HEALTH OF MIGRANTS – THE WAY FORWARD

Report of a global consultation

Madrid, Spain, 3–5 March 2010

World Health Organization

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD Y POLITICA SOCIAL

IOM International Organization for Migration
OIM Organisation internationale pour les migrations
OIM Organización Internacional para las Migraciones

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Acronyms and abbreviations

APEC	Asia-Pacific Economic Forum
ASEM	Asia-Europe Meeting
CALD	Culturally and linguistically diverse
CAN	Community of Andean Nations
CARAM Asia	Coordination of Action Research on AIDS and Mobility in Asia
CARICOM	Caribbean Community
CIDA	Canadian International Development Agency
CLAS	Culturally and linguistically appropriate health services
COE	Council of Europe
CONHU	Hipólito Unanue Convention
CPLP	Community of Portuguese Language Countries
CSME	Caricom Single Market and Economy
EAC	East African Community
ECOWAS	Economic Community of West African States
EPSCO	Employment, Social Policy and Health and Consumer Affairs Council
EU	European Union
GCIM	Global Commission on International Migration
GFMD	Global Forum on Migration and Development
GMG	Global Migration Group
HWG	Health Working Group
ICRMW	International Steering Committee for the Campaign for Ratification of the Migrants Rights Convention
ICSW	International Committee on Seafarers' Welfare
IDP	Internally displaced person
IFRC	International Federation of the Red Cross and Red Crescent Societies
IGAD	Intergovernmental Authority on Development
IHR	International Health Regulations
ILO	International Labour Organization
IMHA	International Maritime Health Association
IOM	International Organization for Migration
IRAPP	IGAD Regional HIV/AIDS Partnership Program
ISF	International Shipping Federation
ITF	International Transport Workers' Federation
JUNIMA	Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia and Southern China
MBDS	Mekong Basin Disease Surveillance
MIDSA	Migration Dialogue for Southern Africa
MiMi	With Migrants, For Migrants
MTM	Mediterranean Transit Migration Dialogue
NGO	Non governmental organization
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
RCP	Regional Consultative Process

RECs	Regional Economic Communities
SAARC	South Asian Association for Regional Cooperation
SADC	Southern African Development Community
SEEHN	South-Eastern Europe Health Network
SEGIB	Ibero-American General Secretariat
UNAIDS	The United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNITAR	United Nations Institute for Training and Research
WAHO	West African Health Organization
WHA	World Health Assembly
WHO	World Health Organization

Foreword

In a globalized world defined by profound disparities, skill shortages, demographic imbalances, climate change as well as economic and political crises, natural as well as man-made disasters, migration is omnipresent. There are an estimated 214 million international migrants, 740 million internal migrants and an unknown number of migrants in an irregular situation all over the world. While these figures comprise a wide range of different migrating populations, such as workers, refugees, students, undocumented migrants and others, and their vulnerability levels vary greatly, the collective health needs and implications of a population cohort of this size are considerable. The health of migrants and health matters associated with migration are crucial public health challenges faced by governments and societies. This notion formed the basis for the Resolution on the health of migrants which was endorsed by the Sixty-first World Health Assembly in May 2008.

We know that approaches to manage the health consequences of migration have not kept pace with growing challenges associated with the volume, speed, diversity and disparity of modern migration patterns, and do not sufficiently address the existing health inequities, nor determining factors of migrant health, including barriers to access health services. Many countries and agencies are promoting the health of migrants and working at improved health services for migrants. However, we are witnessing ample examples of trends that fuel social exclusion of vulnerable migrant groups and leave their health needs unattended. There is much work ahead. We are still far removed from a society that is equipped to provide adequate access to health services to all migrants and address migrants' right to health. The global economic crisis has raised concerns about many migrants' working and living conditions and, as a consequence, of their well-being. Poverty, despair and lack of employment opportunities continue to trigger perilous migration flows and associated health risks. Many migrants in an irregular situation lack access to health services, and many suffer deplorable living and working conditions. Disasters, armed conflict and food insecurities continue to threaten the health of millions of people who are forced to migrate.

Guided and inspired by the action points of the above mentioned Resolution, WHO, IOM and the Ministry of Health and Social Policy of Spain organized a Global Consultation on the health of migrants in Madrid on 3–5 March 2010. This publication provides a synthesis of the key discussion points of the Consultation, its outcomes and the background materials prepared for the event.

The Consultation brought together approximately 100 participants from all geographical regions representing various arms of governments, non governmental organizations, international organizations, regional institutions, the Red Cross and Red Crescent Movement, academics and experts, as well as professional and migrant associations. Their rich experience and knowledge enabled us to identify the gaps, accomplishments and priority areas for action in the vast domain of migrant health. Moreover, the Consultation identified the basic building blocks for an operational framework that will help all stakeholders coordinate and harmonize actions toward enhancing the health of migrants.

Political commitment and the concerted involvement of all stakeholders will be essential in order to ensure that the framework leads to the desired level of action, which should encompass improved monitoring of migrant health, policy reorientation, effective use of legal instruments and the development of health systems reflective of the diversity of today's societies. Moreover, we hope the Consultation has been instrumental in triggering an international technical network on migration and health by bringing together experts across the world, across sectors and across disciplines, ready to address migrant health issues associated with rapidly changing and increasingly diverse societies.

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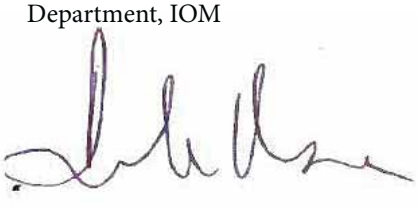


Executive summary

The 2010 Global Consultation on Migrant Health was convened as a result of the 2008 World Health Assembly Resolution on the Health of Migrants, which asks Member States to take action on migrant-sensitive health policies and practices, and directs WHO to promote migrant health on the international agenda, in collaboration with other relevant organizations and sectors.

Accordingly, WHO and IOM, in collaboration with the Ministry of Health and Social Policy of Spain, held a Global Consultation on Migrant Health on 3–5 March 2010 in Madrid to:

- take stock of actions taken since the endorsement of the Resolution
- reach consensus on priority areas and strategies
- identify the elements of an operational framework to assist Member States and stakeholders in making further progress on the issue.

This consultation report offers a summary of the issues discussed at the consultation and presents an outline for an operational framework to guide action by key stakeholders.

Part 1 provides the proceedings of the consultation, including an overview of the consultation process and inputs for discussion. It also summarizes the key issues and controversies raised by the featured speakers in presentations and by participants in their break-out discussions of the four thematic areas listed below.

Part 2 offers an outline for an operational framework to further action on migrant health, with recommendations for moving this agenda forward.

The framework outline is based on a synthesis of the inputs and recommendations from the consultation and suggests key priorities and corresponding actions in each of the four thematic areas. These priorities include:

- *Monitoring migrant health:* ensure the standardization and comparability of data on migrant health; support the appropriate aggregation and assembling of migrant health information; map good practices in monitoring migrant health, policy models, health system models.
- *Policy and legal frameworks:* adopt relevant international standards on the protection of migrants and respect for rights to health in national law and practice; implement national health policies that promote equal access to health services for migrants; extend social protections in health and improve social security for all migrants.
- *Migrant sensitive health systems:* ensure that health services are delivered to migrants in a culturally and linguistically appropriate way; enhance the capacity of the health and relevant non-health workforce to address the health issues associated with migration; deliver migrant inclusive services in a comprehensive, coordinated, and financially sustainable fashion.
- *Partnerships, networks & multi country frameworks:* establish and support migration health dialogues and cooperation across sectors and among large cities and countries of origin, transit and destination; address migrant health matters in global and regional consultative migration, economic and development processes (e.g. Global Forum on Migration and Development).

Part 3 contains a series of recommendations for moving the agenda forward. Countries have a key role to play, particularly in creating a locus of responsibility at the national level for migration and health issues from which policies and programmes can be implemented. WHO and IOM can take the lead by further developing the action agenda, identifying and disseminating information about policy and practice models, and raising awareness and promoting collaboration among key international stakeholders. Special attention should be paid to the important role of migrant participation in social protection programmes in countries, and resources will need to be identified to facilitate action at all levels.

Lastly, this publication contains the thematic papers that informed the consultation discussion, background materials concerning selected migration-related terminology, the text of key speeches, and other relevant documents.

INTRODUCTION

Migration is a topic of interest to almost all countries and communities. Current global estimates of migrants place their numbers at nearly 214 million international migrants and 740 million internal migrants.[1] Growing migration figures reflect the increase in global population growth and, in this respect, migration is not a new phenomenon. However, migration flows have become more complex and comprise a heterogeneous group of individuals, each with potentially different health determinants, needs, and levels of vulnerabilities.

