A SURVEY BASED STUDY ON DOCUMENTED AND UNDOCUMENTED MIGRANTS' DIVERSE HEALTH PROBLEMS

A thesis report submitted to the department of Pharmacy, East West University, Bangladesh, in partial fulfillment of the requirements for the degree of M. Pharm. in Clinical Pharmacy and Molecular Pharmacology

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I, Lucky Dey (ID:2013-3-79-013), hereby declare that the dissertation entitled **"A SURVEY BASED STUDY ON DOCUMENTED AND UNDOCUMENTED MIGRANTS' DIVERSE HEALTH PROBLEMS"**, submitted by me to the Department of Pharmacy, East West University, in the partial fulfillment of the requirement for the degree of Masters of Pharmacy is a genuine & authentic thesis work carried out by me during Spring 2014- Fall 2015 under the supervision and guidance of Farhana Rizwan, Assistant Professor, Department of Pharmacy, East West University.

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Dedicated

To

My Parents

ACKNOWLEDGEMENT

All praise is for Almighty for giving the ability to complete my M. PHARM thesis & the opportunity to study in this subject.

It is my pleasure and proud privilege to express my heartiest regards and gratitude to my respected teacher and supervisor Farhana Rizwan, Assistant Professor, Department of Pharmacy, East West University; for her constant supervision and support, optimistic counseling and continuous backup to carry out the thesis work as well as to prepare this dissertation.

I would like to acknowledge the support of our respected teacher Dr Shamsun Nahar Khan, Associate Professor, Chairperson, Department of Pharmacy, East West University.

I would also like to extend my thanks to all the research students and other staffs of the Faculty of Pharmacy for their help and assistance, friendly behavior and earnest cooperation which enabled me to work in a very congenial and comfortable ambience.

Last but not the least, I would like to thank my family, and friends for their wholehearted inspiration during my thesis work.

Finally, I would like to express my greatest appreciation to my husband Dr. Choton Kanti Chowdhury for his patience, moral support and help during the period of this work.

ABSTRACT

Background: A large number of foreigners were now working in the Bangladesh and most of them did not have any work permit. Most of the foreigners hail from India, Pakistan, Sri Lanka, and Nepal. A significant number of foreigners hailing from China, Ghana, Nigeria South Korea, Palestine and Taiwan are also residing here. They have been employed by local, joint-venture or cent percent foreign companies.

Objective: The objective of the present study was to understanding migrants' health problems, and to provide satisfactory health services to the migrant population.

Design: Interviews were conducted with the migrant's by the help of a semi-structured questionnaire and using the guided field-walk method.

Location: The location was in Chittagong and Dhaka district, Bangladesh.

Subjects: Subjects of this study are migrants' coming from different country to Bangladesh.

Results: The survey was performed on 343 migrants'. Among them most are students (45.2%), service-holder (25.2%), and businessmen (28.9%). Minimum ages of the migrants are 17 years and maximum ages of the migrants are 37 years. Majority of them are male (67.6%) and then female (32.4%). The migrants selected randomly for the survey. Disease pattern are skin disease (28.3%), gastrointestinal disorders (21%), headache (36.7%), psychological problem (15.7%), and many others have observed frequently to the population.

Conclusions: The study helps to consider a range of factors that may explain the experiences and needs of migrants, including those who are most vulnerable and are restricted in their entitlement to free health care in the Bangladesh.

Keywords: Migrants', health service, foreigners, vulnerable, health problem, restricted.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

	their problem	
19	**Percentage (%) of migrants thinks that pollution of Bangladesh is causing their problem**	**74**
20	**Percentage (%) of migrants think that food and water of Bangladesh is causing their problem**	**77**
21	**Percentage (%) of migrants thinks that loneliness of Bangladesh is causing their health problem**	**79**
22	**Percentage(%) of drugs used by migrant's**	**80**

1. INTRODUCTION

1.1. Background

The relationship between migration and health is a complex issue. Health and disease have been a cause of, a means to, and a result of migration (Gatrell & Elliot 2009). For example, McNeil (1976, cited in McGuire 2012) describes how the transition to sedentary agriculture increased population pressure and migration, and consequently led to the spread of diseases to previously isolated people and eventually diseases became endemic. Another example of disease caused by migration (and vice versa) is the plague known as the Black Death, which occurred in Europe in the medieval period. As the spread of the disease often started at sea ports, many people fled inland to avoid contagion. However, those who fled often carried the virus with them and passed it to people elsewhere (Show et al. 2002). During the colonization era, Europeans were exposed to new diseases such as malaria and tuberculosis when they moved to tropical environments in Asia and Africa, where these diseases were endemic. A more contemporary example of the effect of migration on the spread of disease is the spread of HIV as a result of men becoming infected when they migrated for work and subsequently infecting women when they returned (Lurie 2006). Furthermore, tuberculosis remains a major health problem among immigrants who have moved from Africa and Asia to Europe (Rechel et al. 2011). However, whether as a movement of people from one village/town to other within the same country (internal migration) or as a movement of people across the borders (international migration), migration has had significant impact on the health of the people who have moved (i.e. migrants), those they have left behind, and people in the host population (Gatrell & Elliot 2009, Show et al. 2002).

In the present era of globalization, over 200 million people, equivalent to 3% of the world population, live away from their country of birth and the number is increasing (International Organization for Migration 2010). Several factors at global and local level have contributed to triggering the migration of people since the late 20th century. One of the key factors identified is the increased amount of global trade and trade agreements. In response to economic and political demands, governments have loosened their regulations and opened up their countries for the movement of goods, capital, and people by joining agreements such as the EU, EEA, and NAFTA. A further factor is the significant reduction in the costs of travelling and the time involved. In addition, economic instability in different parts of the world and enormous growth in other parts of the world have created large flows of labour migrants from low-income

countries to high-income countries. Most importantly, the increased incidences of political unrest and conflict within countries have contributed to the growing numbers of internal migrants in form of internally displaced people as well as international migration in form of refugees and asylum seekers. As the numbers of migrants have increased worldwide, research has provided evidence for alarming issues relating to the health, human rights, and cultural backgrounds of migrants. Hence, international organizations have become increasingly concerned about the issues of migrants. For example, in 2008, a report to the World Health Assembly on the health of migrants set out four principles that should guide policies for meeting the health needs of migrants through a public health approach. These principles aim to ensure fair access to health services, protect migrants' fundamental right to health, put in place life-saving measures when migration results from conflict or disasters, and guard against adverse health consequences associated with the stresses that often accompany migration. An associated resolution called for World Health Organization to promote the health of migrants on the international health agenda in collaboration with other relevant international organizations (International Organization for Migration 2010).

1.2. What constitutes a 'migrant'?

One difficulty in studying migrant health is defining the subject. There are many sub-categories of 'migrants'. Also, it is unclear how long before a group of people thought of as 'migrants' begin to simply constitute a socially or culturally distinct or ethnic group of residents (eg 'black British') (Landman and Cruickshank, 2001). Also, different understandings of what it means to be a 'migrant' exist across Europe. For example, in Germany there is no national consensus on what exactly constitutes a 'migrant'. Thus, 'migrants' include first, second and third generation 'migrants', i.e. persons who are either born abroad or who are descendents of parents or grand-parents born abroad, who may or may not be naturalized (i.e. have adopted German citizenship), and whose ethnic origin may or may not be other than German (e.g. so called 'Spaetaussiedler' from Eastern European countries are ethnically German). Recently, a definition of the term 'migrant' was suggested as (1) both parents born outside Germany, or (2) person not living in Germany since birth with at least one parent born abroad, or (3) first language other than German (Schenk L et al., 2006).In the Netherlands the notion of 'migrant' is replaced with the word 'allochtonen', used to describe persons from foreign descent. Literally, the word refers to the

Greek words allos (different) and chtonos (country). 'Allochtonen' are all persons who have at least one parent born outside the Netherlands. A distinction is made between persons who themselves are born outside the Netherlands (first generation) and persons who are born in the Netherlands with one parent born outside the Netherlands (second generation). In contrast with the 'allochtonen' are the 'autochtonen', persons who have both parents born in the Netherlands regardless of where they themselves are born. Generally, a further distinction is made between western and non-western 'allochtonen'. Non-western are those persons who have at least one parent from Turkey, Africa, Latin-America and Asia (with an exception of Indonesia and Japan). Western are those persons with at least one parent from Europe (Turkey is not included), Israel, the US, Oceania, and Indonesia and Japan (who on basis of their socioeconomic status and cultural position are considered western 'allochtonen'). To determine the ethnicity of second generation 'allochtonen', the country of birth of the mother is conclusive, except when this is the Netherlands, in which case the country of birth of the father is conclusive. In this report, which focuses mostly on economic migrants, we use the terms 'migrant' and 'immigrant' interchangeably; to refer to persons not born in the country they currently permanently live in. This is a very simplistic definition, employed as a starting point for the discussion. Clarifications are made throughout where appropriate.

1.3. Types of migration

In this paper we define international migration as the movement of people from one country to another to take up employment, to establish residence or to seek refuge from persecution, either temporarily or permanently.

The following typology of international migration is widely accepted:

Students: a large group which includes people of any age moving to another country for the purpose of full time study.

Economic migrants: people leaving their usual place of residence to improve their quality of life. This may include long-term migrants or short-term seasonal workers. Frontier worker are migrants who retain their usual country of residence but work in a neighbouring state returning daily or weekly.

Displaced persons: people fleeing an armed conflict or escaping natural or man-made disasters or their effects. This term primarily covers persons displaced within the borders of their country of origin (i.e. internally displaced persons) who would not come under the 1951 Geneva Convention.

Permanent settlers are legally admitted immigrants who are expected to settle in the country, including persons admitted to reunite families.

Documented labour migrants include both temporary contract workers and temporary professional transients.

• Temporary migrant workers are skilled, semiskilled or untrained workers who remain in the receiving country for finite periods as set out in an individual work contract or service contract made with an agency.

• Temporary professional transients are professional or skilled workers who move from one country to another, often with international firms.

Undocumented migrants are those who do not have a legal status in the receiving country because of illegal entry or overstay.

Asylum seekers: people with a fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, who enter a country and claim asylum under the 1951 Geneva Convention. Once the fear has been proven to be well founded, the claimant is granted refugee status. Asylum seekers are those who appeal for refugee status because they fear persecution in their country of origin.

Recognized refugees are those deemed at risk of persecution if they return to their own country. Decisions on asylum status and refugee status are based on the 1951 United Nations Convention Relating to the Status of Refugees.

Externally displaced persons are those not recognized as refugees but who have valid reasons for fleeing their country of origin (such as famine or war).

Most countries collect some data on migration in all these categories, although there is little consistency between countries on how these definitions are applied. But definitions are

important, as they are used as a rationale for international cooperation in the regulation and control of migratory flows by visas and work permits. The variation, across selected countries, of conditions for the recruitment and temporary residence of skilled foreign workers. Of particular note is the lack of consistency in the definition of "temporary" migration, which can be from 9 months up to 10 years, depending on the country conditions. Lack of consistency may present difficulties in data comparisons and in building a comprehensive picture of the flows of migrants, given the challenges of following the itineraries of individual migrants. Regulation of cross-border movement of people is closely controlled by individual countries by conditions governing entry and length of stay. In recent years many countries have been changing their immigration legislation to make it easier to attract highly skilled labour, to compensate for skills shortages in domestic labour markets.

1.4. Trends in migration

It is estimated that in 2000 almost 175 million people, or 2.9% of the world's population, were living outside their country of birth, compared to 100 million, or 1.8% of the total population, in 1995. Increasingly it is highly skilled professionals who are migrating, as new technologies promote a global labour market. Stalker estimated that there were 1.5 million professionals from developing countries working in industrialized countries, and Mahroum comments that certain sets of skills and competencies are so specialized or in such short supply that they are being sourced on a global basis. At the moment, this global market includes nursing.

During the 1980s and 1990s the inflow of migrants increased in the majority of OECD countries, peaking between the late '80s and early '90s. There are now three major groups of developed countries, based on their migration trends. In the first, inflows have held steady or else fallen slightly, such as in France; in the second group inflows have risen in the late '90s following a previous decline – for example, in the USA and Canada; and in the third group, including the UK, there has been a sustained and steep rise in migration.

The loss of highly skilled professionals is thought to be costly for developing countries, not only in terms of skill shortages but also in fiscal costs from educational subsidies, when these are

available. The movement of health professionals has closely followed the upswing in migration of all professionals.

1.5. Causes of migration

1.5.1. Causes of migration through push-pull theory

The idea was first put forward by Ravenstein (1889). He concluded that pull factors were more important than push factors i.e. few job opportunities, political fear or oppressive laws, heavy taxation, unattractive climate or desertification, uncongenial social surrounding/poor medical care/poor housing, even compulsion (slave trade, poor transportation facilities, pollution) all have produced and still producing currents of migration. But none of these currents can compared in volume with that which arises from the desire inherent in most men to better themselves in material respects. The potential migrant weighs the push and pull factors and moves if the benefits of doing so exceeds the cause. Between the desire to move and the actual decision to do so there also may be intervening obstacles i.e. distance of the expected destinations, cost of getting there, poor health etc. Also migration is associated with career advancement which is one of the major 'pull ' factors of migration. Individuals spend much of their lifetimes pursuing various goals whereby a goal such as more education, a better job, a nicer house, a more pleasant environment people want to attain. Demographers have shown that migrants who respond mainly to pull factors at a place of destination tend to be 'positively' selected. They generally have more education then those have remained behind. On the other hand, migrants responding mainly to push factors in the area of origin tend to be negatively selected. They are the people who cannot seem to be succeeded either because of the poor education or lack of needed talents. Everett S. Lee (1966) noted that there is more to migration than a person calculating the advantages and disadvantages, the positives and negatives, at both the areas of origin and destination. He has observed that two of the more enduring generalizations that can be made about migration are:

1) Migration is selective (that is, not everyone migrates, only a selected portion of the population).
2) The heightened propensity to migrate at certain stages of the life cycle is in the selection of migrants.

Migration push factors are:

- Loss of a Job
- Discrimination
- Low Availability of Social and Life Partners
- Community Catastrophes such as a flood, epidemic or hurricane

Migration pull factors are:

- Better chances of employment
- Education
- Income
- Gentle environment in terms of climate and living conditions
- Race and Sexual orientation

1.5.2. Migration Selectivity by Age

According to Everett S. Lee between every two possible areas of origin and destination are various obstacles that may or may not intervening and have an impact on whether the migration will occur. According to the findings of IOM, young adults were much more mobile than people of other ages. This essentially refers to the fact that migrants are not all alike.

- Young adults between the age of 20-29 as well as slightly older adults between the ages of 30-39 are more likely to move than anyone else.
- Those between 20-29 leave their family home to seek employment or to attend college.
- This is also a time when couples get married which generally involved at least one residential movement, if not two.
- Beginning at around age of 40, levels of residential mobility and migration drop considerably.
- The older people are less likely to move. There is sometimes a slight surge at around the retirement age of 65.

- After the age of 65, when people retire (in case of Bangladesh, the age is 60) an increase in residential mobility is tend to be found, in part to the fact that more and more people these days continue working beyond the age of 65. So the residential mobility is found to be decreasing.

