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## Promoting the Health of Left-Behind Children of Asian Labour Migrants: Evidence for Policy and Action

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### Executive Summary

Despite the political discourse on migration becoming an important issue in the global development agenda, the mental and physical health implications for left-behind children of migrant workers have received less attention. And the current evidence base on the health impacts of labour migration, both for migrants and their families, remains weak. The health impact on families left behind is especially salient for the majority of labour-sending nations, which are mostly low- and middle-income countries that lack adequate resources to respond to broad public health outcomes linked to increased migration and its cascading reverse impact. Changing demographics and shifting epidemiological profiles of disease can compound changes brought on by increased international migration in labour-sending countries. International labour migration, despite its remittance-related and other benefits, can also at times create a negative influence on health, break down family and social cohesion and increase the burden on health systems.

This Issue in Brief explores empirical evidence on the mental health and nutritional impacts of international labour migration on the left-behind children of migrant workers in Asia. Current evidence from Asian countries (Indonesia, the Philippines, Thailand and Vietnam) shows both negative and positive influences from parental migration on the mental health and nutritional status of such children. Results from a nationally representative study from Sri Lanka, however, suggest that socio-emotional maladjustment and behavioural problems occur among children in the absence of a migrant worker parent, with two in every five shown to have mental disorders. In addition, left-behind children were shown to have higher levels of nutritional deficits compared to non-migrant children.

Acceptance by communities of the normalcy of transnational migrant worker families and of transnational parenting may act as a determinant in reducing vulnerability and enabling resiliency among children whose parents are absent owing to migration. Mental health or nutritional issues arising as a consequence of parental separation through migration may be less traumatic if the migration experience is shared collectively, normalized within social/family structures and adequate support systems are in place, allowing children to develop along adaptive trajectories.

Balancing human rights (for instance, the right of a single mother to migrate) with the health and social protection needs of left-behind children and their caregivers (especially elderly ones, such as grandparents) is a critical challenge. In the context of remittance-dependent economies, such challenges form formidable policy tasks for governments (and international agencies) seeking to better manage migration for development and poverty alleviation. This brief describes a possible interventional framework that could be adapted by countries to mitigate health-related risks for left-behind children. This multidimensional intervention framework proposes active engagement from governments, the labour-migration industry, private-sector partners, civil society, academia and migrant worker families themselves.



## I. Introduction

International labour migration has become a vital component in not only driving economic development for many Asian countries, but also in transforming traditional roles of parenting and caregiving practices for millions of children of migrant workers (Lam, 2013).

Asia's labour migration trends consist mainly of movements to the Middle East — primarily to the Gulf Cooperation Council (GCC) countries. The economic growth of countries such as Singapore and Malaysia has also propelled labour migration within the region. Most of these movements involve workers without formal qualifications, often described as low-skilled, particularly female domestic workers (IOM, 2011). More than 3 million people in the Asia-Pacific region leave their countries every year to work abroad. The outflow of migrant workers from the Asia-Pacific countries of Bangladesh, India, Indonesia, Nepal, Pakistan, the Philippines and Sri Lanka to the GCC alone reached 1,070,434 in 2010 (ADB, OECD and ILO, 2015). Women represent 83 per cent of the domestic workers who cross borders in search of work each year globally, mainly within low-skilled “difficult, degrading and dangerous” (3D) jobs (ILO, 2013).

Remittances, consistently sent home by migrant workers, are one of the highest sources of foreign exchange earnings for many countries. In Sri Lanka, one quarter of the total labour force is employed abroad, contributing USD 7 billion in 2014 (Wickramage, 2015). Remittances constituted the largest share of gross domestic product (GDP) in Tajikistan (52%), followed by Kyrgyz Republic (31%), Nepal (25%), Bangladesh (12%), the Philippines (10%), Sri Lanka (10%), Vietnam (7%) and Pakistan (6%) (ADB, OECD and ILO, 2015).

Despite these significant gains for the economies of labour-sending countries, which belong mostly to the low- and middle-income category, studies examining household savings and the socioeconomic status of returning migrants show mixed gains (Dissanayake, 2003). Most often, workers engage in continuous cycles of re-migration to increase their savings and pay off the recruitment and placement fees to migration agents.

