M

Migrant Health in the Nexus of Universal Health Coverage and Global Health Security

Federica Viello[1,2], Elena Val[2] and Dominik Zenner[1,2,3,4]
[1]International Organization for Migration, Brussels, Belgium
[2]International Organization for Migration (IOM), Migration Health Department (MHD), Regional Office (RO), Brussels, Belgium
[3]Migration Health, International Organization for Migration, Brussels, Belgium
[4]Queen Mary University of London, London, UK

Keywords
Migration and health · Health security · Europe · Universal Health Coverage

Definition

A public health topic which refers to the theory and practice of assessing and addressing migration-associated factors that can potentially affect the physical, social, and mental well-being of migrants and the public health of host communities.

Introduction

Within the context of migration health in Europe, health security (HS) and Universal Health Coverage (UHC) represent two important and common discourses. There are differences and commonalities between them. The emphasis has been placed mostly on the former.

Global Health Security aims to prevent, detect, and respond to disease threats of international concern. In the context of migration, this entails limiting the health or socioeconomic impact on members of the receiving country society through the potential importation of diseases. The International Organization for Migration (IOM) is one of the key actors in this framework, particularly due to its Global Health Assessment Program (HAP) and Health, Border & Mobility Management (HBMM) expertise. Nevertheless, the health security perspective is closely linked to UHC, presented as a multidimensional concept grounded in international human rights. As envisaged in the Sustainable Development Goals (SDGs), set in 2015 by the United Nations General Assembly, and promoted by the World Health Organization (WHO), UHC requires acknowledgment of three dimensions of health coverage: the population included, the extent of financial protection provided, and the scope of health services covered, all of these underpinned by an integrated approach to healthcare. Consequently, to comply with international human rights law, states should provide essential

S. Romaniuk et al. (eds.), *The Palgrave Encyclopedia of Global Security Studies*,
https://doi.org/10.1007/978-3-319-74336-3_634-1

health services, especially disease prevention services, to migrants as much as to their own nationals. In spite of this, many have explicitly stated before international human rights bodies and in domestic legal frameworks that they cannot, or do not wish to, provide migrant groups with the same level of protection that they offer to their own citizens (Thompson 2013).

The chapter begins with a brief overview of the public health issues among migrant populations in the European region and their interaction with the receiving country healthcare systems; subsequently, it discusses the nexus between migration and health, which has at its core the well-being of the migrants and their families. Reference to a case study will provide practical grounds for discussing the context in depth. The following paragraphs lay out the two discourses and then weave them together to demonstrate how access to care and Universal Health Coverage is in the self-interest of receiving countries and how improving care can support the health security agenda. Universal Health Coverage and health security narratives are interconnected and interlinked on multiple levels and in multiple dimensions, visually as well as conceptually. The chapter concludes by providing recommendations founded on the human rights approach common to both HS and UHC, in line with the Siracusa Principles (UN Doc 1984).

The Context: Migration and Health in Europe

International migration has resulted in significant flows of people, and in 2019 around 272 million international migrants were recorded globally; this corresponds to 3.5% of the global population (IOM 2019a).

Although the data collected in the past years confirm that the majority of global migration occurs between and within low- and middle-income countries, much of the discourse has focused on migration flows to Europe, shaping the narrative and influencing the political agendas across the region. In 2015, an estimated 1,046,599 migrants made their way to Europe, with over 1 million arriving by sea in Greece and Italy and the majority originating from Syria, Afghanistan, and Iraq (IOM 2015). Migrant flows to Europe are decreasing, and in the last recorded year, between January and October 2019, a total of 103,416 migrants and refugees arrived in Europe through different land and sea routes (IOM 2019a).

IOM, through its Missing Migrants Project, collects, compiles, and analyzes data on migrants who perish or go missing along migratory routes worldwide. In the last 5 years (2014–2018) of systematically recording deaths during migration, the Missing Migrants Project has tracked over 30,900 women, men, and children who lost their lives while trying to reach other countries. During that time, the Mediterranean Sea has seen the highest number of deaths, claiming the lives of at least 17,919 people. In 2018, the Mediterranean continued to have the highest known number of deaths during migration, with the "Western Mediterranean route" seeing a growing number of deaths in comparison with the previous years (IOM 2019a, b).

Europe experiences various types of migration: labor migration, family reunification, migration of students, forced migration, as well as irregular migration. This complex picture is accompanied by a similar complexity and heterogeneity in terms of age, gender, and legal status and therefore also medical requirements, needs, health vulnerabilities, and resilience factors (IOM 2019a).

