in the U.S. were mental health problems, occupational health problems, communicable diseases, and drug abuse. In Russia, the literature mostly frequently identified communicable diseases.

It should be noted that the studies in Russia dealt mostly with migrants from Central Asia (Uzbek, Kyrgyz, Tajik), and not with Slavs from other countries. There is also very little research on migrants in Russia originating among the peoples of the Caucasus, Moldova, Gagauzia, or Kazakhstan.

Health-Systems Issues: The most frequently identified health-systems issues in the U.S. were inadequate access to care, barriers to care, insurance status, and legal status and in Russia were inadequate access and barriers to care, insurance status, availability of health care services, and legal status.

Needs and Practical Recommendations

The global movement of labor migrants presents both opportunities and challenges for the countries receiving them. In both the United States and Russia, the process of migration can have significant implications for the well-being of both the migrants themselves and the native populations. Immigration and health care legislation are key to addressing the economic and social factors associated with migration that affect public health. This study advances several specific ways in which policy makers can promote migrant health through legislation on visa requirements and health care coverage. Additionally, in order to ensure the health of both the migrant and native populations, health care and migration policy makers must seek out further collaborative partners and develop legislation jointly with all interested parties. The following recommendations reflect these needs:

Legislation Regarding Registration Procedures and Visa Requirements

1. Possibly provide prospective migrants with free examinations for communicable diseases prior to migration in order to reduce the cost of legal migration to the migrant, and to reduce the time that infected patients stay the host country, posing a danger to people coming in contacting with them.
2. Implement mandatory registration and medical examinations for all migrants in order to improve the surveillance and monitoring of communicable diseases. Preferably, give screening tests for infectious diseases to all individuals entering the country for employment, study, or other long-term purposes.
3. Expand humanitarian visas for people receiving long-term health care.
4. Support the development of legislation to improve the routes to legal employment.

Legislation Regarding Health Care Coverage

1. Include spouses and dependents of labor migrants in workers' insurance plans.
2. Designate government funds and grants for the establishment of more accessible health care infrastructure (e.g., hospitals, testing centers, clinics), including the provision of services in the native language of the patients.
3. Designate funds for the provision of free vaccinations to undocumented laborers and for informational campaigns on disease prevention aimed at labor migrants.
4. Provide governmental support to NGOs working in the area of migrant health.
5. Include medical interpretation among the services listed and provided at specialized health care facilities that provide care to migrants. If feasible, include such services at health care institutions that provide care to labor migrants.
6. Increase cultural sensitivity and cultural appropriateness in health care.
7. Improve regulations for protecting health in the workplace.

Necessary International Collaboration for Legislation

1. Foster international cooperation between the migration services and public health institutions of the receiving and donor states in order to address migration and health policies.
2. Develop cooperation between donor and receiving states on vaccination, including that of migrants.
3. Further develop collaboration between governmental agencies and relevant NGOs working with migrants.

Promoting Health among Migrants in the U.S. and Russia through a Public Health Approach: Consensus Statement and Practical Recommendations for Health Practitioners

Background and Purpose

A working group of U.S. and Russian public health experts reviewed the existing literature, policies, and practices regarding public health issues for labor migrants in both countries. The review focused on the social determinants of health, health problems, and health-systems issues. Health practitioners can use the knowledge they gain from this review to promote health among migrants and to improve public health in the Russian Federation and in the United States.

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Social Determinants: The most frequently identified social determinants in the U.S. were discrimination and social exclusion, difficult living and working conditions, low language competency, and low income or poverty. In Russia, the most frequently identified social determinants among migrants (predominantly those from Central Asia) were difficult living and working conditions, low social support, low language competency, low education, low income or poverty, and family separation.

Health and Health Behavior Problems: The most frequently identified health problems in the U.S. were mental health problems, occupational health problems, communicable diseases, and drug abuse. In Russia the literature most frequently identified communicable diseases.

It should be noted that studies of labor migrants in Russia dealt mostly with those originating in Central Asia (Uzbek, Kyrgyz, Tajik), and not with Slavs originating in other countries. There is also very little research on migrants in Russia from the Caucasus, Moldova, Gagauzia, or Kazakhstan.

It is true that some migrants “import” communicable diseases to their country of destination; many migrants are also exposed to health risks in their host country due to social and economic factors such as low education levels, language barriers, social isolation, lack of access to health care, and adoption of less healthy lifestyles.