The balance sheet of labour migration typically involves a trade-off between economic well-being and proximity for families of migrant workers (Devasahayam, 2009). In addition, for governments whose economies are dependent on remittances, labour migration involves balancing foreign exchange gains against negative social and health impacts.

## II. International Policy Frameworks

The rights of migrant workers and their families were highlighted in the International Labour Organization (ILO) conventions on migrant worker rights (Nos. 97 and 143), and the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which came into force in 2003. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) General Recommendation 27, aims to elaborate on the circumstances that contribute to the specific vulnerability of female migrant workers and their experiences of sex and gender-based discrimination as a cause and consequence of the violations of their human rights. The UN Committee on the Rights of the Child has also advocated for protection of child rights in the context of international migration (Bryant, 2005).

The World Health Assembly resolution on health of migrants promotes a “safe, dignified and healthy migration” process for the benefit of both migrants and their families (WHO, 2010). The International Organization for Migration (IOM) and the World Health Organization (WHO) have led global efforts to support Member States in enabling migrant-sensitive health systems, adoption of policies and practices to “mainstream migration health” and to ensure realization of the right to health for all migrants and mobile populations (WHO, 2010). The UN General Assembly's High Level Dialogue on International Migration and Development, and the Global Forum on Migration and Development have also articulated the need for migration-related determinants of health as a key component of global development (Brolan et al., 2013).

Despite the political discourse on migration rising on the global development agenda, analysts have also argued that global migration policies have failed to recognize and adopt a family perspective (Yeoh, 2012), and have called for greater empirical evidence on the health status of migrants and mobile populations (PLoS, 2013).

## III. Effects on Child Psychosocial Health

A small but growing body of literature has explored the mental health status of children whose parents (chiefly mothers) are international migrant workers (see Table 1 for more detail on the studies discussed throughout this brief). Current evidence shows mixed patterns of psychosocial health. Most studies analysed the psychosocial health outcomes of children of migrant parents by comparing them with children without migrant parents. The most common instrument used to identify behavioural and emotional problems in children and adolescents was

the *Strengths and Difficulties Questionnaire (SDQ)* (Goodman, 1997). The SDQ, a brief behavioural screening questionnaire for children ages 3–16, was developed in the United Kingdom and has been used in many countries in clinical and epidemiological contexts.

A 2011 study by Graham and Jordan investigated the psychological well-being of children under age 12 whose mothers were migrant workers, in four Southeast Asian countries. Multivariate models showed that left-behind children in Indonesia and Thailand were more likely to have poor psychological outcomes compared to children in non-migrant households. This finding was not replicated in the Philippines or Vietnam. Interestingly, the psychological well-being of children in transnational households in the Philippines was either better than or not significantly different from that of children in non-migrant households, at least for emotional and conduct disorders. Young children ages 3–5 were more likely to exhibit conduct problems than older children in all four study countries. The effects of gender were more consistently significant, with girls less likely to

exhibit conduct problems across all countries except the Philippines. Only in Vietnam and the Philippines were girls significantly likely to have emotional problems.

Adhikari et al. (2014) indicated that the mother's earlier migration history had a significant association with mental health problems of the children left behind, highlighting the need for effective strategies to prevent mental health problems among children.

Results from the only large-scale study (Wickramage et al., 2015) that used a nationally representative sample of migrant worker households in Sri Lanka, which also assessed migrant families irrespective of the gender of the migrant parent, indicated that socio-emotional maladjustment and behavioral problems occur among left-behind children in the absence of one or both parents. Two in every five left-behind children were shown to have mental disorders, with greater emotional and conduct disorders observed in the male-caregiver households. Boys were also more vulnerable to psychopathology than girls. Psychological impacts were also observed in families

