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The Intersection Of Migration And Governance Of Public Health: Access To Healthcare For Migrants And Refugees During Crises

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Abstract: *The paper discusses the role of the public health governance in determining access to healthcare among migrants and refugees in crises with special reference to Balochistan, Pakistan. It is a response to five questions, including how the structure of governance affects the availability, accessibility and continuity of care; how the accessibility of treatment and prevention is mediated by documentation, registration and residency regulations; how migrants and refugees are vulnerable to health compared to the host populations; and how to make health systems more inclusive, accountable, and resilient. The paper use a qualitative research design due to the 21 in-depth interviews carried out based on the purposive sampling in Quetta, Pishin, Killa Saifullah and Loralai. The interpretation of the narratives of the participants was made through the thematic analysis. The results indicate that access is not ensured by the formal health infrastructure. Deliberate exclusion by the administration, discretionary provider gatekeeping, poor accountability and fragmented implementation generate systematic barriers to refugees and migrants particularly at times of crisis. The participants reported documentation issues, referral to an independent clinic, lack of affordability, cause of insufficient treatment, and avoidable worsening of the state of health. This paper postulates that migrant and refugee health is not a governance issue but a humanitarian issue. It endorses that the fair response to crisis needs to be inclusive in registration, non-invasive in service provision, enhanced supervision, and reform of the health system involving the displaced people in the normal and emergency planning of their health systems.*

Keywords: Governance; public health; health care; migrants; refugees

Introduction

Migration, displacement as a force, and governance of public health, become more and more intertwined in the situations characterized by conflict, economical fluctuations, border instability, and frequent crises. The global community experiences unequal barriers to healthcare among migrants and refugees, with the crisis being particularly challenging to access with an already overwhelmed system (Singh & Acharya, 2023). Besides being subjected to diseases or being displaced physically, health requirements of these groups are influenced by their legal status, administrative practice, ineffective institutional coordination, and political recognition that was not equally extended to them. The outcome is the stratified vulnerability whereby health hazards are enhanced by governance failures as opposed to crisis

per se (Kakar et al., 2020).

The World Health Organization has identified that refugees and migrants usually have their own unique health requirements before, during, and after movement, and that their requirements do not always fit with the organization of service provision that in the communities where they move into. Another important point of World Health Organization (WHO) is the need to have equitable and people-centred health systems to provide continuity of fundamental care to these groups (WHO, 2022). United Nations High Commissioner for Refugees (UNHCR) also considers access to healthcare as an issue of protection and emphasizes that refugees must have the opportunity to access national systems or services assisted without any form of discrimination. (Citaristi, 2022). International Organization for Migration (IOM) places the topic of migrant health in the context of more general questions of governance, strengthening of systems, and universal coverage of health, especially during emergencies and displacement (IOM, 2025).

As a matter of fact, the gap between the policy and the reality is still significant. The inclusion, the continuity of care and the reinforcement of data systems are supported by international agencies and global frameworks, but are often selective, disjointed, and conditionalized by documentation regulations, administrative choice and local administrative discretion, and frailty of accountability at the ground. The recent WHO surveillance of the action plan on refugee and migrant health in the world shows that there is a need to have more serious leadership, improved monitoring, long term investment, and effective inclusion of refugees and migrants in health governance (WHO, 2022).

The issues are particularly topical in Pakistan, especially in Balochistan, where the regions receiving refugees also witness the poor service delivery, the distance between the facilities and the even distribution of humanitarian assistance. According to recent studies on the Afghan refugees in Baluchistan, significant impediments in access to maternal, newborn, and child health services were reported as cost and discrimination, and poor referral mechanisms and compounded vulnerabilities post-COVID-19. In another qualitative study on the issue of vaccine access among refugees and migrants in Pakistan, it was also established that legal status, mistrust, information deficits, and structural exclusion influenced the uptake of the services (Malik, et al., 2019; Sumra et al., 2025).