Global processes such as economics, trade, as well as climate change and environmental degradation, are some of the factors that have brought about and will continue to bring about flows of diverse populations. Migration is essential for some societies to compensate for demographic trends and skill shortages and to assist home communities with remittances. Migration is, in and of itself, not a risk to health. In a world defined by profound disparities, migration is a fact of life and governments face the challenge of integrating the health needs of migrants into national plans, policies and strategies, taking into account the human rights of these individuals, including their right to health. Not doing so creates marginalized groups in society, infringement on migrants' rights and poor public health practice. Governments increasingly recognize the need for a paradigm shift in how to think about health and migration and how health systems and related policies address migrants' health. Addressing the health needs of migrants can improve their health status, avoids stigma and long term health and social costs, protects global public health, facilitates integration, and contributes to social and economic development.

CONTEXT OF THE GLOBAL CONSULTATION ON MIGRANT HEALTH

Against this background, Member States requested that the World Health Organization (WHO) develop a Report on the Health of Migrants, which was discussed by the Sixty-first World Health Assembly in May 2008.[2] A Resolution (WHA 61.17) on this subject was subsequently approved by the WHA. This resolution asks Member States for migrant sensitive health policies and practices and requests that WHO promote migrant health, in collaboration with other relevant organizations; encourage interregional and international cooperation; and promote the exchange of information and dialogue among its Member States, with particular attention to strengthening of health systems.

As part of the mandates of the Resolution, WHO, the International Organization for Migration (IOM) and the Ministry of Health and Social Policy of Spain, took the initiative to organize a Global Consultation on Migrant Health in Madrid, in March 2010. The objectives of the consultation were:

1) to take stock of the actions taken by Member States and other stakeholders;
2) to reach consensus on priority areas and strategies to improve the health of migrants and communities in today's increasingly diverse society;
3) to identify the elements of an operational framework to promote migrant health and to work with Member States and stakeholders in their efforts to address health of migrants and health issues associated with migration.

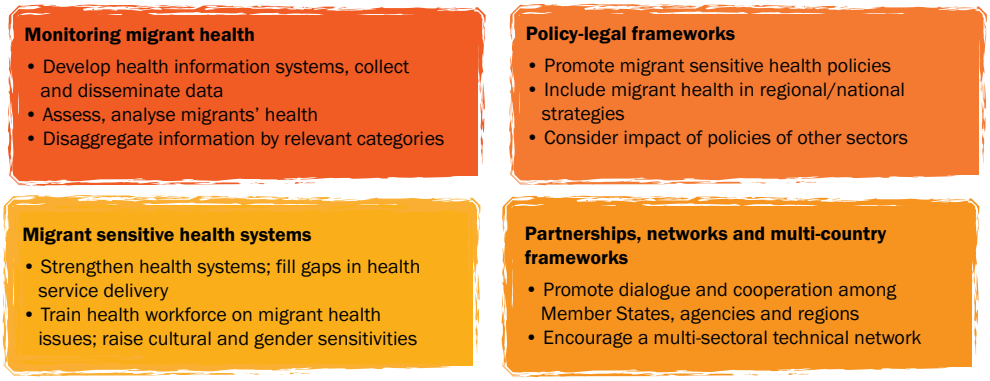
The Global Consultation was attended by some 100 participants from all geographical regions, including representatives from governments, international, non governmental and professional organizations, the Red Cross and Red Crescent Movement, migrant associations, academia and experts.

In preparation for the meeting, participants received background documents designed to give an overview of the current state of affairs and to set the stage for discussion at the consultation. In addition to an introduction paper, there were four thematic papers on the key themes set out in the resolution:

- Monitoring migrant health;
- Policy and legal frameworks affecting migrants' health;
- Migrant sensitive health systems;
- Partnerships, networks, and multi country frameworks.

These interlinked themes were based on the action points of the resolution (Figure 1).

FIGURE 1. WHA RESOLUTION ON MIGRANT HEALTH, SELECTED ACTION POINTS



At the consultation, attendees heard presentations on each theme and broke unto small groups to identify lessons learned, priorities to address, key actions and lead actors. After each break-out session, designated rapporteurs synthesized the comments of all groups and reported back to the plenary. These reports were consolidated into a final product, in the format of an operational framework outline and presented to the plenary on the last day of the consultation. The framework suggests key priorities and related actions in the four thematic areas, which are intended to guide stakeholders on the next steps towards implementation of the resolution.

This report includes a summary of the Global Consultation based on keynote addresses, presentations and debates, as well as a summary of the recommendations on future priorities and actions. It concludes with an outline for an operational framework based on the inputs from the consultation participants, and a "way forward" as formulated by the Organizers.

A clarification of the usage of migration-related terminology and a glossary on selected migration terms are included in the background materials section of this document.

NOTES

1. UNDP. *Human Development Report 2009. Overcoming barriers: Human mobility and development*. United Nations Development Programme, 2009 (http://hdr.undp.org/en/media/HDR_2009_EN_Complete.pdf, accessed 8 January 2010).
2. Resolution WHA61.17on the Health of Migrants (http://www.who.int/gb/ebwha/pdf_files/A61_R17-en.pdf).

PART 1

PROCEEDINGS OF THE CONSULTATION

Opening the Consultation

The consultation opened with welcoming remarks from Spanish representatives Carlos Segovia, Instituto de Salud Carlos III, Ministry of Science and Innovation Research; and José Martínez Olmos, General Secretary for Health, Ministry of Health and Social Policy. Martínez Olmos noted that the Spanish national health system guarantees the same health coverage for migrants as for Spanish citizens, including those migrants whose situation is irregular. He acknowledged that barriers to care still exist for migrants and members of cultural or ethnic minorities due to a lack of adaptation or even discrimination, and described the steps being taken to improve access and utilization. The Spanish health strategy for migrants complements a Strategic Plan for Citizenship and Integration 2007-2010, which promotes social cohesion, and the "Innovation in public health through monitoring the social determinants of health and reducing health inequities" priority that is part of the 2010 Spanish presidency of the European Union (EU). As part of this priority, the Spanish ministry intends to emphasize the importance of guaranteeing migrant children and pregnant women the right to health and full access to health care irrespective of their legal status.

Keynote presenter Jorge Bustamante, United Nations Special Rapporteur on the Human Rights of Migrants, emphasized taking the human rights approach to migration and health and reviewed the health conditions and mental health issues affecting migrants. He reviewed the impact of employment in "3-D" jobs (dirty, difficult and dangerous) and other informal work with no participation in social protection schemes. He pointed out that strict immigra-

tion controls often increase the use of clandestine and dangerous entry methods, which can compromise the health of migrants and increase their exposure to exploitation and sexual and gender-based violence. Bustamante outlined the challenges of migrant access to health services, observing that policies vary by country, and are often linked to the to immigration status of migrants. He singled out women, children, and people in detention as facing particular vulnerabilities in staying healthy and accessing needed services.

Daniel López-Acuña, World Health Organization (WHO), noted that the health of migrants is a central element for social cohesion for contemporary societies. Access of migrants to health care has become of paramount importance in a rights-based health system and to efforts aimed at reducing health inequities. Despite progress made in promoting the health of migrants and improving health services for migrant populations in some countries, there are trends that fuel social exclusion of vulnerable migrant groups and leave their health needs unattended. Much work is needed to provide equal access to health services to all migrant groups. He supported the important Spanish EU presidency proceedings that heavily emphasize innovation in public health, the reduction of inequities in health, and the inclusion of migrant health matters, thereby continuing the efforts of the Portuguese EU presidency that led to the WHA resolution that is the focus of the consultation.

Davide Mosca, International Organization for Migration (IOM), said that equitable access to health services for migrants is both a right and is essential to harnessing the contributions of migrants to global economic development. Migrants should be seen as part of the solution, not the problem. Yet during economic downturns, migrant workers are often the most vulnerable in terms of job losses and workplace treatment. Discrimination and stigma increase during difficult times, as migrants are mistakenly perceived as taking the jobs of local workers. A strong degree of solidarity between countries of origin and destination is necessary to harness migration benefits. Therefore flexible, coherent and comprehensive migration management policies are needed, along with reinforced international cooperation, to maximize the benefits of migration and protect migrants.

Setting the scene

To set the context for discussion, López-Acuña and Mosca gave an overview on the relationship between current migration trends and public health. They also provided background on the 2008 Resolution.

MIGRATION FIGURES AND TRENDS

When addressing migrant health and the health of hosting communities, it is important to highlight some major changes in migration trends over the past decades. Firstly, today's migration patterns are such that most countries are simultaneously countries of origin, transit and destination. This is in contrast to half a century ago when, after World War II, countries of origin were mostly in Europe, and destinations included the United States of America, Canada, Argentina, Brazil and Australia. An additional major change in trend is the diversification of migratory behaviour, including short and long term relocation, permanent migration and circular migration back to the place of origin. About half of international migrants are women.[1]

Global estimates of migrant populations demonstrate the considerable impact of migrants around the world. They also reflect the great differences in the demographic and health determinants of migrants. People migrate for different reasons, some out of free will in search of better opportunities for themselves and their family members, and others forced by conflict or disaster in search of safety. Those who migrate through unofficial channels or whose migration documents have expired are difficult to count, and statistics on migrants in an irregular situation are therefore unreliable (Table 1).