1.5.3. Selectivity of Migration by Sex

An important step in the derivation and formulation of generalizations concerning migration in different kinds of societies is found on the basis of differential of sex effecting the pattern of migration. According to Lee, because the costs involved in migration are substantial and are closely related to distance. According to the distance model of migration, males generally migrate in long distances where women migrate in shorter distances. The income model of migration argues that, income and job opportunities provide a better explanation that where job opportunities are unknown and scarce, females tend to avoid those places. They always try to migrate into a known place where job opportunities are higher and less laborious. According to Poston, Luo & Zhang (2006), migration by sex differs between the following aspects:

a) The effects of distance
b) Income
c) The physical cost of migration
d) Having the proper information about the destination of migration
e) Personal characteristics
f) Individual expectations
g) Community and kinship ties

According to the physical cost model of migration suggest that the physical cost influence resource allocation and migration by influencing the private cost of migration. According to this model, women want to engage themselves in white collar jobs while males tend to do more laborious job i.e. blue collar jobs .The information model emphasizes that, "the availability of information concerning alternative localities plays a prominent role in the potential migrants'

decision regarding a destination". Comparing between males and females, males tend to migrate to those places which are unknown, more difficult to go and adventurous where females intend to migrate known and safer places. Based on the personal characteristics model, personal demographic characteristics i.e. age, sex, education, number of dependents, net works, race etc exert important on the individual's decision or propensity to migrate. Based on this model, studies have shown that women migrate to those places which seem to be comfortable for them. The individual expectation model assumes that the dynamics of migration decision making are based on individual expectations about the advantages and disadvantages of the home community Versace possible alternative destination communities. According to the studies, males migrate to those places where chances of their economic development increasing their standard of living are higher and females tend to follow them. The community and kinship ties model points out that the presence of relatives and friends is a valued aspect of life which encourages migration by increasing individual's potential for adjustment through the availability of aid in location at an alternative area of residence". Based on this we can see that both males and females tend to migrate to place where their relatives or known one lives. No matter the place of destination is far or near. This eventually creates a migration stream from the place of origin to that specific area of destination.

1.5.4. Migration Selectivity by Marital Status

Migration differential by marriage helps to illustrate the relationship of migration to life cycle stages since there is a societal expectation that people will set up a new household on getting marriage. Once married, the incidence of migration also varies according to the number and ages of children. From the perspective of human ecology, migration is the major mechanism of social change and adaptability for human population. Knowledge of migration pattern tells us about "Populations maintain themselves in particular areas". The inter relationships among and between these dimensions inform our understanding of migration patterns. The technology at the population's disposal set the boundaries for the form and type of environmental adaptation that the population assumes. According to E.G. Ravenstein, there exists some laws of migration on the basis of which migration pattern regulates. And one of the major determinants is marriage. In USA 35% of the young women moved at least as far as between countries higher than the earlier two decades. This was much higher than the mobility of all women of that same age between 25-

34 years. Among young couples, the smaller the family and the younger the children, the greater the probability of migration. For example, among couples with husbands, aged 25-34, 42% of those had migrated to another country, dropping to 33% for couples with one child and down to 26% for those with 4 per more children.

So the larger the family, the greater the barrier to migration. Furthermore the likelihood of migration was greater if the oldest child was under 6 years old; once a child is old enough, the temptation to move seems to go down. But after passing 20 years, the probability of migration tends to rise up.

1.5.5. Migration selectivity by Educational Attainment

Since the differences between migration rate for males and females are not very great, Ravenstein tend to look at the reasons why there lies a gap between the migration pattern of male and female. The answer seems to be "may be".

Studies by Da Vanzo (1976) and Duncan and Perrucci (1976) indicate that, among wives who are literate and work neither their occupational prestige nor their relative contribution to total family income effects the probability that a family will move. But when a male specially husband is educated, gets promoted to a work and his promotion tends to shift him from the area of origin then the whole family including his educated wife migrates which does not happen for a female. Nonetheless Duncan and Perucci found that, when a woman is matured, literate, works outside, she has a higher probability in participating of the decision making of migration while it does not happen for an illiterate woman. Furthermore Lichter (1982), having analyzed the data from the national longitudinal survey of matured women conclude that a wife's job outside the home may indeed lower the chance of a family moving.

1.6. Migrant health

One difficulty in studying migrant health is defining the subject. At least five sub-categories of 'migrants' have been be identified: students; economic migrants; asylum seekers; irregular migrants (or undocumented or clandestine); and displaced persons. However, it is still unclear how long before a group of people thought of as 'migrants' begin to simply constitute a socially

or culturally distinct or ethnic group of residents. Also, different understandings of what it means to be a 'migrant' exist across Bangladesh. Another difficulty is lack of data. The data that is available gives rise to a complex and dynamic picture. Many studies indicate that infectious diseases, including STIs, accidents, injuries, musculoskeletal disorders, violence and drug abuse all appear to disproportionately affect certain migrants groups compared to autochthonous European populations. These patterns are likely to be linked to increased exposure to risk factors, either in the country of origin and/or in some countries where migrants are forced to live and work in poor conditions. Migrants are not necessarily disadvantaged in all areas of health though. Relatively low rates of low birth-weight have long been observed in migrant groups in the US and Europe. Many studies have shown that chronic diseases are less prevalent in some, though by no means all, migrant groups compared to autochthonous European (and North American) populations. It has been suggested that (self-) selective migration may play a role. This is known as the 'healthy migrant effect'. Such findings may be explained by a difference in timing between the health benefits and the health risks of migration. Findings that immigrants are comparatively healthy and underutilize health services refute the simplistic assumption that immigrants represent a disproportionate burden on health care systems. To be sure, the relative advantage does not translate across all countries and across all migrant groups. Also, the advantage may diminish over time (length of stay) or in subsequent generations. In short, a review of the literature suggests that it is not useful to make generalizations about the health of migrants, since mortality and morbidity patterns vary across space, time, age, gender, disease, across different countries of origin and type of migration. Disaggregating mortality and morbidity data by cause, and by country of origin, is crucial.

Five explanations for the differences in health between ethnic groups have been identified: genetic differences; cultural differences; socio-economic position; short-term migration history; and ethnic identity. In terms of more proximal determinants, varying patterns in risk factor prevalence (smoking, inactivity, alcohol consumption and so on) account in part for the differences in health between migrants and autochthonous populations. It seems that access and utilization of health services also plays a role.

1.7. Experiences of health care personnel

According to Goth et al. (2010), general practitioners experience that migrants often seem helpless in dealing with the public health services due to having language difficulties and differences in expectations, as well as systematic failures in the co-ordination of care services. A study conducted on doctors' experiences of their patients with a refugee background identify that both the doctors

and the patients were mainly occupied with a language barrier (Varvin & Aasland 2009). As a consequence, the doctors experienced that their patients intentionally withheld information about their pre-migration background even though such information could have been relevant for the identification of the cause of their illness. As a result, the doctors usually did not know whether they were dealing with patients with a traumatic background. Following an exploration of intensive care unit (ICU) nurses' perceptions of their encounters with family members of patients with a multicultural background, Høye & Severinsson (2008) found that

understanding the cultural diversity between and among immigrant groups is important for ICU nurses in order for them to work effectively in a very stressful environment. Johansen (2006) examined Norwegian health workers' care of infibulated Somali women during childbirth, and why the efforts of highly qualified Norwegian health workers did not always produce optimal results despite the fact that most of them were dedicated to their work and tried to be culturally sensitive towards the Somali women. Johansen concludes that health workers' emotional challenges in dealing with female genital cutting (FGC) tend to lead to silence and a misinterpretation of culture, which in turn has a negative effect on the care procedures. The language barrier between immigrant groups and health care personnel is an ongoing discussion with regard to addressing the health issues of immigrants. (Kale et al. 2010, Kale & Syed 2010, Kale et al. 2011, Kale et al. 2013). Further, in order to provide satisfactory health care for immigrants, researchers have urged for an increase cross-cultural understanding between immigrants and health care personnel, and the provision of information on immigrants' backgrounds, socio-economic status, and particularly their migration status to the health personnel (Goth et al. 2010, Høye & Severinsson 2010 & 2008).

1.8. Migrant health trends

Five main ways of explaining differences in health between ethnic groups have been identified. (Stronks *et al.*, 1999, Ingleby *et al.*, 2005)

1) Genetic differences
2) Cultural differences
3) Socio-economic position
4) Short-term migration history
5) Ethnic identity

However, it is not useful to try to make generalisations about the health care needs and utilization of migrants in general, since the health of migrants and access issues vary across space, time, age, gender, across different countries of origin and type of migration. For example, it is well known that African Americans have a lower life expectancy than Caucasians in North America (Sen, 1999). However, first generation immigrants do not experience health inequalities in the same way as minority groups residing in a country over several generations. For example, in the US, analysis of the 2000 and 2001 National Health Interview Surveys (NHIS) revealed that African-born blacks have better health as measured by self-rated health, activity limitation, and limitation due to hypertension compared to U.S.-born blacks and whites (Read *et al.*, 2005). Such findings illustrate that disaggregating health data on ethnic minorities is crucial. Echoing the American example, despite the fact that most migrants originate from countries with a substantially higher mortality rate than Europe, and once settled in Europe they tend to belong to the lowest socio-economic strata, many studies have found that immigrant groups in Europe have similar or more favourable total mortality rates than the native population. In the UK, compared to the national average, Caribbean-born people had significantly better all cause mortality and South Asian and East African-born were no different (Landman and Cruickshank, 2001). In France, migrants also experience lower mortality than the local-born population; health benefits are particularly noticeable in Mediterranean men, especially for affluence-related diseases such as cancer and cardiovascular diseases (Darmon and Khlat, 2001). It has been suggested that (self) selective migration may play a role (Mackenbach *et al.*, 2005). This is known as the 'healthy migrant effect'. Such findings may be explained by a difference in timing between the health benefits and the health risks of migration. Findings that immigrants are comparatively healthy and underutilize health services refute the simplistic assumption that immigrants represent a disproportionate burden on European health care systems. To be sure, the relative advantage does not translate across all countries and across all migrant groups. In a Dutch study, compared

with native Dutch men, overall mortality was higher among Turkish , Surinamese and Antillean/Aruban males, but lower among Moroccan males. Among females, inequalities in mortality were small. In general, mortality differences were influenced by socioeconomic and marital status. Also, most minority groups had a high mortality at young ages and low mortality at older ages, a high mortality from ill-defined conditions (which is related to mortality abroad), infectious diseases and external causes, and a low mortality from neoplasms. Cardiovascular disease mortality was low among Moroccan males and high among Surinamese males and females. Homicide mortality was elevated in all groups (Bos *et al.*, 2004). For total avoidable mortality4, there is also a slightly elevated risk for migrant populations in the Netherlands, suggesting that migrants underutilize services (Stirbu *et al.*, 2006a). In another Dutch study using a different indicator, the overall picture changes though; life expectancy in Amsterdam is lowest among residents of Dutch descent (73.3 yr for males and 79.1 yr for females) and highest among those of Mediterranean origin (Morocco, Turkey and Southern Europe) (77.6 yr for males and 86.1 yr for females) (Uitenbroek and Verhoeff, 2002).These findings suggest that disaggregating mortality and morbidity data by cause, and by country of origin, is crucial if policy makers are to gain a clearer picture of what areas of health care need to be developed in order to meet migrants' needs.

1.9. Health determinants in countries of origin and transit

Migrants moving to industrialised countries have been exposed to different morbidity and mortality patterns, characterised by higher mortality rates and a higher burden of communicable diseases and reproductive complications in women. The role of gender related contextual determinants is particularly relevant in developing countries, where women's social position places them at a far greater social disadvantage compared with men than their counterparts in industrialized countries. Women have less access to basic rights, lower rates of education and employment, lower salaries and less access to healthcare services. Childcare and domestic duties fall almost exclusively on women. These limitations, together with cultural norms involving taboos and strong social pressures, exert a great impact on women's personal autonomy. Their lack of financial autonomy has been identified as a factor fuelling the HIV epidemic in women in developing countries. Likewise, gender violence is more frequent and more brutal in countries where women are relegated to a lower social status (Landman and Cruickshank, 2001).

People who migrate are not always the poorest or the least educated, nor is their social status in their country of origin necessarily low. This applies to both men and women but may affect women differentially, since they are more prone to losing status, especially as observed in recent migrations to southern Europe, which have been characterised by high levels of irregular employment among women. Others gain status, particularly among women going from homemaking to the labour market. Distance between the respective social positions enjoyed in the countries of origin and destination has been described as a determinant of poor mental health.

Furthermore, the migration journey itself may involve dangers to physical and mental health, particularly in cases where migration is illegal. Women are more often victims of violence, abuse and rape. A particular phenomenon associated with immigration is the trafficking in women whose primary intention is economic immigration. This mostly affects young women and is associated with high levels of physical, psychological and sexual violence. An estimated two million individuals, mainly women and girls, are trafficked annually (approximately 2.3% of all female migrants) (Landman and Cruickshank, 2001).

1.10. Health determinants in countries of destination

On arriving in their country of destination, migrants are confronted by a new physical and socioeconomic environment, which involves a series of interrelated factors that affect their health. The absence of a comprehensive model that would integrate these has led us to present a descriptive overview, ranging from more structural factors, such as entry status or employment, to more individual ones, such as individual health behaviour or use of health services (Schenk L *et al*., 2006).

Upon arrival, entry status, characterised by whether the prospective immigrant is in a regular or irregular administrative situation, sets the stage for life in the host country. Entry status often determines access to the labour market, residency and employment rights, ability to acquire legal citizenship, access to social services such as health and education, and access to language

training and social security programmes. Women who enter as wives may need to have residence permits that depend on their husbands' consent, which makes them especially vulnerable to the latter's authority (Sen, 1999).

Ethnic density, the proportion of people of one's own ethnic background living in a particular area, could be a health risk or protective factor, and its role is the subject of debate. Studies showing a protective effect argue that this is mediated through enhanced social cohesion and support, and protection against racism. The detrimental effect on health has been attributed to poor economic and social investment in these areas. While a number of authors have studied the effect of ethnic density on both physical and mental health for various minority groups, no specific studies testing a differential effect on men and women have yet been published. High ethnic density could offer more protection to men, while women could be at risk of social isolation from the society at large and reinforcement of traditional gender roles, something that would, in turn, render any effort to adapt to the host culture even more stressful (Sen, 1999).

At a more proximal level, access to employment is the gateway to basic resources. Immigrants are segregated in the labour market and channeled towards jobs that are unskilled, poorly paid and demanding long hours; in short, generally precarious employment with little recognition of their rights. Immigrant women are more likely to be in the submerged economy or unemployed than are men. The types of jobs offered to men and women are different, as are the risks to health involved. Women are directed to domestic and caretaking services, while men obtain jobs in sectors such as mining, construction or agriculture. The precariousness of the labour market for female immigrants means they are more prone to suffer violence and sexual harassment, since they often depend on their employers to obtain or retain their work permits. However, some developed countries give higher preference to immigrants with professional and technical skills needed in the local labour markets and these immigrants are not channeled towards unskilled jobs (Schenk L *et al*., 2006).

Neighborhoods characterized by high unemployment may increase the risk of poor health among immigrants. Active work has been reported to be associated with better self rated health among immigrants and denial of work to be strongly associated with psychological distress, though unemployment seems to affect men's health more strongly than women's.

A consequence of precarious employment, particularly during the first years after arrival, is poverty, which is a major challenge to health, as has indeed been recognized in the special report on poverty in Europe, Canada and the United States.

The health benefits to be derived from social networks and social support are particularly salient for immigrant populations. Most immigrants risk social isolation: this is particularly true of housewives who have followed their husbands and have little opportunity to recreate a functional social network in their host country, and of immigrant women who work in domestic service, who are often invisible and have little chance of establishing social relationships. Men may have more chances of social interaction through the workplace. Social networks can be established within and outside their own ethnic groups, but their possible differential effects on mental and physical health are unclear (Schenk L *et al*., 2006).

As has been described for elderly populations in the United States and Europe, different kinds of social support may also have differential effects on the health of migrant women and men. It has been proposed that social networks, largely made up of family rather than friends or civic engagement, may actually prove harmful to migrant women's health, owing to social isolation and role engulfing. Although the importance of family networks is accepted, situations of negative influence can nevertheless occur.

Immigrants belonging to visible minorities—namely, people who can easily be ascribed to an ethnic origin other than that of the majority—are often the subject of discrimination and women may thus face triple discrimination as immigrants, minorities and women. Racial/ethnic discrimination and cultural distance display strong associations with mental disorders among immigrants. This effect can be modified by coping skills and resilience, which depend on age, gender and occupation. To our knowledge, however, no studies have been conducted on gender specific coping mechanisms for discrimination in immigrant populations.(Landman and Cruickshank, 2001).