This research aims at discussing the role of public health governance in influencing the accessibility of migrants and refugees to healthcare in the event of crisis in Quetta, Pishin, Killa Saifullah and Loralai. The paper aims to examine the role of governance structures in the access to, availability and persistence of healthcare services among displaced populations; how documentation status, registration regimes and residency policies are relevant to access to treatment and preventive care; how migrants and refugees are more vulnerable to health issues than host populations during crises; where disjunctions exist between the policy promises and actual practice on the ground; and how health systems can be transformed to be more accommod The article claims that the issue of healthcare exclusion in times of crisis is not a mere by-product of the recognition, documentation and institutional responsiveness that can be redistributed unequally as a result of governance structures, but rather the result of a political and administrative process that defines whose lives are valued and whose access to care is conditional.

2. Review of Literature

The migration and health research literature has a consistent pattern where the access to healthcare depends on the social, legal, and institutional factors instead of the medical necessity. Traumas caused by war, health risks associated with mobility, substandard housing, broken treatment records, unstable employment, and inadequate finances are some of the overlapping burdens that refugees and migrants have to deal with (Chiarenza et al., 2019). The assumption that border issue is a narrow assumption on migrant health is no longer acceptable by global health institutions. Rather, they consider it as a systems problem in terms of service provision, funding, information, rule and rights safeguarding. The global framework of WHO on refugee and migrant health focuses on inclusion in national health policies,

provision of continuity in the essential services, and interventions in health of the populace that operate both in emergency and long-term contexts. ((Hossin, 2020).

One of the themes that are evident in the literature is that of governance. The health outcomes with regard to migration are highly determined by the control measures of states on registration, legal identity, residency, and entitlement. UNHCR advice on documentation observes that identity and registration documents frequently become a requirement to access services including healthcare, education, freedom of movement and others. In case of lack of documentation, ambiguity, expired or unaccepted by local providers, there is exclusion. (Juárez et al., 2019). This is because documentation is not an objective administrative instrument. It is a gatekeeping mechanism that identifies the practical access to the rights.

The second theme that comes out is the disjuncture between commitments and a reality that is lived. The UNHCR public health strategy provides that refugees can enjoy quality healthcare services provided by the national systems or other complementary support systems and WHO reporting indicates that nowadays, many countries use the terms refugees and migrants in the health policy frameworks. However, the paper inclusion does not necessarily lead to the equal access in daily clinical practice. Street-level discretion matters. Registration clerks, clinicians, hospital administrators and frontline officials have an unequal interpretation of rules. Nominal entitlements are compromised by discrimination, unofficial charges, manipulation of referrals, or bureaucratic procrastination in most of the environments (Abbas et al., 2028; Fisher et al., 2024).

A third literature looks at the issue of differentiated vulnerability in the time of crisis. High exposure to infectious disease, mental distress, maternal risk and interruption of chronic care is commonly encountered by refugees and migrants as they tend to reside in overcrowded settlements, dependent on unstable incomes and face a language or legal barrier. According to WHO, the needs of refugees and migrants in health are based on the pre-movement, peri-movement, and post-movement experiences and might not be consistent with the design of the services provided in the host country (WHO, 2022). IOM also emphasizes the fact that in times of crisis and movement, individuals might be deprived of routine and preventive healthcare, and their conditions are getting worse, which could have been mitigated with the help of timely intervention (IOM, 2025).

Another public health externality that is brought out in the literature is the destruction of externalities through exclusion. The effects go beyond an individual where the migrants and refugees inaccessible to diagnosis, vaccination, antenatal services, and treatment of communicable and non-communicable diseases. Delayed care contributes to the risk on a community level, overloads the emergency service, and compromises the surveillance of the disease and the continuity of care. The global health security, system resilience, and health equity are explicitly linked to the migrant inclusion within the global health care context as monitored by WHO in terms of the global action plan. Being unjust, it is also inefficient and epidemiologically counterproductive (WHO, 2022; WHO, 2023).