Health-Systems Issues: The most frequently identified health-systems issues in the US were inadequate access to care, barriers to care, insurance status, and legal status, and in Russia were inadequate access and barriers to care, insurance status, availability of health care services, and legal status.

Needs and Practical Recommendations

The health care needs of migrant populations are rooted in financial, legal, and social barriers to care. In the United States, all citizens and documented migrants can receive coverage under the Affordable Care Act, while undocumented migrants are not eligible for this and usually cannot afford to purchase health insurance independently. Similarly, the Russian government provides health care through either mandatory insurance, available to citizens and officially registered migrants, or voluntary insurance that individuals can purchase. Because of their legal status, undocumented migrants are not eligible for the mandatory insurance, and they usually cannot afford voluntary insurance plans. Russian law does make

emergency medical care available to everyone for free, irrespective of insurance status. Further social factors, such as language barriers, limit access to care for some migrants, especially those from Asia. A lack of routine medical examinations contributes to worse health outcomes in migrant communities.

Health practitioners, as respected experts in the medical field, are ideally positioned to overcome these barriers by working directly to improve services and by supporting health education and advocacy efforts.

Practical Recommendations for Improved Services

1. Collaborate with governmental medical facilities to provide migrants (including undocumented ones) with primary health care and prevention services.
2. Develop and implement special educational and training programs for health care providers, covering topics of cultural appropriateness, communication with and counseling of migrant populations, and distinctive cultural traits.
3. Support organizations that provide basic health care services to migrants in their native languages and promote healthy lifestyles among migrants in a culturally appropriate manner.
4. Develop and implement health-education campaigns in the target languages of migrants that give them information on available health services, including mental health services. Recruit, develop, and support peer specialists from the community to work on health promotion among migrants.
5. Recruit individuals from migrant populations and from medical universities, as well as students, physicians, nurses in training, and others in related fields, to work as volunteers at health clinics serving migrant populations.
6. Collaborate with academic institutions to promote more engaged research partnerships between universities and health care practitioners.
7. Establish affiliation agreements between colleges of medicine and migrant-serving Federally Qualified Health Centers in the U.S., as well as other safety net clinics, and establish residency training programs connecting them, to increase access to care for underserved migrant workers and dependents.
8. Collaborate with governmental and non-governmental organizations in the countries of origin of migrants in order to identify the best practices for preventative and health promotion programs in the host country.
9. Engage the leaders of migrant communities in health outreach and promotion efforts.
10. Enhance the existing programs in health clinics that are aimed at the prevention and treatment of HIV/AIDS and other STIs, including programs specifically for at-risk populations such as sex workers and migrants.

Practical Recommendations for Preventive Activities of Health Practitioners

1. Support educational campaigns aimed at specific migrant populations, and ensure that materials are available in the native language of the group and are phrased in culturally appropriate terms.
2. Use different kinds of media, including mobile phone technologies and social media, for communicating information on healthy lifestyles and treatment in the native language of migrants.

3. Increase the implementation of community health worker models and health outreach by involving people from the community.

Practical Recommendation to Support Advocacy Efforts

As a medical expert, endorse both advocacy campaigns aimed at ensuring access to health care (including for undocumented migrants) and those aimed at fighting misconceptions about the public-health impacts of migrants.

Promoting Health among Migrants in the U.S. and Russia through a Public Health Approach: Consensus Statement and Practical Recommendations for Educators and Researchers

Background and Purpose

A working group of U.S. and Russian public health experts reviewed the existing literature, policies, and practices regarding public health issues for economic and labor migrants in both countries. The review focused on the social determinants of health, health problems, and health-systems issues. Educators and researchers can use the knowledge they gain from this review to promote better health among migrants.

This study divides migrant health issues into three categories:

Social Determinants: The most frequently identified social determinants in the U.S. were discrimination and social exclusion, difficult living and working conditions, low language competency, and low income or poverty. In Russia, they were difficult living and working conditions, low social support, low language competency, low education, low income or poverty, and family separation.

Health and Health Behavior Problems: The most frequently identified health problems in the US were mental health problems, occupational health problems, communicable diseases, and drug abuse, and among migrants in Russia (predominantly from Central Asia), the most identified problems were communicable diseases.

