


# Structural vulnerability: migration and health in social context

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**To cite:** Carruth L, Martinez C, Smith L, *et al.* Structural vulnerability: migration and health in social context. *BMJ Global Health* 2021;**6**:e005109. doi:10.1136/bmjgh-2021-005109

This article is submitted as part of the BMJ Global Health “Migration and Health in Social Context” collection edited by Emily Mendenhall and Seth M. Holmes.

Received 25 January 2021  
Accepted 30 January 2021

## ABSTRACT

Based on the authors' work in Latin America and Africa, this article describes and applies the concept 'structural vulnerability' to the challenges of clinical care and healthcare advocacy for migrants. This concept helps consider how specific social, economic and political hierarchies and policies produce and pattern poor health in two case studies: one at the USA–Mexico border and another in Djibouti. Migrants' and providers' various entanglements within inequitable and sometimes violent global migration systems can produce shared structural vulnerabilities that then differentially affect health and other outcomes. In response, we argue providers require specialised training and support; professional associations, healthcare institutions, universities and humanitarian organisations should work to end the criminalisation of medical and humanitarian assistance to migrants; migrants should help lead efforts to reform medical and humanitarian interventions; and alternative care models in Global South to address the structural vulnerabilities inherent to migration and asylum should be supported.

## INTRODUCTION

How does structural vulnerability impede good health and healthcare? The concept of *structural vulnerability* considers how social, economic and political hierarchies produce and pattern poor health. Structural vulnerability emphasises how institutions and practices designed to offer care and assistance can sometimes, even unintentionally, contribute to medical risks and poor health outcomes.<sup>1–3</sup> For example, people's entanglements within inequitable and sometimes violent global migration systems produce shared structural vulnerabilities that then differentially affect health and other outcomes. This is particularly important as it affects irregular, unauthorised or undocumented transnational im/migrants and asylum seekers who have limited state protections. Here we use the terminology and legal designations for different kinds of migrants based in international law and developed by the United Nations International Organization for Migration,

## Summary box

- ▶ Global migration can create structural vulnerabilities that affect migrants' and asylum seekers' health and the ability of health and service providers to provide them with care.
- ▶ Vulnerabilities caused by the social, political and economic structures inherent to global migration and asylum systems increase the risk of poor health outcomes among migrants, and also place clinicians at risk.
- ▶ Providers require training and support for their care of and advocacy on behalf of different types of migrants.
- ▶ Professional associations, healthcare institutions, universities and humanitarian organisations should work to end the criminalisation of medical and humanitarian assistance to migrants.
- ▶ Given their unique expertise, migrants should help lead efforts to reform medical and humanitarian interventions.
- ▶ Alternative models for addressing the structural vulnerabilities inherent to migration and asylum already exist in the Global South, and should be supported.

available here: <https://www.iom.int/glossary-migration-2019>. In this way, vulnerability can be attributed to global migration and asylum systems as opposed to migrants themselves, similar to how racial inequities derive from structural and institutional racism rather than purported innate racial differences.<sup>4</sup> Given people's various positions within these social structures—as researchers, clinicians, advocates, migrants and so on—we are all also part of and subject to these structures.

## MIGRATION AND HEALTH IN SOCIAL CONTEXT

This article considers how structural vulnerability manifests among undocumented migrants, irregular migrants, asylum seekers, deportees, and the providers who care for them. Providers tasked with caring for and bearing witness to these migrants' suffering also face limited resources, time and control



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### Definition Box

#### Structural vulnerability

A social science and social medicine concept that highlights the ways social, economic, and political hierarchies produce and pattern negative health outcomes. Structural vulnerability includes the ways in which various institutions and practices designed to offer care and assistance can also, at times unintentionally, contribute to health risks and poor health outcomes.

over the social determination of their patients' health. We draw on our social science and health work to describe how providers serving migrants at the USA–Mexico border, in Djibouti, and elsewhere frequently find themselves entangled in systems and institutions that challenge and constrain their ethical obligations and professional training. Contemporary global migration and asylum systems may even at times risk clinicians' own health and well-being.