The literature is smaller but it is becoming relevant with the context of Pakistan. The studies of the Afghan refugees in Quetta record the barriers that comprise cost, limited mobility, inadequate transport, language barrier, institutional responsiveness, as well as discrimination in maternal and child health services (Kaleem et al., 2024; Sumra, 2025). The study of COVID-19 vaccination among refugees and migrants in Pakistan revealed that regular and irregular migrants had poor access and confidence related to the issue of documentation, lack of information, and distrust towards institutions. Such results help to adopt a governance framework: the issue is not only the lack of services but the conditional and stratified accessibility (Ali et al., 2022; Yasmin and Najeeb, 2021).

The other piece of literature is the one addressing accountability and health system reform. Both IOM and WHO claim that the health of migrants must be considered as a part of universal health coverage, social security, and crisis response and not as a humanitarian one-off intervention. This means that it

would reform the data systems, financing, provider training, anti-discrimination protection, the referral pathways and the participation mechanisms. It also needs to organize the collaboration between state institutions and international agencies, local health departments and host communities (IOM, 2022; WHO, 2022).

Although such advances are made, there are still a number of gaps in the literature. To begin with, the majority of studies concentrate on the design of a policy or the particular services yet offer little concern with the impact of administrative discretion on the access in the daily contexts. Second, the qualitative literature produced by the refugee-hosting districts in Balochistan beyond the generalized national discourses is lacking. Third, the current academic literature tends to consider migrants and refugees as the same category, whereas variations in legal status, history of documentation and movement patterns may generate different types of exclusion. Fourth, the concept of crisis governance is not frequently grounded in the evidence provided in the field of its application, people approaching hospitals, registration systems, and treatment pathways (Ali et al., 2022; Kaleem et al., 2024; Sumra, 2025; Yasmin and Najeeb, 2021).

The paper adds to the body of literature by putting the lived experiences of migrants and refugees in the focus of four districts of Baluchistan and putting the healthcare access in the perspective of the healthcare governance. It does not simply focus on the question of the availability of services, but instead on the availability of those services in practice as defined by rules, institutions and power relations.

3. Research Methodology

The research design applied in this study was qualitative design, which investigated the intersection of migration, governance and access to healthcare in times of crisis. A qualitative method was selected to respond to lived experiences, institutional relations, exclusion perceptions, and senses that migrants and refugees develop towards documentation, treatment, and vulnerability. These problems need to be more in-depth and more contextual, which cannot be fully dealt with by quantitative techniques. The study was carried out in four Balochistan districts, which included Quetta, Pishin, Killa Saifullah, and Loralai. These zones were chosen as they accommodate migrant and refugee groups and represent various degrees of healthcare access, administrative coverage and the service availability. Quetta is a significant metropolitan and health-service facility whereas the rest of the districts are more dispersed and limited. Purposive sampling was applied to identify 21 participants who had direct experience regarding their request of healthcare services in crisis situations. The sample was not created at an analytical level but at a statistical level. The data were obtained with the help of in-depth interviews where participants could speak about such sensitive points as discrimination, fear, administrative exclusion, unaffordable care, delayed treatment, and relationships with the state and aid institutions. The qualitative analysis was performed using thematic analysis. The repetitive analysis of transcripts and notes yielded five central themes, namely; public health governance and healthcare access; documentation and administrative exclusion; unequal health vulnerabilities in crises; policy-practice gaps in service delivery; and resilient, inclusive health system reform. The weaknesses of the study population made ethical issues revolve around confidentiality, anonymity, and voluntary participation. The article is weak in terms of its local nature and the use of self-reported experiences but it is useful as qualitative data demonstrates the experience of healthcare systems as faced and experienced by marginalized groups.