It should be noted that the studies of labor migrants in Russia dealt mainly with those from Central Asia (Uzbek, Kyrgyz, Tajik) and not with Slavs from other countries. There is also very little research on migrants in Russia from the Caucasus, Moldova, Gagauzia, or Kazakhstan.

It is true that some migrants “import” communicable diseases to their host country; many migrants are also exposed to health risks in their host country due to such social and economic factors as low education levels, language barriers, social isolation, lack of access to health care, and adoption of less healthy lifestyles.

Health-Systems Issues: The most frequently identified health-systems issues in the US were inadequate access to care, barriers to care, insurance status, and legal status, and in Russia were inadequate access and barriers to care, insurance status, availability of health care services, and legal status.

Needs and Practical Recommendations

Research Needs: To better inform the development, implementation, and evaluation of multilevel interventions, additional research is needed that overcomes the methodological limitations of existing studies and focuses on building new, contextually tailored interventions and policies. The findings of this white paper reveal several ways in which current knowledge is incomplete because of such methodological limitations and provides insight into how this can be improved upon.

1. There are an inadequate number of studies of migrants and health. There is, understandably, a preponderance of reports on HIV and TB, but there are not enough

- reports that address other infectious diseases, including STDs, and non-communicable diseases, including mental illness, tobacco use, and drug and alcohol abuse;
2. The studies of migrants are for the most part limited to the receiving country, and do not include data from the sending country;
 3. There is a need for greater methodological rigor in studies of migrants and health. Most of the existing study designs are cross-sectional, which limits them to providing snapshots of a single moment in time. Longitudinally designed studies are necessary for capturing time-dependent changes.
 4. Researchers should promote the use of qualitative methods and mixed methods in addition to quantitative studies, which currently dominate the research.
 5. Publications on migrant health in the U.S. do not cover medical examinations required to obtain work permits, in the manner of the Russian studies, because no such examinations exist in the U.S. However, comparable medical examinations may exist in various industries, although they could not be included in this white paper because they are not yet reflected in the scientific literature.
 6. Existing studies do not adequately address protective factors or processes that promote better health and mental health outcomes. In particular, research focused on modifiable cultural protective factors, such as family- and community-protective resources, is needed in order to increase health promotion and behavior change among migrants.
 7. The studies do not adequately address the comorbidity of conditions, including especially the comorbidity of physical with mental health conditions.

Practical Research Recommendations: If we are to better understand the health challenges facing labor migrants, and how labor migrants as a group differ from other vulnerable populations, and to better inform the development, implementation, and evaluation of targeted multilevel interventions, additional research is needed. In particular, this research should address the following questions:

1. What are the social determinants of the highest-priority health problems and behaviors?
2. Which determinants, at which levels, are potentially modifiable under real world conditions?
3. Which policies and programs are potentially effective, optimal, feasible, and appropriate, and are also acceptable to migrants, their families, the organizations that work with them, and the relevant nation states?

Educational Needs: There is a deficit of knowledge regarding the relationship between public health and economic and labor migrants, and a consequent shortage of welcoming attitudes toward such migrants, among the receiving countries' general public, health care workers, program developers and policy makers, and their media and social networks. Too often people fall back on stereotypical or discriminatory attitudes towards migrants and regard them as simply the source of problems.

Practical Education Recommendations: Promote the education of health-care practitioners, community advocates, the media, and the general public on health among migrants in the US and Russia through a public health approach. In particular, educational approaches should emphasize these facts:

1. Economic and labor migrants find themselves in situations of health vulnerability because of structural and social issues that are not of their making, but they are then left to pay for the costs of health problems.

2. The health risks faced by economic and labor migrants can be mitigated through multilevel strategies for changing both social and structural conditions and individual responses to those conditions.
3. Collaborative and cooperative approaches are needed to solve challenging health problems. Collaboration is needed between sending and receiving countries, between different government agencies, between governments and NGOs, and between host populations and migrants.

High-Priority Steps for Educational and Research Practice:

1. Develop web-based educational materials on ways of improving health among migrants for media and for health care workers.
2. Establish an ongoing U.S.-Russia scientific working group on the health issues of economic and labor migrants.
3. Develop and partnered research programs on economic labor migrants and health, and acquire funding from federal funders in the US and Russia.