First, structural vulnerability combines two concepts: structural violence and vulnerability. *Structural violence*, originally developed by peace studies scholar Johan Galtung, refers to the invisible and indirect forms of violence inherent to repressive or inequitable social orders.<sup>5</sup> This differs from physical violence—a directive, interactive term—as structural violence is prolonged and indirect, and as such, can shape the presentations and progressions of disease.<sup>6,7</sup> Our work focuses on migrants who are undocumented, irregular, and fleeing political and social insecurity, who often face multiple forms of violence before, during and following their journeys.<sup>8,9</sup>

*Vulnerability*, on the other hand, is an established concept in the fields of public health and medicine, and describes the patient or person at heightened risk of negative health outcomes. However, the term can also connote powerlessness, victimhood and a need for external and potentially stigmatising interventions.<sup>10</sup> Social structures like immigration laws, for example, shape collective forms of vulnerability and can cause structural violence.<sup>11</sup>

Combining these two ideas into one concept, *structural vulnerability*, highlights the ways elevated risks for negative health outcomes are often not a result of individual or cultural failings but rather are caused by social, political and economic structures. This enables a focus on holding responsible and working to change the powerful structures that shape and constrain individuals' and groups' lives, choices, and behaviours.

Second, clinicians serving unauthorised migrants and asylees often face a double bind, where structural vulnerability combines inequities embedded in health systems and global migration at once—thereby complicating their social role as clinicians. For example, case 1 focuses on Dr L's clinical care for a woman we call by the pseudonym Maria and other migrants during the COVID-19 pandemic along Mexico's border with the USA, and illustrates how the precarity of care to people on the move

can be experienced not only by unauthorised migrants but also by the clinicians who serve them. Despite a relatively strong health system in Mexico, medical services available to unauthorised migrants and asylum seekers remain inadequate. Clinicians who care for these patients often have to take unusual risks, work in situations outside their comfort zones, and provide ad-hoc forms of assistance outside traditional clinical spaces. Thus, structural violence can make both patients and clinicians vulnerable in different but interrelated ways.

Third, the work of a Djiboutian physician we call Dr M, tasked with caring for Ethiopian women migrating through Djibouti to the Gulf States, described in case 2, illustrates how clinicians do their best to serve their migrant and asylee populations given legal, logistical and material limitations. But often, clinicians like her cannot attend to these irregular migrants' long-standing needs, as many are fleeing violence in their homes and communities. Even so, clinicians care for these patients in creative yet limited ways, such as providing supplies of prescription medications and bandaging wounds before people depart on the next leg of their journeys.

Fourth, Dr M and Dr L demonstrate how healthcare providers do not always address only the physiological needs of their patients, but sometimes try to act outside the walls of clinics as *clinician advocates*. However, their advocacy often remains censored, penalised, thwarted by immigration procedures, or viewed as a threat to clinical operations. More generally, healthcare providers like Dr L and Dr M who serve irregular migrants and asylum seekers remain constrained and frustrated by limited resources and a lack of political will to change the structural conditions that risk their patients' lives, constrain their work and at times even jeopardise their own health and safety.

### IMPLICATIONS FOR CLINICIANS AND GLOBAL HEALTH SYSTEMS

While the COVID-19 pandemic presents existential threats to migrants' health and healthcare, this time of crisis also opens new opportunities for imagining how medical care and health policies for migrants might be transformed. Effective reform requires more than supplying clinics like those we describe in Tijuana and Djibouti City, but also addressing the structural vulnerabilities that place migrants and their healthcare providers in harm's way. This involves tackling the ways in which health and global migration systems are structured.