**Table 1: Review of Key Studies Examining Mental Health Status of Left-Behind Children**

Main Author, Year Published and Country Studied	Psychometric Instrument Used and Study Characteristics	Key Findings
Graham and Jordan (2011) in Indonesia, the Philippines, Thailand and Vietnam (CHAMPSEA study)	<ul style="list-style-type: none"> <li>- Strengths and Difficulties Questionnaire (SDQ)</li> <li>- 3,876 children under age 12 where mother is the migrant worker</li> </ul>	Multivariate models showed that children of migrant fathers in Indonesia and Thailand are more likely to have poor psychological outcomes, compared to children in non-migrant households. This finding was not replicated in the Philippines or Vietnam.
Adhikari et al. (2014) in Thailand	<ul style="list-style-type: none"> <li>- SDQ</li> <li>- 1,030 children where mother is the migrant worker</li> </ul>	Study found no association between current parental migration status and mental health status of the children left behind. Mother's earlier migration history had a significant association with mental health problems of the children left behind.
Vanore et al. (2015) in Moldova	<ul style="list-style-type: none"> <li>- SDQ</li> <li>- 1,979 children where mother is the migrant worker</li> </ul>	Migration of mothers infrequently results in worse psychosocial outcomes for children. Multivariate regression analyses showed that parental migration seldom corresponds to worse emotional symptoms outcomes but does correspond to increased conduct problems in children. Separate analyses for male and female children show significant gendered differences.
Hewage et al. (2011) in Sri Lanka	<ul style="list-style-type: none"> <li>- Executive Function (EF) Clinical evaluation, including Children's Home environment assessment using the "HOME" scale</li> <li>- 120 schoolchildren, 11 years age where mother is the migrant worker</li> </ul>	Children of migrant mothers had poorer EF. EF evaluations were made twice over a one-year interval, as well as teacher ratings of internalising and externalising behaviour of children. The migrant-group children were found to have poorer EF and higher levels of externalising behaviours than children in non-migrant households.
Senarathna et al. (2007) in Sri Lanka	<ul style="list-style-type: none"> <li>- Child behaviour was assessed by the Child Behaviour Checklist (CBCL). It indicated emotional and behavioural problems in children and adolescents</li> <li>- 253 children (ages 5–10 years) where mother is the migrant worker</li> </ul>	Mean CBCL scores were significantly higher in the migrant group. A high awareness is required among health and social care authorities regarding mental health problems in these children and relevant risk factors in order to take preventive measures.
Wickramage et al. (2015) in Sri Lanka	<ul style="list-style-type: none"> <li>- SDQ, nutritional status, health-seeking behaviour and household assessment</li> <li>- 820 children where mother or father is the migrant worker</li> </ul>	Two in every five left-behind children were shown to have mental disorders, suggesting that socio-emotional maladjustment and behavioural problems may occur in absence of a parent in left-behind children. Male left-behind children were more vulnerable to psychopathology.



where the father was the overseas worker. Related qualitative studies also undertaken by the authors have suggested that it is more challenging for migrant fathers to achieve intimacy with their children than for the mothers (Siriwardhana et al., 2014).

Hewage et al. (2011) harnessed the Executive Function (EF) exam, which aims at capturing a child's control of cognitive processes, including working memory, reasoning, task flexibility, planning, execution, and internalising and externalising behaviour. The EF was evaluated in each child enrolled in the study twice over a period of a year. Household dynamics and ratings of internalising and externalising behaviour of children were also captured. The migrant-group children were found to have poorer EF and higher behavioural problems than children in non-migrant households.

Senarath et al. (2011) showed that the absence of the father living with the left-behind child, the mother having a grade 5 or lower education, change of principal caregiver twice or more, living with a relative (or not living in own home), the child not communicating freely with caregiver, and not being permitted to engage in recreational activities at school were significantly associated with abnormal mental health among children of migrant women.

#### **A. Link with mental health of adult left-behind family members**

Two recent studies have demonstrated for the first time that living in a transnational household and caring for children left behind is also associated with an increased likelihood of poor mental health for mainly elderly caregivers (Siriwardhana et al., 2015; Graham, 2015). Health needs and psychological vulnerabilities are prevalent among adults providing child care in transnational households in Southeast Asia (Siriwardhana et al., 2015; Graham, 2015). The level of common mental disorders (CMD) among adult caregivers of left-behind children in Sri Lanka were comparable to CMD levels among adults with conflict-related trauma (Siriwardhana et al., 2015).

#### **B. Factors influencing the psychosocial health of left-behind children**

Proximal factors that may influence psychosocial outcomes of left-behind children identified through analysis of findings from the review of literature include: (a) access to regular and frequent communication with the migrant parent/s; (b) existence of effective child-care preparedness plans and support strategies for the primary caregiver/s; (c) appropriate respite for such caregivers; (d) skills and capacities in child rearing to effectively manage/utilize remittances for enhancing child growth and development; (e) child education support; (f) access to affordable, equitable and quality

healthcare services and health insurance schemes (see Figure 1).