4. Findings and Discussion

4.1 Public Health Governance and Healthcare Access

The participants constantly stated that the availability of hospitals and physicians did not necessarily mean health access. One of the key conclusions of the research is that the healthcare exclusion is directly related to the failure of governance. The participants did not deny the existence of public hospitals and

availability of doctors but explained how the institutions are rendered inaccessible due to informal practices, discrimination attitudes as well as accountability. One of the stories that kept on reoccurring was that when a doctor detected a patient to be a refugee or migrant, he or she would not treat the patient in the state hospital and refer the patient to a private clinic or a private hospital. This was seen as a calculated move by the participants that was associated with profit and impunity. In such situations the publicly-provided facility was formally available, but the real care was pushed out of reach into prohibitively expensive privatised means. This kind of referral conducts healthcare access into a market deal that the populations which cannot be replaced cannot afford. The participants said that most of the refugee community lives with chronic illness that is not treated or they die back home as they cannot afford to pay private fees.

The fact is important to the governance of the health of the population. Formal denial is not the only form of access block. Weak control over provider behavior, lack of complaint systems as well as state control failure also undermine it. Governance failure in this case is in form of uncontrolled discretion. Frontline providers have power over who can access the treatment pathways and displaced patients lack the institutional resources to fight abuse. This is in line with more generalized literature that formally health policy tends to fail at the implementation stage, whereby practices of the provider, and local administrative culture define actual access (Vogelaar, 2017). There is also the crisis aspect of the issue. The demand in quick, cheap, and uninterrupted treatment becomes even more acute in the case of emergency. Referral to the private care in case of crisis conditions brings in delays, heightened financial suffering and heightened morbidity. An availability and accessibility is inseparable to accountability, in a governance point of view. The presence of infrastructure is not sufficient to make a health system become accessible. It should also make sure that the delivery of the public services is on a fair basis without any coercion to divert to the private payment schemes.

4.2 Documentation and Administrative Exclusion

The documentation status was found to be one of the most determining factors to access to healthcare among the participants. A significant number of participants described how individuals who lack documents or their papers are incomplete or have blurred and outdated documents are automatically excluded when seeking treatment. Even the legal document holders reported challenges which means that the possession of the documents does not always lead to identification. This observation shows that documentation is a gatekeeping technology. It is mediating identity, as well as eligibility, legibility and institutional trust. According to the participants, a lot of migrants and refugees often cross borders or live under unstable conditions, which complicates the need to keep documentation. Some are of illiterate origin and have not been socialized into documents based system of governance. To such groups, legal identity is weak and weakness reflects into disrupted access to care.

The UNHCR instructions clearly point out that registration and documentation tend to be a prerequisite to receiving services, such as healthcare (Vogelaar, 2017). The data in the field substantiate this, though also go beyond it: the issue is not only the absence of documentation. Administrative exclusion caused by rigid, poorly explained, weakly coordinated, or punitive registration systems is the problem. Participants reported that authorities and health professionals were unwilling to help when papers were missing or misinterpreted. Others have said that partial assistance would still be given by some government doctors, but this was not always the case and it was a matter of their goodwill and not a system requirement. It means that the ability to get treatment and preventive care is conditional based on administrative navigation ability. This puts a disadvantage to the illiterate, mobile, poor, traumatized, or irregularly documented. It also increases the gap between regular and irregular migrants only partially, as even regular status is not guaranteed to achieve access. Participants continued to stress that the two categories are both hindered.

The governance issue in this case is systemic. Registration systems are handled as neutral administrative filters, but in reality they allocate exclusion. Such systems are more consequential in case of crisis, as

people require immediate treatment, vaccination, maternal care, and preventive services. A healthy society should therefore avoid the confusion of identity management and refusal of critical care. In cases where documentation is a hindrance to life-saving or preventive services, governance is no longer protecting of health.