The vast majority of migrants move within their country, an estimated 740 million people. About 40% of the estimated 214 million international migrants move to a neighbouring country. The share of people migrating from so-called developing countries to developed countries has increased over the past 50 years, a trend associated with growing gaps in opportunities. Only an estimated 37% of

migration is from developing to developed countries, about 60% of migrants move between developing or between developed countries, and only 3% from developed to developing countries.

The population demography of modern migration has resulted in situations where migrant and foreign born cohorts represent significant proportions of national populations in many countries. If all migrants in the world were a country, it would be the fifth largest in population size. The demographic realities of migration of this scale have corresponding impacts and effects on national health programmes and policy development related to the specific needs and health status of migrants.

TABLE 1. GLOBAL ESTIMATES OF MIGRANT POPULATIONS

Category of migrant	Population estimates
Internal migrants	~ 740 million (stock in 2009)[2]
Immigrants	Annual flow between 2005-2010 ~ 2.7 million with a stock of ~ 214 million international migrants in 2010[3]
Migrant workers	~ 100 million (stock in 2009)[4]
International students	~ 2.1 million (stock in 2003)[5]
Internally displaced persons	51 million (stock in 2007) includes those displaced by natural disasters and conflict. (UNHCR)
Refugees	15.2 million (stock beginning of 2009)[6]
Asylum seekers or refugee claimants	838 000 (stock beginning of 2009)[7]
Temporary – recreational or business[8] travel	922 million in 2008[9]
Trafficked persons (across international borders)	Estimated 800 000 per year (2006)[10] There are no accurate estimates of the stocks and flows of people who have been trafficked[11]

MIGRATION AND HEALTH

When migrating, temporarily, seasonally, or permanently, people connect individual and environmental heath factors between communities. Migrants travel with their health profiles, values and beliefs, reflecting the socio-economic and cultural background and the disease prevalence of their community of origin. Such profiles and beliefs can be different from those of the host community, and may have an impact on the health and related services of the host community as well as on the health of and usage of health services by migrants. Migrants may introduce conditions into host communities and/or can acquire conditions while migrating or residing in host communities. Migrants can also introduce acquired conditions when returning home. This is by no means only of relevance in the context of infectious problems, but as evidence proves, also with respect to non-communicable conditions.

Most migrants are healthy, young people, and some may even benefit from a so-called "healthy migrant effect" when they first arrive in their host community. However conditions surrounding the migration process can increase vulnerability to ill health. This is particularly true for people who migrate involuntarily, flee natural or man-made disasters and human rights violations; and for those who find themselves in an irregular situation, such as those who migrate through clandestine means or have no documents. Other risk factors may include poverty, stigma, discrimination, social exclusion, language and cultural differences, separation from family and socio-cultural norms, administrative hurdles and legal status – the latter often the determining factor for access to health and social services. Lack of social security and protection for migrants can lead to excessive costs for migrants who may pay out-of-pocket, and to the exacerbation of health conditions, which could have been prevented if lower-cost services had been available.

PARADIGM SHIFT

Policies and strategies to manage the health consequences of migration have not kept pace with growing challenges related to the volume, speed, and diversity of modern migration, and they do not sufficiently address the existing health inequities, and determining factors of migrant health, including barriers to accessing health services. Governments are recognizing the need to move

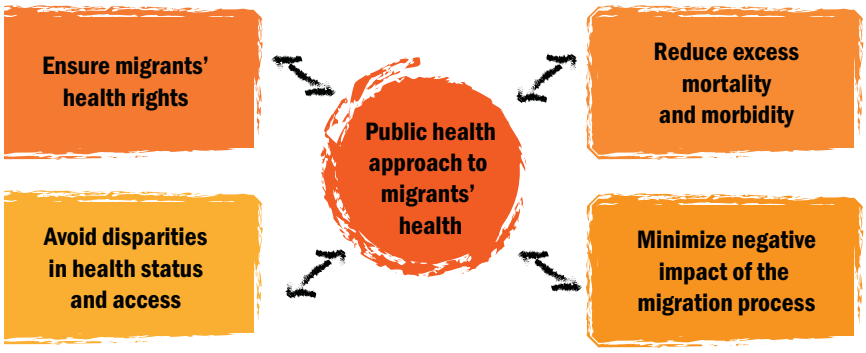
from an exclusive to an inclusive and multidimensional approach to migrant health. Traditional approaches are often based on the principle of exclusion of migrants with certain health conditions, with the interests of the nation at the centre, using security and disease control as the primary rationales. The modern approach is based on inclusion, and focuses on reduction of inequalities and social protection in health in the context of a multi-country and multi-sectoral approach.

PUBLIC HEALTH APPROACH TO MIGRANT HEALTH

In 2008, the WHO Secretariat prepared a report in support of the WHA Resolution on the health of migrants. This report identified four basic principles for a public health approach to address the health of migrants and host communities:

- to avoid disparities in health status and access to health services between migrants and the host population;
- to ensure migrants' health rights. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions, which are the basic health entitlements of the host population.
- to put in place lifesaving interventions so as to reduce excess mortality and morbidity among migrant populations. This is of particular relevance in situations of forced migration resulting from disasters or conflict.
- to minimize the negative impact of the migration process on migrants' health outcomes. Migration generally renders migrants more vulnerable to health risks and exposes them to potential hazards and greater stress arising from displacement, and adaptation to new environments.

FIGURE 2. PUBLIC HEALTH APPROACH TO MIGRANT HEALTH



Monitoring migrant health

Session chair Raj Bhopal, of the University of Edinburgh (United Kingdom) offered a spirited introduction on the complexities and potential benefits of more accurate monitoring frameworks for migrant health, while noting the great contributions migrants make to societies, including the health sector itself. The main presentation on the topic was delivered by Brian Gushulak, a research consultant in health and migration (Canada) and writer of the thematic paper (see under the section Thematic papers of this publication). Starting with the global demographic context, he observed that the modern phenomenon of migration is multidimensional and circular, making the categorization of current migrants more challenging than for historical movements that were predominantly linear, based on long term resettlement and involving fewer countries. In addition to considering health profiles and vulnerabilities in countries of origin and destination, the process of mobility itself has influences that can affect health outcomes.

Nevertheless, standardized and reproducible data categories and definitions to describe migrants are essential for the comparative understanding of the ever-changing health status of migrants. This

understanding can assist in measuring the impact of migration on health systems in migrant-receiving locations and support the effective tailoring of services and interventions aimed at improving service utilization and health outcomes. Some of the suggested approaches for monitoring migrant health include the standardized recording of migration-related elements such as country/region of birth and/or last residence, the nature of the migratory process, and duration of residence. Additional avenues of approaching migrant health monitoring are those based on population factors similar to those already used in the study of health and diversity. Social determinants of health that impact migrant health outcomes include poverty, education, employment, and micro/macro environmental factors. Tools that can assist in acquiring migrant-relevant health information include adding basic migration questions to existing data collection processes, such as census, national statistics reports and health surveys, as well as in routine medical/health information gathering. When standardized and uniform health information about migrants is shared between countries and sectors (e.g. between immigration or employment data sets and health), regional and global patterns can be more easily appreciated.

Katrin Kohl, Centers for Disease Control and Prevention (United States), commented on various aspects of data collection related to migrants in the United States. The practiced classification systems that emphasize race and ethnicity may be of limited use, and recording of legal status, country of birth or parent's birth may be better. The United States emphasizes health status for newcomers through its statutory health assessments or screening for visa applicants. This process aims at protecting the public health of the host country. Although health assessments are supposedly carried out before entry or soon after, in reality they may be carried out a long time after entry. Recent changes to the health assessment policy, such as no longer considering the HIV status as a possible exclusory condition for entry, and considering epidemiological factors at the country of origin, emphasize the increased public health objectives of the health assessment process.

PRINCIPAL POINTS OF DISCUSSION

Need for a standardized approach

In their discussion groups, participants agreed that monitoring variables related to migrant health is an essential aspect of improving both health status and utilization of health services by migrants. Health stakeholders, from civil society organizations to national governments, would benefit from a policy statement and recommendations on what data to collect, how to collect it, and how this information can be used. Currently there is no standardized approach to any of these questions, and an analysis of existing practices with respect to data collection on migrant health could lay the foundation for a new approach that would increase the comparability and application of data to specific health goals.

What data and for what purpose?

In order to develop a viable framework for data collection on migrant health, it is essential for all stakeholders to understand what the data will be used for and by whom, and to make the case to those who will participate in designing and executing the data collection process. The main reasons for collecting health-related data about migrants are to understand their health needs and conditions and to improve their health status and effective utilization of health services. To do this, we must answer the questions – what health conditions affect migrants, how do they use available health services, and does their health status improve over time? Other issues to consider include the health-seeking behaviours of migrants, what populations might require targeted interventions or services, provider attitudes about migrants, and how health systems perform with respect to timeliness, effectiveness and other quality of care variables. This information can help health systems initiate programmes to improve the quality of care for migrants, and to integrate migrant health issues into larger health reform agendas such as primary health care renewal and key local and national health initiatives.

There are many potential users for this data, including government planning departments, public health agencies, institutions that deliver health services, and researchers, and each will require different kinds of information and approaches to collecting it.

