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Occupational health and migration

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Who are migrant workers?

A migrant worker can be considered “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” (1,2). Migrant workers can vary substantially in, for example, their level of education, skill and language (2,3), and cannot therefore be treated as a homogeneous group: individual and contextual factors are critical.

Europe’s reliance on migrant workers

Migrant workers are a significant minority group in Europe: 12.6% of the workforce of all European Union Member States (EU28) has a migrant background (4) and this figure is only likely to increase. Although sectors such as information technology (IT) and professional work rely on skilled labour from abroad to make up labour shortages, migrant workers are also concentrated in low-skilled jobs with poor or difficult working conditions (5), particularly in agriculture, accommodation and food services, cleaning, manufacturing and construction.

The reliance on migrant workers and the division between high- and low-skilled jobs are particularly evident in the hotel industry, where migrant workers from developed countries typically occupy highly skilled and/or managerial positions, and migrant workers from poorer countries are employed in low-skilled positions (6).

Furthermore, with the proportion of older workers in the EU workforce projected to rise, and most migrants being relatively young (7), migrant workers are likely to play an increasingly important role in Europe’s labour market in the future. EU-OSHA’s Healthy Workplaces for All Ages campaign (8) raises awareness of the importance of good occupational safety and health (OSH) management throughout working life and of tailoring work to individual abilities — whether at the start of a worker’s career or at its close. By managing OSH and considering and dealing with the diversity that exists within the workforce, healthy ageing at work and retirement in good health can be achieved.

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Dr Christa Sedlatschek

Safety and health risks specific to migrant workers

Migrant workers are considered by policy-makers to be one of the groups most at risk of safety and health issues at work (9); that is, in terms of both physical and psychosocial risks.

Employment is often precarious

Migrant workers reportedly experience greater levels of job insecurity and fewer entitlements (2,5), and are more often engaged in temporary employment than native workers (10). As well as the harmful effects on health, being in precarious work often results in migrant workers being given difficult and unwanted jobs (5). These workers are thus likely to have low levels of employment protection and could even be vulnerable to exploitation and abuse (2).

Many suffer poor psychosocial working conditions

More migrant than native workers report undertaking monotonous tasks and an unfavourable working pace (11), and low-skilled jobs are often characterized by low levels of control and autonomy. Migrant workers also report fewer positive features of work – that is, less involvement in complex tasks, job rotation and job involvement – than native workers. Many migrant workers (34%) are also overqualified for their work (compared with only 19% of native workers) (12), which can lead to job dissatisfaction and frustration, leaving migrant workers vulnerable to work-related stress (5).

On top of work-related stress, more migrants than native workers experience discrimination and bullying in the workplace (13). Verbal abuse, unwanted sexual attention, threats and humiliating behaviour were all reported by migrant workers more than by their native counterparts, with various potential effects on health and performance. And discrimination – whether based on nationality, sex or religion – can seriously hamper migrant workers' attempts to enter or progress in the labour market.

Exposure to dangerous substances is high

Various factors make migrant workers more likely to be exposed to dangerous substances. Their tendency to work in high-risk sectors (for example, farming) inherently increases their exposure to (for example) pesticides. With long working hours or overtime work, the length of time they are exposed to such substances increases. It is also common for migrant workers to receive poor-quality (or no) personal protective equipment and they are less likely to receive suitable training.

Language barriers can significantly hamper the communication of safety and health information to migrant workers, and cultural differences may mean they are accustomed to different or lower safety and health standards. What's more, the precariousness of their work situations can often leave little time for inductions and conveying safety information.

EU-OSHA's upcoming Healthy Workplaces for All Ages campaign in 2018–2019 will promote a prevention culture on dangerous substances in the workplace across the EU and beyond.

Low-skilled work often leads to musculoskeletal disorders (MSDs)

Many of the risk factors for MSDs – such as moving heavy loads, repetitive movements, and exposure to noise and vibrations – are features of low-skilled jobs, and agriculture and construction are the two sectors in which employees are most affected by MSDs (14). With migrant workers abundant in these sectors, and a lack of control of MSD risk factors for this group, they are significantly at risk of MSDs.