> The International Organization for Migration (IOM) defines migrants as "any person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally

defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students" (IOM 2019c).

Migration and health are interrelated. Health, as "physical, mental, and social well-being" (WHO 1946), is influenced by the so-called determinants of health. Both individual (e.g., age, gender, genetic predisposition to disease) and structural (e.g., legal frameworks, health policies, access to safe transit, quality housing, and healthcare) determinants of health can have a positive and/or negative impact on the health and well-being of individuals and communities. Migration can be seen as a social determinant of health. On the one hand, the benefits of migration, such as escape from persecution and violence, improvement of socioeconomic status, or education opportunities, may contribute to improving the health status of migrants and their families. Conversely, the migration process can contribute to or cause health risks, and the journey can expose migrants to violence, malnutrition, and infectious diseases. In addition, throughout the journey and in destination countries, risks can be caused by changes in lifestyle, limited access to prevention and quality healthcare, or interrupted care which is particularly relevant to those with chronic diseases (Abbas et al. 2018).

The following diagram (Fig. 1) describes the migration cycle, focusing on the social determinants of health in each phase: pre-migration, during movement, upon arrival and in the course of integration, and upon (potential) return.

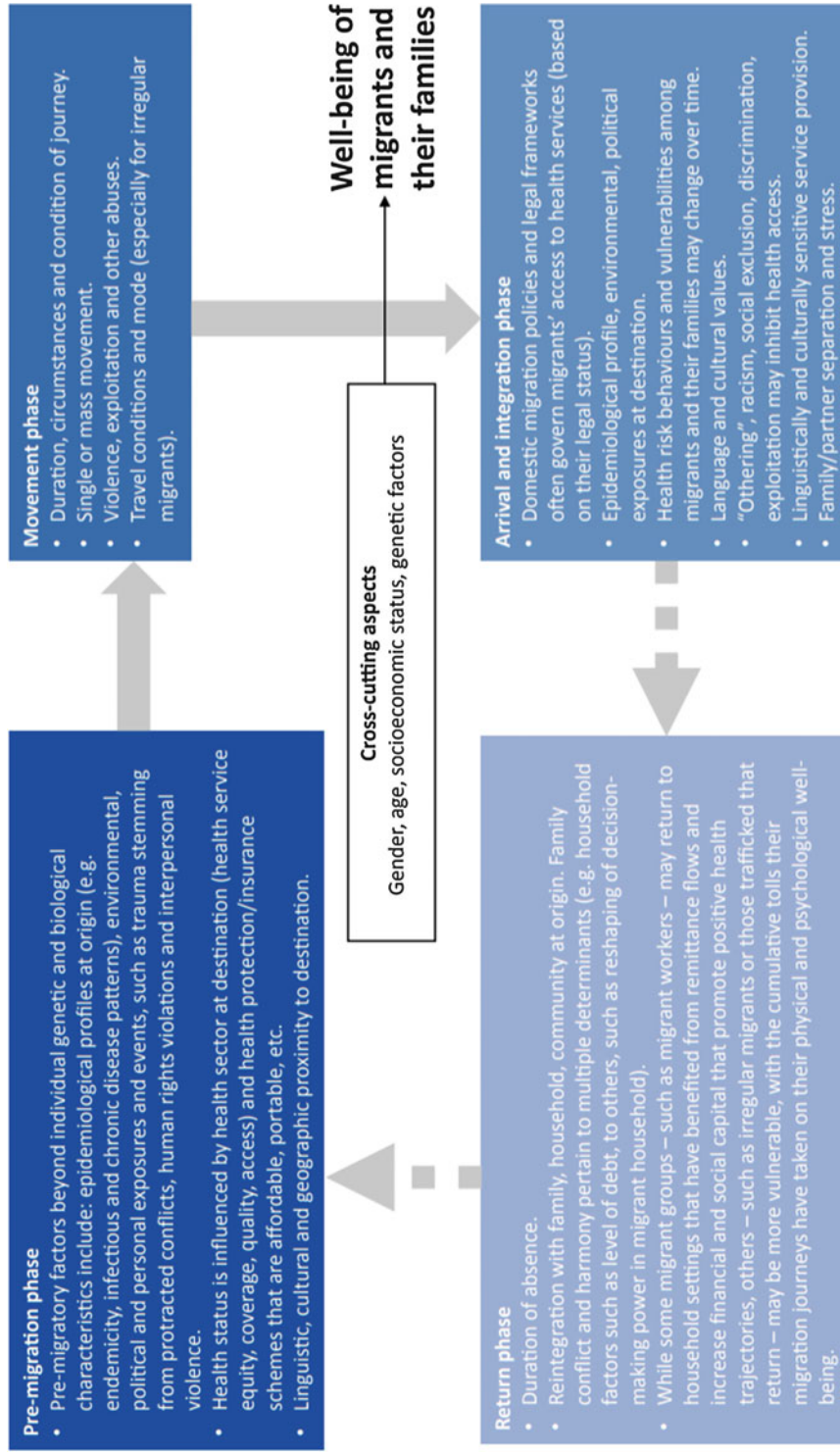
The perspectives of HS and UHC have a central role in shaping and defining the experience of migrants in the arrival and integration in the host country. Entitlements and equal access to healthcare (at the core of UHC), health assessments, screening, and other health security-related measures – linked to Global Health Security – represent important determinants of health.