The next key issue is what data to collect. While there were many calls for standardization and comparability, of both categories and definitions, many participants pointed out local and national contexts that may complicate the application of global standards. In addition to collecting the data that would yield the information described above, participants stressed the need for collecting data on variables related to age, social determinants of health, and mental health conditions.

Methodological and social considerations in data collection

The issue of how to collect data prompted a good deal of discussion. Participants felt strongly that migrant health variables should be integrated into existing data collection systems in a way that allows for disaggregation by specific population groups, age and gender. Other data collection instruments to consider include census data, data collected by other sectors such as housing, education and employment, and data collected by the private sector and non governmental organizations. This should be supplemented with targeted surveys aimed at harder-to-reach or smaller populations, and qualitative investigations that can inform interventions that address how socio-cultural factors affect health behaviour. There was some concern that the approaches being described may be too complicated and expensive for countries or health care organizations to carry out, particularly with respect to analysis and application, thereby requiring a minimum standard for data collection.

Participants expressed particular concern about how to interact with migrants around issues of data collection. Migrants can be distrustful of attempts to collect information about their migration status, ethnicity, religion or socio-cultural factors, based on valid fears about the discrimination, exclusion, and the potential for negative interactions with authorities. Migrants with an irregular status may fear deportation if details about their lives are known. Cultural and linguistic factors may influence how migrants perceive and respond to questions about health status, utilization, and satisfaction, complicating how this data is interpreted. Because many migrants do not access the health care system except in dire necessity, data samples related to particular groups may provide an incomplete view of the health status of the entire population. It will be important to engage migrants and their trusted community representatives in the process of designing, explaining and conducting monitoring processes in order to maximize their participation in this effort.

Policy and legal frameworks affecting migrants' health

Session chair Isabel de la Mata, of the Directorate-General for Health and Consumers of the European Commission, emphasized the importance of migrant health in the context of changing migration patterns affecting the EU. She highlighted the challenges of harmonizing different EU policies and noted that a lack of agreed-upon migration related terminology within the EU is hampering debate and progress on this topic. José Pereira Miguel, of the National Health Institute (Portugal), gave the main presentation on the paper by Brian Gushulak and Paola Pace, of the International Organization for Migration. He highlighted the need for internal and international coherence in policies across all sectors that might have an impact on migrant health. Solutions should be developed in a multidisciplinary and multi-sectoral fashion. Yet too often countries have policies related to migrants that are restrictive in one sector (such as acquiring health insurance) while promoting access to services in another (accessing health centres or attending school). Working from the basis of health care as a right, and using international and regional legal norms as a foundation, countries must take a public health approach in the development of policy that affects migrant health, keeping in mind that legal or social exclusion has a negative impact on health status of migrants that can lead to health inequalities that affect overall national health status. Migrants are often excluded from social protection policies such as pensions, unemployment benefits, health insurance programmes and social safety nets like vouchers and food transfers, which can lead to marginalization and social insecurity. All these factors can have a negative impact on health, and on the productive integration of migrants into society. Countries have the primary responsibility for instituting policies that facilitate access to health facilities, goods and services for migrants and that comply with international standards. They should

be supported by multilateral cooperation around immigration issues and the inclusion of migrants in global health priorities.

Discussant Pia Oberoi, of the Office of the High Commissioner for Human Rights, focused attention on the human rights framework that should underlie all policies related to migrants and their access to health care (including those whose status may be irregular). She identified policies that support migrant health, such as agreements between countries to pay for the healthcare of migrant workers, as well as policies that worked against health, such as the deportation of migrants on health grounds or reporting of irregular migrants who access the health system.

PRINCIPAL POINTS OF DISCUSSION

Equal access to health services

Discussion among the participant groups identified some common points of understanding. Participants affirmed health as a human right for all, and that human rights considerations are essential in the design, implementation, and evaluation of health policies and practices. States have a legal, social, and political responsibility to respect, protect and fulfil the human rights of migrants, regardless of legal status. Their national legislation should clearly specify entitlements in national law and legislation and should be effectively implemented. There was considerable debate on whether migrants should be entitled by law to receive only minimum services, goods and facilities or whether they should be provided with the same access as others. There was a general agreement that equal access to health services should be assured for all migrants as both human rights and public health considerations call for it.

Nevertheless, participants recognized that in many states, policies and practices may differ by distinct categories of refugees and migrants, and in relationship to the health services provided to the general public. Resistance to universal access for migrants in many countries stems from popular and political demands to regulate immigration for national security, population control and economic burden rationales, as well as from prejudice and ill-will towards migrants from sectors of society.

Economic considerations in migrant health policy

With respect to the economic aspects of migrant health, there is a need to generate and disseminate further evidence on the overall cost-benefits of migration and the potential cost-effectiveness of paying for health services to promote an economically productive migrant workforce. The principles of health economics show that cost containment is achieved in the case of timely and appropriate use of health services, particularly preventive services. In this view, policies and financing for migrant health are not a burden, but an investment. More research can be done to evaluate the impacts of equal access to health for migrants in countries that have such policies, as some studies now suggest that access to social security schemes are not typically a "pull-factor" for migrants.

Participants identified a number of policy and legislation models that address access to, financing and delivery of health services for migrants. They agreed that such models should be analysed and disseminated to promote adoption or adaptation by other countries.

Raising awareness about migrant health needs

The groups also observed that policy development is greatly influenced by popular opinion and perceptions related to migrants. A higher level of awareness is required among decision-makers and the media about the benefits of attending to migrant health in a proactive manner. The migrant health agenda can be linked to other health and development advocacy efforts like HIV, maternal health and achievement on the Millenium Development Goals. Non governmental organizations have an especially important role in advocating for the most vulnerable and hard-to-reach migrants in relation to their rights and increasing their access to services.

Migrant sensitive health systems

The session chair Harald Siem, of the Norwegian Directorate of Health, reported on the recent action of the Norwegian government to extend health services to irregular migrants, based on the recommendations of the country's 2009 Migrants and Health report. He also gave an update on the activity of the Council of Europe Committee of Experts on Mobility, Migration and Access to Health Care, whose recommendations on migrant health will be taken up by the Council later this year.

Julia Puebla Fortier, of DiversityRx-Resources for Cross Cultural Health Care (United States and France) and writer of the thematic paper, defined migrant sensitive health systems as those that "consciously and systematically incorporate the needs of migrants into health financing, policy, planning, implementation and evaluation," including such considerations as the epidemiological profiles of migrant populations, relevant cultural, language and socio-economic factors, and the impact of the migration process on health. She reviewed the types of services that can enhance the ability of health systems to deliver migrant sensitive care, including interpretation and translation services, culturally informed care delivery, culturally tailored population programmes (e.g. health promotion, disease prevention, disease support), and the use of cultural support staff such as intercultural mediators, community health workers, and patient navigators. She also discussed the need for improving the capacity of health systems to address migrant health needs through explicit organizational frameworks supported by policy, management strategies, and adequate data, and highlighted the importance of preparing the health workforce to understand and respond effectively to the needs of migrants. She concluded by emphasizing the need to increase awareness among a variety of stakeholders about good practices in migrant health service delivery, and to pursue a coordinated and sustainable response to migrant health needs.

Khaled Abu Rumman, of the Jordanian Ministry of Health, responded to Fortier's presentation by describing the response to a recent influx of migrants in Jordan, which is among the top ten Arab state migrant destination countries. Policies and practice have been changed to make health services, in particular with respect to tuberculosis, more accessible to migrants, supported by formal structures in relevant ministries to address migrant needs. This has been accompanied by an increased emphasis on training health workers about common diseases affecting migrants and the use of mobile health units to improve access.

PRINCIPAL POINTS OF DISCUSSION

The discussion groups used the examples and recommendations from the background paper as a springboard for a deeper discussion about the challenges and opportunities related to improving how health systems respond to the health needs of migrants.

Migrant inclusive health services, data and models

A key point raised was the importance of moving towards a migrant-*inclusive* health system, rather than one that sets up parallel migrant sensitive services outside the mainstream. The approach needed is one that echoes other calls for more patient-centered and holistic health care delivery for all. It recognizes that true progress in overall health status for migrants and all populations will come from acknowledging the impact of social determinants of health, and therefore will benefit from a multisectoral dialogue and effort. Because migrants often intersect first with the employment sector upon arrival, initiatives that focus on outreach and health service delivery in the workplace can greatly improve access.

Within health systems, accurate data about migrant health status and service utilization can be used to target interventions that can lead to improved outcomes. The ability to communicate across health systems/cities through portable medical records that have migration-related data (e.g. country of origin, language spoken, migration process, traumatic events) can be used to transfer relevant social and medical information between providers and facilitate the continuity of treatment.

Acknowledging the excellent examples of migrant sensitive service delivery around the world, participants expressed the need for more systematic dissemination of models to the front lines, along

with analyses of good practices. Those responsible for the design and delivery of health services could benefit from a framework or checklist of the key features of a migrant sensitive health system, as well as a network for exchanging ideas and technical resources for implementation.