► *Professional associations must work with migration and humanitarian organisations to guide and support providers to care for migrants and to help their migrant patients negotiate the global migration and asylum systems.* National Medical Associations should use their collective power to investigate and speak out against the unethical, inhumane and harmful structures migrants and

### Case 1. Dr L: healthcare in transit along the USA–Mexico border

In May 2020, Maria presented with a fever and low oxygen saturation in the Asylum Health Committee clinic, a volunteer-run free healthcare facility in Tijuana, Mexico. Dr L, an emergency medicine physician based in Los Angeles who volunteers his time with the Asylum Health Committee, diagnosed her with COVID-19 using a rapid test he brought from the USA. However, providing treatment and isolation remained challenging.

Maria had arrived in Tijuana in mid-2018 with her young daughter, after several family members were murdered by gang members in El Salvador. With the support of a legal advocacy organisation, by 2020 she was in the midst of the lengthy and challenging process of applying for asylum in the USA. However, in December 2018, the U.S. Department of Homeland Security implemented the Migrant Protection Protocols (MPP), also referred to as the ‘Remain in Mexico’ policy. Under the MPP, over 60 000 asylum seekers like Maria have been returned to Mexico for the duration of their immigration proceedings. Moreover, MPP hearings have been completely suspended because of the COVID-19 pandemic, resulting in an increased backlog in court proceedings and leaving many asylum seekers indefinitely stranded in Mexico.<sup>18</sup>

Many migrants and asylum seekers now wait in Mexican border towns in precarious, unsafe and crowded shelters, in ad-hoc camps, or on the streets for their court proceedings. Mexico’s public healthcare system is overwhelmed with patients with COVID-19, and consequently frequently denies care to people like Maria who lack documentation or legal status in Mexico.

Because of travel bans and resource constraints, Dr L is one of the Asylum Health Committee’s few remaining clinicians who continues to provide care for patients like Maria. But his work remains risky and fragmented. The Asylum Health Committee placed Maria and her daughter in a hotel for 2 weeks after her COVID-19 diagnosis, as she otherwise would have no space to isolate inside the shelter. Dr L transported them there in his own car and provided them food and daily check-ups outside his work with the clinic. There was no other way to ensure they received the care they needed as a family and to protect others from COVID-19. Thus, immigration policies and public health systems that rendered Maria structurally vulnerable to disease also impeded Dr L’s and the clinic’s ability to provide adequate care, and placed him and the organisation at risk.

providers encounter. This must involve agreements with national and multilateral migration and humanitarian organisations like the United Nations International Organization for Migration, the United Nations High Commissioner for Refugees and international human rights organisations that support professional organisations and the providers they represent.

- ▶ *Medical schools should offer structural competency training tailored to the needs and procedures different migrants face.*<sup>12</sup> Clinicians must be made aware of the ways immigration and refugee laws and policies both affect the health of their patients and structure their own clinical care.
- ▶ *Governments should end the criminalisation of humanitarian assistance and medical care to irregular migrants and asylum seekers.* The criminalisation of assistance to migrants is increasingly common. For example,

### Case 2. Dr M: healthcare in transit in Djibouti

Dr M is a physician in a government-run clinic in Djibouti City, the capital of Djibouti. While most of her patients are local residents, she also assists many irregular migrants. Her migrant patients mostly include some of the thousands of women from Ethiopia and other countries travelling extralegally or being smuggled out of Africa every year through Djibouti in search of domestic work in Saudi Arabia and other Gulf States.<sup>19 20</sup> Some of her patients are women who have journeyed on foot hundreds of miles through the desert, and with the help of ‘delalas’ (extralegal guides or smugglers), plan to board boats across the Red Sea and then walk through war zones in Yemen to reach Saudi Arabia and other Gulf States. While some voluntarily leave home in search of gainful employment, many others leave after experiencing great duress, escaping intimate partner violence, conflict and poverty.<sup>17 19 20</sup> Often, their relatives have been detained, displaced or killed for their political activism. Because many of these Ethiopians’ migration decisions occur within a structurally violent context,<sup>17</sup> and because they must travel and live in the shadows, many struggle to access adequate medical care.