The Health Security Discourse in Europe

Global Health Security aims to prevent, detect, and respond to disease threats of international concern to limit any health or socioeconomic impacts on members of the receiving country society of potentially imported diseases.

The IHRs empower the WHO Director General to proclaim a Public Health Emergency of International Concern (PHEIC) and to issue temporary recommendations regarding health measures to state parties. Key actors in the early detection process are border officers (BOs) and medical staff at point of entry (PoE) who encounter migrants on their traditional or extraordinary migratory routes. Staff competence in health promotion and health assessments, together with inclusive health governance ensuring both access and continuity of care, is crucial for an effective response as well as for the handling of migrant populations at any time. Based on the experience of the Ebola virus disease (EVD) PHEIC in 2014, the WHO further engaged with its member states in order to strengthen health security and to open the joint external evaluation (JEE) of IHR core capacities in order to assess country-specific status, progress in achieving the targets, and recommend priority actions to be taken across 19 technical areas, which have been implemented (WHO 2005a). In Europe (EURO), 10 of 53 (19%) countries have completed JEE; final recommendations highlighted on different occasions the further need of training for staff at POE and standard operating procedures (SOPs).

The IHRs in its text also touch upon the human rights of the individuals affected, but there are only few references to the international human rights framework (Zidar 2015). The use of human rights law as a means to ensure compliance is supported by instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Siracusa Principles (UN Doc 1984). This covenant does not contain a right to perfect health but a slightly lesser objective of the "enjoyment of the highest attainable standard of physical and mental



Migrant Health in the Nexus of Universal Health Coverage and Global Health Security, Fig. 1 The social determinants of health in the different stages of migration. (Source: IOM Migration World Report 2020. Adapted from Gushulak et al. 2009)

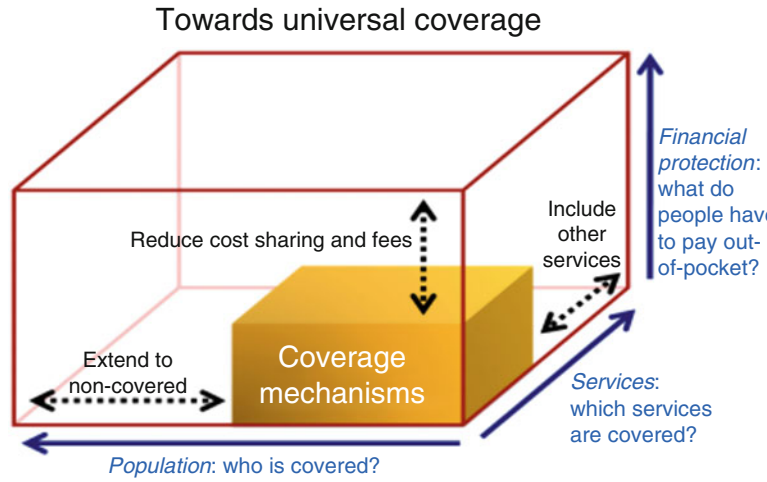
health." Article 12 (2) of the ICESCR lays out a number of steps that state parties should take to substantiate a full realization of this right. Among these is the obligation of the state to refrain from directly or indirectly interfering with this right and to provide international assistance and cooperation (UN Doc 1966). The Siracusa Principles state that "A limitation to a human right based upon the reputation of others shall not be used to protect the state and its officials from public opinion or criticism" (UN Doc 1984).

The purpose and scope of the WHOs (2005a) are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade, including the protection of the human rights of persons and travelers" (WHO 2005a). However, under the IHRs, member states have, "in accordance with the Charter of the United Nations and the principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies" (WHO 2005a).