The future safety and health of migrant workers

With their high exposure to both physical and psychosocial risk, migrant workers are often particularly susceptible to health issues, accidents and even death. And with the number of EU workers with a migration background set to increase further in the future, greater monitoring and

research of the risks faced by this group are essential. Migrant workers represent a significant potential in the context of labour shortages and the ageing workforce. Thus, to allow them to participate healthily and productively in the workforce, ways of improving their working conditions and their integration into the labour market need to be identified, looking particularly at risk assessments and key interventions.

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OVERVIEW

How occupational health impacts migrant health: a case study from Portugal

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Background

Owing to increasing migration, cultural diversity is on the rise, challenging the responsiveness of national and local health welfare provision and the enforcement of human rights. Migrants tend to occupy the so-called 3-D jobs: dirty, dangerous and demeaning,¹ and as such are exposed to greater risk of work-related accidents and diseases. Interestingly, in the growing body of literature on migrant health, migrants' occupational health has been overlooked. Research has shown how migrants have more limited access to legal protection, as well as facing linguistic, social and cultural barriers when trying to access health services. Many are excluded because they tend to work in the informal sector and receive no health coverage. Migrants' precariousness illustrates the absence of the welfare state for a large part of the working population.

Previous research (1–5) suggested that socio-cultural and structural barriers led migrants to be more exposed to unsafe work-related situations and health risks. In Portugal, most migrants arrive for economic reasons and work in less desirable jobs: construction (10.0% in 2012), restaurants/hospitality (19.5%) and domestic aid/cleaning/caregiving (18.5%) (6). The segmentation of the labour market may reflect other related factors, such as language and legal barriers, limited social solidarity networks, and discrimination in the labour market, leading the migrant population to risky situations (3). Employers, on the other hand, can take advantage of the situation, increasing the burden on migrants' health (4), both financially and in terms of their well-being.

While studies have identified different types of barriers to accessing health care, less attention has been given to what migrants actually do to access health services. Also, most of

the literature looks at migrants as a homogeneous category, which means that diversity among migrants and minorities goes unnoticed. To fill this gap, a multidisciplinary team decided to investigate the everyday health practices of residents living in so-called superdiverse neighbourhoods, looking at how welfare systems shape health care provision and choices. Superdiversity is characterized by the inter- and intra-group diversification within the neighbourhoods in question, which are inhabited by “new migrants, well-established minorities and often impoverished and/or elderly, less-mobile majority group[s]” (7:2).

UPWEB

“Understanding the practice and developing the concept of welfare bricolage”, or UPWEB, is a two-year project that began in January 2015, funded by NORFACE² and carried out in four European countries and cities (Birmingham in the United Kingdom, Bremen in Germany, Lisbon in Portugal, Uppsala in Sweden). As the project is concerned with the local dimension, two superdiverse neighbourhoods were then selected in each city.

By using a combination of methods (ethnography and health surveys) UPWEB hopes to “contribute to a better understanding of how residents in superdiverse neighbourhoods deal with health and healthcare in everyday practices” (7:1). Superdiversity covers a broad range of dimensions applied to migrant and autochthonous populations. For all individuals, age, gender and socioeconomic status are relevant variables, while for migrants, place of origin, nationality, race/ethnicity and legal status are also taken into account. Findings are intended to help practitioners and policy-makers understand what changes are needed to improve the system in order to make it more responsive to superdiverse contexts.

¹ While most sources include dirty and dangerous, some sources use demeaning or demanding to refer to the third D.

² NORFACE is a collaborative partnership of national research funding agencies from 18 European countries in the area of social and behavioural sciences, entitled New Opportunities for Research Funding Agency Co-operation in Europe.

The Portuguese case

In Lisbon the two selected neighbourhoods were Mouraria and Lumiar. After conducting 43 interviews with residents (23 of whom were migrants) and 15 interviews with key informants (including health professionals, local associations, community leaders, and so on), and carrying out participant observation in so-called health hot-spots (health care units, local nongovernmental organizations (NGOs), mobile health units, etc.), the team used grounded theory – which involves inductive and deductive approaches – to identify that occupational health is a relevant issue for most migrants, even if it appears that only few concerns arise in direct relation to occupational health.

Of the 23 migrant interviewees, the majority work in low-skilled jobs, matching the so-called 3-D jobs profile, and mainly in construction, domestic aid, cleaning, caregiving and hospitality/restaurants. When asked about their health concerns, most of them mentioned job-related issues associated to poor working conditions and occupational safety and health (OSH) risks, such as long working hours, lack of rest, heavy lifting and psychological problems (stress, anxiety, etc.).