According to the Child Health and Migrant Parents in South-East Asia (CHAMPSEA) Project, children in the Philippines appear to have greater access to modern communication technologies (such as e-mail and Skype) and therefore have greater opportunity to practice individual agency in different ways than children in Indonesia and Vietnam (Graham et al., 2012). Although communication through the Internet is more cost-effective than the use of telephones, it was reported that most migrants and their families could not afford the equipment or were computer illiterate (Graham et al., 2012). Fewer Vietnamese migrant families own cellphones as compared to non-migrants (Lam et al., 2013).

Also within the CHAMPSEA study, the existence of a psychological vulnerability was higher among Indonesian fathers who are caregivers (30.8%) than mothers who are caregivers (26.9%). However, the reverse is true for respondents from migrant households in the other two countries, where mother-caregivers (14.8% Filipino; 22.9% Vietnamese) are more likely to be psychologically vulnerable than father-caregivers (10.7% Filipino; 11.8% Vietnamese). The assumption that mothers heading the household can "cope better simply based on traditional gender roles" is challenged. However one fifth of the left-behind adult caregivers in Indonesia, the Philippines and Vietnam, regardless of gender, may suffer from potential psychological vulnerabilities.

It is also hypothesized that as international migration becomes more normative within high-emigration communities, certain child behavioural problems may decrease (Graham, 2011), with children developing along adaptive trajectories (Luthar, 2000). Acceptance by families and communities of the normalcy of transnational parenting (especially with low-skilled domestic workers) may reduce the vulnerability and enable resiliency in the children left behind. The Philippines has a long history and tradition of international labour migration, and this experience may serve to directly and indirectly sustain the normalization of migration within the social fabric. The Philippines was one of the first countries to establish institutional programmes and welfare support schemes for migrant workers and their families. Further research is needed to establish the extent to which such programmes enable a safe and dignified labour migration experience, and how they may protect the children of migrants. Enabling a culture of support and recognition of the efforts of migrant families requires partnerships with civil society, the private sector, media and non-governmental organizations.

In summary, current evidence shows mixed patterns of psychosocial health among left-behind children.



By drawing upon the results of these studies and the peer-reviewed literature, a number of factors that may account for the varying degree and extent to which the international migration of one or both parents affect the health status of their children have been identified and presented as a conceptual framework (see Figure 1).

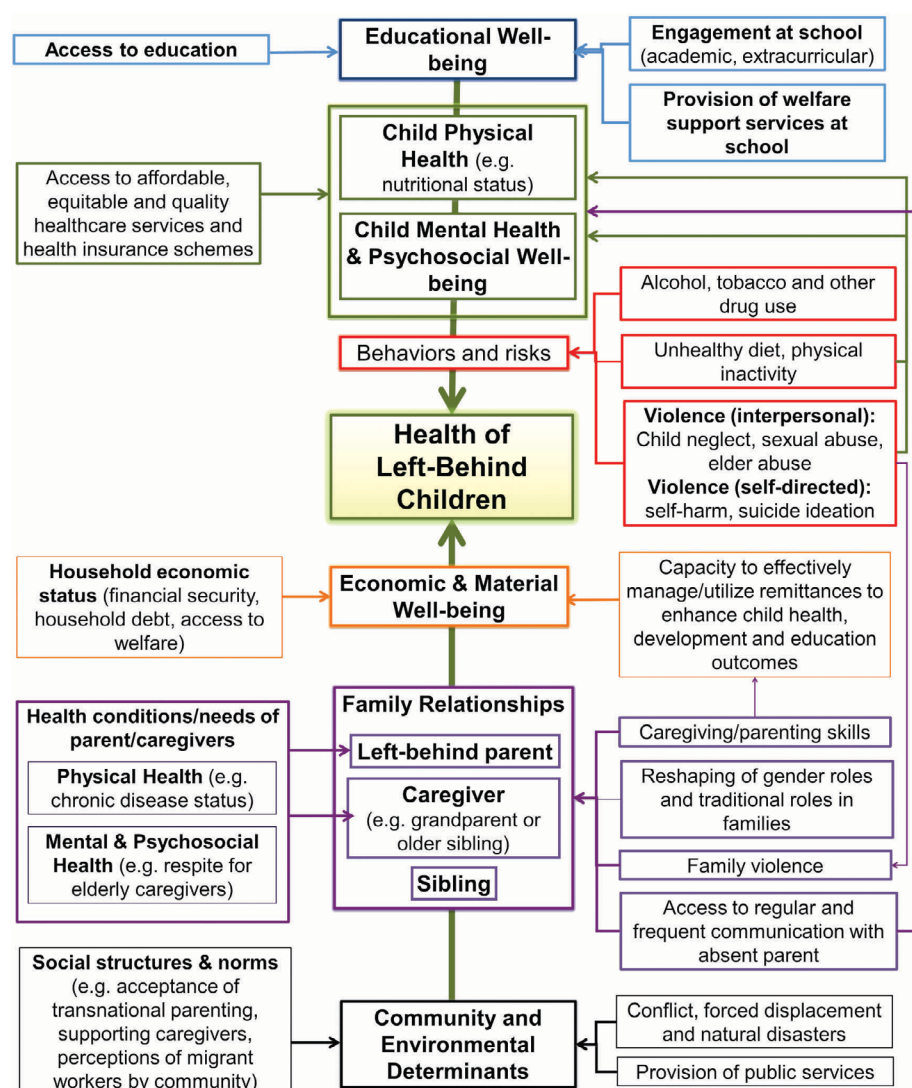
## IV. Effects of Parental Labour Migration on Child Nutrition

