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Gender, migration and health: are there any gender-specific migration issues?

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The global health perspective – which defines as a priority the improvement of health and the achievement of equity in health for all people, worldwide[1] – emphasizes the interdependence of the different determinants of health in affecting the health of individuals and communities. In this regard, the role of gender and migration is coming to the fore.

Gender – defined as the socially constructed roles, behaviors, activities and attributes that a given society considers appropriate for women and men[2] – is increasingly recognized as a central aspect of migration that influences the reasons for the migration itself, the experiences made during migration, and the opportunities and resources available in the countries of destination.

Migrants of any sex and age, including those with diverse sexual orientations, gender identities and expressions, and sex characteristics (SOGIESC), often face additional migration-related challenges.

Migrant women are 135 million, nearly 50% of the global stock of international migrants.[3] Being a migrant increases the risk for women and girls to experience various forms of gender-based violence (GBV), including sexual, physical, mental and economic harm in the countries of origin, transit and destination. Most of the worldwide estimated 225,000 victims of trafficking between 2003 and 2016 were women.[4] In particular, the central Mediterranean route (from North Africa mostly to Italy) is known to be dangerous, with staggering levels of physical and sexual violence[5] usually inflicted by traffickers but also military and security forces. Also migrants with diverse SOGIESC face high rates of discrimination, and higher risk of human trafficking and gender-based violence that, however, do not spare heterosexual migrant men and boys either.[6-8] In this context – besides cultural bias that can make it harder for males to report violence – , since the majority of gender-based violence support services are provided in maternal and reproductive health clinics, this might increase the male victims' barriers to receiving adequate support.[9] Moreover, male migrants are frequently perceived as being less vulnerable than women and children, who are usually prioritized in the provision of humanitarian services and aid, thus generating the risk of neglecting or underestimating their needs.[10]

In host countries, migrants tend to be employed in "3D" jobs (*dirty*, *dangerous* and *demeaning*) with lower salaries, fewer rights and higher occupational hazards, much more frequently than national workers.[11] Men are more likely than women to die or be injured at work, given that they are employed in more dangerous jobs (e.g., agriculture, farming, construction, mining, manufacturing, transportation), but also female-dominated sectors, such as domestic work, pose particular risks, including abuse and violence.[12]

Actually, whereas in the past women often migrated as dependent on their spouses or other family members, today they increasingly migrate alone for study or work, encouraged in part by the growing demand for gender-specific care work in the host countries (e.g., Europe and North America). In these settings, women often work in the informal economy, with limited bargaining power, no (or uncertain) contractual arrangements and only a few opportunities to claim or be guaranteed sick leave.[13] In addition, if their legal status is bound to a specific employer, or if they do not hold a valid residence permit, their reporting of possible abuse and exploitation may be hindered, thus further increasing their vulnerability.[14]

In host countries, women may be more vulnerable than men to abuse and denial of rights, also due to economic hardship, financial dependence and legal insecurity. A recent survey in Australia found that one-third of migrant and refugee women experience domestic violence and that, among these, temporary visa holders consistently report proportionately higher levels of it.[15]

The lack of a systematic collection of health data reported by gender is still an issue that obstructs the production of scientific evidence in this area.

Migrant men and women are generally both healthy at departure, and do not have particularly different health conditions on arrival compared to the native population.

However, an increased risk of developing post-traumatic stress disorder (PTSD) following the exposure to traumatic events has been reported in women (twice as likely than in males),[16] together with an increased risk of psychological distress, depression[17] and postpartum depression,[18] childhood diabetes and obesity – especially among North African female migrants – and ges-

tational diabetes mellitus (among South Asian migrants).[19,20] Depression, anxiety and PTSD are frequently recorded among migrants with diverse SOGIESC, particularly when their condition is associated with detention or living in camps, and high social isolation.[21]

Cultural and religious beliefs, language barriers, concerns about payment for health care services, uncertainties about the rules for accessing them, lack of communication with healthcare providers, and fear of discrimination may hinder the migrant's adequate access to healthcare services, even when they are free. In this regard, the literature has particularly focused on health outcomes in migrant women, highlighting a higher risk of unmet sexual and reproductive health needs and adverse pregnancy outcomes – including high maternal mortality – even when they are entitled to access services.

In particular, migrant women access female cancer screening services less than native women. In Italy, it has been reported that foreign women are 40% less likely than Italian women to receive a Pap test, and 55% less likely to get a mammogram.[22] They are also twice as likely as Italian women to undergo their first prenatal visit beyond the tenth week of pregnancy (the date recommended by Italian guidelines), to have higher rates of neonatal and post-neonatal mortality,[23] as well as a rate of induced abortion 2-3 times higher.[24]

In addition, it has been estimated that today about 600,000 women and girls who have undergone female genital mutilation/cutting are living in Europe: this represents a major challenge for the healthcare systems.[25] Indeed, healthcare professionals struggle to identify and manage possible clinical complications, and policymakers are called to implement multi-sectorial policies to help prevent these practices in second-generation and first-generation migrant girls coming from countries that still implement them.

Finally, the COVID-19 pandemic has also increased the vulnerability of migrant men and women. Refugees and migrants reported a significant impact of COVID-19 on their access to work, their safety and their financial means.[26] Many of them, who work in essential services, have been on the front line during this period and – with particular reference to those with non-regular employment – suffered from an increased economic insecurity, due to unprotected unemployment conditions and the absence of social security contribution schemes such as social safety nets, access to healthcare or paid family and medical leave, with the greatest impact reported for women.[27]

Placing the gender perspective at the center of global politics is a key priority today, as also highlighted by the Sustainable Development Goals set out in the United Nations 2030 Agenda.[28]

Adopting the global health perspective implies increasingly acknowledging the role of gender, also with regard to migration.

In this regard, designing and implementing gender-sensitive migration policies and pathways – that consider the diverse experiences, needs, and vulnerabilities faced by women, men and gender non-conforming individuals at all stages of migration – is therefore essential in order to advance gender equality, ensure health protection and support human rights.

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