Specific occupational health concerns among migrants

Jose (male, Cape-Verdian, 54 years old) was working in the construction industry when he suffered a serious accident. Within two months he had undergone surgery twice, but in the end he lost his arm. Jose was forced to retire, but disability benefits are limited and he is currently facing financial problems, struggling to afford rent, food and to take care of his ill health.

Cristina (female, Angolan, 61 years old) used to work as cleaner but had a work-related accident from which she never recovered. She uses a local health centre and a public hospital for ongoing treatment, but her condition (a leg problem) prevents her from working and having a normal life.

Anu (female, Brazilian, 38 years old) works as a cook in a vegetarian restaurant, where she developed chronic arm pathology. She is under a great deal of stress as she works 10 hours per day without a break in the kitchen, standing up for long periods of time. Her biggest concern is unbearable muscle pain in her arms and knees owing to repetitive movements and being on her feet all day. Although she could access a family doctor within the health system, she does not trust the system, so instead she prefers to use alternative treatments such as massage sessions, which are not covered

by the National Health Service. To avoid missing work (she cannot take sick leave), her employer has given permission to have the massages in the workplace. Anu believes her employer is very supportive of her, expressing that she feels lucky and as if she has been granted a privilege.

Devi (female, Nepalese, 42 years old) works for around 10.5 hours per day as a kitchen helper in a restaurant. One of her health concerns is unbearable back pain, related to the long working hours without adequate breaks, and the constant pressure of the job. She said,

“There is too much pressure while working. We have to work continuously ... In Nepal, when someone just joins the work then they do not have to work for long time, like non-stop. People who work get to rest ... But here, they are strict at work ... no rest”.

Nando (male, Indian, 42 years old) works as a cook in the kitchen of a temple and has vision problems; however, most of the time he cannot wear his glasses because they fog up, which blocks his vision further. He said, “I try to protect myself but work is work and we have to do our job”. Nando is enrolled with the local health centre, but he avoids going there because of (a) the excessive waiting times for a medical consultation (he asserted, “nothing is treated quickly”); and (b) his difficulties communicating with staff and doctors, unless he is able to go with a friend, as his interpreter.

These case studies show that exposure to work-related risks leads to health hazards, with consequences that range from acute to chronic diseases, including amputations, eye problems, musculoskeletal disorders, chronic arm pathology and depression, among others. Work-related stress, along with other factors – such as emotional vulnerability from living abroad in inadequate conditions; isolation from family, friends and community support; feelings of nostalgia, combine to aggravate migrants’ situations. As Devi asserted,

“[t]ension ... comes forth once in a while. It comes especially as we are away from home, staying far away ... Everyone is suffering from mental problems ... it is because we leave our country and because of the new environment; it makes us this way... [some] people I know have even committed suicide”.

Such extreme situations obviously reach beyond the labour sphere; however, it is clear that migrants are at-risk populations working in pressurized situations and with limited outreach services. Precarious occupational health impacts on their overall health.

Conclusions

Despite the fact that the majority of migrants were exposed to risk of work-related accidents and diseases, they did not know what to do about it, nor did they have a clear idea about their rights. In fact, some of them seemed to be resigned to the poor and dangerous working conditions, the diseases caused by their jobs, and the psychological distress, as though they were part of the employment agreement. On the one hand this reflects migrants' difficulties understanding their rights (specifically to social security that guarantees "a healthy and decent standard of living for every individual"

(2:2)), and on the other, it highlights the unscrupulous hiring practices of many employers.

In addition, the vulnerability of migrants' occupational health is often further compromised because they are not a target population for health promotion and disease prevention measures, apart from cases of public health concern. As most health systems have been designed to serve a homogeneous population, many changes are needed in order to be responsive to superdiversity. Occupational health should be taken seriously in the framework of health policies and within the field of research on migrant health.