Leadership for multi-sectoral engagement

Participants noted the critical role of leadership at all levels in making the institutional changes necessary to improve delivery of care to migrants. At the national level, migrant health needs must be included in national plans and the allocation of resources. The ideal approach will involve dialogue and cooperation within health programmes as well as between health and other sectors such as employment, education, housing and those responsible for immigration policy. Local governments have a key role to play in service delivery across all sectors and in promoting the effective integration of migrants into communities. Because of their close proximity to the needs of migrants, they can be a useful interlocutor with national leaders.

Inclusion of migrants and the non governmental organizations that serve them in design and delivery

Of equal importance is the need for deliberate inclusion of migrants as active players in the improvement of their own health and in the services they use. As a component of integration, migrants should be educated about how health systems work and how they can maintain their own health and most effectively utilize services. Through a progressive empowerment model, they should be engaged in the planning, implementation and oversight of health services, and health systems should facilitate an ongoing dialogue with migrant communities and their representatives. Migrants can be involved in bridging the gap between their communities and health care systems by participating as interpreters, intercultural mediators and educators in outreach programmes, and those with health professional credentials from other countries can be supported to re-qualify and enter practice. This goes hand-in-hand with recognizing the role and value of recruited global health workers, while minimizing the exploitation of this resource to the detriment of sending countries.

Non governmental organizations can and should play a role in health service advocacy, outreach, planning and delivery, but participants cautioned that using such organizations to make up for the inadequacies of the mainstream health system risks perpetrating a two-tier system, with potentially adverse impacts on quality, continuity, and accountability for outcomes. Governments should not simply download responsibility for migrant health to non governmental organizations, saying they do not have the expertise, but work collaboratively with these organizations in a formalized way with adequate resources, using these partnerships to improve their own capacity to build a migrant-inclusive health system.

Sustainability through funding and education

Overall, the issue of sustainability for migrant inclusive services was a key issue identified in discussions. Health systems should recognize that getting migrants into care early, before conditions become too severe and consequently more expensive to treat, would be both cost-effective and improve outcomes. Unfortunately, many migrant-focused programmes are funded for the short term or as demonstration projects. Demographic projections suggest that mobile populations are a permanent feature of a globalized society and countries should begin to integrate both the services and costs related to caring for migrants into permanent budgets and programme frameworks.

With respect to workforce preparation, participants called for the inclusion of migrant-specific information into the training and continuing education of all health professionals and others who interact with migrants, including reception staff, managers, social workers, border guards, and detention facility staff. The content of these training programmes should draw from models in use around the world, and address the impact of communication, socio-cultural differences, ideas about health and illness and seeking care, and the epidemiological profiles of different populations.

Partnerships, networks, and multi country frameworks

Session chair Manuel Carballo, of the International Centre for Migration, Health and Development (Switzerland), introduced the main presentation by observing that the role of WHO is to provide leadership to member states by offering recommendations and technical assistance to enable them to take action. Because of the multi-national and multi-sectoral dimension of migrant health, the role of collaborative action and awareness-raising across many platforms is essential to reach these goals.

Houssam Mu'allem, of the International Federation of Red Cross and Red Crescent Societies, presented the main points raised in the discussion paper by Barbara Rijks, of the International Organization for Migration. He provided an overview of actions related to migrant health by Regional Economic Communities, global and regional consultative processes on migration, and other international, inter-regional and regional networks and partnerships. Few migration networks are addressing the health of migrants in a comprehensive way, illustrating the complexities of integrating health into non-health dialogues. Furthermore, he commented on the key reasons for promoting action on migrant health, which include attention to their vulnerabilities, their dignity and their right to health, and the role that health plays in development. He concluded by emphasizing the power of partnerships as a means to improve migrant health, and described the factors involved in effective partnerships such as high-level support, honesty among partners, a common sense of purpose and direction, and the identification of mutual benefits and measures for success.

Innocent Modisaotsile, of the Southern African Development Community Secretariat (SADC), expanded on the main presentation by describing the complications of treating communicable diseases, in particular tuberculosis, malaria and HIV, in an environment where migration is often circular, services vary by county, and continuity of treatment is not assured. A framework on mobility and health for harmonized free services has been developed for SADC, but it has not been official adopted by its member states and faces financial and implementation challenges.

PRINCIPAL POINTS OF DISCUSSION

The discussion in the working groups emphasized many of the cross-cutting issues raised at other points in the consultation. Regional and international partnerships are a key venue for promoting an approach to migrant health that is multi-stakeholder and multi-sectoral. They offer opportunities to raise awareness about migrant health issues, policies and practices, and can be used to advance the notion of harmonization and coherence of relevant policies between sectors and between countries.

In particular, civil society and private sector involvement should be stimulated given the important role of these sectors in the migration context. Their involvement is necessary to achieve effective responses and to improve migrant health programmes. Citing several examples, there was enthusiasm for introducing the issues surrounding migrant health in existing cooperative platforms, such as the Global Forum on Migration and Development. There was also interest in building a partnership specifically on migrant health, perhaps lead by WHO and IOM, and starting with a small working group that would further refine an action agenda and work to get a broad base of stakeholder and donor support.

One issue that was seen as a barrier to true partnership is the power differential between countries of origin and receiving countries, which often see migration inflows, especially irregular ones, as a problem. As an example, it was pointed out that the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) has not been ratified by any major country of destination, while countries of origin are parties to it.

Closing the consultation

Following the discussions on the four themes, WHO staff led a small team in the analysis and synthesis of the inputs and recommendations provided by each rapporteur. Danielle Grondin, of the Public Health Agency of Canada, chaired the final session of the consultation where she presented

an outline of an operational framework for action. The consultation participants offered additional comments and suggestions that have been incorporated into the final version of the operational framework outline, which is presented in the next section.

After plenary discussion of the draft framework, the meeting closed with remarks from several speakers. Enrique Iglesias, of the Ibero-American General Secretariat, noted that the global economic crisis has made the migration situation even more complex by exacerbating the conditions of vulnerability associated with many migrants. The challenge in this situation is to not move backwards by adopting restrictive and unilateral measures that disproportionately affect migrants. He reviewed the actions taken by members of the Organization to address the integration and good health of migrants, and noted that human rights, migration and health will be one of the items on the agenda of the second Ibero-American Forum on Migration and Development later this year, with the goal of moving from principles and agreements to action.

Alberto Infante Campos, Ministry of Health and Social Policy of Spain, noted some important lessons on migrants and health learned from Spanish experience. First, public authorities must attach prime importance to the human rights of migrants, including the right to health. Second, the financing of health services should correlate to the total population of a given territory, creating an incentive to count the total population and avoiding the impression that immigrants are competing for limited resources designed to serve populations that do not include them. Third, governments should continually emphasize the contribution that migrants make to their host country, both economically and socially. Fourth, targeting some migrant groups, especially women and children, for inclusion in services pays high social and health dividends.

Infante Campos noted the importance of using legal frameworks to guarantee access to health services and to protect migrants from discrimination. He emphasized the critical effect of the attitude of politicians, the media, professionals and the authorities towards the migrants and migration. If migration is primarily seen as a threat, then many of the opportunities offered by globalization will be lost.

Mosca highlighted that *country leadership* is paramount in advancing a sustainable migration health agenda. The *establishment of migration health units within ministries of health* is critical in order to create a venue for effective programming and start a multi-sectoral dialogue. While pursuing a comprehensive and inclusive migrant health agenda, there must also be progress in defining globally accepted *minimum standards of migrant health* that are rights-based and rooted in the public health concepts of equity and safety. This will require long-term partnerships across sectors and among countries, along with the engagement of governments and other actors willing to champion this agenda at multiple levels of advocacy, debate, and resource mobilization. Progress on these goals will help migrants benefit from an improved standard of physical, mental and social well-being, enabling them to contribute substantially to the social and economic development of their home and host communities.

López-Acuña praised the contributions and commitment of all participants in the consultation. The identified key priorities and actions will guide WHO in its future steps in this domain. He reiterated that the health of migrants is not solely a health matter and WHO is by no means the only organization to support the migrant health agenda, lending strength to the recommendation for a multi-stakeholder working group. The upcoming World Health Assembly in May will receive a short progress report on the 2008 Resolution on the health of migrants and will be informed about this Consultation and its outcomes. This will hopefully stimulate the needed high-level commitment and strategies to ensure the implementation of the concrete actions derived from this process.

NOTES

1 IOM. World migration 2008. Managing labour mobility in the evolving global economy. Geneva, International Organization for Migration, 2008.

2 UNDP. Human Development Report 2009. Overcoming barriers: Human mobility and development. United Nations Development ProgramProgrammeme, 2009 (http://hdr.undp.org/en/media/HDR_2009_EN_Complete.pdf, accessed 8 January 2010).

3 UN. Department of Economic and Social Affairs, Population Division. International migration 2009.

United Nations, New York, 2009 (http://www.un.org/esa/population/publications/2009Migration_Chart/ittmig_wallchart09.pdf, accessed 8 January 2010).

4 ILO. Facing the global jobs crisis: Migrant workers, a population at risk (http://www.ilo.org/global/About_the_ILO/Media_and_public_information/Feature_stories/lang--en/WCMS_112537/index.htm, accessed 8 January 2009).