Violence is a strong risk factor for physical and mental health, and immigrants are more likely to suffer from violence because of discrimination. Immigrant women are at high risk of victimisation at work, as they may be subjected to ongoing, repeated sexual abuse, especially if they are undocumented and work in the sex industry, though this can also happen to female

domestic workers, caregivers or attendants. Immigrant women are also likely to suffer domestic violence from abusive partners, particularly if they come from countries where male violence towards wives is tolerated. Furthermore, intimate partner violence may increase with time elapsed since immigration (Landman and Cruickshank, 2001)

Before immigration, health behaviors are shaped by the values and social norms of the country of origin, but upon arrival in the host country, these may change. Determinants of such behavioural changes include both individual factors, such as social class, gender, age, ethnicity, length of stay and country of birth, and societal features of the host country, such as the availability of health and social services and the existence of an established, like, ethnic community, which may avoid or delay a cultural break. Health behaviours of migrant populations also converge with those of destination countries but this process is quite complex, inasmuch as some of these behavioural changes are detrimental to health while others are protective. Among the women of some cultures, low alcohol and tobacco intake and certain reproductive patterns—earlier childbearing and longer breastfeeding—can protect them from certain cancers, but these behaviours are not sufficiently protective in the destination country to counterbalance newly adopted cardiovascular risk behaviours. It is difficult to generalize without considering the background risks in the origin and destination populations. For instance, the direction of change in cardiovascular risk may be very different depending upon whether the immigrant comes from and arrives in a country with high or low cardiovascular risk. Luo & Zhang (2006)

Comprehensive information on immigrants' health behaviors and how they maintain, adopt or change preventive behaviors is increasingly available. However, less information is available on gender differences in health behaviors and behavioral change in immigrant populations.

While many studies have examined the use of health services among immigrant populations, most of these lack a gender perspective. Findings are difficult to summarize, owing to heterogeneity across immigrant groups and health systems. Newcomers tend to be unfamiliar with the health system in the host country, and tend to overuse emergency room services. In general, immigrants tend to underuse mental health services, with fewer psychiatric hospitalisations and more emergency and compulsory psychiatric hospitalizations. According to one of the few studies with a gender perspective, while a very low prevalence of psychiatric

admissions was reported among female immigrants coming from countries that were geographically and culturally further away from Western societies, community prevalence of mental disease showed the prevalence of mental disorders in women to be double that of men, thus providing evidence of underutilization of in-hospital mental services by immigrant women. This underutilization could be because of a gender bias in diagnostic classification or lower likelihood of hospitalization once diagnosis is established, Luo & Zhang (2006).

Finally, since family health care revolves around the women in the immigrant family, the importance of eliminating barriers that impede women's access to social and health services, is particularly relevant. Many of the so called cultural barriers to health services are, in fact, the result of the rigidity of the health services.

1.11. Effects of migration

The migration of skilled health professionals directly affects the health system, and in consequence also affects population health outcomes and health workers remaining in the country (Landman and Cruickshank, 2001).

1.11.1. Effects on health workers

Those health workers who remain in public health systems with inadequate numbers of health workers experience added stress and greater workloads. Many of the remaining health workers are ill-motivated, not only because of their workload, but also because they are poorly paid, poorly equipped, inadequately supervised and informed and have limited career opportunities. Mutizwa-Mangiza reports that as a result of increased stress, staff were neglecting public sector responsibilities to work in the private sector, and there was a high turnover of staff (Landman and Cruickshank, 2001).

1.11.2. Effects on health systems

Migration threatens the functioning of the health system, if there is a net loss of human capital, and this has become a cause for concern in some developing countries, where emigration exceeds immigration. This may be a general loss if a large proportion of the workforce is leaving

the country, or area-specific, if there is migration from the rural to urban areas or from the public to private sector. The health system depends on a balanced mix of professional skills, appropriately deployed, for equitable coverage (Show et al. 2002).

Effective coverage is defined as the ratio of the realized health gain from a set of interventions (weighed by the health risk) over the total population health gain possible if providers performed at their optimal level for a health system. Losing part of the professional mix in the health workforce may result in either an absence of some services or in professionals' having to adapt their roles to deliver services commonly outside their scope of practice. The education cycle of preparation for health workers is long, and response to loss of human capital from the health workforce is not usually fast or flexible (Show et al. 2002).

Dovlo, in his 1998 survey of seven African countries, found vacancy levels in the public health sector to range between 7.6% (for doctors in Lesotho) and 72.9% (for specialists in Ghana). Malawi reported a 52.9% vacancy level for nurses. Such vacancy rates will inevitably lead to inadequate coverage, and some population health needs will remain unmet. For example, in some developing countries the shortage of nurses and physicians is thought to have resulted in rural clinics being staffed by aides who are trained to deal only with uncomplicated conditions. This not only affects coverage and access for communities, but also health outcomes, if conditions are present that are not adequately treated (Dovlo 1998).

However, vacancy rates are only one way of demonstrating shortages, and may not give a true reflection of the capacity of the health system to expand, nor of the requirements for health workers to be placed in unpopular areas. Even if all the migrant workers were to return to their home countries, the system may not be able to create jobs for all of them, nor keep them in the places where they are most needed (Dovlo 1998).

1.12. Migrants in Bangladesh

A Special Branch office said nearly 400,000 foreigners were now working in the country and more than 100,000 of them did not have any work permit. Most of the foreigners hail from India, according to sources familiar with the development. Citizens from Pakistan and Sri Lanka are also dominating different service sectors. They have been employed by local, joint-venture or

cent per cent foreign companies. A significant number of foreigners hailing from China, South Korea, Palestine and Taiwan are also residing here, the sources have hinted. Citizens from Ghana and Nigeria are also reportedly living both legally and illegally in the country. They have also said citizens from European countries are, however, residing here legally. A source said most of the foreigners entered Bangladesh on tourist visas and overstayed here taking jobs in violation of the related laws and without any work permit. In many cases they marry local women to get the legal status for staying in the country. A large number of foreigners had been residing in the country as the student of universities, colleges and schools. (Show et al. 2002)

Again International tourism; number of arrivals in Bangladesh was last measured at 267000 in 2009, according to the World Bank. Tourism is a promising sector in Bangladesh having a steady growth rate of around 13% except in 2008-09 which has a growth rate of only 10.38%.Earning from tourism has a slow rising growth trend till 2007-08. Though there is sudden fall in tourism growth in 2008-09, total GDP growth is almost unaffected. It implies that GDP is not very much depending on tourism apparently. On an average, around BDT4598.32 million is earned from tourism which has been experienced an average growth rate of 8.41%, (Zakiul 2013).

1.13. Measurement and indicators

Measurement of migrant health and health care utilization is challenging for a variety of technical and political reasons: medical research favors homogenous samples, resulting in ignorance about the effectiveness of treatments on ethnic minorities; recording ethnicity in clinical records can be perceived as discriminatory; ethnic minorities often have low response rates in epidemiological surveys; monitoring undocumented immigrants is difficult; information is not validated, and thus its accuracy is unknown; and immigrant mortality in the population may be underestimated in register based studies because sizeable numbers of immigrants who subsequently leave their new homeland (the host country) fail to register this fact with the national registration authorities. Several techniques have been developed to counter a lack of data on migrant health, for example linking datasets and developing algorithms to identify persons of ethnic origin by surname in registries. If surveys do include migration variables, they mostly depend on a broad 'social science' definition of immigrant status, employing country of birth, parental country of birth and length of stay in the host country as indicators to identify this

population. Conceptually, there are two main problems with this. Firstly, the paradigm incorporates important sub-categories of persons, such as refugees, who may experience specific non-random patterns of health and health care that differ to those of non-refugee immigrants. Secondly, the paradigm does not capture legal status which may affect access and utilization of health services, which in turn may also affect patterns of disease in a non-random manner. To make these indicators relevant to health research, an understanding of the way immigration law relates to eligibility in accessing public services is important. This may become complex when legal criteria for the eligibility of immigration subcategories change over time. Reflecting these technical difficulties, but also due to political concerns, in most Asian countries there are very few, if any, national or Asian surveys currently available to measure the health of first and second generation migrants relative to the health of the native population. There are also generally low levels of reporting on migrant health. Exceptions include the Netherlands and to some extent Sweden and the UK. Countries such as Belgium, Spain and Germany have only very recently started to introduce questions on migration in health surveys. New Member States, reflecting their relatively low levels of immigration, hardly include indicators of immigration in health surveys, but this may change in the future as numbers of immigrants are now increasing. (Zakiul 2013).

1.14. Health care access and utilization

Several studies suggest migrants do experience unequal access to health care. One issue is that requirements for permanent status vary across Bangladesh. Secondly, undocumented migrants in many countries are not granted equality of treatment. Besides the legal barriers, migrants also face other specific difficulties in accessing health care. In clinical encounters, language and literacy are by far the most obvious cultural obstacles to providing good quality care. In addition to language, miscommunication and dissatisfaction stemming from cultural differences and expectations can also contribute to suboptimal care. Categories and concepts used by migrants to explain health problems may differ significantly from Western understandings, as the field of medical anthropology has long demonstrated. This suggests there is a major role for user involvement in the design of effective services for migrants. A lack of knowledge about the health care system may be a serious obstacle to access, sometimes even despite tailored publications and orientation services. Mistrust of service providers may be an important issue for

some, particularly undocumented migrants fearing detection. In countries with complex registration systems for social health insurance, administration and bureaucracy is a major barrier. Barriers to health care may result in worse health outcomes, as is suggested by the relatively higher rate of avoidable mortality found among migrants in some studies, resulting in health inequalities. They also may result in increased consumption of more expensive emergency treatments. Migrant health issues are not confined to the treatment and prevention of diseases. The needs of migrants in all aspects of health care may need to be considered by policy makers, including social work, long term care for older people, home care services, and youth services. Certainly, migrants are likely to face different barriers/inequalities in our countries. There are also difficulties with measuring utilization. Also, immigration may not always be the primary explanatory factor for differences in health care utilization, with income being an important confounding variable. Nevertheless, in countries with immigrant populations, it does seem that language-adapted and culture-sensitive programs are needed to decrease inequality in access for ethnic minority groups. Comparison of migrant health with minority ethnic health is linked with evidence that the health status of some migrants deteriorates over time in receiving societies. The concept of 'acculturation' – the adoption of norms, values and behaviours that prevail in the receiving society – has been used to explain changes in the health behaviour of migrants that have negative consequences on health outcomes in the longer term. Examples are higher levels of smoking, including in pregnancy; lower levels of breast feeding; and diets with a higher fat content. Other accounts avoid the limitations of using models of acculturation to explain migrants' health, particularly the unidimensional emphasis on changes in values, norms and beliefs and focus more on structural barriers to good health and to access to and uptake of health care in the receiving country, largely using local evidence (Zakiul 2013). These barriers include:

- Low income and poverty leading to a lack of a decent standard of life (such as poor nutrition)
- Sub-standard and overcrowded housing in local areas of deprivation where many recent migrants live
- Poor health and safety practices in some industries employing migrants
- Lack of access to reliable transport for accessing services

- Inadequate information on how to access health services, such as immunizations and screening, and lower uptake of these compared to UK-born groups
- Lack of knowledge about or denial of entitlement to primary health care, particularly for failed asylum seekers and undocumented migrants
- Inadequate language and other support
- Cultural insensitivity on the part of some health care providers

1.15. Points for improving policy and practice

Policy makers and service commissioners and providers at a local level should make concerted efforts to:

- Establish centralised systems of data collection on the health outcomes and service use of people in local areas – for instance, through Primary Care Trust information systems – that wherever possible include 'migration variables' (e.g. country of birth, length of residence in the Bangladesh, language use, nationality and immigration status) as well as ethnicity and socio-demographic information (recognising that migration data collection can be sensitive) (Zakiul 2013).
- Gain information about the health needs of and barriers to health care access and uptake among diverse groups of migrants. This could be done in part through the experiences of statutory and voluntary organisations, those representing different migrant groups in local areas and migrants' own welfare networks. Primary research that provides evidence on age, gender, socio-economic status, ethnicity, religion, language and country of birth is also important. The establishment of Regional Strategic Migration Partnerships (RSMPs) is potentially a means towards that end, but evaluation of outcomes is needed. A particular effort should be made, in research and in service provision, to reach those more vulnerable groups who are less likely to register for primary care because of inadequate information or insecure legal status. Places of religious worship, such as churches, mosques and temples, may contribute to effective mapping, particularly of those who do not have a legal immigration status and are helped to access services by religious institutions.

- Adopt a community development-based approach incorporating the following key elements: a focus on improving access as an outcome in itself; a focus on user and community empowerment as outcomes; a focus on partnership working across disciplinary and departmental boundaries; a recognition of timescales involved in addressing barriers to effective access to health care; and a move away from an emphasis on measurable health outcomes as a short-term objective and success indicator. (Zakiul 2013).

We have aimed to strengthen the evidence base on documented and undocumented migrants' health problems by describing characteristics of the migrant patients in different places of Bangladesh. The migrants faces different health problem due to environmental changes, difference in food habit, changes in source and place of drinking water etc.

These changes cause diverse health problems. Some patients present with critical disease, and an alarming number of pregnant women do not seek medical care until a late stage, and they did not return for infant care after giving birth. Another problem is for some tourist with Child who is under vaccination, often feel difficulties and confusion about taking vaccine and their source (Zakiul 2013).

2. LITERATURE REVIEW

In 2011 Dan Biswas and his co-worker studied on the " Access to healthcare and alternative health-seeking strategies among undocumented migrants in Denmark" and showed that undocumented migrants in Denmark have restricted access to healthcare. The aim of this study is to describe and analyse undocumented migrants' experiences of access to healthcare, use of alternative health-seeking strategies; and ER (emergency room) nurses' experiences in encounters with undocumented migrants. The barriers to healthcare were: limited medical rights, arbitrariness in healthcare professionals' attitudes, fear of being reported to the police, poor language skills, lack of network with Danish citizens, lack of knowledge about the healthcare system and lack of knowledge about informal networks of healthcare professionals. ER nurses expressed willingness to treat all patients regardless of their migratory status, but the challenges for ER nurses were: language barriers, issues of false identification, insecurities about the correct standard procedures and not always being able to provide appropriate care. This study shows the need for policies and guidelines, which in accordance with international human rights law, ensure access to healthcare for undocumented migrants and give clarity to healthcare professionals, Dan Biswas *et al* (2011).

In 2010 Marc B and his co-workers studied on "A global perspective of migration and occupational health" and showed that global migration has dramatically increased over the past decade and is at an all-time high, approaching 200 million persons per year. Demographics and economic interdependence suggest that immigration will continue for the near future at record high levels. A review of the few studies that have investigated occupational injury and illness rates among immigrant populations. Existing data indicate that higher rates of fatal and non-fatal injuries are common compared to native populations. This increase is in part due to immigrants working in higher risk occupations (e.g., agriculture, construction), but occupational morbidity and mortality is higher among immigrants than native-born workers within occupational categories. Research is needed to identify the causes of increased risk among immigrants and to provide direction to effective public health interventions. Research methods must be adapted to different epidemiologic characteristics of immigrant populations, including lack of standard sampling frames, different language and culture from the dominant culture, and precarious work status, Marc B *et al* (2010).

In 2014 Boje Kvorning Ehmsenand his co-workers studied on the "Undocumented migrants have diverse health problems" and showed that in 2008, 1.9-3.8 million undocumented migrants lived in Europe. They aimed to strengthen the evidence base on undocumented migrants' health problems by describing characteristics of undocumented migrant patients in a Danish non-governmental organization (NGO) health clinic. Total of 830 patients (39.75% women and 60.25% men) visited the clinic, which led to a total of 2,088 visits and 1,384 ICPC-2 classifications. The patients seen had 94 different nationalities. The most common reasons for medical contact correspond well with the pattern seen in general practice and several chronic and severe cases were observed in the NGO clinic. Furthermore, a larger share of pregnant women presented (11.6%) compared with a Danish general practice (5.1%), and these were seen first in a late gestational age on average (16+ weeks). Undocumented migrants presented with diverse health problems. Some patients presented with critical disease, and an alarming number of pregnant women did not seek medical care until a late stage, and they did not return for infant care after giving birth Boje Kvorning Ehmsenand *et al* (2014).