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Respiratory health issues among migrants in Europe

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War, political instability, religious issues and the need for a better income are all factors that necessitate millions of people to move from their native countries to others, often in a dangerous and dramatic way. This happens in all corners of the world; today nearly 3% of the global population are migrants. In terms of the European Union (EU), 3.4 million people migrated to one of the EU28 countries during 2013, of which 1.4 million were from non-EU countries. Almost 104 000 were refugees, of which over 20 000 were authorized to stay for humanitarian reasons (1). The total number of undocumented migrants in Europe is estimated to be 5–8 million (2). Within this group, about 1.5 million work in an EU Member State, accounting for a share of 7% of total EU employment (3). The main employment sectors for migrants are agriculture, manufacturing and construction (4), very often with employment in so-called 3-D jobs (dirty, dangerous and demanding).

The main problems faced by migrants in the countries to which they migrate are inequality in accessing the health care system (that is, diagnosis, treatment, preventive services, and so on), poor-quality housing and conditions, lifestyle risks and religion-related problems, lack of social security and legal protection, as well as risks not experienced in the countries of origin (for example, contact with allergens).

In this scenario, it becomes fundamental for primary health care providers to refine tools to assist migrants with the specific health problems they face. Since the problem of contact with new allergens is potentially relevant in terms of health consequences, and involves the whole migrant population, this paper addresses the specific problem of migration-related allergies. To this end, a broad literature search was carried out in PubMed, and selected data obtained from the bibliographic research are briefly discussed here.

The global situation seems to suggest a higher risk of sensitization among migrants. In fact, a broad collaborative

study conducted in 18 European countries involving 19 516 participants showed higher rates of asthma in migrants (odds ratio (OR): 1.21, 95% confidence interval (CI): 1.00–1.51) and emigrants (OR: 1.31, 95% CI: 0.96–1.51), compared to non-migrants (migrants 11.2%; emigrants 11.0%; non-migrants 8.6%) (5). However, further investigation provides very interesting data regarding the time frame and the conditions affecting the risk of sensitization. In particular, Albania – a country characterized by a very high emigration rate – has among the lowest prevalence of allergic diseases; significantly lower than that of several westernized countries, including Italy (6,7), which has similar climatic and aerobiological conditions but a more westernized lifestyle. A study conducted of Albanian migrants showed an increase of hay-fever from 2.5% in 42 subjects with a duration of residence of under three years to 20.4% in 49 subjects with a duration of residence of longer than seven years in the Apulia region (southern Italy). Specific testing showed that prevalence of sensitization to pollens (established by carrying out a skin test) increased from 5.0% in those living in Apulia for fewer than three years to 28.6% in those living there for more than seven years (8). In adults from south Asia that had migrated to the United Kingdom, asthma prevalence is lower than in the native population: in fact, the crude prevalence of asthma is 10.9% (95% CI: 9.4–12.4) in migrant women and 21.8% (95% CI: 20.6–22.9) among local native women ($P < 0.001$). The factors positively associated with asthma prevalence were: being born in the United Kingdom or having migrated before the age of 5 years; speaking English; eating mostly an English instead of an Asian diet; and active smoking. Factors negatively associated were: limited education; overcrowding; lack of electricity for cooking; and lack of central heating (9). A similar situation was reported in the United States, where black and Hispanic immigrants had low mortality from chronic obstructive pulmonary disorder (COPD), pneumonia and influenza (10).

Turkish migrants' children living in European metropolises appear to be protected from allergic diseases (11). Interestingly, the protection seems inversely associated with the level of adaptation to the host country culture. In particular, factors contributing to protection are having parents, who do not speak the host country's language, and having maintained the lifestyle of the country of origin. The same findings are true of the Netherlands, where Turks, Moroccans and the Surinamese have low mortality relative to Dutch people (12).

Conclusions

Some data suggest a higher risk of allergies among migrants; however, further investigation suggests that the risk of outcomes such as rhinitis, oculorhinitis and asthma is age and time dependent, and that a younger age and a longer time in the new environment increase that risk (13). The risk affects mainly the subgroups that are mostly integrated in the host country and have adapted their lifestyle and dietary habits accordingly. In this light, it seems that the so-called hygienic hypothesis can also be adapted also to migrants. According to this hypothesis, those who experienced contact with

allergens in early life are protected, whilst others are not, in particular if also exposed to typical urban contaminants in the urban environment. This scenario brought some authors to create the definition of a "healthy migrant effect" (14).

The results of an international conference held in 2010 point to an explanation of the action mechanisms of this healthy migrant effect; namely, centred on the protective role of intracellular mild pathogens, able to colonize antigen presenting cells for a long time, thus affecting the future development of immune responses (15).