Promoting Health among Migrants in the U.S. and Russia through a Public Health Approach: Consensus Statement and Practical Recommendations for Private Business Representatives

Background and Purpose

A working group of US and Russian public health experts reviewed existing literature, policies, and practices regarding public health issues for labor migrants in both countries. The review focused on the social determinants of health, health problems, and health-systems issues. Private business representatives can use the knowledge they gain from this review to promote health among migrants and to improve public health in the Russian Federation and in the United States.

This white paper divides the migrant health issues into three categories:

Social Determinants: The most frequently identified social determinants of health in the US were discrimination and social exclusion, difficult living and working conditions, low language competency, and low income or poverty. In Russia, the most frequently identified social determinants were difficult living and working conditions, low social support, low language competency, low education, low income or poverty, and family separation.

Health and Health Behavior Problems: The most frequently identified health problems in the US were mental health problems, occupational health problems, communicable diseases, and drug abuse. Among migrants in Russia (predominantly from Central Asia) the foremost were communicable diseases.

It should be noted that studies of labor migrants in Russia dealt mostly with migrants from Central Asia (Uzbek, Kyrgyz, Tajik), and did cover those from Ukraine, Moldova, Belorussia and other Slavic countries. There is very little research evidence on migrants in Russia from the Caucasus, Moldova, Gagauzia, or Kazakhstan.

It is true that migrants sometimes “import” communicable diseases to their host country; many migrants are also exposed to novel health risks in the host country due to social and economic factors such as low education levels, language barriers, social isolation, lack of access to health care, and adoption of less healthy lifestyles.

Health-Systems Issues: The most frequently identified health-systems issues in the US were inadequate access to care, barriers to care, insurance status, and legal status. In Russia they were inadequate access to and barriers to care, insurance status, availability of health care services, and legal status.

Needs and Practical Recommendations

The healthcare needs of migrant populations are rooted in financial, legal, and social barriers to care. In the United States, all citizens and documented migrants can receive coverage under the Affordable Care Act, but undocumented migrants are not eligible for this and usually cannot afford to purchase health insurance independently. Similarly, the Russian government provides health care through either mandatory insurance, which is available to citizens and officially registered migrants, or voluntary insurance, which individuals can purchase on their own. Because of their legal status, undocumented migrants are not eligible for the mandatory insurance, and they usually cannot afford voluntary insurance plans. Further social factors, such as language barriers, further limit access to care for some

migrants' particularly those from Asia. The lack of routine medical examinations contributes to worse health outcomes in migrant communities. Private business representatives are ideally placed to help overcome these barriers by working directly to improve the social determinants of health among migrants and their family members.

Practical Recommendations

1. This white paper identifies several actions that should be given high priority:
2. As much as possible, make use of international intergovernmental organizations, including WHO and IOM, bi- and multi-lateral cooperation among governmental agencies, and business associations and civil society for resolving migrants' health issues.
3. Establish and sustain working relationship among the diaspora communities, the ministries of health in their sending country, and the health organizations in the receiving country in order to collaborate on projects and programs for improving the social determinants of health, optimizing the migration processes from the point of view of migrants' health, and ensuring that labor migrants have access to health care services and health information. These relationships should include health care organizations, nonprofit organizations working with migrants, diaspora organizations, and religious communities, with due consideration of the real influence and potential of civil society.
4. Develop internet portals: global and regional resource centers that accumulate statistics, research evidence, and best practices on issues of migrant health.
5. Promote the development of centers that provide relatively inexpensive legal services to undocumented migrants seeking to apply for legal residency. Support the development of specialized nonprofit organizations providing such services.
6. Enforce labor protection laws, as well as the norms and rules of occupational safety, in order to protect labor migrants from environmental and occupational health hazards.
7. Provide occupational safety education in either the local language (i.e., Russian or English) or the migrants' language.
8. Promote employment by labor unions and more active involvement in them among labor migrants in order to ensure safer and higher-quality working and living conditions.
9. Promote media outreach and popular education on migrants' health issues order to personalize labor migration issues to citizens of the host country and to improve their attitudes toward labor migrants and their families.
10. Provide labor migrants and their families with resources for obtaining access to legal, medical, and social services, including free help hotlines, free legal assistance organizations, and migrant-friendly primary care clinics.
11. Improve labor migrants' access to information on nutrition; reproductive health; prevention and treatment of infection diseases (including TB, HIV, and other STIs); use of tobacco, alcohol, and other drugs; and basic health assessment.
12. Provide culturally appropriate health information services in the labor migrants' native or other known languages.
13. Provide comprehensive health education and training to community health workers and members of diasporas and religious communities.
14. Improve labor migrants' access to primary health care services in their host countries.
15. Develop health promotion and disease prevention strategies among labor migrants, especially regarding infectious diseases.
16. Include information on migrants' health issues and possible solutions to them in the training programs of government, health, and social service professionals, including corresponding methodological and teaching kits.