Two points should be further considered. The IHRs only enter into force if a PHEIC is declared. The implementation of their own health policies within and outside the EU is otherwise a sovereign right of the member states. In addition, the EU itself does not define health policies nor the organization and provision of health services and medical care. EU-level actions in public health complement national policies supporting cooperation between member countries. Consequently, if a country or region does not share information or details of the specific strain of pathogen, or meaningfully engage in global disease surveillance and control efforts, then this has the potential to delay early response and containment measures (Wickramage 2018).

Much of the health security discourse at the global and European level has been anchored in disease screening, often related to borders and so-called points of entry (PoE) or points of control (PoC). At the same time, there are tendencies to reduce migration solely to an (often misleading) narrative of the potential risk to public health. Conversely, there are also pressures to ease travel and to encourage the movement of workers across national borders to support economic development and growth (IOM 2010). IOM, together with partner organizations, is working at the global and European level to ensure that the movement of migrants is conducted in a safe and dignified way through different actions, including its large Health Assessment Program (HAP) and the Health, Border & Mobility Management (HBMM) (IOM 2010). Health assessments usually include an evaluation of the physical and mental health status of migrants, made either prior to departure or upon arrival, for the purpose of resettlement, international employment, enrollment in specific migrant assistance programs, or obtaining a temporary or permanent visa. Reflecting national differences in immigration and public policies and practices, there is a great variation in health assessment procedures. However, the key tenet is the desire to ensure that migration does not result in health risks to the affected populations, primarily in the destination country (IOM 2019a). HBMM in its framework aims to improve detection and response to the spread of diseases at points of origin, transit, destination, and return and in their Spaces of Vulnerability (SOVs), where migrants interact with communities. HBMM links border management with health security and serves the implementation of the IHRs (IOM 2019). After arrival in the European Union, member states are responsible for the follow-up and provision of care in keeping with national policies.

At the core of the health security concept is therefore the protection of society. However, member states also have international obligations, particularly during a PHEIC, to ensure that the detection of and response to disease take place – including ensuring proportionate follow-up



Migrant Health in the Nexus of Universal Health Coverage and Global Health Security, Fig. 2 The key dimensions of Universal Health Coverage. (Source: WHO World Health Report, 2010)

mechanisms also for migrants as members of the host society.

Universal Health Coverage: A Multidimensional Concept

Universal Health Coverage is defined by WHO as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access." It means that *all* individuals and communities are able to access "comprehensive, appropriate, timely and quality health services" – including prevention, treatment, rehabilitation, and palliative care – without risk of financial hardship (OHCHR and WHO 2008). Built around the core principle of nondiscrimination, this definition reflects concerns for health equity, setting the objective of equity in service use, quality, and financial protection (Kutzin 2013).

The explicit acknowledgment of the concept of Universal Health Coverage took place in 2005, when the World Health Assembly (WHA) endorsed it as the goal of sustainable healthcare financing with the resolution on "Sustainable health financing, universal coverage and social health insurance" (WHO 2015). Recognized by the UN in 2010, the commitment to Universal Health Coverage was subsequently reinforced in 2012 when the WHA supported the resolution on "Global health and foreign policy" (WHO 2015). Regarded as a prerequisite for sustainable development, in 2015 it became a core component of the Sustainable Development Goals (SDGs) which include a specific health goal: "Ensure healthy lives and promote wellbeing for all at all ages." Within this, target 3.8 focuses specifically on the achievement of UHC, including "financial risk protection, access to quality essential healthcare services and access to safe, effective, quality essential medicines and vaccines for all" (Abiiro and Allegri 2015).

UHC consists of three interrelated components, which are anchored on the foundation of the "right to health": universal population coverage, universal financial protection, and universal access to quality healthcare (Abiiro and Allegri 2015). This is depicted in the WHO model (Fig. 2).

The first dimension, aiming at guaranteeing access to the needed health services for *all*, focuses on the extent of inclusion in the system of coverage: Who is covered? Is coverage unconditional, or do only certain individuals qualify for it? Are *all* categories of migrants included?

The second dimension refers to the access to healthcare: Which health services are covered? Are *all* migrants entitled to access the same health services as nationals?

The third dimension focuses on the financial protection: What additional payments do patients have to make when accessing health services (IOM 2016)?

In 2015, in collaboration with COST Action IS1103, ADAPT, and the Migration Policy Group (MPG), and within the Equi-Health Project, IOM developed the Migrant Integration Policy Index (MIPEX) Health Strand, an instrument for measuring the equitability of a country's policies relating to the health of migrants. The MIPEX Health Strand highlighted the difficulties which EU countries are encountering in providing the level of healthcare coverage committed to the UN 2030 Agenda for Sustainable Development.