With high rates of malnutrition in low- to middle-income countries that are also major source countries for labour migrants, it is important, particularly for policy formulation, to explore the effects of parental migration, both positive and negative, on child nutrition. Remittances flowing from migrants may affect child nutrition through two broad pathways.

First, the migrant-sending household may have increased income to buy food and other goods as a result of the parent's remittances, which may allow the nutritional needs of children to be better met. Second, by changing time and task allocations within the household, the absence of a parent may reduce the time spent to prepare food and/or to care for the child's nutritional needs.

A review of the literature identified only a few studies that examined nutritional outcomes in the children of migrants, and even fewer that have been conducted in Asia. A study by Cameron and Lin (2011) highlighted that the absence of a parent in migrant-sending households had a negative effect on short-term child nutrition in Thailand. However, the authors suggested increasing levels of household remittances may help lessen the negative effect on child nutrition. Frank

Figure 1: Conceptual Framework on the Health of Children of International Labour Migrants



Notes: Factors identified through analysis of findings from empirical research described in this issue and from authors' research. The following sources were also used in constructing the conceptual framework: UNICEF (2007) model on "Dimensions and Components of Child well-being", Jampaklay (2014) exploration of "Parental Absence and Children's School Enrolment" and WHO, "Violence and Health report" (Krug, 2008).

and Hummer (2002), who studied Mexican migrant and non-migrant households, found that membership in a migrant-sending household reduced the risk of low birth weight, largely because the receipt of remittances improved maternal nutrition.

The study by Wickramage et al. (2015) in Sri Lanka showed that more than one-quarter (30%) of left-behind children 6–59 months of age were underweight or severely underweight compared to 17.7 per cent of non-migrant children (Jayatissa, 2009).

In summary, similar to psychosocial health, the few studies that have described nutritional outcomes in children with a migrant parent have shown mixed effects. Their nutritional status may be influenced by a complex interplay of underlying social determinants and cultural gradients that extend beyond the effects of enhancing purchasing power due to remittance income, child-care demands and food-preparation dynamics at the household level. Further research is required not only to unpack these factors and their associated inter-relationships, but also to explore the nutritional impact on child mental health and development.