It should be noted that such activities, according to expert opinions, would be more efficient if initially directed just at prevention of communicable diseases among labor migrants and their families.

Promoting Health among Migrants in the U.S. and Russia through a Public Health Approach: Consensus Statement and Practical Recommendations for Religious Leaders

Background and Purpose

A working group of U.S. and Russian public health experts reviewed the existing literature, policies, and practices regarding public health issues for labor migrants in both countries. The review focused on the social determinants of health, health problems, and health-systems issues. Representatives of religious communities can use the knowledge they gain from this review to promote health among migrants and improve public health in the Russian Federation and in the United States.

This white paper divides the migrant health issues into three categories:

Social Determinants: The most frequently identified social determinants of health in the U.S. were discrimination and social exclusion, difficult living and working conditions, low language competency, and low income or poverty. In Russia, the most frequently identified social determinants were difficult living and working conditions, low social support, low language competency, low education, low income or poverty, and family separation.

Health and Health Behavior Problems: The most frequently identified health problems in the U.S. were mental health problems, occupational health problems, communicable diseases, and drug abuse. Among migrants in Russia (mostly from Central Asia) the most frequently identified were communicable diseases.

It should be noted that studies in Russia covered predominantly migrants from Central Asia (Uzbek, Kyrgyz, Tajik) and did not include Slavs from other countries. There is also very little research on migrants in Russia from the Caucasus, Moldova, Gagauzia, or Kazakhstan.

It is true that some migrants “import” communicable diseases to their country of destination; many migrants are also exposed to health risks in the host country due to social and economic factors such as low education levels, language barriers, social isolation, lack of access to health care, and adoption of less healthy lifestyles.

Health-Systems Issues: The most frequently identified health-systems issues in the U.S. were access to and barriers to care, insurance status, and legal status. In Russia they were access to and barriers to care, insurance status, availability of health care services, and legal status.

Needs and Practical Recommendations

The health care needs of migrant populations are rooted in financial, legal, and social barriers to care. In the United States, all citizens and documented migrants can receive coverage under the Affordable Care Act, but undocumented migrants are not eligible for this and usually cannot afford to purchase health insurance independently. Similarly, the Russian government provides health care through either mandatory insurance, which is available to citizens and officially registered migrants, or voluntary insurance, which individuals can purchase. Because of their legal status, undocumented migrants are not eligible for the mandatory insurance, but they usually cannot afford voluntary insurance plans. Further social factors, such as language barriers, also limit migrants’ access to care. The lack of routine medical examinations contributes to worse health outcomes in migrant communities.

Religious leaders and health practitioners are in an ideal position to overcome these barriers by working directly to improve social determinants of health among migrants and their families.

Practical recommendations

On the basis of this white paper, several actions are recommended:

1. As much as possible, use international intergovernmental organizations, including WHO and IOM, bi- and multi-lateral cooperation of governmental agencies, and business associations and civil society for resolving migrants' health issues.
2. Establish and sustain working relationships among diaspora communities, the ministries of health in their sending countries, and the health organizations in the receiving country, in order to collaborate on projects and programs for improving the social determinants of health, optimizing the migration processes from the point of view of migrants' health, and ensuring that labor migrants have access to health care services and health information. The relationships should include health care organizations, nonprofit organizations working with migrants, diaspora organizations, and religious communities, with due consideration of the real influence and potential of civil society.
3. Develop internet portals: global and regional resource centers that can accumulate statistics, research evidence, best practices, and other data on issues pertaining to migrants' health.
4. Promote the development of centers for providing relatively inexpensive legal services to undocumented migrants seeking to immigrate or otherwise stay in the country legally. Support the development of specialized nonprofit organizations providing such services.
5. Enforce labor protection laws and the norms and rules of occupational safety, all of which protect labor migrants from environmental and occupational health hazards.
6. Provide occupational safety education in either the local language (i.e., Russian or English), or in the migrants' own language.
7. Promote employment by labor unions and more active involvement in them among labor migrants to ensure safer and higher-quality working and living situations.
8. Promote media outreach and popular education on migrants' health issues to personalize labor migration and to improve attitudes within the host country toward labor migrants and their families.
9. Provide labor migrants and their families with access to legal, medical, and social services, including free help hotlines, legal assistance organizations, and migrant-friendly primary care clinics.
10. Improve labor migrants' access to information on nutrition; reproductive health; prevention and treatment of communicable diseases (including TB, HIV, and other STIs); tobacco use; drug and alcohol use; and basic health assessment. Cooperate with nonprofit organizations in this undertaking.
11. Provide culturally appropriate health-information services in the labor migrants' native or other known languages.
12. Provide comprehensive health education and training to community health workers and members of diasporas and religious communities.
13. Improve labor migrants' access to primary health care services in their host countries;
14. Develop health promotion and disease prevention strategies among labor migrants, especially regarding infectious diseases;

15. Include information on migrants' health issues and possible solutions to them in the training programs of workers in civil service, health service, and social services. This should include corresponding teaching and methodological kits.
16. It should be noted that according to expert opinion, such activities would be more efficient if targeted initially at prevention of infectious disease among labor migrants and their families.

Promoting Health among Migrants in the U.S. and Russia through a Public Health Approach: Consensus Statement and Brief for Civil Society Representatives

Background and Purpose

A working group of U.S. and Russian public health experts reviewed existing literature, policies, and practices regarding public health issues for labor migrants in both countries. The review focused on the social determinants of health, health problems, and health-systems issues. Civil society representatives can use the knowledge they gain from this review to promote health among migrants and to improve public health in the Russian Federation and in the United States.

This white paper divides migrant health issues into three categories:

Social Determinants: The most frequently identified social determinants of health in the US were discrimination and social exclusion, difficult living and working conditions, low language competency, and low income or poverty. In Russia, the most frequently identified social determinants were difficult living and working conditions, low social support, low language competency, low education, low income or poverty, and family separation.

Health and Health Behavior Problems: The most frequently identified health problems in the US were mental health problems, occupational health problems, communicable diseases, and drug abuse. Among migrants in Russia (mostly from Central Asia) the most frequently identified were communicable diseases.

It should be noted that studies of labor migrants in Russia have covered predominantly those from Central Asia (Uzbek, Kyrgyz, Tajik), and not Slavs originating from Ukraine, Moldova, Belarus, or other countries. There is very little research on migrants in Russia from the Caucasus, Moldova, Gagauzia, or Kazakhstan.

It is true that some migrants “import” communicable diseases to their host country; many migrants are also exposed to health risks in the host country due to social and economic factors such as low education levels, language barriers, social isolation, lack of access to health care, and adoption of less healthy lifestyles.

Health-Systems Issues: The most frequently identified health-systems issues in the U.S. were access to and barriers to care, insurance status, and legal status, while in Russia they were access to and barriers to care, insurance status, availability of health care services, and legal status.

Needs and Practical Recommendations

The healthcare needs of migrant populations are rooted in financial, legal, and social barriers to care. In the United States all citizens and documented migrants can receive coverage under the Affordable Care Act, but undocumented migrants are not eligible for this and usually cannot afford to purchase health insurance independently. Similarly, the Russian government provides health care through either mandatory insurance, which is available to citizens and officially registered migrants, or voluntary insurance, which individuals can purchase. Because of their legal status, undocumented migrants are not eligible for the mandatory insurance and usually cannot afford voluntary insurance. Further social factors, such as language barriers, limit migrants’ access to care. The lack of routine medical examinations

contributes to worse health outcomes in migrant communities. Civil society representatives are in an ideal position to overcome those barriers by working directly to improve social determinants of health among migrants and their families.