5 Böhm A et al. Vision 2020 – Forecasting international student mobility a UK perspective. British Council. 2004 (http://www.britishcouncil.org/eumd_-_vision_2020.pdf, accessed 8 January 2010).

6 UNHCR. Refugee figures (http://www.unhcr.org/pages/49c3646c1d.html, accessed 8 January 2010).

7 UNHCR. Asylum-seeker figures (http://www.unhcr.org/pages/49c3646c20.html, accessed 8 January 2010).

8 Although human mobility due to recreational or business travel is an important public health topic, this group does not fall within the scope of this consultation.

9 United Nations World Tourism Organization. Tourism highlights, 2009 edition (http://unwto.org/facts/eng/pdf/highlights/UNWTO_Highlights09_en_HR.pdf, accessed 8 January 2010).

10 United States Department of State. Office to Monitor and Combat Trafficking in Persons. Trafficking in persons report June 2008. Washington DC, United States Department of State, 2008 (http://www.state.gov/g/tip/rls/tiprpt/2008/, accessed 9August 2009).

11 See note 2.

PART 2

OUTLINE FOR AN OPERATIONAL FRAMEWORK

The main product of the consultation is an outline for an operational framework to implement the principles and priorities expressed in the 2008 WHA Resolution on the health of migrants.

The outline for an operational framework, based on a synthesis of the inputs received from participants, was presented to participants on the final day of the consultation. The outline is based on the underlying public health principles from the 2008 Resolution that were strongly reaffirmed throughout the discussion:

- Ensuring migrants' health rights
- Minimizing the negative impact of the migration process
- Avoiding disparities in migrants' health status and access to health care
- Reducing excess mortality and morbidity among migrants

In addition, several key cross-cutting issues that emerged from the discussions of each theme were highlighted:

- Key stakeholder groups should develop a standard set of **definitions for migrants and migration-related processes** that impact health and social integration. Consistency in the use of terminology is key in the monitoring and evaluation processes related to migrant health and can support effective policy and programme development, appropriate financing, and service implementation.

- Dialogue, strategies and action on migrant health should be **multi-sectoral, multi-level, and multi-country.** For example, activities to improve migrant health initiated at the local level involving different sectors and stakeholders can inform policy development and strategy at a national level. Countries with sending-receiving relationships can harmonize policies and develop formal agreements related to the delivery and financing of health services for migrants.
- Similarly, a **wide variety of stakeholders** – health professionals, employers, international organizations, non governmental organizations, and others – should be part of the process of developing action plans on migrant health and determining what actions they should take among their own constituencies.
- Particularly important is the **engagement of migrants** in all areas of the operational framework. As users of health systems, migrants should be involved in service design, implementation and evaluation, including those activities related to monitoring. They can also be a valuable in the delivery of migrant-sensitive health services. Migrants should be involved in consultation processes related to policy development, and represent their needs and points of view in partnerships and dialogues.
- Progress measurement and accountability are essential in each of the action areas. Data can be used to identify and target areas for improvement in migrant health status and outcomes. This information can be integrated into service delivery planning and evaluation and the development of policy and financing strategies. Globally and regionally, policy tools and partnership efforts should be mapped and monitored to facilitate assessments of progress.
- Information sharing and awareness raising are critical components of all the action areas, from the collection and dissemination of good models and practices in monitoring, policy development and service delivery, to the need for sensitizing the public, government leaders and stakeholders at all levels about migrant health rights, needs and potential solutions.

There crosscutting issues apply to the entire operational framework outline as presented below, and are not repeated in the framework.

OUTLINE FOR AN OPERATIONAL FRAMEWORK ON MIGRANT HEALTH

MONITORING MIGRANT HEALTH

Priorities to address	• Ensure the standardization and comparability of data on migrant health. • Increase the better understanding of trends and outcomes through the appropriate disaggregation and analysis of migrant health information in ways that account for the diversity of migrant populations. • Improve the monitoring of migrants' health-seeking behaviours, access to and utilization of health services, and increase the collection of data related to health status and outcomes for migrants. • Identify and map: 1) good practices in monitoring migrant health; 2) policy models that facilitate equitable access to health for migrants; and 3) migrant-inclusive health systems models and practices. • Develop useful data that can be linked to decision-making and the monitoring of the impact of policies and programmes.
Key actions	• Identify key indicators that are acceptable and useable across countries. • Promote the inclusion of migration variables in existing census, national statistics, targeted health surveys and routine health information systems, as well as in statistics from sectors such as housing, education, labour and migration. • Use innovative approaches to collect data on migrants beyond traditional instruments such as vital statistics and routine health information systems. • Clearly explain to migrants why health related data is being collected and how this can benefit them, and have safeguards in place to prevent use of data in a discriminatory or harmful fashion. • Raise awareness about data collection methods, uses, and data sharing related to migrant health among governments, civil society, and international organizations. • Produce a global report on the status of migrants' health including country-by-country progress reports.

POLICY AND LEGAL FRAMEWORKS

Priorities to address	• Adopt and implement relevant international standards on the protection of migrants and the right to health in national law and practice. • Develop and implement national health policies that incorporate a public health approach to the health of migrants and promote equal access to health services for migrants, regardless of their status. • Monitor the implementation of relevant national policies, regulations and legislation responding to the health needs of migrants. • Promote coherence among policies of different sectors that may affect migrants' ability to access health services. • Extend social protection in health and improve social security for all migrants.
Key actions	• Develop frameworks and indicators to monitor the success of policy implementation. • Promote and monitor the sufficient availability of resources for adequate policy development, formulation of strategies and programme implementation. • Conduct advocacy and public education efforts to build support among the public, government and other stakeholders for migrant-inclusive health policies and adoption of key international instruments. • Develop guidance, models and standards to assist countries, based on best practices. • Identify mechanisms for extending social protection in health and increasing social security coverage for migrants.

MIGRANT SENSITIVE HEALTH SYSTEMS

Priorities to address	• Ensure that health services are delivered to migrants in a culturally and linguistically appropriate way, and enforce laws and regulations that prohibit discrimination. • Adopt measures to improve the ability of health systems to deliver migrant inclusive services and programmes in a comprehensive, coordinated, and financially sustainable way. • Enhance the continuity and quality of care received by migrants in all settings, including that received from NGO health services and alternative providers. • Develop the capacity of the health and relevant non-health workforce to understand and address the health and social issues associated with migration.
Key actions	• Establish focal points within governments for migrant health issues. • Develop standards for health service delivery, organizational management and governance that address cultural and linguistic competence; epidemiological factors; and legal, administrative, and financial challenges. • Develop frameworks for the implementation and monitoring of health systems' performance in delivering migrant sensitive health services. • Develop methods to analyse the costs of addressing or not addressing migrant health issues. • Include diaspora migrant health workers in the design, implementation and evaluation of migrant sensitive health services and educational programmes. • Include migrant health in the graduate, post graduate and continuous professional education training of all health personnel, including support and managerial staff.

PARTNERSHIPS, NETWORKS AND MULTI COUNTRY FRAMEWORKS

Priorities to address	• Establish and support ongoing migration health dialogues and cooperation across sectors and among key cities, regions and countries of origin, transit and destination. • Address migrant health matters in global and regional consultative migration, economic and development processes (e.g. Global Forum on Migration and Development, Global Migration Group, RCPs, United Nations High Level Dialogue on International Migration and Development). • Harness the capacity of existing networks to promote the migrant health agenda.
Key actions	• Create a multi-stakeholder working group to further refine and implement the operational framework on migrant health and to develop a resource mobilization plan. • Develop an information clearinghouse of good practices in migrant health monitoring, policy development and service delivery. • Encourage local, regional and international migration dialogues and processes to assist governments in coordinating and harmonizing policies and regulations related to health and the determinants of health for migrants. • Promote the inclusion of migrant health needs in existing regional and global funding mechanisms.

PART 3

THE WAY FORWARD

Migration affects many aspects of life and sectors in society including the health sector. Global estimates of the size of migrant populations are of such magnitude that their global demographic significance is obvious. While health related vulnerability levels between the various migrant populations greatly vary, the collective health needs and implications of today's sizable migrant population cohorts are considerable.

The dynamics of modern migration that are closely associated with globalization, differ from traditional immigration trends and call for changed approaches to the management of health issues associated with migration and for health systems that are reflective of modern, diverse and constantly changing societies.

The human rights dimension is compelling and important. Many international agreements proclaim health as a right, and that these rights should extend to non-citizens and migrants. But countries also should attend to migrant health because it makes sense. There are significant benefits to addressing migrant health needs proactively. In a world where disease and illness knows no boundaries, it is good public health practice, both locally and globally. It is cost-effective to care for people before they become seriously ill, reducing the overall burden on the health system. Positive interactions with the health system promote both wellness and social inclusion. In good health, migrants can become productive and integrated members of society, contributing to the social and economic development of both host countries and countries of origin.

The 2008 WHA resolution on the health of migrants, the global consultation and the resulting outline for an operational framework provide a clear pathway to improve the health of migrants, address disparities in health status between migrant and host communities, and support social cohesion. The framework outline takes into account the experiences, accomplishments, successes and failures of existing policies and programmes.