Substantial gaps are observed in access to healthcare for migrants, both in terms of entitlements and accessibility. Most European countries have either a tax-based or a statutory insurance-based system of coverage for health expenses or a mixture of both (IOM 2016). However, not everyone is entitled to join the system; and entitlements for migrants vary from country to country and also relate to the status of migrants (Beauclercq et al. 2018). In most of the EU countries, health assessment, including screening for communicable diseases, is not systematic, and the need for a standardized system of data collection concerning health-related information has been pointed out. Living conditions in reception centers are poor and not in line with international standards. A lack of training on migration health among professionals working with migrants has been reported, together with the lack of training among interpreters and cultural mediators. In addition, the provision of appropriate, culturally sensitive health services is missing in most of the countries, creating a further barrier to access to health services for migrants (Beauclercq et al. 2018). The Médecins du Monde (MdM) report – based on a study conducted in seven European countries (Belgium, France, Germany, Sweden, Switzerland, and United Kingdom) between January 2017 and December 2018 – confirmed these results and shows that large numbers of migrants are excluded from health systems (MdM 2018).

A Case Study

In order to illustrate the synergies between GHS and UHC, the influenza A (H1N1) outbreak of 2009 can be taken as an example. The outbreak evoked significant interest in Europe at the time, and its links to migration health were well-visible.

During the outbreak, several stakeholders, including the European Commission – DG SANTE – advocated to ensure that migrants were considered as vulnerable populations during the response. It was pointed out that the outbreak affected all types of persons regardless of their nationality and that good access to care and appropriate and understandable information for all people was of interest to society as a whole. At this time, it was estimated that migrants and refugees may be more exposed to influenza A due to their vulnerabilities (limited access to health services, numerous types of barriers, lack of entitlements, risks/challenges during their journey, their medical history, their living conditions, etc.).

The authors analyzed influenza-related episodes among medical conditions in the Madrid Regional Public Health System (MRPHS) – severe influenza cases reported to the Public Health Register in particular – and compared migrant populations with the native population in this respect. "The study found that severe influenza in pregnancy was more common among migrant women and that the probability of admission to intensive care units was higher for men from Central and Eastern Europe and for North African women. It assessed that some migrant populations might be more vulnerable than others to pandemic influenza. This information should be taken into account for the purposes of future pandemic preparedness" (García-Armesto et al. 2010).

At the time, all residents in Spain were entitled to full health coverage, regardless of their nationality and legal status, and, therefore, the main barriers to access were cultural and linguistic ones. The case demonstrates that efforts to improve access to care among migrants increase infectious disease protection of the population at large, through the early recognition and treatment of cases and contacts.

The case study therefore shows how the two approaches of GHS and UHC can benefit from each other and work in synergy when migrants are taken into consideration as any other member of the community. In the next section, we seek to unpack this case example to look at the relationship between GHS and UHC.

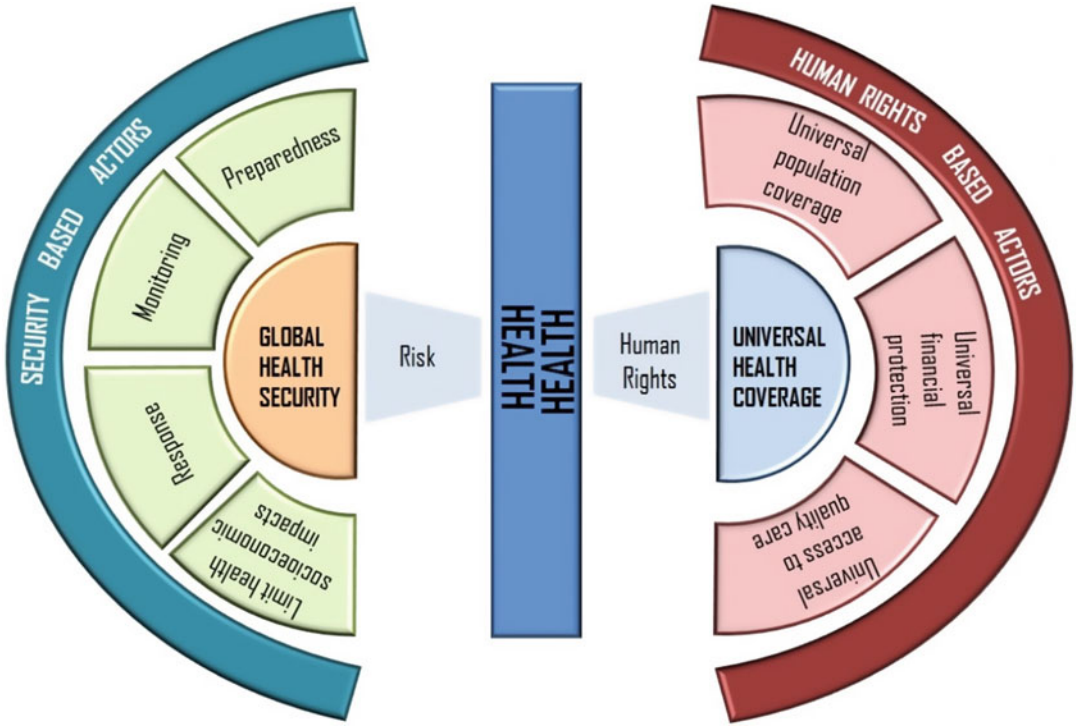
Synergies and Differences Between Global Health Security and Universal Health Coverage