Practical Recommendations

On the basis of this white paper, several actions are recommended:

1. As much as possible, use international intergovernmental organizations, including WHO and IOM, bi- and multi-lateral cooperation of governmental agencies, and business associations and civil society for resolving migrants' health issues.
2. Establish and sustain working relationships among diaspora communities, the ministries of health in their sending countries, and the health organizations in the receiving country, in order to implement coalition projects and programs for improving the social determinants of health, optimizing the migration processes from the point of view of migrants' health, and ensuring the access of labor migrants to health care services and health information. These relationships should include health care organizations, nonprofit organizations, migrants themselves, diaspora organizations, and religious communities, with due consideration of the real influence and potential of civil society.
3. Develop internet portals: global and regional resource centers for the accumulation of statistics, research evidence, best practices, and other data on migrant health.
4. Promote the development of centers for providing relatively inexpensive legal services to undocumented migrants seeking to immigrate or to otherwise stay in the country legally. Support the development of specialized nonprofit organizations to provide such services.
5. Enforce labor protection laws as well as norms and rules of occupational safety, which protect labor migrants from environmental and occupational health hazards.
6. Provide occupational safety education in either the local language (i.e., Russian or English) or the migrants' language.
7. Promote employment through trade unions and more active involvement with them among labor migrants to ensure safer and higher-quality working and living conditions.
8. Promote media outreach and popular education on migrants' health issues in order to personalize labor migration and to improve attitudes in the host country towards labor migrants and their families.
9. Provide labor migrants and their families with access to legal, medical, and social services, including free help hotlines, legal assistance organizations, and migrant-friendly primary care clinics.
10. Improve labor migrants' access to information on nutrition; reproductive health; prevention and treatment of infectious diseases (including TB, HIV, and other STIs); tobacco use; alcohol and drug use; and basic health assessment. Work in cooperation with nonprofit organizations.
11. Provide culturally appropriate health information services in the labor migrants' native or other known languages.
12. Provide comprehensive health education and training to community health workers and members of diasporas and religious communities;
13. Improve labor migrants' access to primary health care services in their host countries.
14. Develop health promotion and disease prevention programs.
15. Include information on migrant health issues and possible solutions to them in the training programs of government, health, and social service professionals. Include corresponding methodological and teaching kits.

16. It should be noted that, according to expert opinion, such activities would be more efficient if initially aimed at infectious disease prevention among labor migrants and members of their families.

Promoting Health among Migrants in the U.S. and Russia through a Public Health Approach: Consensus Statement and Practical recommendations for Prospective and Current Migrants

Background and Purpose

A working group of U.S. and Russian public health experts reviewed existing literature, policies, and practices regarding the public health issues for labor migrants in both countries. The reviews focused on the social determinants of health, health problems, and health-systems issues. Prospective and current migrants can use the knowledge they gain from this review to promote health among migrants and to improve public health in the Russian Federation and in the United States.

This white paper divides migrant health issues into three categories:

Social Determinants: The most frequently identified social determinants of health in the U.S. were discrimination and social exclusion, difficult living and working conditions, low language competency, and low income or poverty. In Russia the most frequently identified social determinants were difficult living and working conditions, low social support, low language competency, low education, low income or poverty, and family separation.

Health and Health Behavior Problems: The most frequently identified health problems in the U.S. were mental health problems, occupational health problems, communicable diseases, and drug abuse. Among migrants in Russia (predominantly from Central Asia) the most frequently identified were communicable diseases.

It should be noted that the studies of labor migrants in Russia covered predominantly those originating in Central Asia (Uzbek, Kyrgyz, Tajik), and did not include Slavs originating in Ukraine, Moldova, Belarus, or other countries. There is very little research on migrants in Russia originating in the Caucasus, Moldova, Gagauzia, or Kazakhstan.

It is true that some migrants “import” communicable diseases to their destination countries; many migrants are also exposed to health risks in their host countries due to social and economic factors such as low education levels, language barriers, social isolation, lack of access to health care, and adoption of less healthy lifestyles.

Health-Systems Issues: The most frequently identified health-systems issues in the U.S. were inadequate access to and barriers to care, insurance status, and legal status, while in Russia they were inadequate access to and barriers to care, insurance status, availability of health care services, and legal status.