In 2014 Anna Wahlberg anr and her co-worker studied on the **"**Causes of death among undocumented migrants in Sweden, 1997–2010" and showed that undocumented migrants are one of the most vulnerable groups in Swedish society, where they generally suffer from poor health and limited health care access. Due to their irregular status, such migrants are an under-researched group and are not included in the country's Cause of Death Register (CDR). Out of 7,925 individuals surveyed, 860 were classified as likely to have been undocumented migrants. External causes (49.8%) were the most frequent cause of death, followed by circulatory system diseases, and then neoplasms. Undocumented migrants had a statistically significant increased risk of dying from external causes (odds ratio [OR] 3.57, 95% confidence interval [CI]: 2.83–4.52) and circulatory system diseases (OR 2.20, 95% CI: 1.73–2.82) compared to residents, and a lower risk of dying from neoplasms (OR 0.07, 95% CI: 0.04–0.14).They believe our study is the first to determine national figures on causes of death of undocumented migrants. They found inequity in health as substantial differences in causes of death between undocumented migrants and residents were seen. Legal ambiguities regarding health care provision must be addressed if equity in health is to be achieved in a country otherwise known for its universal health coverage Anna Wahlberg anr *et al* (2014).

In 2014 Valeska Padovese and his co worker studied on the **"**Migration and determinants of health: clinical epidemiological characteristics of migrants in Malta (2010–11)" and showed that over recent years Malta has experienced a growing influx of migrants from Africa. With the aim of defining demographic characteristics and assessing the prevalence of conditions of public health significance among asylum seekers in Malta, a clinical research study was implemented in the framework of the European Union project 'Mare nostrum'. Migrants included in the study were 2216, 82.7% were males, their mean age was 25 years and 70.1% were from Somalia. Out of the total females, 42.5% had undergone some type of Female Genital Mutilation/Cutting. A total of 5077 diagnoses were set, most common were skin diseases (21.9%), respiratory diseases (19.8%) and gastroenteric diseases (14.2%), whereas 31% of migrants reported good health conditions. Conclusions Immigrants have a lower morbidity burden compared with their fellow countrymen living in the origin country. However, living conditions during the journey, in transit countries and after arrival can influence their health status. The present study provides a comprehensive picture of this growing population that is in need for health promotion, mental health services and fair policy planning, Valeska Padovese *et al* (2014).

In 2015 Erik Teunissen and his co-worker studied on "Mental health problems of undocumented migrants in the Netherlands: A qualitative exploration of recognition, recording, and treatment by general practitioners."and showed that to explore the views and experiences of general practitioners (GPs) in relation to recognition, recording, and treatment of mental health problems of undocumented migrants (UMs), and to gain insight in the reasons for under registration of mental health problems in the electronic medical records. GPs recognized many mental health problems in UMs. Barriers that prevented them from recording these problems and from delivering appropriate care were their low consultation rates, physical presentation of mental health problems, high number of other problems, the UM's lack of trust towards health care professionals, and cultural differences in health beliefs and language barriers. Referrals to mental health care organizations were often seen as problematic by GPs. To overcome these barriers, GPs provided personalized care as far as possible, referred to other primary care professionals such as social workers or mental health care nurses in their practice, and were a little less restrictive in prescribing psychotropics than guidelines recommended. It is recommended that GPs address mental health problems more actively, strive for continuity of care in order to gain

trust of the UMs, and look for opportunities to provide mental care that is accessible and acceptable for Ums, Erik Teunissen *et al* (2015).

In 2011 Tina Dorn and her co-worker studied on the "Health care seeking among detained undocumented migrants: a cross-sectional study" and showed that as in many European countries, access to care is decreased for undocumented migrants in the Netherlands due to legislation. Studies on the health of undocumented migrants in Europe are scarce and focus on care-seeking migrants. Among the 224 male migrants who arrived at the detention centre between May and July 2008, 173 persons were interviewed. 122 respondents met inclusion criteria. Only half of the undocumented migrants in this study knew how to get access to medical care in the Netherlands if in need. Forty-six percent of respondents reported to have sought medical help during their stay in the Netherlands while having no health insurance (n =57). Care was sought most frequently for injuries and dental problems. About 25% of these care seekers reported to have been denied care by a health care provider. Asian migrants were significantly less likely to seek care when compared to other ethnic groups, independent from age, chronic health problems and length of stay in the Netherlands. The study underlines the need for a better education of undocumented patients and providers concerning the opportunities for health care in the Netherlands, Tina Dorn *et al* (2011).

In 2014 Erik Teunissena and his co worker studied on the " Mental health problems in undocumented and documented migrants: a survey study" and showed that undocumented migrants (UM) frequently report mental health problems. It is unknown to what extent these migrants seek help for these problems in general practice and how these issues are explored, discussed, registered and treated by GPs. A total of 541 migrants were included (325 UM and 216 DM).UM consulted a GP significantly less than DM (3.1 versus 4.9 times per year). Only 20.6% of the UM had at least one mental health problem diagnosis registered compared to 44.0% of the DM. In both groups, ~10% mentioned at least one main mental health complaint during the consultation that was not coded in the record. No significant differences were found in the prescription of psychotropic medication between the two groups. UM were referred less to mental health care institutions but more often to psychiatrists than to psychologists. UM had less consultations with their GP, and in these consultations, less mental health problems were registered. UM were referred less to psychologists but more often to psychiatrists. GPs are

advised to explore and register mental health problems more actively in UM Erik Teunissena *et al* (2014).

In 2013 Aniek Woodward and his co-worker studied on the "Health and access to care for undocumented migrants living in the European Union: a scoping review" and showed that literature on health and access to care of undocumented migrants in the European Union (EU) is limited and heterogeneous in focus and quality. Authors conducted a scoping review to identify the extent, nature and distribution of existing primary research (1990–2012), thus clarifying what is known, key gaps, and potential next steps. Major access barriers included fear, lack of awareness of rights, socioeconomics. Mental disorders appeared widespread, while obstetric needs and injuries were key reasons for seeking care. Pregnant women, children and detainees appeared most vulnerable. While EU policy supports health-care access for undocumented migrants, practices remain haphazard, with studies reporting differing interpretation and implementation of rights at regional, institutional and individual levels. It underlines the need for more and better-quality research, increased co-operation between gatekeepers, providers, researchers and policy makers, and reduced ambiguities in health-care rights and obligations for undocumented migrants, Aniek Woodward *et al* (2013).

In 2014 Anna Wahlberg and her co-worker studied in the "Causes of death among undocumented migrants in Sweden, 1997–2010" and showed that undocumented migrants are one of the most vulnerable groups in Swedish society, where they generally suffer from poor health and limited health care access. Due to their irregular status, such migrants are an under-researched group and are not included in the country's Cause of Death Register (CDR). Out of 7,925 individuals surveyed, 860 were classified as likely to have been undocumented migrants. External causes (49.8%) were the most frequent cause of death, followed by circulatory system diseases, and then neoplasms. Undocumented migrants had a statistically significant increased risk of dying from external causes (odds ratio [OR] 3.57, 95% confidence interval [CI]: 2.83–4.52) and circulatory system diseases (OR 2.20, 95% CI: 1.73–2.82) compared to residents, and a lower risk of dying from neoplasms (OR 0.07, 95% CI: 0.04–0.14). We believe our study is the first to determine national figures on causes of death of undocumented migrants. They found inequity in health as substantial differences in causes of death between undocumented migrants and residents were seen. Legal ambiguities regarding health care provision must be addressed if

equity in health is to be achieved in a country otherwise known for its universal health coverage Anna Wahlberg *et al* (2014).

In 2010 Dr. Brian D. Gushulak and his co-worker studied on the **"**Migration and health in Canada: health in the global village" and showed that immigration has been and remains an important force shaping Canadian demography and identity. Health characteristics associated with the movement of large numbers of people have current and future implications for migrants, health practitioners and health systems. They aimed to identify demographics and health status data for migrant populations in Canada. Currently, immigration represents two-thirds of Canada's population growth, and immigrants make up more than 20% of the nation's population. Both of these metrics are expected to increase. In general, newly arriving immigrants are healthier than the Canadian population, but over time there is a decline in this healthy immigrant effect. Immigrants and children born to new immigrants represent growing cohorts; in some metropolitan regions of Canada, they represent the majority of the patient population. Access to health services and health conditions of some migrant populations differ from patterns among Canadian-born patients, and these disparities have implications for preventive care and provision of health services. Because the health characteristics of some migrant populations vary according to their origin and experience, improved understanding of the scope and nature of the immigration process will help practitioners who will be increasingly involved in the care of immigrant populations, including prevention, early detection of disease and treatment Dr. Brian *et al* (2010).

In 2014 Suess A and his co-worker studied on " The right of access to health care for undocumented migrants: a revision of comparative analysis in the European context" and showed that the recent introduction of adjustment measures in the Spanish context by means of the Royal Decree-law 16/2012 (RDL 16/2012), which limits access to health care for undocumented migrants, raises the question about the state of the matter in different European Union member states. The review shows a high degree of variability regarding health care entitlements of undocumented migrants in different European countries, a frequent legal restriction of access to health care, as well as barriers in the effective access to health care. The studies coincide in recommending access at all health care levels, regardless of the administrative status of the person seeking treatment. The analysis of the impact of the current economic crisis

on access and quality of the health care directed to undocumented migrants, as well as the knowledge of the migrants' perspective are identified as future research areas. Compared with other European countries, the introduction of the measures established in the RDL 16/2012 modifies the place of the Spanish Public Health Care System from being situated in the group of countries that permit undocumented migrants access to all health care levels, towards the category of highest restriction Suess A *et al* (2014).

In 2012 Biswas D and his co-worker studied on the " Access to health care for undocumented migrants from a human rights perspective: a comparative study of Denmark, Sweden, and The Netherlands" and showed that undocumented migrants' access to health care varies across Europe, and entitlements on national levels are often at odds with the rights stated in international human rights law. The aim of this study is to address undocumented migrants' access to health care in Denmark, Sweden, and the Netherlands from a human rights perspective. Undocumented migrants in Denmark have the right to emergency care, while additional care is restricted and may be subject to payment. Undocumented migrants in Sweden have the right to emergency care only. There is an exception made for former asylum-seeking children, who have the same rights as Swedish citizens. In the Netherlands, undocumented migrants have greater entitlements and have access to primary, secondary and tertiary care, although shortcomings remain. All three countries have ratified international human rights treaties that include right of access to health care services. We identified international treaties from the United Nations and the Council of Europe that recognize a right to health for undocumented migrants and embrace governmental obligations to ensure the availability, accessibility, acceptability, and quality of health services, in particular for specific groups such as women and children Biswas D *et al* (2012).

In 2011 Jensen NK and his co-worker studied on the "Providing medical care for undocumented migrants in Denmark: what are the challenges for health professionals?" and showed the rights of undocumented migrants are frequently overlooked. Denmark has ratified several international conventions recognizing the right to health care for all human beings, but has very scanty legislation and no existing policies for providing health care to undocumented migrants. This study focuses on how health professionals navigate and how they experience providing treatment for undocumented migrants in the Danish health care system. The emergency room physicians

express that treatment of undocumented migrants is no different from the treatment of any other person. However, care may become more complicated due to lack of previous medical records and contact persons. Contrary to this, general practitioners explain that undocumented migrants will encounter formal barriers when trying to obtain treatment. Additional problems in the treatment of undocumented migrants include language issues, financial aspects for general practitioners, concerns about how to handle the situation including possibilities of further referrals, and an uncertainty as to whether to involve the police Jensen NK *et al* (2011).

In 2008 Therese Hesketh and his co-worker studied on the " Health Status and Access to Health Care of Migrant Workers in China" and showed that they explored living and working conditions, health status, and health-care access in Chinese rural-to-urban migrants and compared them with permanent rural and urban residents. Migrants were young, worked very long hours, and their living conditions were very basic. Nineteen percent had some form of health insurance and 26% were entitled to limited sick pay compared with 68% and 66%, respectively, for urban workers. Migrants had the best self-rated health and reported the least acute illness, chronic disease, and disability, after controlling for age and education. There were no HIV infections detected in either the migrant or urban workers. However, 15 urban workers (0.68%, 95% confidence interval [CI] 0.35, 1.02) and 20 migrants (0.48%, 95% CI 0.26, 0.66, p=0.06) tested positive for syphilis. The high cost of health care in the city was a barrier to health-care access in the last year for 15% of the migrants and 8% of the urban workers. Forty-seven percent of the migrants were unwilling to make contributions to health insurance. Poor living conditions and inattention to health may make migrants vulnerable to poor long-term health. Because health insurance schemes will remain limited for the for seeable future, attention should focus on providing affordable health care to both uninsured migrants and the urban poor Therese Hesketh *et al* (2008).

3. AIM OF THE STUDY

3.1 Aim and objective of the study

In Bangladesh, an understanding immigrants' health problems and their choices and actions related to health, which are based on their socio-economic, cultural, and gender backgrounds, is becoming of crucial interest to policy planners and to service providers in order to provide satisfactory health services for the country's migrant population. This is important because the well-being of the migrant population affects the living conditions of the nation as a whole

The specific objectives are as follow:

- To understanding migrants' health problems.
- To determine the major reason behind the migrants' health problems.
- To provide satisfactory health service to the migrants' population.

4. METHODOLOGY

4.1 Type of study

The study was a survey based study.

4.2 Study area

The study was done in the different area of Chittagong & Dhaka. In Chittagong various places are included specially the campus of USTC (University of Science and Technology) and in Dhaka specially IUT (Islamic University of Technology), Bashundhara residential area, Banasree area.

4.3 Study population

The survey was performed on 343 migrant all of them are adu**lt.**

4.4 Inclusion criteria

In this survey, only the migrant who are staying in this country more than 15 days are included.

4.5 Exclusion criteria

In this survey, the migrant who are staying in this country below 15 days are not included.

4.6 Study tools

Structured questionnaire.

4.7 Questionnaire development

The questionnaire was developed based on some common criteria which are related to usual life lead of migrants people in Bangladesh. The questionnaire was prepared based on some important factors such as age, sex, weight, height, location, education, profession, origin country weather, disease condition before coming to Bangladesh, disease condition after coming to Bangladesh ,list of drug they uses frequently, and some other relevant question also included.

We will identify the different zone or colony where the migrated people live in Bangladesh. Patient contacts will systematically analyze for age, sex, country of origin, medical referrals,

symptoms and diagnoses. Contacts will classify by patient complaints or symptoms based on the International Classification of Primary Care, 2nd Edition (ICPC-2).

For performing the study, we will try to make a direct contact with them by one or several visit. We will ask them about their place of birth, Nationality, Date of visit in Bangladesh, What types of health problem they have faced or suffering (both mental and Physiological), Whether they have taken health care from our health care professionals or not, What types of difficulties they have faced during the hospitality. All the point of study will be documented based on a written survey completed by them or by the direct help of us.

5. RESULTS

5.1. Percentage (%) of various migrants' residing in Bangladesh:

We find highest number of migrant residing in our country is people from Srilanka which are around 17.5%. Second highest migrant were found to be people from Somalia (10.2%).Thereafter, Nepal (9.0%), Maldives (7.3%), India (7.0%), Pakistan (6.4%) and so on.

Conversely, the lowest number of migrant residing here is people from Indonesia, Senegal and Ethiopia which were 0.3%. And other countries like Columbia and Oman (0.6%), South Africa and Cameron (0.9%) from where lowest people residing here and so on.