4.3 Unequal Health Vulnerabilities in Crisis Settings

The participants noted that the migrants and refugees do not feel crisis as their host populations. They are vulnerable because of their economic disadvantages, insecurity, fear of institutions, and inequality in accessing services. Vulnerability was not a condition in the stories of the participants. It was pinned to certain risks: the inability to get treatment, medicine or to be exploited, lack of care in the general facilities and the worsening of the untreated disease. This observation is in line with the broader body of literature on migrant health where it is found out that refugees and migrants tend to be burdened by their health before, during, and after displacement. They can have a need in trauma, chronic disease, maternal risk, exposure to infectious disease, malnutrition, and mental distress and unstable or broken histories of care (WHO, 2022). The interviews however show that the vulnerability is also relational: whereby it comes out due to the health system reacting in different ways to them as compared to citizens or settled host populations.

The participants were found to propose that they do not receive equal treatment because of what they are supposed to be. Being a refugee or migrant identifies them as less deserving, less urgent, or more of a burden to the administration. This causes a chain of deservingness where the host populations easily sail through the public systems whereas the displaced populations would tend to wait until the illness is at an advanced stage. These inequalities are more acute in the case of a crisis. Individuals with good social connection, economic savings, documents that are known or well-known and people who have knowledge of the institutions can re-enter an access much faster. These buffers are usually lacking to migrants and refugees. This causes growing drawback: poorer baseline circumstances, increased barricades to care, later treatment and poorer results. The interviews also suggest that women, children, the elderly, and those having chronic disease can be especially vulnerable because the current data can be arranged in terms of larger community-based themes. This part supports the main argument of this paper, that health vulnerability cannot be biologically reduced to a risk. It is produced in terms of politics and administration. The crisis does not bring the exclusion out of nothing, it reveals and increases the already existing inequalities within the governance.

4.4 Policy-Practice Gaps in Healthcare Delivery

The participants reiterated several times that refugees are assured at the policy level to be safeguarded by UNHCR and other broader international rules but this is not the case with the actual experiences. This is one of the most obvious themes of the study as this is a divergence between the official policy and the actual service delivery. Participants claimed that the aid organizations and institutional actors tend to project the healthcare support of refugees in increased or positive terms. But down here, there is still partial access, which is geographically unequal, and generally insufficient to the extent and intricacy of demand. The participants pointed out that a significant number of refugees and migrants are the victims of war and conflict zones who bring with them severe diseases and prolonged health effects. Fragmented or symbolic service provision cannot be adequate in such a case.

This observation is in line with that of other countries. Inclusion, continuity of care, and better inclusion into national systems is promoted by both WHO and UNHCR, and still recent WHO monitoring has found that there are still significant implementation gaps, such as incomplete implementation, weak data, and lack of accountability (Citaristi, 2022; WHO, 2023). The Balochistan field data reveal how this divide is instantiated at the bottom, that policy is there, access is in practice both geographically and discretionally distributed and aid-intensive, and the uneven distribution of facilities which do work. It was observed that most of the places where refugees are received do not have proper healthcare

facilities. When this happens, policy undertakings turn out to be highly rhetoric. The presence of global standards is not the solution to transport obstacles, manpower deficit, lack of drugs, prejudiced behavior, and discriminatory registration processes. This leads to pragmatic exclusion in circumstances of nominal inclusion.

This policy-practice gap is important analytically in that it demonstrates that failure in implementation is not peripheral to governance, but it is governance. The health systems are evaluated based on the actual performance rather than the statements they make in the real world. The problem is not merely the lack of resources in situations where the communities are still marginalized even when the policy has been emphatic about that. It is breakdown of translation of norm to institution, institution to frontline practice, and service presence to actual use.