Needs and Practical Recommendations

The healthcare needs of migrant populations are rooted in financial, legal, and social barriers to care. In the United States, all citizens and documented migrants can receive coverage under the Affordable Care Act, but undocumented migrants are not eligible for this and usually cannot afford to purchase health insurance independently. Similarly, the Russian government provides health care through either mandatory insurance, which is available to citizens and officially registered migrants, or voluntary insurance that individuals can purchase. Because of their legal status, undocumented migrants are not eligible for the mandatory insurance, and they usually cannot afford voluntary insurance plans. Further social

factors, such as language barriers, limit migrants' access to care. A lack of routine medical examinations contributes to worse health outcomes in migrant communities. Prospective and current migrants should collaborate with all interested parties to improve social determinants of health among migrants and their families.

Practical recommendations

This white paper identifies several actions that should be prioritized:

1. As much as possible, use international intergovernmental organizations, including WHO and IOM, bi- and multi-lateral cooperation of governmental agencies, and business associations and civil society, for resolving migrants health issues.
2. Establish and sustain working relationships among diaspora communities, the ministries of health in their sending countries, and the health organizations in the receiving country, in order to implement coalition projects and programs for improving the social determinants of health, optimizing the migration processes from the point of view of migrants' health, and ensuring the access of labor migrants to health care services and health information. These relationships should include health care organizations, nonprofit organizations, migrants themselves, diaspora organizations, and religious communities, with due consideration of the real influence and potential of civil society.
3. Develop internet portals: global and regional resource centers on issues of migrant health that will accumulate statistics, research evidence, best practices, and the like.
4. Promote the development of centers that provide relatively inexpensive legal services for undocumented migrants seeking to apply for legal residency. Support the development of specialized nonprofit organizations to provide such services.
5. Enforce labor protection laws as well as norms and rules of occupational safety, which protect labor migrants from environmental and occupational health hazards.
6. Provide occupational safety education in either the local language (i.e., Russian or English) or the migrants' language.
7. Promote employment through trade unions and more active involvement in them among labor migrants to ensure safer and higher-quality working and living conditions.
8. Promote media outreach and popular education on migrants' health issues in order to personalize labor migration and to improve attitudes within the host country towards labor migrants and their families.
9. Provide labor migrants and their families with resources on obtaining access to legal, medical, and social services, including free help hotlines, legal assistance organizations, and migrant-friendly primary care clinics.
10. Improve labor migrants' access to information on nutrition; reproductive health; prevention and treatment of STIs, TB, and other infections; tobacco use; alcohol and drug use; and basic health assessment. Work on this in cooperation with nonprofit organizations.
11. Provide culturally appropriate health information services in the labor migrants' native or other known languages.
12. Provide comprehensive health education and training to community health workers and members of diaspora and religious communities.
13. Improve labor migrants' access to primary health care services in their host countries.
14. Develop health promotion and disease prevention strategies among labor migrants, especially regarding infectious diseases.

15. Include sections on migrants' health issues and possible solutions to them in the training programs of government, health, and social services professionals. Include corresponding teaching and methodological kits.

It should be noted that according to expert opinion, such activities would be more efficient if targeted initially at disease prevention, particularly at prevention of infectious disease, among labor migrants and their families.

Prospective and Current Migrants could consider following activities

1. Before migration, undergo medical examination to determine what health risks are likely to arise during migration.
2. Learn about migrants' rights to health care and about how to access health care services in the destination country. Possible sources of information include the internet, acquaintances, and nonprofit organizations in the country of origin.
3. Learn about probable health risks in the destination country (changed diet, climate, infectious diseases, etc.). Possible sources of information include the internet, acquaintances, non-profit organizations in the country of origin, and government agencies (which can also supply information during the preparation of documents for migration).
4. Find out which organizations in the destination country provide support to migrants, including assistance in obtaining health care services (hot lines, advisory points, translation services, legal services, etc.). Possible sources of information include the internet, acquaintances, nonprofit organizations in the country of origin, and government agencies.
5. If the above-mentioned information was not acquired while in country of origin, it should be pursued upon arrival in the destination country.
6. Plan for and pursue only legal employment.
7. While looking for a job, pay special attention to the enforcement of occupational safety regulations at the prospective workplace.
8. Participate in trade union activities.
9. Rely on the support and resources of family members, relatives, friends, and the wider diaspora and religious communities.

Notes

¹ “232 Million International Migrants Living Abroad Worldwide–New UN Global Migration Statistics Reveal,” *United Nations Department of Economic and Social Affairs (UN-DESA)*, 2013, <http://esa.un.org/unmigration/wallchart2013.htm>.

² Ibid.

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