Due to the fact that Dr M’s migrant patients seek care surreptitiously and are often accompanied by a delala, clinical encounters can be rushed, fragmentary and awkward. Dr M can address many of these women’s basic physical problems, including infectious diseases, dehydration and injuries incurred before and during their journeys. She can also provide limited supplies of medications and basic services, such as testing and treatments for malaria, TB and HIV. Sometimes, without an ability to insist on in-person examinations or follow-up visits, Dr M occasionally covertly supplies first aid kits and caches of antibiotics and contraceptive pills at the request of these women’s delalas. However, very often, she acknowledges she cannot provide optimal or continuing care.

When women or dalalas leave Dr M’s clinic, she assumes she will never see them again, and she can do little to mitigate the risks they may face en route and in their destinations. Her medical care may potentially save their life, lessen their physical pain and immediate distress, and enable them to continue on their migration journey, but the lasting physical and psychological effects of their lives, arduous migrations, and work in the Gulf remain elusive.

volunteers with the non-profit No More Deaths along the USA–Mexico border have been arrested and charged with felonies for harbouring migrants<sup>13</sup>; volunteers on rescue ships in the Mediterranean Sea have been arrested and charged with conspiracy to transport and harbour migrants<sup>14</sup>; and healthcare workers with the White Helmets have been targeted by the Government of Syria.<sup>15</sup> Dr L and Dr M both risk similar sanctions. Coordinated pressure on governments and legal and legislative advocacy are necessary from professional associations, educational institutions, civil society organisations, human rights organisations, patient advocates and healthcare employers.

- ▶ *Health professionals and healthcare organisations must follow the lead of migrants and migrant-led organisations in medical and humanitarian work, because these individuals and organisations understand well the difficulties migrants and displaced persons face, and because they can work within informal and social networks to organise care and distribute resources.* Health and

other service providers with experience in migration and asylum should be empowered to contribute their expertise within health systems and advocacy organisations. Their experience working with mobile and minority groups and their knowledge of non-Western health systems and medical pluralism should be understood as valuable assets.<sup>16</sup>

- ▶ *Finally, alternative models for supporting migrant health and humanitarian assistance—many already prevalent in countries in the Global South, in places with long histories of migration and refugee flows—should be considered and supported.* For example, the Djiboutian government's Office of National Assistance for Refugees and Displaced Persons (ONARS) provides assistance to all migrants and displaced people in need regardless of legal status, documentation, or national origin.<sup>17</sup> In recent years, ONARS has spearheaded nimble responses to meet the basic health needs of all people on the move, regardless of immigration or asylum status, and has helped develop legislation to decriminalise transnational migration. Similarly, in Tijuana and other Mexican border cities, volunteer-led non-governmental health organisations have innovated mobile and telehealth modalities for deportees and asylum seekers.

Militarised borders, unfair immigration courts and under-resourced and overcrowded detention facilities are products of the structural vulnerabilities that affect migrants' health and the ability of clinicians serving migrants to do their jobs. These structural vulnerabilities are inherent to global migration and asylum systems, and therefore require structural reforms. The institutional cooperation and systemic changes we suggest may be time consuming and at times politically unpopular, but ameliorating the roots of these problems has the potential to improve not just the health and safety of migrants, but the health and safety of clinicians and other service providers and the quality of care they can provide.

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**Contributors** All authors have contributed equally to this manuscript.

**Funding** This collaboration and our individual research projects were supported by the DAAD German Academic Exchange, Georgetown University Global Futures Initiative, University of California Berkeley, American University's Center for Health, Risk & Society, and the ANID in Chile through the Fondecyt Postdoctoral Project N-3180173.

**Competing interests** None declared.

**Patient and public involvement** Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

**Patient consent for publication** Not required.

**Ethics approval** Data collection and research discussed in this article were approved by the IRBs at American University, Georgetown University, and the University of California.

**Provenance and peer review** Not commissioned; internally peer reviewed.

**Data availability statement** No data are available.

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