Table 1 – Percentage (%) of various migrants' residing in Bangladesh

Country of origin	Percentage (%)	Frequency
India	7.0	24
Srilanka	17.5	60
Nepal	9.0	31
Uganda	2.0	7
Yemen	6.1	21
Kabul	2.0	7
Somalia	10.2	35
Cameron	0.9	3
Djibouti	3.5	12
Nigeria	4.4	15
UAE	0.3	1
Afghanistan	2.6	9
Colombia	0.6	2

Sudan	2.0	7
Oman	0.6	2
Palestine	3.8	13
Jordan	0.6	2
Indonesia	0.3	1
Ethiopia	0.3	1
South Africa	0.9	3
Pakistan	6.4	22
Comoros	4.1	14
Gambia	0.6	2
Senegal	0.3	1
Arab	0.3	1
Maldives	7.3	25
Bhutan	6.4	22

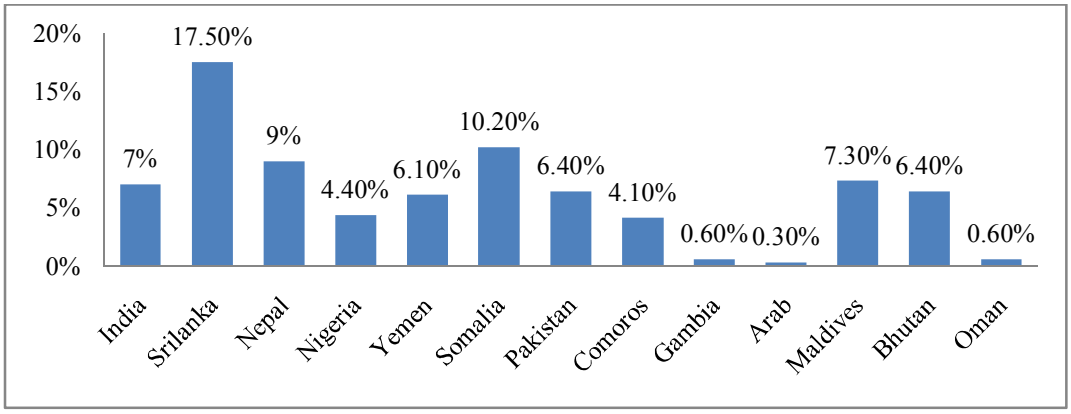

Figure-1: Percentage (%) of various migrants' residing in Bangladesh

5.2 Socio-demographic status of migrants':

We find that, maximum age of the migrants is 37 years whereas minimum and mean age is 18 years and 23.43(±2.68) respectively**.** Among 343 migrants, majority is male and hence rest is female. Maximum height of the migrants is 6.7 whereas minimum and mean height is 4.6 and 5.56(±0.31) respectively. Maximum weight of the migrants is 135 kg and minimum and mean weight is 42 kg and 65.40(±11.65) respectively.

We find that, numbers of male migrants are 67.6% and those of female are 32.4%. Among the migrants, most people are students (45.2%), and then service-holder (28.9%), Businessman (25.7%), housewife (0.3%). In terms of educational qualification, there is 95.3% graduate, 3.5% postgraduate, 1.2% HSC. Among them, there is 97.4% unmarried and married (2.6%). Only 0.6% had child but rest (99.4%) was childless.

Table-2: Socio-demographic status of migrant's (Part 1)

		Age	Sex	Height (feet-inches)	Weight (kg)
N	Valid	340	343	342	340
	Missing	3	0	1	3
Mean		23.43	1.32	5.560	65.407
Std. Deviation		2.681	0.469	0.3064	11.6541
Minimum		18	1	4.6	42.0
Maximum		37	2	6.7	135.0

Table 3 – Socio-demographic status of migrant's (Part 2)

	Percentage (%)	Frequency
Sex		
Male	67.6	232
Female	32.4	111
Profession		
Student	45.2	155
Housewife	0.3	1
Service	28.9	99
Business	25.7	88
Educational qualification		
Graduate	95.3	327
post-graduate	3.5	12

HSC	1.2	4
Marital status		
Married	2.6	9
Unmarried	97.4	334
Have any children		
Yes	0.6	2
No	99.4	341

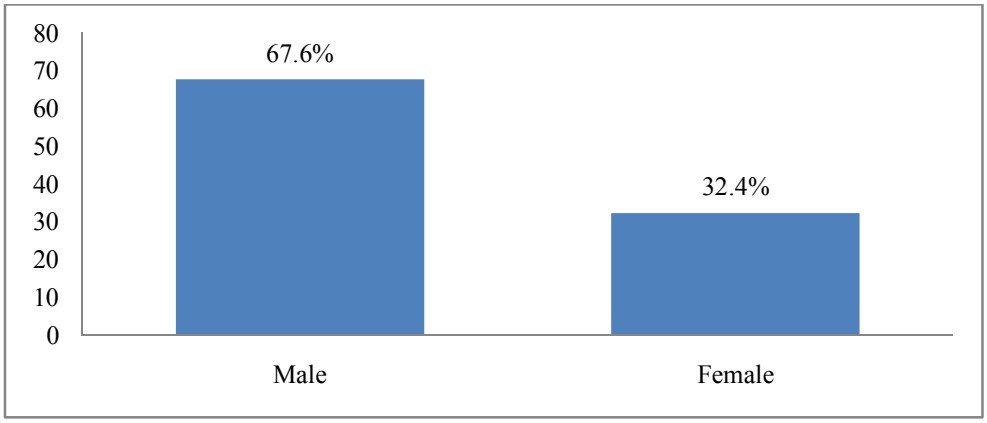

Figure-2: Percentage (%) of migrant's sex ratio

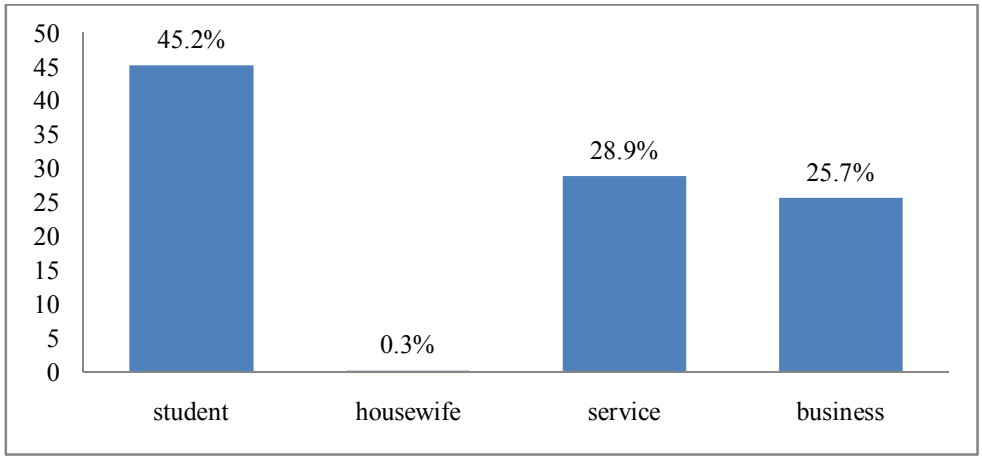

Figure-3: Percentage (%) of migrant's profession's ratio

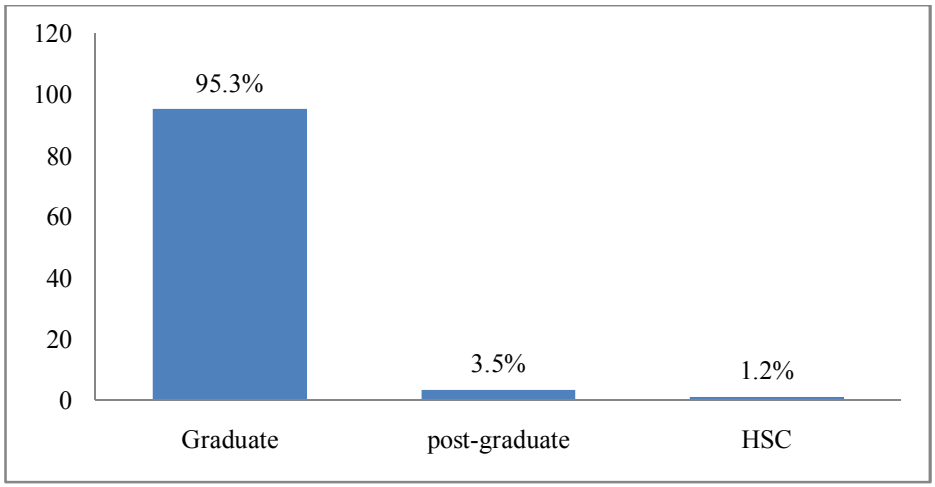

Figure-4: Percentage (%) of migrant's educational qualification's ratio

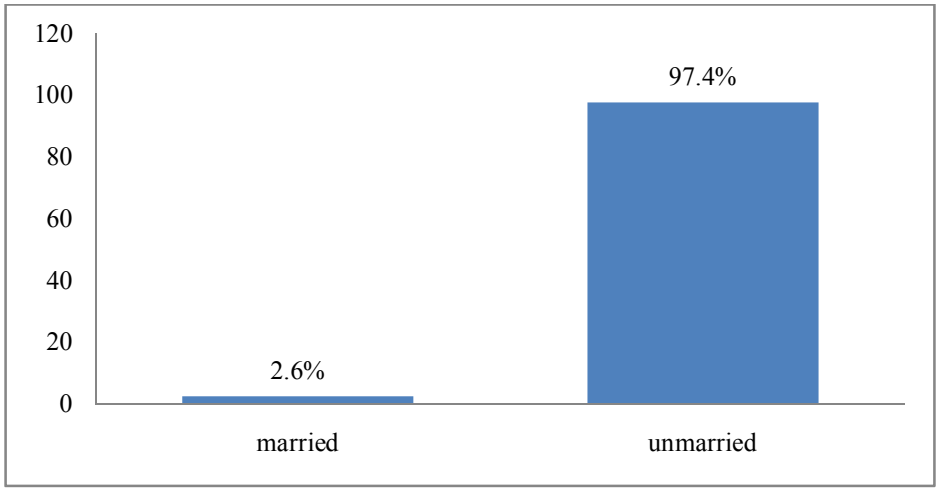

Figure-5: Percentage (%) of migrant's marital status ratio.

5.3. Migrants health status:

We find that, Number of migrants suffering from any disease at the time of arrival and after arrival in Bangladesh is 11.7% and 38.3% respectively. Among them, 33.5% feel weather is responsible for their health problem and whereas food and water, pollution, loneliness are causative factors for 38.8%, 28.0% and 15.2% respectively.

Among them 24.2% of migrants consult with doctor but 75.8% of migrants do not.

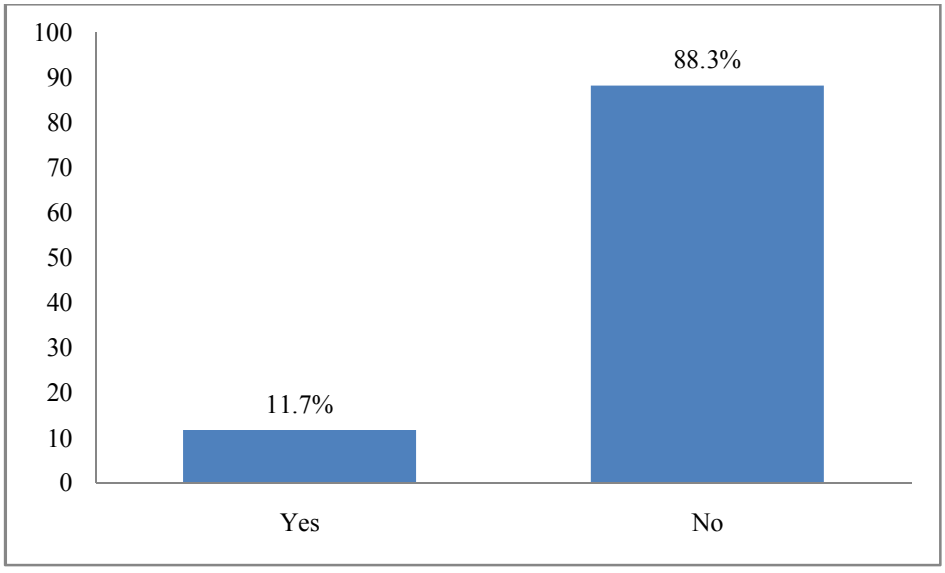

Figure-6: Percentage (%) of migrant's is suffering disease at the time of coming Bangladesh

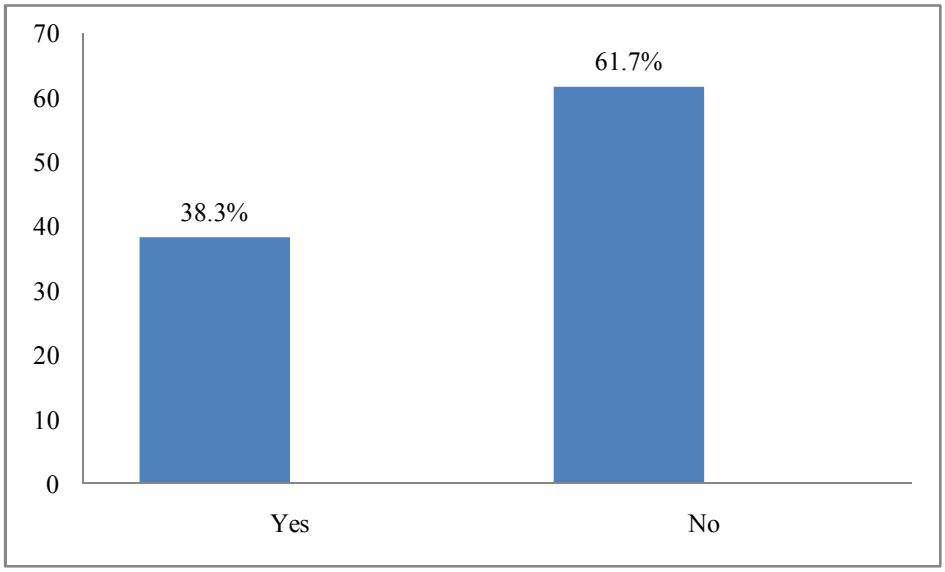

Figure-7: Percentage (%) of migrant's is suffering disease after coming to Bangladesh.