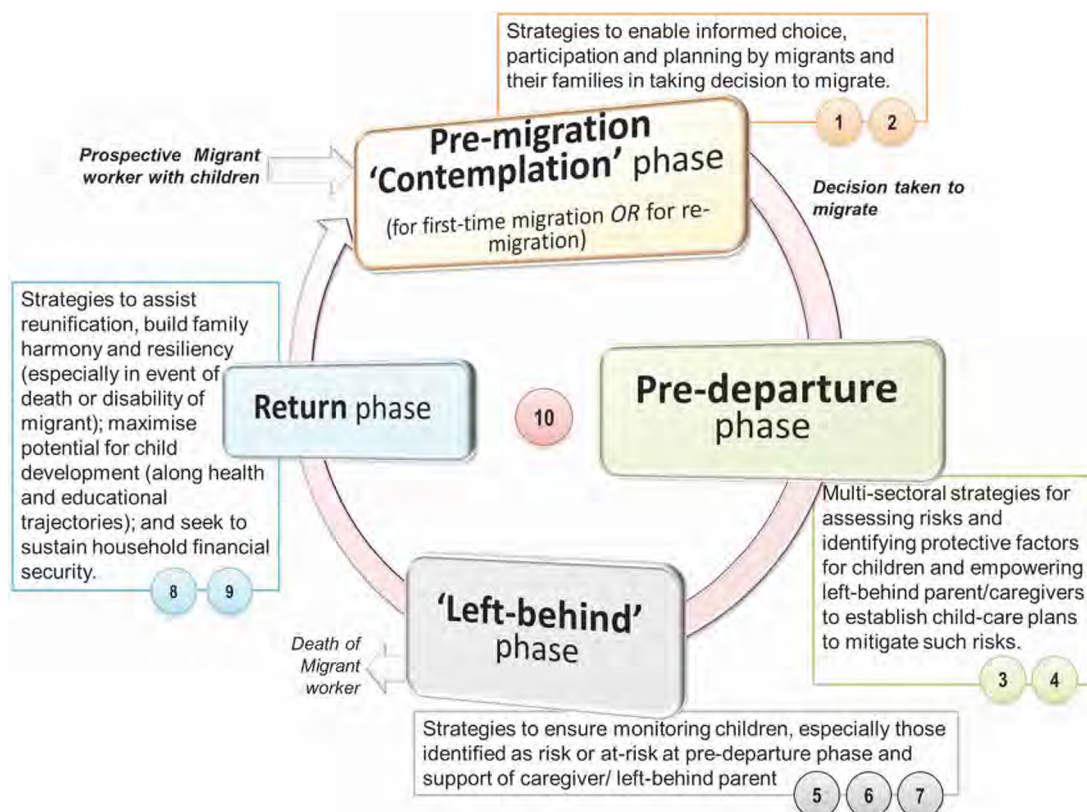
## V. Existing Support Programmes and Practices

A number of countries within the Asia-Pacific region have implemented programmes and practices aimed at supporting the welfare needs of transnational families. These include pre-departure orientation programmes for migrant workers and their families, health insurance and migrant welfare fund schemes and direct credit to support investment requirements (ADB, OECD and ILO, 2014).

Mandatory health insurance schemes for migrant workers and their family members are provided in varying degrees in the Philippines (PhilHealth), Sri Lanka, Thailand and India (Mahatma Gandhi Pravasi Suraksha Yojana). The Sri Lanka Bureau of Foreign Employment (SLBFE) also offers child educational scholarships and school equipment to migrant families facing major financial difficulties.

However, existing strategies are mainly centred on the individual migrant worker, with little focus on their family during the various phases of the migration cycle: when migration is being considered (pre-migration), when preparing for migration (pre-departure) and during the family member's absence (separation) (see Figure 2).

Figure 2: A Strategic Approach to Promote Well-being, Enable Resilience and Mitigate Risks for Left-Behind Children



## VI. Need for a Multisectoral Approach

To mitigate social and health-related risks, promote resilience and enable children of migrants to flourish, it would be worth considering creation of a multidimensional intervention framework, with engagement from governments (both migrant-sending and receiving), the labour migration industry, private sector, civil society, regional governance structures, donors and development partners and migrant families themselves. Figure 2 indicates a multi-disciplinary and programmatic approach that could harness multisectoral partnerships at country and regional levels, as described below.

### Pre-migration contemplation phase:

- 1) Research indicates that many spouses and family members feel disenfranchised in the process of making a decision whether to migrate. Ideally, the decision is best made through a consultative process involving the potential migrant worker, spouse and other relatives (see Box 1). Planning to address child-care support needs and the reshaping of gender roles (especially for male caregivers) is an essential step. Household savings and livelihood planning may be useful in order to maximise the benefits of remittances.
- 2) Governments can support families in making a decision whether or not to migrate through information campaigns in areas with high levels of new migration, by creating Migrant Resource Centres (MRCs). Such centres can provide access to information and facilitate informed choice in migration by facilitating partnerships with local job-network providers or domestic free trade zones (some of which offer monthly wage rates comparable to those of foreign jobs), and by ensuring protection against abusive and corrupt practices of employment agents through a strong regulatory and enforcement framework.