Global Health Security and Universal Health Coverage, as previously described, appear as two different concepts, with different objectives and priorities, responding to different philosophies.

On the one hand, Universal Health Coverage aims at ensuring that all individuals and communities, without discrimination, have access to "comprehensive, appropriate, timely, and quality health services" and to "safe and affordable medicines," without risk of financial hardship (Wenham et al. 2019). On the other hand, Global Health Security is a framework under which the activities concerning prevention, detection, and response to infectious disease threats operate to limit any health or socioeconomic impacts on members of receiving country societies by potentially imported disease (WHO 2016). The case study links the two concepts: the Spanish health system provided Universal Health Coverage in the context of a PHEIC mechanism, with the aim to limit health or socioeconomic impacts on members of the host society as well as on migrants. Actively promoting access was thus also beneficial in the context of health protection.

The main difference between the two frameworks lies in how they frame the concept of risk and security. In the perspective of Universal Health Coverage, the risk is at the individual level, where a person with specific health needs may face financial and/or nonfinancial barriers to access health services. This form of individual or familial risk is centered on cost, rather than the type of illness, and can relate to both acute and chronic conditions. Conversely, Global Health Security is focused on protecting (host) societies, and may therefore conceptualize individual illness as a risk to the (host) society, which is to be mitigated, for example, by treatment or exclusion. In this perspective, the risk is transnational, emerging from transmission across international borders. Risk is typically seen as resulting from an infectious disease hazard which could result in a large-scale outbreak, and may pose a threat to a population creating economic or political risks, for example, because of interrupted access to international markets or reduced international travel, among others (Wenham et al. 2019).

A key difference between GHS and UHC lies in their nature, modalities of implementation, and responsible actors. As mentioned above, GHS falls into an international legal framework regulated by the International Health Regulations (WHO 2005a). In addition, a complex and structured mechanism has been created to ensure that the countries possess an adequate level of preparedness for health emergencies (annual reporting, joint external evaluation, simulation exercise, and after action review). In contrast, the UHC is not based on binding legal instruments, but rather built on the basis of the right to health, which is recognized in numerous international and regional human rights instruments. The International Covenant on Economic, Social and Cultural Rights is considered as the most authoritative international expression of the right to health (OHCHR and WHO 2008). Its application cannot count on a structured mechanism with identifiable actors responsible for it. The UHC is rather based on voluntary decisions and actions by countries, frequently on the basis of political considerations. Once approved, the principle is not coordinated by a single entity but applied by the entire health system. Often, the IHR focal point within a Ministry of Health does not share information with the focal point addressing vulnerable populations, the person typically in charge of migrants and their access to care. In the case of the influenza A (H1N1) outbreak of 2009 in Spain, the lack of communication between the responsible actors hampered efforts to ensure that health services appropriately address the migrant populations.



Migrant Health in the Nexus of Universal Health Coverage and Global Health Security, Fig. 3 Synergistic views on health: bringing together Global Health Security and the Universal Health Coverage. (Figure developed by the authors)

It is worth considering the synergies between the two types of discourse, GHS and UHC. As explained by Wenham, through supporting access to individual care, UHC offers an effective risk reduction intervention for individuals: assured financial mechanisms increase the ability to access healthcare and to avoid delaying healthcare until the individual concerned becomes very ill, which in turn increases healthcare costs for everyone. Accordingly, risk reduction through UHC benefits both individuals and societies, which is the main concern of GHS (Wenham et al. 2019).