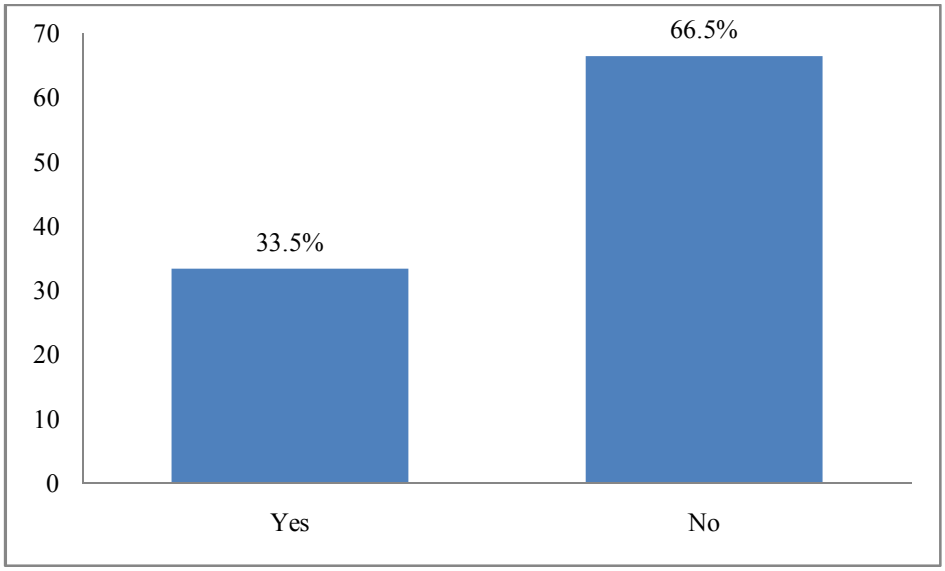

Figure-8: Percentage (%) of migrant's feels weather of Bangladesh is causing their health problem

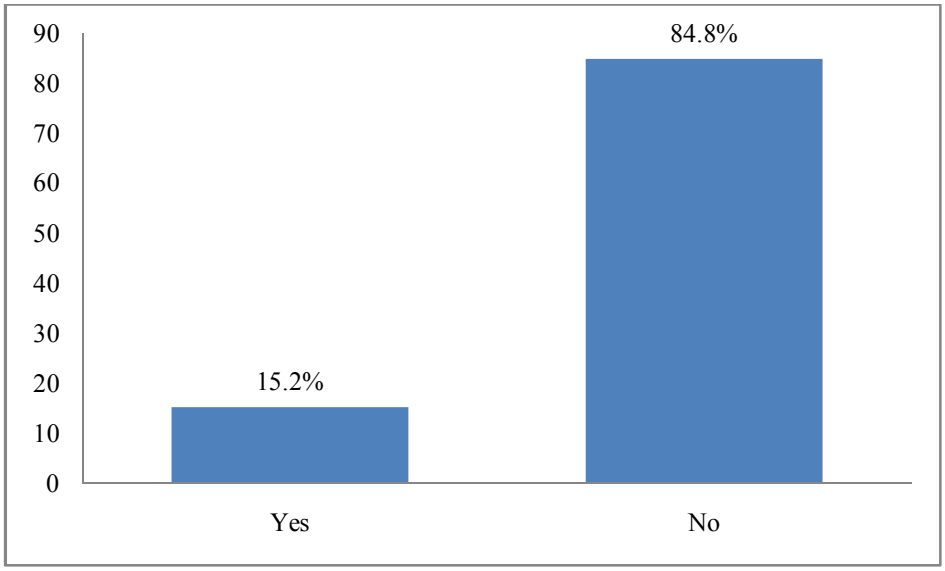

Figure-9: Percentage (%) of migrant's feel loneliness causing their health problem

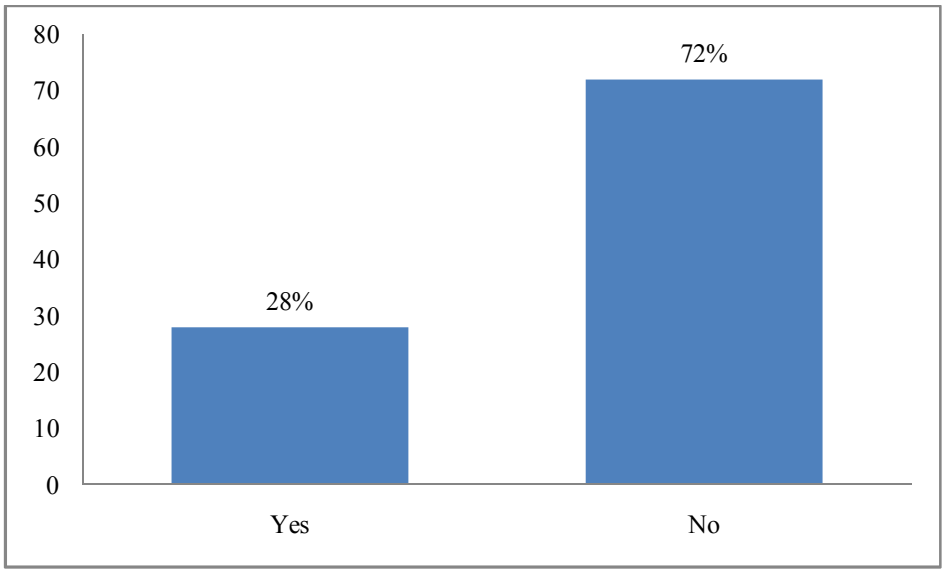

Figure-10: Percentage (%) of migrant's feel pollution of Bangladesh causing their health problem

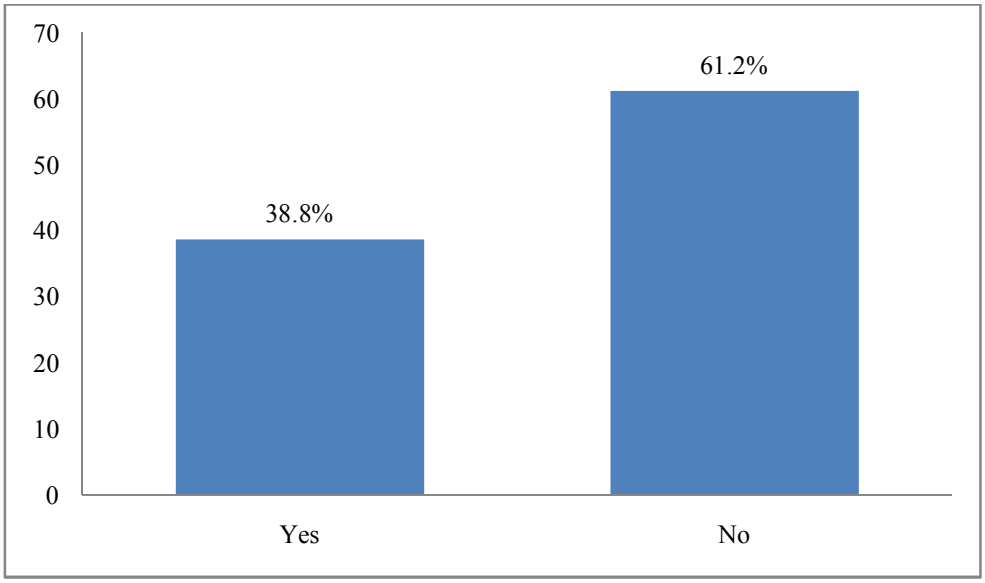

Figure-11: Percentage (%) of migrant's feel food and water of Bangladesh causing their health problem

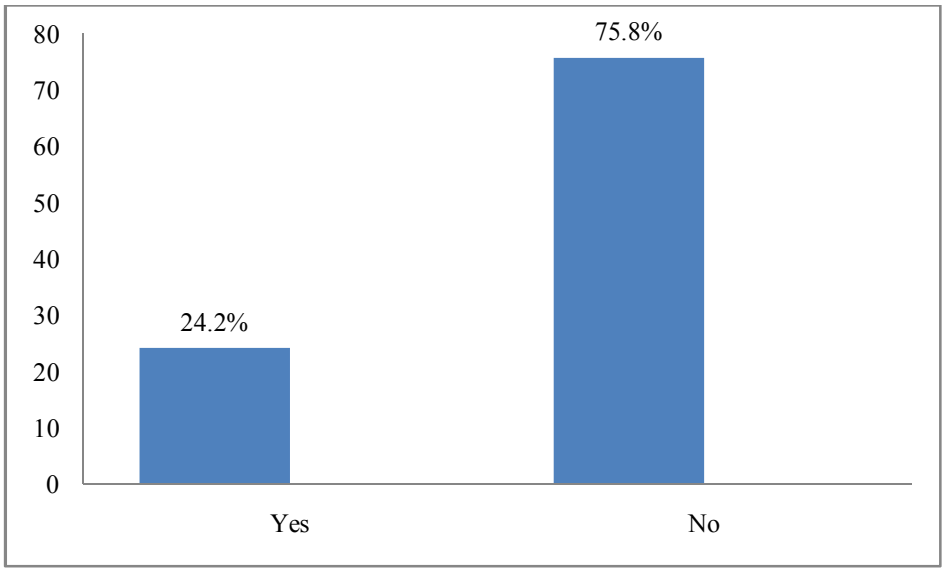

Figure-12: Percentage (%) of migrant's have consulted to any doctor

5.4 List of diseases affecting migrant's health

From table -4 we can conclude that, Migrant's health problems are skin disease (28.3%), intestinal disease (21.0%), psychological problem (15.7%) and headache (36.7%).

Table-4: List of Diseases affecting migrant's health

Disease	Yes	No
Skin disease	28.3%(97)	71.7%(246)
Intestinal disease	21.0%(72)	79.0%(271)
Psychological problem	15.7%(54)	84.3%(289)
Headache	36.7%(126)	63.3%(217)

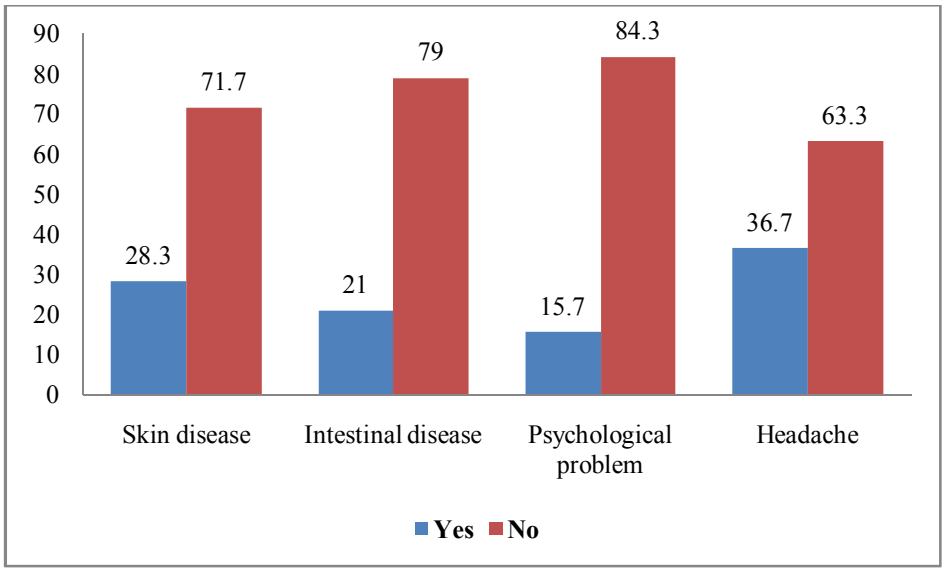

Figure-13: List of Diseases affecting migrant's health

From table 5, 35.1% of migrant's do not consult doctor because of disease is not so worth, 28% have financial problem and 36.9% think that doctors of Bangladesh is not reliable.

Table-5: Percentage (%) of reason for not consulting doctor

Reason	Percentage (%)	Frequency
Not so worth to see	35.1	119
Financial problem	28.0	95
Doctors of bd not reliable	36.9	125

5.5 Percentage (%) of Skin diseases in migrants' based on nationality:

We get that, frequency of skin disease are high in migrants from Somalia (17) and Srilanka (16), and then Palestine, Djibouti (7) and so on.

Table-:6 Percentage (%) of Skin diseases in migrants' based on nationality

Percentage (%) of Skin diseases		
Name of the country	**Percentage (%)**	**Frequency**
India	16.7	4
Srilanka	26.7	16
Nepal	16.1	5
Uganda	0.0	0
Yemen	38.1	8
Kabul	28.6	2
Somalia	48.6	17
Cameron	33.3	1

Djibouti	25.0	3
Nigeria	46.7	7
UAE	0.0	0
Afghanistan	55.6	5
Colombia	50.0	1
Sudan	42.9	3
Oman	50.0	1
Palestine	53.8	7
Jordan	0.0	0
Indonesia	100.0	1
Ethiopia	100.0	1
South Africa	0.0	0
Pakistan	22.7	5
Comoros	7.1	1
Gambia	0.0	0
Senegal	0.0	0
Arab	100.0	1
Maldives	12.0	3
Bhutan	22.7	5

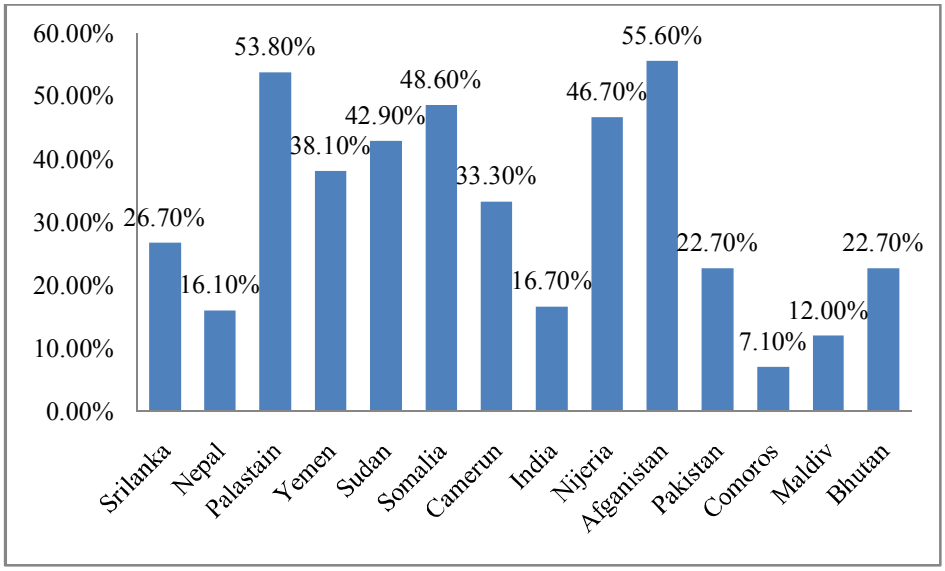

Figure-14: Percentage (%) of Skin diseases in migrants' based on nationality

5.6. Percentage (%) of Intestinal diseases in migrants' based on nationality:

We may conclude that, frequency of intestinal disease are high in migrants from Srilanka(19) and then that of Nepal(12)and Bhutan(9) and so on.

Table-7: Percentage (%) of Intestinal diseases in migrants' based on nationality.

Percentage (%) of Intestinal diseases		
Name of the country	**Percentage (%)**	**Frequency**
India	29.2	7
Srilanka	31.7	19
Nepal	38.7	12
Uganda	0.0	0
Yemen	9.5	2
Kabul	0.0	0

Somalia	14.3	5
Cameron	0.0	0
Djibouti	0.0	0
Nigeria	20.0	3
UAE	0.0	0
Afghanistan	0.0	0
Colombia	50.0	1
Sudan	0.0	0
Oman	0.0	0
Palestine	15.4	2
Jordan	0.0	0
Indonesia	100.0	1
Ethiopia	100.0	1
South Africa	0.0	0
Pakistan	22.7	5
Comoros	21.4	3
Gambia	0.0	0
Senegal	0.0	0

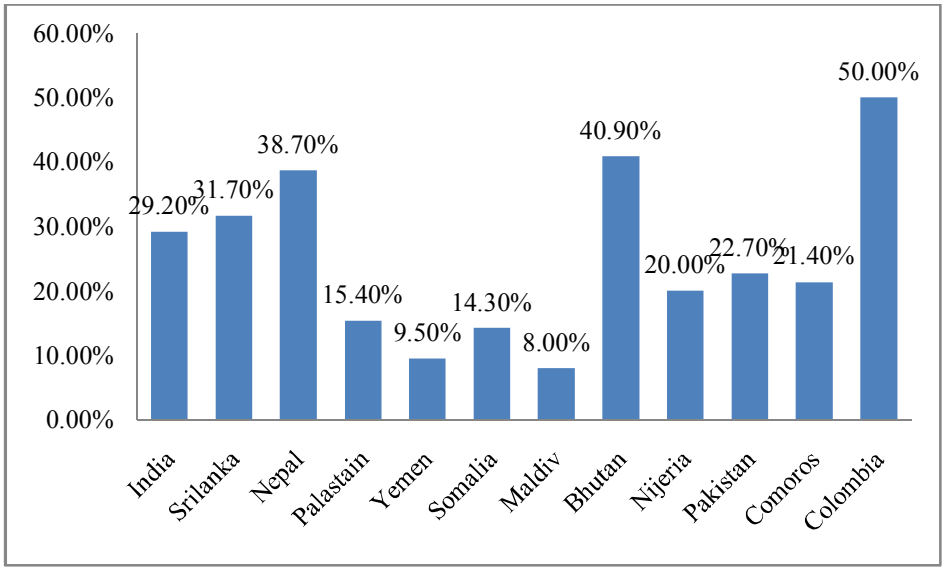

Figure-15: Percentage (%) of Intestinal diseases in migrants' based on nationality.