What are the main consequences of this situation for primary health care providers? First, it is necessary to train migrant workers (among others) to deal with the risks of post-migration contact with environmental contaminants and allergens; second, owing to the presence of allergic risks, planning and conducting specific screening activities becomes increasingly relevant, to identify both vulnerable subjects (primary prevention) and asymptomatic sensitized individuals (secondary prevention). These activities are only possible by promoting wider access for migrants to the primary health care systems of the countries to which they migrate.

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NEWS

Day 2 highlights: RC66 adopts European strategy and action plan for refugee and migrant health

<http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2016/09/day-2-highlights-rc66-adopts-european-strategy-and-action-plan-for-refugee-and-migrant-health>

13 September 2016

At summit for refugees and migrants, senior UN officials underline the importance of collective action

<http://www.un.org/apps/news/story.asp?NewsID=54953#.V-Dxvfl96Uk>

19 September 2016

Obama: Refugee crisis is test of our humanity

<http://edition.cnn.com/2016/09/20/politics/obama-refugees-summit/>

20 September 2016

Immigrants are good for the economy and governments need to explain that, says OECD

<http://www.telegraph.co.uk/business/2016/09/19/immigrants-are-good-for-the-economy-and-governments-need-to-expl/>

19 September 2016

An OPEC for migrant labour?

<http://knowledge.insead.edu/blog/insead-blog/an-opec-for-migrant-labour-4932>

19 September 2016

Getting migration governance right

<https://www.project-syndicate.org/commentary/getting-migration-governance-right-by-sheikh-hasina-2016-09>

19 September 2016

EVENTS

9th European Public Health Conference: All for Health – Health for All

9–12 November 2016, Vienna, Austria

<https://ephconference.eu/>

Preconference European Public Health Conference workshop: Migrant health – economics, human rights and quality of care

9 November 2016, Vienna, Austria

<https://ephconference.eu/2016-pre-conference-programme-277>

High-level conference on working together for better health and well-being

7–8 December 2016, Paris, France

<http://www.euro.who.int/en/media-centre/events/events/2016/12/high-level-conference-on-working-together-for-better-health-and-well-being>

OPINION

This article represents the opinion of the author(s) and publications and does not necessarily represent the views of WHO, the University of Pécs or the Editorial Board of this newsletter.

Sexual harassment against female migrant domestic workers

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At least 52.6 million people were employed as domestic workers across the world in 2010, 83% of which were women and many of them migrants (1). Migrant women occupied as domestic workers are known to be particularly exposed to sexual harassment (2).

Sexual harassment at work can take many forms, including derogatory sexist remarks; being exposed to sexually oriented pictures, comments, and gestures; solicitation; touching; expectation of quid-pro-quo arrangements; and even forced sexual contact (3). The consequences of sexual harassment are evident in terms of both the mental and physical health of the victims (e.g. stress, irritable bowel, and so on) and their work performance (e.g. low productivity, increased tardiness, absenteeism, and reduced turnover as a result) (4,5).

Certain factors are known to place female migrants at a disadvantage when occupied as domestic workers, including the status of the occupation itself, the labour market policies regarding the sector, the migrant status of the workers, immigration policies, the workers' gender itself, and public attitudes.

Interestingly, the domestic sector is different from other labour market sectors because of its lower language and educational requirements, which place domestic work among the low-status, low-skilled and low-paid jobs. Demand for such work is usually driven by the employer; that is, the work has to be carried out when it is suitable for those buying the service. This results in an uneven work load that usually includes work on weekends and bank holidays. Another special characteristic of domestic work is that it takes place in the private household, away from the outside world and the

oversight of regulatory bodies, which is thought to exacerbate workers' isolation and invisibility (2,6,7).

Most importantly, labour market policies regarding the domestic sector seem to contribute to undeclared and asymmetrical working relationships and thus increase migrants' vulnerability to abusive situations. In other words, females who are sexually harassed in the domestic sector have little control over their situation, little power over their relationship with their employer and low chances of being noticed by regulatory bodies, owing to the so-called invisibility of their position and the lack of work colleagues. In fact, domestic work is categorized as part of the large informal sector, primarily driven by the employers themselves, who often do not declare working relationships in an attempt to avoid the burdensome administrative procedures involved in the registration of domestic workers. This is even more evident in the case of recruiting migrant workers, which is often burdensome because of strict migration policies. Despite the fact that international human rights laws and labour law standards prohibit differential treatment based on status, it has been suggested that the current policy in European countries varies considerably, with access to fundamental rights in reality largely determined by the employer (2,6–8).