Implementing the framework will require high-level commitment and engagement from all stakeholders. Their efforts are essential to achieve the desired level of improved evidence, comprehensive monitoring, policy reorientation, effective usage of legal instruments and developments of health systems reflective of the diversity of today's societies.

The consultation produced key priorities and actions for stakeholders to forward the agenda of migrant health globally. However, it is understood that priorities will need to be set at country level and in that respect, countries will take the leadership in deciding on the best ways forward given their national migration and health related context. Indeed, member states have the key responsibility for action in many of the areas outlined in the operational framework. With technical support from WHO and IOM, member states can take stock of current activities, identify areas for improvement, and prioritize actions. As a starting point, countries can benefit greatly from creating a "home" within their governments to focus on migrant health issues and to begin working towards a national strategic plan that emphasizes policy coherence, adequate financing, and new way of thinking about health services delivery for migrants. While country ownership needs emphasizing, the nature of the migration process calls for bilateral, regional and inter regional discussion to foster dialogue among countries of origin, transit, destination and return to ensure policy coherence within as well as among countries.

To promote action key stakeholders from multiple sectors, WHO and IOM are prepared to take the lead in developing collaborative efforts with other international organizations, multi-country dialogues, and civil society. A working group should be convened to address the need for agreed definitions and consistent use of terminology and to develop a timetable and methodology for action related to the operational framework. A larger partnership of stakeholders would facilitate the coordination of activities and implementation of an awareness-raising plan that supports the insertion of migrant health issues onto the agenda of a variety of stakeholder organizations.

The establishment of a global clearinghouse can fulfil the key goal of identifying and sharing information about good practices and models in the areas of monitoring migrant health, policies for equitable access to services, and migrant sensitive health systems. In this respect, identifying key indicators that are acceptable and usable across countries has priority. Standardizing and comparing data on migrant health are essential to start providing meaningful information on the health of migrants, identify salient health determinants, support evidence- and population-based programmes, and policy design at national and international levels.

An important part of the strategy to improve migrants' health and their overall social integration is to increase their access to social protection and social security systems. There is a strong relationship between economic security and good health status, and migrants who have access to systems of social support are more likely to be well-integrated and make positive social and economic contributions over the long term. Social protection schemes will need to be re oriented to fit the realities of today's increasingly mobile population. People no longer are born, study, work, and retire in the same location or country. This concept of transnationalism will need to be accompanied with flexible approaches to social protection that create win-win situations for all involved, hosting countries, the migrants and their families. There are an increasing number of countries making advances in this area, and it is important to analyse the impact of their efforts and to promote replicable approaches more broadly.

As much as health services should be migrant sensitive, so does the workforce involved in the services development and delivery. A migrant sensitive workforce that understands the diversity of health determinants, needs and vulnerabilities among society members will be essential to ensure that health systems are adapted to needs of modern societies.

Resources for these activities can come from many sources. At the international organization level, migrant health priorities can be included in existing work plans, and donor support will have to be secured for supporting the activities described in the framework that go beyond the scope of current activities. Member states will have to make allocations for specific programme activities and organizational adjustments and factor the cost of improving care for migrants into their health budgets. Migrant needs and public health issues related to migration can be better represented in existing regional and global funding mechanisms and innovative schemes involving the private sector better explored.

As international agencies with technical expertise in the areas of health and migration, WHO and IOM can guide in defining the scope of action globally and at the member state level. Starting from a policy approach and moving towards technical guidance, actors must be identified and steps for implementation and tracking developed for each key action in the operational framework. The 2008 resolution and consultation inputs offer an accountability framework for developing and reviewing progress.

PART 4

THEMATIC PAPERS

Monitoring migrants' health

EXECUTIVE SUMMARY

Health and migration currently receives a considerable amount of interest and investigation. However, much of the traditional research and study of migrants' health occurs at national level, focussing mainly on the health of newly arrived immigrants, and tends to be disease based, frequently emphasizing communicable conditions. Given contemporary migration dynamics, including the great diversity in vulnerability levels among the different migrant groups, the study and monitoring of migrant health needs should be expanded. Those working in the field of health and migration have suggested that the monitoring of migration health in relation to social and economic risk factors, and health promotion and prevention activities, will support improved national and global policies and programs. Examining these factors in the context the migration cycle, including the long term health effects that extend beyond first generation migrants, are increasingly being explored.

Countries and researchers define migrants in many different ways, for example by country of birth, nationality, ethnicity, country of origin, race, refugee status, etc. All definitions have their limitations. The lack of agreed definitions and consistency in use of terminology to describe migrants and denominators can limit the comparability of health information for different migrant populations in different locations. The use of more standardized tools in an evidence-based population health approach can provide global information to better support programme and policy design at national and international levels. This chapter refers to efforts to overcome the monitoring challenge and suggests possible directions that take into account underrepresented groups, access to services, prevention and health promotion, and economic aspects. Moreover, it argues that identifying and defining migrants by universal health associated criteria as opposed to demographic status or administrative or legal status, could be helpful to overcome the current limitations in analysing and interpreting health outcomes of migrants.

OVERVIEW

All human activities can affect and influence health and health outcomes either through direct effects on illnesses and disease or secondarily by affecting the social determinants of health. Such effects and influences may occur both at the level of the individual as well as the community and population level. Migration and the associated flows of people, communities and populations, which is both a process and an activity, has long been recognized as being associated with or influencing health outcomes in certain situations. Attempts to manage or deal with health and disease in travellers and migrants represent some of the earliest aspects of humanitarian medicine (hospices) and public health (the control of imported disease).

Migrant health monitoring lacks a global integrated scope

Over time it has become appreciated that the health aspects of migration are not limited to the migrants themselves. Depending on the situation and location, it has been observed that the health of migrants may have important implications for the host populations from which migrants originate, transit or travel through, and live and work. At the same time aspects of migrants' health are influenced and affected by where and how they travel, reside or settle. Traditionally much of the interest in this regard reflected situational events and outcomes related to a particular, time, place or population cohort. Due to the fact that many of the legal and administrative aspects of citizenship and right of residence are aspects of national sovereignty, attention to migrant health frequently occurred at the national level or, in some cases, regional level. That is also where information gathering, monitoring and analysis of migrant health have also tended to occur. As a consequence, the majority of research and study on the health aspects and implications of migration has and continues to take place at the national or regional level. Differences in the nature and quality of the information exist between

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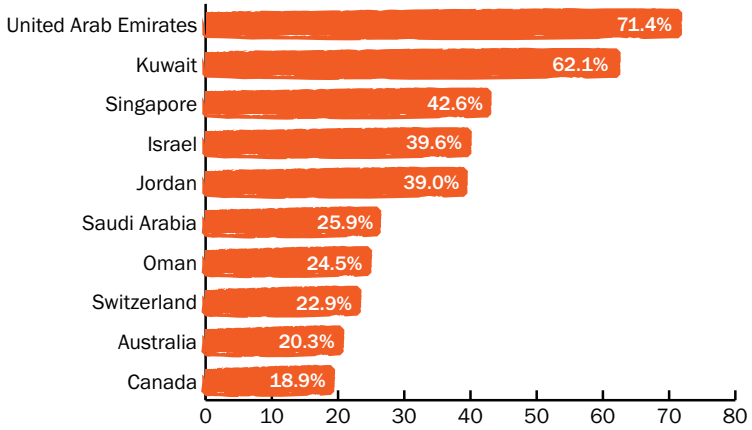
many of the various jurisdictions, hampering the development of relevant and broadly applicable international or global policies and programmes in migrant health.

More recently, as the health implications of modern globalization are being addressed through a lens of population health principles, the broader global aspects of health and migration are assuming greater international prominence. The modern world is more interconnected and interdependent than it has ever been. The effects of these shared connections and dependency extend to health. At the same time, global society is ever more mobile and migration is an important part of that mobility. Recent United Nations estimates on international migration suggest that the number of international migrants to be in range of some 214 million people.[1] It is anticipated that continued globalization, environmental change, social and political evolution will be associated with the continued growth and expansion of migration.

It is expected, for example, that there will be continued expansion of the migrant labour workforce over the foreseeable future[2] and that some countries with declining birth-rates and aging populations will require increasing immigration to support their economic and social development.[3] Considering the dynamics of migration in a global population-based context, it is interesting to note that if international migrants were considered as a country they would currently represent the fifth largest country (by population size) in the world. The collective health needs and implications of a global population cohort of this size are obviously considerable. Additionally, the population demography of modern migration has resulted in situations where migrant and foreign born cohorts represent significant proportions of national populations in many countries (Figure 1). The demographic realities of migration on this scale have corresponding impacts and effects on national health programmes and policy development related to the specific needs and health status of the migrants themselves.

FIGURE 3. TOP TEN COUNTRIES WITH THE HIGHEST SHARE OF MIGRANTS IN THE TOTAL POPULATION (PERCENTAGE OF TOTAL POPULATION, 2005) (COUNTRIES WITH 1 MILLION OR MORE RESIDENTS)



(Source: Migration Policy Institute,[4] 2010)

Like other populations, migrants display disparate health determinants and health outcomes

Similar to other large national populations, the health characteristics, indicators, outcomes and needs of migrants are not uniformly distributed across the population. Wealth, employment, education, nutrition and historical experiences all influence individual and population health. The same is true for migrant populations and communities where disparities in the social and economic determinants of health in migrant communities affect vulnerability and create adverse health outcomes.