5.7. Percentage (%) of Psychological problem in migrants' based on nationality:

We found that, frequency of psychological problem is high in migrants from Srilanka (19) and so on. But in so many countries frequency is zero (0) namely Cameron, Colambia, Sudan, Oman, Indonesia, Bhutan.

Table 9: Percentage (%) of Psychological problem in migrants' based on nationality.

Percentage(%) of Psychological problem		
Name of the country	**Percentage (%)**	**Frequency**
India	20.8	5
Srilanka	31.7	19
Nepal	12.9	4
Uganda	42.9	3

Yemen	23.8	5
Kabul	14.3	1
Somalia	8.6	3
Cameron	0.0	0
Djibouti	16.7	2
Nigeria	6.7	1
UAE	0.0	0
Afghanistan	22.2	2
Colombia	0.0	0
Sudan	0.0	0
Oman	0.0	0
Palestine	7.7	1
Jordan	50.0	1
Indonesia	0.0	0
Ethiopia	0.0	0
South Africa	33.3	1
Pakistan	22.7	5
Comoros	0.0	0
Gambia	0.0	0
Senegal	0.0	0

Arab	0.0	0
Maldives	4.0	1
Bhutan	0.0	0

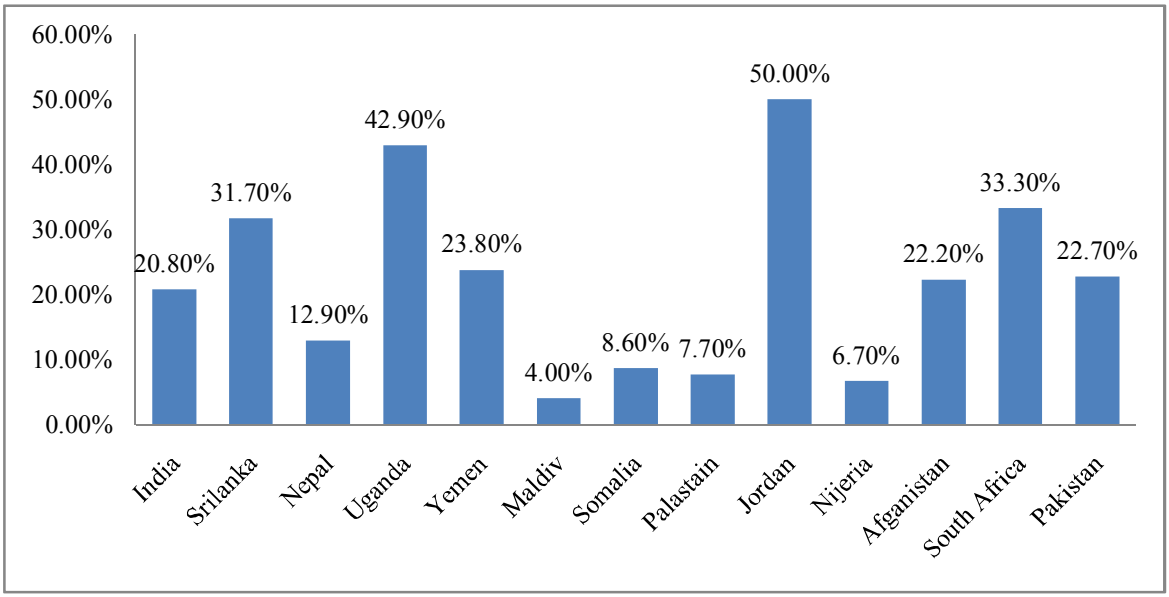

Figure 16: Percentage (%) of Psychological problem in migrants' based on nationality.

5.8. Percentage (%) of Headache problem in migrants' based on nationality:

We find that, frequency of headache problem is high in migrants from Srilanka (29) and then that of Nepal (20), Bhutan (16), Maldives (15) and so on.

Table-9: Percentage (%) of Headache problem in migrants' based on nationality.

Percentage(%) of migrant's Headache problem		
Name of the country	**Percentage (%)**	**Frequency**
India	58.3	14
Srilanka	48.3	29
Nepal	64.5	20
Yemen	9.5	2
Kabul	0.0	0
Somalia	25.7	9
Cameron	0.0	0
Djibouti	16.7	2
Nigeria	6.7	1
UAE	0.0	0
Sudan	14.3	1
Oman	0.0	0
Palastine	15.4	2
Indonesia	0.0	0
South Africa	0.0	0

Pakistan	45.5	10
Comoros	21.4	3
Gambia	50.0	1
Arab	100.0	1
Maldives	60.0	15
Bhutan	72.7	16

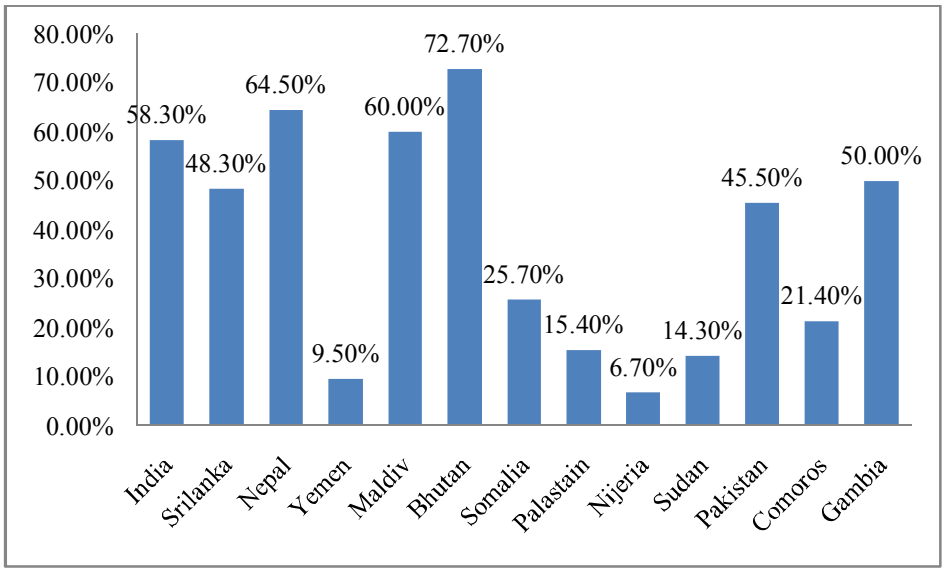

Figure-17: Percentage (%) of migrant's Headache problem based on nationality.

5.9. Percentage (%) of migrants feeling that weather of Bangladesh is causing their health problem:

Here, we get to know that, among 343 migrants of various countries; 27 Srilankan, 12 Nepalese, 10 Somalis , 9 Pakistani and Maldivian, 8 Bhutanese migrants think that weather of Bangladesh is causing their health problem.

Table-10: Percentage (%) of migrants feeling that weather of Bangladesh is causing their health problem

Percentage(%) of migrants feeling that weather of Bangladesh is causing their health problem		
Name of the country	**Percentage (%)**	**Frequency**
India	29.2	7
Srilanka	45.0	27
Nepal	38.7	12
Uganda	28.6	2
Yemen	14.3	3
Somalia	28.6	10
Cameron	33.3	1
Djibouti	33.3	4
Nigeria	0.0	0
UAE	0.0	0
Afghanistan	11.1	1
Colombia	50.0	1
Sudan	14.3	1
Oman	0.0	0
Palestine	38.5	5
Jordan	0.0	0

Indonesia	0.0	0
Ethiopia	100.0	1
South Africa	0.0	0
Pakistan	40.9	9
Comoros	42.9	6
Gambia	100.0	2
Senegal	100.0	1
Arab	100.0	1
Maldives	36.0	9
Bhutan	36.4	8

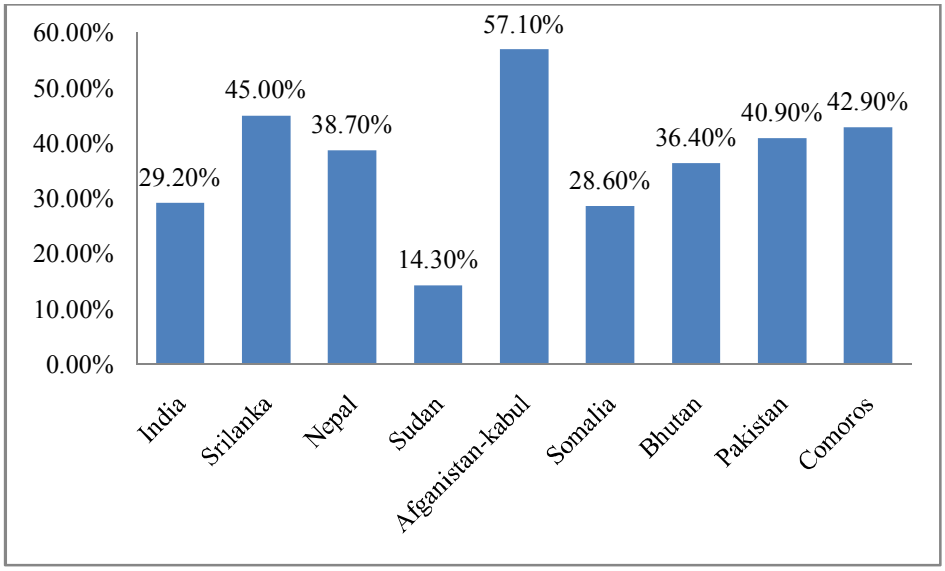

Figure-18: Percentage (%) of migrants feeling that weather of Bangladesh is causing their health problem.

5.10. Percentage (%) of migrants feeling that pollution of Bangladesh is causing their health problem:

From table 11 we get to know that, among 343 migrants of various countries; 14 Srilankan, 11 Somalis, 10 Bhutanese and 8 Maldivian migrants think that pollution of Bangladesh is causing their health problem.

Table-11: Percentage (%) of migrants feeling that pollution of Bangladesh is causing their health problem

Percentage (%) of migrants feeling that pollution of Bangladesh is causing their health problem		
Name of the country	**Percentage (%)**	**Frequency**
India	16.7	4
Srilanka	23.3	14
Nepal	29.0	9
Uganda	14.3	1
Yemen	19.0	4
Kabul	57.1	4
Somalia	31.4	11
Cameron	33.3	1
Djibouti	41.7	5
Nigeria	20.0	3

Afghanistan	22.2	2
Sudan	28.6	2
Palastine	23.1	3
Indonesia	100.0	1
Ethiopia	100.0	1
Pakistan	18.2	4
Comoros	35.7	5
Gambia	100.0	2
Senegal	100.0	1
Maldives	32.0	8
Bhutan	45.5	10

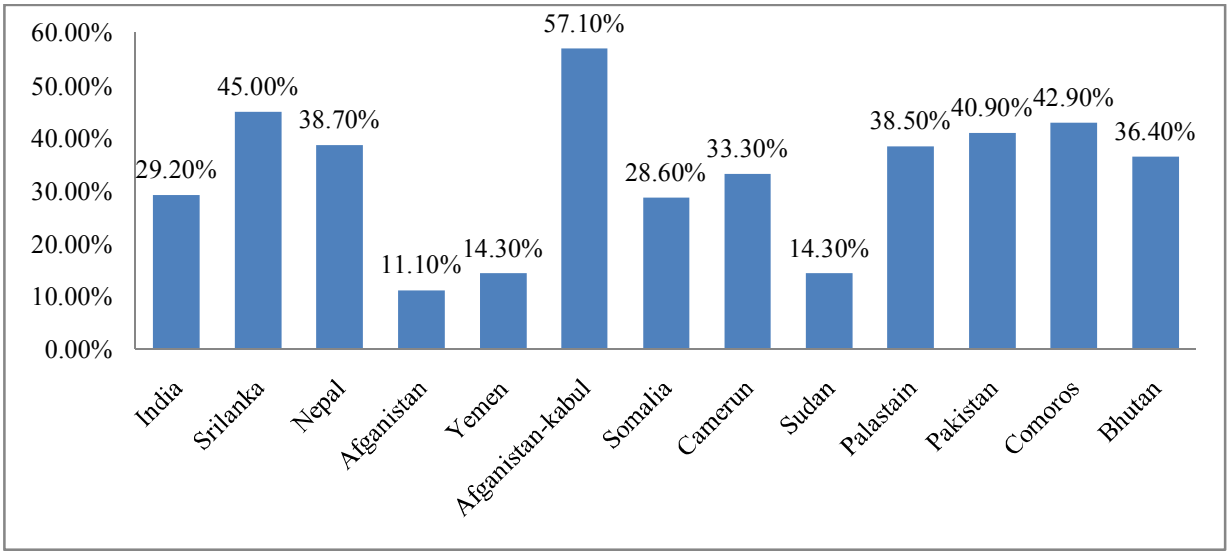

Figure-19: Percentage (%) of migrants feeling that pollution of Bangladesh is causing their health problem

5.11. Percentage (%) of migrants feeling that food and water of Bangladesh is causing their health problem:

Here, we get to know that, among 343 migrants of various countries; 28 Srilankan, 14 Nepalese and Somalis, 12 Maldivian and Bhutanese migrants think that food and water of Bangladesh is causing their health problem.

Table-12: Percentage (%) of migrants feeling that food and water of Bangladesh is causing their health problem.

Percentage (%) of migrants feeling that food and water of Bangladesh is causing their health problem.		
Name of the country	**Percentage (%)**	**Frequency**
India	37.5	9
Srilanka	46.7	28
Nepal	45.2	14
Yemen	33.3	7
Kabul	42.9	3
Somalia	40.0	14
Cameron	33.3	1
Djibouti	8.3	1
Nigeria	6.7	1
Afghanistan	22.2	2

Sudan	14.3	1
Oman	50.0	1
Palestine	23.1	3
Indonesia	100.0	1
Ethiopia	100.0	1
South Africa	33.3	1
Pakistan	50.0	11
Comoros	50.0	7
Gambia	100.0	2
Senegal	0.0	0
Arab	100.0	1
Maldives	48.0	12
Bhutan	54.5	12

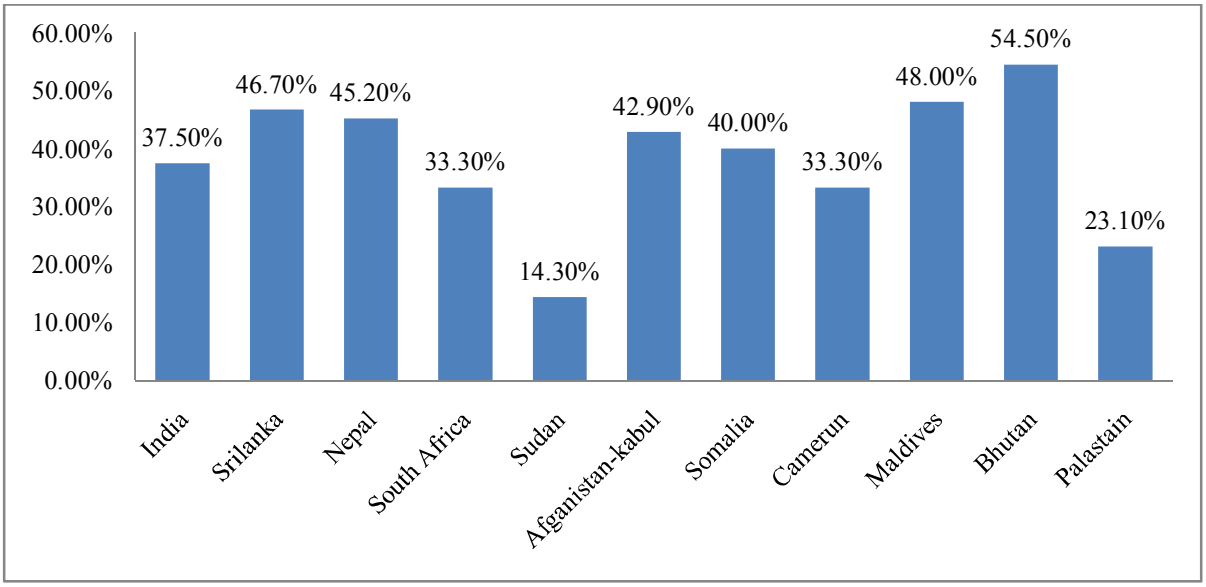

Figure-20: Percentage (%) of migrants feeling that food and water of Bangladesh is causing their health problem.