### Pre-departure phase:

- 3) Existing registration and pre-departure orientation processes focus exclusively on the migrant worker, with little or no engagement of their families (ADB, OECD and ILO, 2015). Meaningful inclusion of family members in mandatory pre-departure programmes may facilitate better understanding of labour migration-related processes and risks. Measures to mitigate migration-related risks for families, including pathways to seek support and referral, may be integrated within pre-departure orientation curricula.

Empowering the left-behind spouse (parent) and/or elderly caregivers in planning for and undertaking essential child-rearing and care strategies such as food preparation, school homework support and child recreational needs

form a vital part of preparedness. Financial planning and investment to maximize the use of remittances may also be provided within such pre-departure orientation programmes.

### Box 1: Questions for Potential Migrant Workers at Pre-Migration Contemplation Phase

- Do I clearly understand my reason for seeking overseas employment?
- Does my family understand the objectives of seeking overseas employment?
- Have I explored all options for employment within the country?
- Can I stay away from my family for a two-year period?
- Do I have infants or children under 5 years old who need my care?
- Who will care for them in my absence?
- Can family members manage to be away from me for two years?
- Can family members manage day-to-day activities without my support?
- Can family members manage the finances without my support?
- Can my children (over 5 years) continue their school work effectively without my support?
- Can I assure the safety, nutrition and health of my children if I stay home?
- Will I get the required support of my immediate and extended family members?
- Will the elderly family members be able to manage without me? If not, what is the available alternative for their care?

(SLBFE, 2013)

- 4) Half of the world's malnourished children are found in Bangladesh, India and Pakistan (Bhutta, 2000), which are also among the leading labour-sending countries in South Asia. The high prevalence of diarrheal disease, malaria and low immunisation rates warrants greater efforts to ensure children of migrants are monitored and their participation enabled in community-health and early childhood education programs. Community-level health workers, education officers and migrant welfare workers can be mobilized through an integrated family assessment conducted pre-departure to monitor children who may have special needs—for example, those under 5 years of age within male-headed households in settings where mothers were usually the primary household health caregiver. Figure 3 presents a case study on the Coordinated Care Plan for Left-Behind Children in Sri Lanka, which provides an example of such a family assessment undertaken pre-departure, using a multisectoral approach to identify risk and at-risk children.<sup>1</sup>

### Left-behind phase:

- 5) Research evidence indicates that elderly caregivers who acquire child-care responsibilities within left-behind families are afflicted with



adverse health conditions, including mental health ones (Siriwardhana, 2015; Graham, 2015; Lam, 2013). Implementation of respite programmes for elderly caregivers at the community level and wider recognition of their services through supportive partnerships between foreign employment agencies, civil-society groups, NGOs, media and community volunteers may contribute to reducing the psychological burden of care.

- 6) MRCs in areas of high migration may be a source of information, counselling and referral, as well as providers of Internet and phone access to enable families to connect with relatives abroad and reduce the burden of separation. Some analysts have proposed the creation of a tariff-free central hotline service that provides information and counselling services as well as allows migrants and their families to share their difficulties.
- 7) Research findings by Siriwardhana et al. (2015) and Lam et al. (2013) highlight the need to improve connectivity to maintain family relationships across transnational spaces. Lowering telecommunications costs and related technological barriers could enable migrants to connect more frequently with their children. Making remittance transfers more affordable and offering credit schemes to support migrant families would also be of value in reducing financial pressures. Government policies could encourage and stimulate such schemes.