While extraordinary conditions define the occupation itself, migrants seem to be in an even more disadvantageous position compared with local workers, owing to their lack of local language skills, low awareness of the local laws and customs, inadequate access to appropriate jobs and limited knowledge of their rights (6–10).

Furthermore, as domestic work is often undertaken out of economic need rather than intrinsic interest in the work, fear of job loss may be particularly effective in suppressing complaints. Most remarkably, immigration policies exist that increase dependency on employers to obtain or retain work permits and this often contributes to the perpetuation of sexual harassment and the low numbers of formal complaints against abusive employers. In some cases, strict laws and regulations exist allowing short time limits for obtaining another job before migration status is revoked, or individuals might foresee losing their residence permit in the case of changing employers. Many domestic workers feel that they have no choice but to stay and suffer abuse because fleeing their employer would mean lapsing into irregular status, having to admit to the authorities if they are in an irregular situation and/or losing their right to work. Under these circumstances, it is obvious that the inadequacy of the legal system to protect the rights of migrant domestic workers places them in a position of disadvantage, both for documented workers (who risk deportation if they attempt to escape exploitative work environments), but also, and even more so, for undocumented migrant workers, who face the prospect of abuse and exploitation without legal recourse (2,6–10).

Gender seems to be another factor that increases the vulnerability of female migrants occupied in the domestic sector. This is understood on the one hand as a function of contact between the sexes at work, with women becoming suitable targets in the proximity of motivated offenders, while on the other hand, the likelihood of sexual harassment is thought to increase because domestic workers, specifically females, are thought to be in a subordinate role. The dominant theory posits that women's subordinated positions lessen their power in relation to potential harassers, rendering them vulnerable to sexual harassment (8).

Other challenging aspects are the cultural norms and negative public attitudes, which seem to condone the sexual victimization of female migrant domestic workers. Racism and xenophobic notions, prompted by ignorance and fear of different religions and cultures, are thought to be prominent both at the institutional and the personal levels, resulting in disrespect of migrants' rights. In some cases, migrant women are seen in stereotypical roles, as prostitutes or maids, and they are considered more sexually accessible and open to advances (6).

Under these circumstances, governments have been criticized twofold: on the one hand for the lack of state-provided social welfare, which feeds the migrant phenomenon and the informal working relationships in domestic services; and on the other hand for serious weakness in safeguarding migrants' rights against abusive situations (8–11).

In response, it could be said that there is no one-shot solution to the problem. The surrounding gender-based cultural assumptions that often legitimize unwanted sexual advances towards females intersect with a number of other vulnerabilities, such as disadvantageous economic conditions, labour exclusion, uncertain legal status, social isolation, and ethnic vulnerability. What seems to be important for the prevention and management of the problem is improving migrants' capacity to deal with sexual violence, along with governments' capacity to assist female migrants through migrant-friendly approaches and procedures. Most importantly, the working conditions surrounding domestic work must be improved, by acknowledging in the relevant labour legislation the special attributes that characterize women who are employed in this sector. In this regard, governments need to adopt a clear policy framework for migrant working and effective enforcement and regulatory mechanisms. Safe job enquiry systems need to be designed to protect migrants from unreliable job offers, especially those offered on the Internet, while smart portable technologies could be developed for use by people registered as domestic workers, to provide them with emergency support options. Such preventive and crisis intervention systems and services for migrants who are victimized (or at risk of victimization) should anticipate special roles and links to local migrant community organizations, which are often the only accessible – and sometimes the only culturally trusted – option for certain groups of female migrants. Special attention needs to be paid to raising public awareness of human rights and reducing discrimination based on gender, employment and ethnicity. Last, but not least, there is a need to strengthen the knowledge base on sexual violence against migrant domestic workers, through rigorous research and efficient monitoring of the problem. Above all, immigration, labour and social policies need to be reconsidered in parallel, to address holistically the existing policy gaps which currently have a negative impact on migrants' human rights.

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