4.5 Resilient and Inclusive Health System Reform

The last theme is the theme of reform. The experiences of the participants lead to the fact that health systems should be more equitable, responsive, and sustainable when dealing with displacement and emergency. This research indicates that there are various reform areas to be taken. To begin with, the accountability should be enhanced within the governmental facilities. Grievances of discriminatory practices, denial of care, or forceful referral to out-of-pocket centers should have a well-defined mechanism of control. Hospitals that are publicly owned are not supposed to act as points of entry to extraction privately. The areas of health governance should include the monitoring, redress of grievance, and enforcement. Second, documentation and registration systems should be restructured in a way that do not hinder care that is vital. Identity verification might be necessary to keep administrative controls, however in case of emergency treatment, maternity, vaccination, chronic illness, and preventive measures should not be denied due to a lack or the imperfection of documents. Both UNHCR and IOM are advocates of more inclusive and system-based access and social protection (Citaristi, 2022).

Third, the health system planning of refugee-hosting districts should go beyond the humanitarian supplementation that is ad hoc. Migration and refugee health ought to be included in the normal district health government, funding, human resource planning, referral services, and community health monitoring. Both IOM migration-health framework and WHO global action plan facilitate this change towards integration of the systems and resilience. Fourth, reform needs training and anti-discrimination protection of the providers. The frontline workers should be directed on the rights of migrants, refugees, referral ethics, crisis-sensitive care, and communicating with the vulnerable populations. Legal and policy reform do not be very deep without reforms at the point of service delivery (Hossin, 2020; IOM, 2025).

Fifth, inclusive reform is participatory. Migrants and refugees are not to be manifested as recipients and case numbers. They ought to be identified as stakeholders whose experiences would be required to come up with workable systems. The recent reporting by WHO demands the inclusion of refugees and migrants into the processes of decision-making more strongly (WHO, 2023). This does not symbolize anything. It is also more realistic in its policies because it bases the reform on the actual experience of exclusion. A robust health system is thus one that is functional when it is under pressure as well as allocates care in a non-discriminatory manner. Unequal survival is merely maintained by resilience that does not include it. The research has revealed that equity, accountability, and resilience should not be policy goals to be considered as autonomous.

5. Conclusion

The paper has discussed the crossover of migration and the issue of governance of public health in a qualitative study of the experiences of migrants and refugees to healthcare in Quetta, Pishin, Killa Saifullah, and Loralai. These results indicate that the presence of formal services is less important in defining access to healthcare in crisis situations than are governance frameworks that control access,

identification and responsibility. To start with, the governance of public health influences availability and accessibility, which is an institutional practice. The participants referred to the practice of doctors in the public hospitals redirecting refugee and migrant patients to the private clinics and transforming nominal access into unaffordable exclusion. This is a sign of poor responsibility and biased discretion. Second, administrative exclusion is caused by documentation, registration systems and rules that relate to residency. Inaccessibility to treatment and preventive services is caused by the lack of documents, ambiguous papers or failure to navigate bureaucratic requirements. Even legally registered people are not always taken care of showing that legal status does not necessarily guarantee successful access. Third, migrants and refugees have different health vulnerabilities compared with the host populations due to the effects of crisis that are mediated by poverty, mobility, legal precarity, poor social protection, and unequal institutions treatment. They are not only weak in the medical sense, but also socially and politically. Fourth, policy promises and the reality on the ground continue to be significantly different. The refugee health rights might be acknowledged by the international and national structures, but the service delivery in the areas hosting refugees is still incomplete, inconsistent, and poorly implemented. Fifth, structural reform has to be done to make health systems more inclusive and resilient: improved regulation of practices at the frontline, non-discriminatory access despite documentation barriers to essential services, inclusion of migrant health in the planning of districts and provincial jurisdictions, provider training, improved grievance mechanisms, and involvement of the displaced communities in the governance process. The wider connotation of this work is obvious. The health of migrants and refugees in the times of crisis should not be considered as a marginal humanitarian issue. It is one of the key examinations of governance in the sphere of health. The failure of systems to safeguard displaced people means that the system also fails the equity, accountability and resiliency upon which public health relies.

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