5.12. Percentage (%) of migrants feeling that loneliness of Bangladesh is causing their health problem:

Here, we get to know that, among 343 migrants of various countries; 9 Srilankan, 7 Maldivian, 6 Nepalese think that loneliness causing their health problem.

Table-13: Percentage (%) of migrants feeling that loneliness of Bangladesh is causing their health problem.

Percentage (%) of migrants feeling that loneliness of Bangladesh is causing their health problem.		
Name of the country	**Percentage (%)**	**Frequency**
India	16.7	4
Srilanka	15.0	9
Nepal	19.4	6
Uganda	0.0	0

Yemen	19.0	4
Kabul	28.6	2
Somalia	5.7	2
Cameron	0.0	0
Djibouti	16.7	2
Nigeria	6.7	1
UAE	0.0	0
Afghanistan	11.1	1
Colombia	0.0	0
Sudan	14.3	1
Oman	50.0	1
Palestine	7.7	1
Jordan	0.0	0
Indonesia	100.0	1
Ethiopia	0.0	0
South Africa	0.0	0
Pakistan	13.6	3
Comoros	14.3	2
Gambia	0.0	0
Senegal	100.0	1

Arab	0.0	0
Maldives	28.0	7
Bhutan	18.2	4

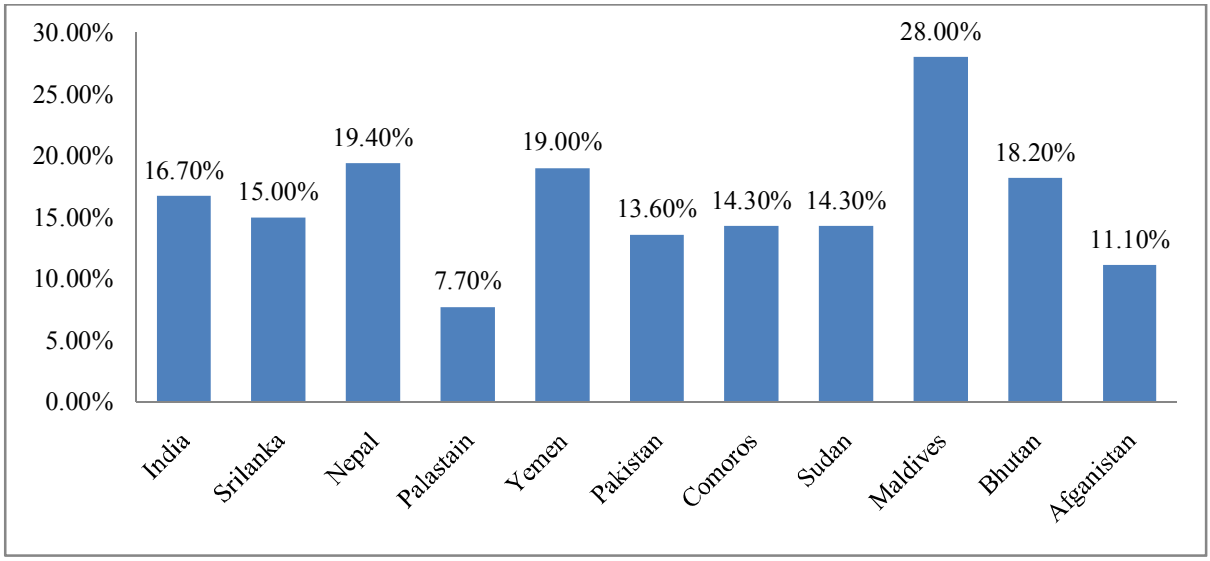

Figure-21: Percentage (%) of migrants feeling that loneliness of Bangladesh is causing their health problem.

5.13. Percentage of drugs used by migrants':

We realize that, various drugs used by migrants are Antipyretic (60.0%), Antiulcerative (55.90%), NSAIDS (35%), Antibiotics (35.10%) and antiasthmatics(12.40%) and so on.

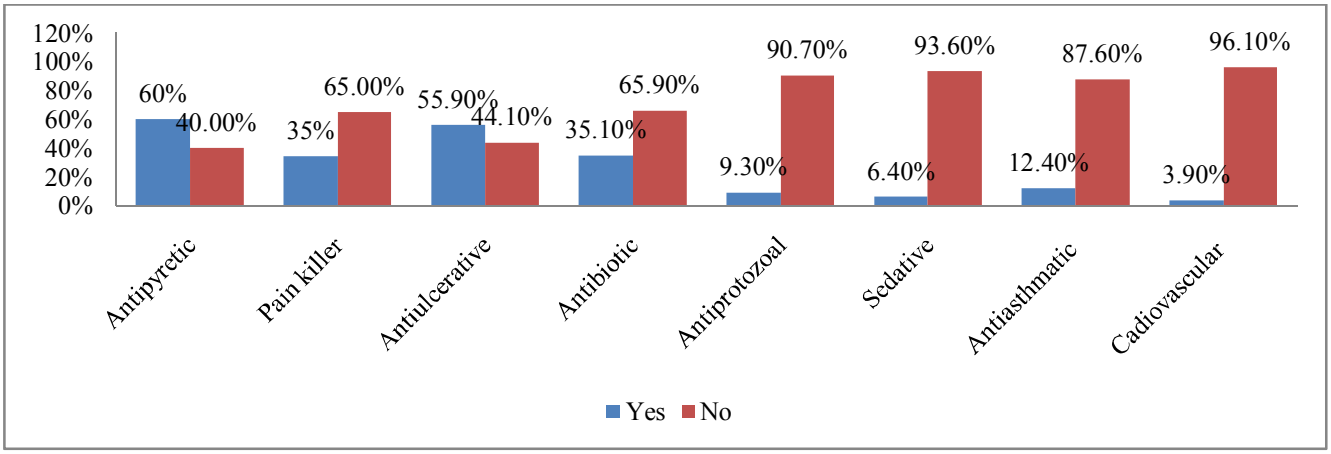

Figure-22: Percentage of drugs used by migrants'.

6. DISCUSSION

This study provided an overview of the scope and main findings of empirical work, on 'A survey based study on documented and undocumented migrants' diverse health problems.'

We performed our study on 343 migrants of various countries. Among them most are students (45.2%), service-holder (25.2%), and businessmen (28.9%). Minimum ages of the migrants are 17 years and maximum ages of the migrants are 37 years. Majority of them are male (67.6%) and then female (32.4%). The migrants selected randomly for the survey.

A study performed by Ashwin Swaminathan *et al* (2009) a total of 25,867 returned travelers were analyzed, of whom 7442 (29%) patients had a total of 8273 gestrointestinal diagnoses. Multivariate analysis demonstrated that IGD presentation was associated significantly with female sex (OR: 1.11; $p = 0.001$); younger age group; attending a pre-travel medical appointment (OR: 1.28; $p < 0.0001$); and travelling for the reason of tourism. Travelling for longer periods (>28 days) was associated with lower risk (OR: 0.93; $p = 0.04$). Of the 2902 clinically significant pathogens isolated, 65% were parasitic, 31% bacterial and 3% viral. Presentation of IGD by specific pathogen varied markedly dependent on geographic region of recent travel, and reason for travel.

Another study was performed by Karin Leder *et al* (2010) respiratory tract infection was diagnosed in 1719 persons who presented to a Geo Sentinel site during the period of September 1997 through August 2001 (48 months) out of a total of 21,960 patient entries. Respiratory tract infections accounted for 7.8% of all infections in returned travelers reported to Geo Sentinel. Of the patients who had complete demographic data entered 830 were male and 874 were female. The mean age of the patients was 34.2 years (range, 0–95 years). The majority of respiratory infections were reported by the Geo Sentinel site in Nepal (1100 cases [64%]). Two hundred sixty-one cases (15.2%) were reported from Germany, 115 (6.7%) were reported from the United States, 94 (5.5%) were reported from Australia, 57 (3.3%) were reported from Italy, 37 (2.2%) were reported from Switzerland, 32 (1.9%) were reported from Canada, 14 (0.8%) were reported from Israel, 5 (0.3%) were reported from the United Kingdom, and 4 (0.2%) were reported from New Zealand.

Whereas in our study 28.3% of migrants faces gastrointestinal problem after coming to Bangladesh and 71.7% migrants does not faces this problem.

The majority of respiratory infection were reported in migrants from India(29.2%), Srilanka(31.7%), Nepal(38.7%),Somalia(14.3%), Pakistan(22.7%), Comoros(21.4%), Bhutan(40.9%), Maldives(8.0%). Respiratory tract infections are common in migrants, and improving our knowledge of risk factors associated with specific types of respiratory infections should enable implementation of better preventive strategies.

Headache is the another health problem in migrants of Bangladesh.

A study performed by TREVOR *et al* (2004) Twelve of the 23 travelers (52 percent) met the case definition for eosinophilic meningitis. Nine of the 12 were hospitalized. The median time from departure from Jamaica to the onset of symptoms in the 12 patients was 11 days (range, 6 to 31). All 12 patients had a headache, since this was part of the case definition; visual disturbances or photophobia, neck pain or nuchal rigidity, and fatigue were the most common accompanying symptoms. Hyperesthesias or paresthesias of the trunk or arms and legs (or all three) were reported by 9 of the 12 patients. Five patients reported having had a fever, but only two of the nine patients who were hospitalized had documented temperatures of more than 37.8°C.

In our findings 36.7% percent of migrants have headache and 63.3% percent of migrants have no headache .The majority of headache problem were reported in migrant's from India(58.3%), Srilanka (48.3%), Nepal(64.5%),Somalia(25.7%), Pakistan(45.5%), Comoros(21.4%), Bhutan(60.0%), Maldives(72.7%).

It was seen that skin disease and infectious disease are common in migrants.

Study performed by Dahle et al. 2007, the prevalence of tuberculosis and HIV/AIDS is higher among immigrant groups, particularly among those from Africa, compared to the Norwegian population and other immigrant groups. This is due in turn to the high prevalence of the diseases in countries of origin. The prevalence is not considered a threat to public health in Norway as a whole because the necessary control strategies are in place (Farah et al. 2005, Harstad et al. 2010). Studies of screening and preventive strategies show that the control of infectious disease focuses primarily on asylum seekers. In addition, infectious diseases such as malaria and hepatitis are reported as health problems, although there are very few incidences compared to the

incident rates of immigrants' country of origin. Only one study has focused on experiences of tuberculosis patients (Sagbakken et al. 2010).

We observed that most of the skin disease type is allergy, rash, dermatitis, fungal infection, bacterial infection. In our study we found that, 28.3% percent of migrants have skin disease and 71.7% percent of migrants have no skin disease. The majority of problem were reported in, migrants from Srilanka (26.7%), Nepal (16.1%), Somalia (48.6%), Pakistan (22.7%), Comoros (7.1%), Bhutan (22.7%), India (16.7%), Maldives (12.0%).

Foods available in our country are generally made of more spices, salt and oil; moreover the hygiene and nutritional level is not so satisfactory. Food poisoning is common problem in migrants. Ulceration is also the common problem in migrants because of spiciness of food

Water of Bangladesh is generally pungent in test. Migrant's faces so many problems in Bangladesh due to water. For unhygienic water, some disease condition usually arises in migrants. Diarrhoea, dysentery, GI tract infection, typhoid are commonly occur.

In this study 38.8% percent of migrants think that food and water causes their health problem and 61.2% percent of migrants don't think that. The major percentage of migrants think that food and water are causes their health problem are found in migrants from Bhutan (54.5%), Pakistan (50%), Somalia (48.6%), Maldives (48.0%), Srilanka (46.7%), Nepal (45.2%), India (37.5%).

A study by Dalgard et al. 2008 compares the mental health status of Western immigrants. Generally, the studies conclude that the immigrant groups, especially those from low-income countries with war and conflict backgrounds, suffer from more mental health problems than ethnic Norwegians and immigrants from high-income countries (Dalgard et al. 2006, Thapa et al. 2007). According to the Norwegian Directorate of Health, mental health problems are lowest among Norwegian-born immigrants (10%), followed by Western immigrants (14%) (Forland 2009).The prevalence rate is high among immigrants from non-Western countries (24%) and highest among the refugee population (31%).

In our study mental health problem like loneliness, are observed in migrant's from India (16.7%), Srilanka (15.0%), Nepal (19.4%), Somalia (5.7%), Pakistan (13.6%), Comoros

(14.3%), Bhutan (18.2%), Maldives (28.0%), Sudan (14.3%). In some country these percentages were remains 0%, like Uganda, Cameron, South Africa, and Gambia.

Studies show that, whereas more men with a non-Western immigrant background have been admitted for emergency psychiatric health care than Norwegian men, significantly fewer women with an immigrant background have been admitted compared to Norwegian women (Ayazi & Bøgwald 2008, Berg 2009, Berg & Johnsen 2004).

Lversen & Morken (2003) show that the risk of admission to a psychiatric hospital is highest among asylum seekers. Further, studies have shown that non-Western immigrant women have been admitted to hospital due to severe mental disorders, such as schizophrenia, although the hospital admission rates for women with other mental disorders are very low compared to their male counterparts. (Hauff & Vaglum 1997). Iversen et al. (2011) show that involuntary admission to psychiatric hospital for schizophrenia is higher among non-Western immigrants than Norwegians.

From our data psychological problem, were reported in migrant's from India (20.8%) Srilanka (31.7%), Nepal (12.9%), Somalia (8.6%), Pakistan (22.7%), Comoros (14.3%), Sudan(14.3%), Yemen (23.8%). This is due to socio-economic problems, lack of knowledge of available assistance, and inability to communicate with service providers, which ultimately leads to increases in immigrants' aggressive or violent behaviour.

From past studies it was seen that migrants uses OTC drugs frequently. Antipyretic, analgesic, are commonly used. Antibiotic, antiulcerative, antiprotozoal, antiasthmatic, cardiovascular drugs also used under physician recommendation.

From our observation, drugs used by migrant's are mostly Antipyretic(60%),Analgesic (35%), Antibiotic (35.10%), Antiulcerative (55.90%), Cardiovascular (3.90%), Antiprotozoal (9.30%), Antiasthmatic (12.40%).

7. CONCLUSION

The changing size, diversity and needs of migrants in the Bangladesh have yet to be sufficiently addressed in academic research and mainstream health policy and practice. It is important to move beyond a framework of ethnic differences and inequalities in health and to consider a range of factors that may explain the experiences and needs of migrants, including those who are most vulnerable and are restricted in their entitlement to free health care in the Bangladesh. This is important to the goal, set out in the Marmot Review (Marmot et al., 2010), of creating a fairer and more just society. Bangladesh could play an important role in facilitating the development and transfer of evidence and information on migrant health policy. Topics identified as theoretically central and/or under-researched include: methodological problems of migrant health research; children and youth, particularly in terms of psychosocial health; sexuality, reproduction and family life; older migrants; access of illegal/undocumented migrants to health services; user involvement in the design and provision of services; 'linkages' between sender countries and receiver countries; preserving the health 'advantage' of some newly arrived migrants; analysis approaches to preventing and controlling disease among migrants; multi-sectoral policy; and sharing of knowledge and data, and the improvement of data collection. Prospective studies are needed to understand migrant health better and to inform interventions for immigrants' health maintenance. The focus should be on vulnerable immigrant groups such as irregular migrants, work migrants, and marriage migrants. Further, care for the elderly immigrant population is an emerging issue.

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