Another consideration is the concept of human rights, which are at the core of UHC. Human rights are often conceptualized as a matter of individual security, although their protection can have a collective impact. Achieving both Global Health Security and UHC requires states to comply with their obligations and duties under international, regional, and domestic human rights law. IHRs regulate the actions that states must take in order to "prevent, treat and control epidemic, endemic, occupational and other diseases"(WHOs 2005a).

The two ideals have therefore a number of areas of convergence and synergy. Even though the two agendas are not comprehensively aligned and by no means fully overlap, it is important in order to have healthy communities, which include migrants as well, to identify where these synergies lie and where these may mutually benefit one another.

Diagram Visualizing the Possible Relationships Between the Two Approaches

See Fig. 3

The figure shows the two concepts of Global Health Security (GHS) and Universal Health Coverage as two viewpoints on health. The components of each viewpoint are presented:

preparedness, monitoring, response to disease threats of international concern, and limiting health/socioeconomic impacts for the receiving country in the case of Global Health Security and the three dimensions of universal population coverage, universal financial protection, and universal access to quality care in the case of Universal Health Coverage.

The main actors involved in GHS are member states (with quarantine stations, staff at the point of entry, centralized and decentralized bodies), the UN, and more specifically WHO and civil society. The actors responsible for the realization of Universal Health Coverage are the UN and in particular WHO, ministries of health, civil society, and NGOs. The two concepts look at the same goal through different lenses: the lens of the risk in the case of GHS and the lens of human rights in the case of UHC. The conceptual model does not present areas of overlapping but rather the opportunities for synergies between the two halves.

Conclusions

While most of global migration occurs between and within low- and middle-income countries, the dominant recent discourse focused on migration flows to Europe, shaping the narrative and influencing political agendas at the global and regional levels.

Within this context, there has been an emphasis on health security to ensure protection of receiving societies. Conversely, there has also been a drive toward Universal Health Coverage, emphasizing the human rights of persons and travelers and acknowledging the international obligations of member states. WHO defines UHC as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access." Built around the core principle of nondiscrimination, this definition reflects the concerns for health equity, setting the objectives of equity in service use, quality, and financial protection (Kutzin 2013).

Migration and health are interconnected. The experience of migration in itself is a social determinant of health. In this chapter, GHS and UHC were analyzed underlining the possible synergies and differences between them and the links to health, even as the two take very different routes and approaches. The actors engaged in each approach may often belong to the same entity, but they may also differ in terms of their focus, competences, and understanding of the societal needs. The diagram above does not show areas of overlapping but rather opportunities for synergies between the two halves.

The chapter illustrated this concept through a case study reflecting on the 2009 influenza outbreak in Spain, where improved information and access to care among migrants will have increased infectious disease protection of the population at large through the early recognition and treatment of cases and contacts.

Cross-References

▶ Health Security
▶ Health System

References

1946 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, No. 2:100) and entered into force on 7 April 1948.

Abbas, M., Aloudat, T., Bartolomei, J., Carballo, M., Durieux-Paillard, S., Gabus, L., Jablonka, A., Jackson, Y., Kaojaroen, K., Koch, D., Martinez, E., Mendelson, M., Petrova-Benedict, R., Tsiodras, S., Christie, D., Saam, M., Hargreaves, S., & Pittet, D. (2018). Migrant and refugee populations: A public health and policy perspective on a continuing global crisis. *Antimicrobial Resistance and Infection Control, 7*(1), 113. https://doi.org/10.1186/s13756-018-0403-4.

Abiiro, G. A., & De Allegri, M. (2015). Universal health coverage from multiple perspectives: A synthesis of conceptual literature and global debates. *BMC International Health and Human Rights, 15*(1), 17. https://doi.org/10.1186/s12914-015-0056-9.

Beauclercq, I., Viello, F., Petrova-Benedict, R., & Val, E. (2018). Overview of migration and health in Europe. In *Refugee migration and health: Challenges for Germany and Europe* (pp. 19–37). https://www.springer.com/gp/book/9783030031541

García-Armesto, S., Abadía-Taira, M. B., Durán, A., Hernández-Quevedo, C., & Bernal-Delgado, E. (2010). Health systems in transition. In *Health system review Spain* (pp. 1–295). World Health Organization 2010, on behalf of the European Observatory on Health Systems and Policies. http://www.euro.who.int/__data/assets/pdf_file/0004/128830/e94549.pdf

Gushulak, B., Weekers, J., & Macpherson, D. (2009). Migrants and emerging public health issues in a globalized world: threats, risks and challenges, an evidence-based framework. *Emerging Health Threats Journal, 2*, e10. https://doi.org/10.3134/ehtj.09.010