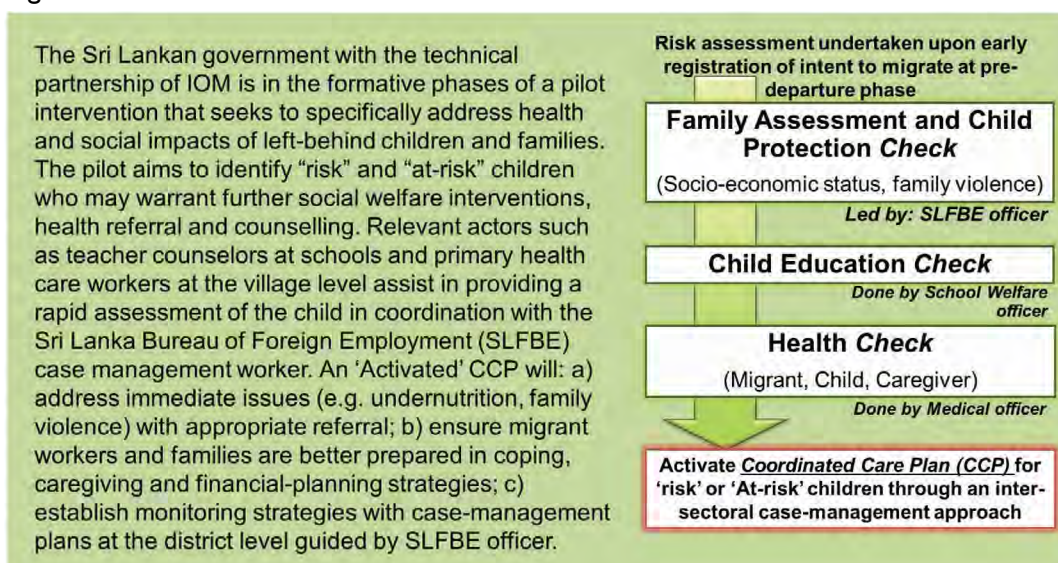
#### Return phase:

- 8) Families face significant vulnerability and hardship in situations where the migrant worker incurs major injury, disability or abuse, or dies during employment abroad.

Financial support, counselling and welfare support should be facilitated for members of such families, including children and elderly caregivers, with adequate provision for insurance payments and other livelihood support. In Sri Lanka, the Sahana Piyasa Centre, which is supported by SLFBE, serves as a refuge for female migrant workers who have been subjected to abuse during their labour migration experience.

- 9) Re-adjustment to traditional parental and/or spousal roles may become difficult for the returning migrant, especially after long periods of absence. Post-arrival social service support may help family members adjust to new roles. Post-arrival budgeting programmes offered through the MRCs could help families maximise their long-term financial security.
- 10) Community awareness campaigns, media and communication strategies targeted to reach migrant households pre-departure could stress a number of key points, among them the importance of (a) ensuring preparedness and planning for migrants with dependents, (b) avoiding predatory, unregistered migration agents and (c) recognition of the vital and under-appreciated role elderly caregivers play in contributing to nations' current and future wealth—both financial and human. As research evidence shows, in many Asian cultures, female migration remains stigmatised (Oishi, 2002). In the Philippines, returning migrant workers are provided a 'red carpet' welcome at the airport, and at times honoured by the president. In contrast in Bangladesh, social legitimacy for female migration is generally low (Oishi, 2002). Such stigma must be addressed at the societal level, through civil society, mass and social media and government-led campaigns to educate populations and change negative perceptions.

Figure 3: Coordinated Care Plan for Left-Behind Children in Sri Lanka





## VII. Conclusion

As labour migration to places such as the Middle East and the fast-growing economies of Asia increases in the many labour-sending countries of the Asia-Pacific region, its impact on the children of migrant workers and their health leave many unanswered questions.

Concerns centre on how separation from parents may affect childrens' nutritional, behavioural and psychological development.

While the current evidence base on the health impacts of labour migration, both for migrants and their families, remains limited, studies do suggest a number of programmes and policies that could benefit left-behind families.

Community programmes to strengthen the capacity of relevant government workers are needed to identify and address social, health and nutrition issues of families with a parent working abroad. From the Sri Lankan example (see Figure 3) such officers could include public health midwives, child protection officers, school counsellors and foreign employment agency welfare officers.

Programmes could undertake mapping and vulnerability assessments of children of migrant families at the pre-departure phase; development of case management or care plans for left-behind children using community participatory approaches; provision of information to prospective migrant families; and guidance for primary caregivers of left-behind children.

Finally, despite ever-increasing migrant flows and the importance of migration to economic development, there is a lacunae of public-health evidence in this area. Now more than ever, governments, development partners and researchers should work together to provide an evidence-informed voice on the health status of migrant workers and their families, especially left-behind children. Such evidence is needed for policy formulation and developing practical interventions to ensure a safe and healthy labour migration experience for millions of migrant workers and their families.

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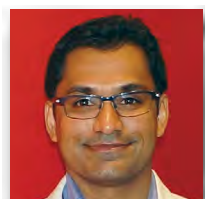
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## Endnotes

1. IOM is providing technical assistance to the Ministry of Health and SLBFE in the development of the CCP.

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