IOM. (2016). S*ummary report on the MIPEX health strand and country reports*. https://migrationhealthresearch.iom.int/mrs-no-52-summary-report-mipexhealth-strand-and-country-reports

IOM. (2019a). *World migration report 2020*. https://publications.iom.int/system/files/pdf/wmr_2020.pdf

IOM. (2019b). *Missing migrants project*. https://missingmigrants.iom.int/region/mediterranean

IOM. (2019c). *Glossary on migration* (International Migration Law Series No. 34). IOM. https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf

IOM, U. M. (n.d.). *Migration health assessments & travel health assistance* [IOM]. Retrieved 15 Jan 2020, from https://www.iom.int/migration-health-assessments-travel-health-assistance

IOM-OIM. (2010). *Increasing Public* MHD. (2019). *Health, Border & Mobility Management (HBMM)* [Info sheet]. IOM. https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/mhd_infosheet_hbmm_18.01.2019_en.pdf

IOM-OIM. (2015). *Mixed migration flows in the Mediterranean and beyond, compilation of available data and information*. https://www.iom.int/sites/default/files/situation_reports/file/Mixed-Flows-Mediterranean-and-Beyond-Compilation-Overview-2015.pdf

Kutzin, J. (2013). Health financing for universal coverage and health system performance: Concepts and implications for policy. *Bulletin of the World Health Organization, 91*(8), 602–611. https://doi.org/10.2471/BLT.12.113985.

Médecins du Monde. (2018). *Doctors of the world- annual report*. Médecins du Monde. https://www.medecinsdumonde.org/en/actualites/publications/2019/09/05/annual-report-2018

OHCHR & WHO. (2008). *The right to health*. https://www.ohchr.org/Documents/Publications/Factsheet31.pdf

Publ. World Organization (Ed.). (2007). *The world health report 2007 – a safer future: Global public health security in the 21st century World Health Organization*. https://www.who.int/whr/2007/en/

Thompson, L. (2013). Protection of migrants' rights and state sovereignty. UN Chronicle. https://unchronicle.un.org/article/protection-migrants-rights-and-state-sovereignty

UN. (n.d.). *Sustainable Development Goals knowledge platform*. Retrieved 15 Jan 2020, from https://sustainabledevelopment.un.org

UN Doc. (1966). *International covenant on economic, social and cultural rights, G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 3, 1976.* http://hrlibrary.umn.edu/instree/b2esc.htm

UN Doc. (1984). *Siracusa principles on the limitation and derogation of provisions in the international covenant on civil and political rights, Annex, UN Doc E/CN.4/1984/4 (1984) I.* https://www.uio.no/studier/emner/jus/humanrights/HUMR5503/h09/undervisningsmateriale/SiracusaPrinciples.pdf

Wenham, C., Katz, R., Birungi, C., Boden, L., Eccleston-Turner, M., Gostin, L., Guinto, R., Hellowell, M., Onarheim, K. H., Hutton, J., Kapilashrami, A., Mendenhall, E., Phelan, A., Tichenor, M., & Sridhar, D. (2019). Global health security and universal health coverage: From a marriage of convenience to a strategic, effective partnership. *BMJ Global Health, 4*(1), e001145. https://doi.org/10.1136/bmjgh-2018-001145.

WHO. (2005a). *The International Health Regulations (2005)* (IHRs Brief No. 1). https://www.who.int/ihr/publications/ihrbrief1en.pdf?ua=1

WHO. (2005b). *Strengthening health security by implementing the International Health Regulations (2005), WHO European Region: JEE mission reports Joint External Evaluation (JEE) mission reports*. World Health Organization. https://www.who.int/ihr/procedures/mission-reports-europe/en/

WHO (Ed.). (2010). *Health systems financing: The path to universal coverage*. Geneva: World Health Organization.

WHO. (2015). *WHO, Anchoring universal health coverage in the right to health: What difference would it make? Policy Brief* [Policy Brief]. https://www.who.int/gender-equity-rights/knowledge/anchoring-uhc/en/

Wickramage, K. (2018). State sovereignty over deadly pathogens: Ensuring Global Health Security. *Journal of International Law. University of Colombo. Faculty of Law Journal*. https://www.researchgate.net/publication/330924737_State_Sovereignty_over_Deadly_Pathogens_Ensuring_Global_Health_Security_Journal_of_International_Law_University_of_Colombo_Faculty_of_Law_Journal

World Health Organization (Ed.). (2016). *International Health Regulations (2005)*. Geneva: World Health Organization.

Zidar, A. (2015). WHO International Health regulations and human rights: From allusions to inclusion. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.2593962.