The process of migration itself adds an additional component to the dynamics of migrant health. Population movement which involves the crossing of boundaries and frontiers as well as that which takes place within national borders provides an opportunity for geographically separated health and disease risks and outcomes to move between different social, economic and epidemiological

environments. Some groups and communities may be particularly susceptible to health influences specifically associated with migration. Examples include: 1) the vulnerabilities of refugees and involuntarily displaced populations forced to leave their normal place of residence; 2) the workplace and occupational health challenges faced by migrant workers, particularly those in an irregular situation; 3) the risks encountered by smuggled migrants and trafficked persons, and 4) the vulnerabilities and poverty of the irregular and other migrants facing abuse or exploitation.

Together, these vulnerabilities may apply differently to individuals or migrant communities in relation to place, time and person.[5] The outcome of these vulnerabilities may be manifest through disparities and differences in terms of availability of, access to and use of appropriate health and medical services, therapeutics and facilities as well as relevant information about health.[6] For example, new migrants may be unfamiliar with the use of health care systems and protocols at their new place of residence. In locations where health care is provided on a fee for service basis, poverty, a common factor for many new migrants, may limit their ability to seek or pay for health care. Additionally, many migrants move to destinations where linguistic, social and cultural factors are different from their home. Studies have demonstrated that these and similar factors affect the access and use medical services following migration.[7] The systematic monitoring of the nature and impact of health vulnerabilities in migrants will provide improved metrics for better and targeted policy and programme development.

The health aspects of migration do not end with resettlement

It is important to note that many of the health vulnerabilities and adverse health outcomes associated with migration develop or continue after the arrival and resettlement phases of the process of migration. Several Member States who monitor aspects of migrant health have noted that some migrant communities arrive in their new host societies with health indicators and status that that may be better than those in the host population. In some cases those positive findings remain while in other situations they deteriorate over time. This observation is known as the Healthy Migrant Effect,[8] and while there may be several reasons for it, a better understanding is important to the population-health based monitoring of migrant health. Sustaining good health and preventing further deterioration in migrant health will be an increasingly important aspect of future endeavours in the monitoring of migrant health. Better understanding of the nature and origin of the Healthy Migrant Effect will also assist in the design of programme and policies to reduce some of the future health needs of migrants and to mitigate long term impact of newly arriving migrants on downstream health and medical services. Monitoring the many factors associated with the healthy migrant effect and linking this information to other social and population-based determinants of health is a goal that demands greater attention. It is not, however, an undertaking without implications. The systematic understanding of the Healthy Migrant Effect will require routine and systematic evaluation of the health status of migrants on arrival, practices that may be currently undertaken.

These dynamic relationships of health and migration, including the needs of more vulnerable migrants and the public health aspects of migration, were reflected in the report by the World Health Organization (WHO) Secretariat to the World Health Assembly in 2008.[9] That report noted that strategies to improve migrant health in WHO Member States would require collaborative and cohesive assessments of the status and trends of migrants' health as well as the better monitoring and analysis of health information. The report also describes the importance of addressing migrant health needs in an integrated manner that included countries of origin, transit, and destination and, in some cases, return.

TRADITIONAL MIGRANT HEALTH INFORMATION SOURCES AND TREND MONITORING

What is currently known about migrant health?

The collection of health information about migrants varies by country and type of data. In countries where immigration has been a long standing component of nation building, such as Australia, Canada, New Zealand, the United States and others, health assessments have been a routine component of the immigration process. In some of these countries, country of birth or migration status

is a routine element of disease surveillance and reporting. Historical examples in that regard have included infectious diseases, but more recently longitudinal studies of other determinants of health have been included.[10] As the importance of place of origin and length of residence in a new country are increasingly recognized as having importance in identifying problems and improving health outcomes, recent recommendations ask for routinely collecting this information in areas such as maternal child health.[11] Comparative research and analysis exploring health and disease elements between migrant and host populations in those countries has been frequent. However, comparing the results of those studies between countries is often limited by the use of different variables and population definitions.

Countries with national health insurance systems may collect information regarding citizenship or nationality but this may not include the immigration status of the individual. Countries with multicultural populations may collect and record health information on the basis of ethnicity, some of which may reflect migration activities. Additionally, medical research and health investigation in countries with large or significant migrant or foreign born populations may compare health characteristics and outcomes in cohorts of migrants.[12] More recently, as migration is recognized as a global factor affecting and influencing more countries, including those not traditionally or historically considered immigration sending or receiving, the nature and quality of health information regarding migrants is receiving greater focus.[13]

Moving beyond a disease-based focus

Reflecting historical associations with public health efforts to control imported or transported illness and disease, a considerable amount of migration health information, data gathering and research has been disease-based.[14] In addition, public health interest and in some cases regulatory requirements have supported the monitoring of communicable diseases in the context of migration. Together these factors and forces ensure that disease-based monitoring of migration health issues may be overrepresented in the medical literature. However, as the nature and diversity of migration evolved during the latter decades of the 20th century, greater attention was drawn to the health needs of migrant populations themselves. In 1983, WHO undertook a consultation on health and migration with a primarily European focus.[15] Those consultations recommended more in-depth studies on differential mortality and morbidity, the impact of irregular migration status and a focus of country of origin as a reference point. In 1990, the International Organization for Migration (IOM) and WHO organized an international conference dealing with the needs of the migrants themselves.[16] Since that time an increasing number of organizations, institutions, researchers and countries have been exploring and examining migrant health.

MODERN AREAS OF INTEREST IN MIGRANT HEALTH MONITORING

The interface between migration and the social determinants of health

While the gathering of health indicators and migrant health metrics (metrics refer to sets of measurements that quantify results) has historically focused on disease-based indicators, the improved understanding of how health is affected by social and economic factors has widened the area's interest. Issues such as access to care, poverty, unemployment and marginalization affect many migrant populations although they also affect the health outcomes of other populations and communities. Additionally, it is increasingly appreciated that many of the health outcomes of migrant communities and populations are also influenced by or result from migration-related social determinants of health.[17]

In many areas of the world, it has been demonstrated that the availability of and access to health and medical services can have major impact on health outcomes.[18] It has been shown, for example, that access to appropriate services can improve the early diagnosis and treatment of communicable diseases. Similar benefits are observed in situations where accessing and using health services facilitates the early treatment of non-infectious diseases, preventing or delaying their progression to stages that require more intensive or costly care. Additionally, it has been demonstrated that improving access to and utilization of maternal-child health services delivers better health outcomes. Extensive work has been undertaken in exploring and defining the effects, influences and impact of the wide range of social determinants health. Guidelines for health equity surveillance systems encompassing

health inequities, outcomes, determinants, and consequences have been developed and validated.[19] These guidelines can be easily adapted to the monitoring of migrant health.

Positive outcomes resulting from improved access to health services are not solely limited to improvements in the personal health of migrants themselves. They are also associated with social and economic benefits for the host society. The early diagnosis and treatment of communicable infections, for example, reduces the risks of outbreaks and limits the need for, costs of and public anxiety associated with outbreak control activities. At the same time, the early and appropriate provision of health promotion, prevention and treatment provides much more cost effective care than having to deal with advanced disease and illness. While all migrants experience the benefits of better access to health and medical services, the needs of vulnerable migrant populations such as irregular migrants for whom access issues are often more complex or challenging are areas of current and important interest.[20]

Defining and better quantifying the specific elements related to these and similar observations, using population-based outcome indicators, is important to both plan and validate polices, programmes and activities intended to improve migrant health. However, current global migration is diverse in terms of migration dynamics and demography and most of the focus on migrant health tends to be national in both scope and reporting. As a consequence, more widely applicable lessons and good practices may not be easily apparent or obscured by local or national factors, definitions and limitations in data gathering.

The better understanding of the complex relationships between migration and health will require expanding the collection of information to regional and multilateral levels. The resulting regional and global perspective on the relationships between access to care and migrant health outcomes will be important in evaluating how migration policies may influence downstream health system demands and future programme costs. However, the global applicability of such an undertaking will require the use of standardized monitoring and reporting metrics.

CHALLENGES IN MONITORING MIGRANT HEALTH

Challenges
Diversity in source data (differing definitions and denominators)
Dynamics of modern migration (evolving population dynamics)
Health effects of migration extending beyond first generation
Access to some populations/communities

Data integrity

The comparative monitoring, interpreting and reporting on migrant health can be challenging. As historical and traditional methods were frequently national in scope, differences in the methods and nomenclature used by different countries had limited importance. However, considering issues in a global or international context requires standardized methodology to allow for comparative analysis and evaluation. Activities to minimize differences in the classification and comparability of data and migrant health information represent one of the greatest needs as countries move forward in the understanding of migrant health.

Data comparability issues are primarily the result of two factors.

Monitoring the denominator

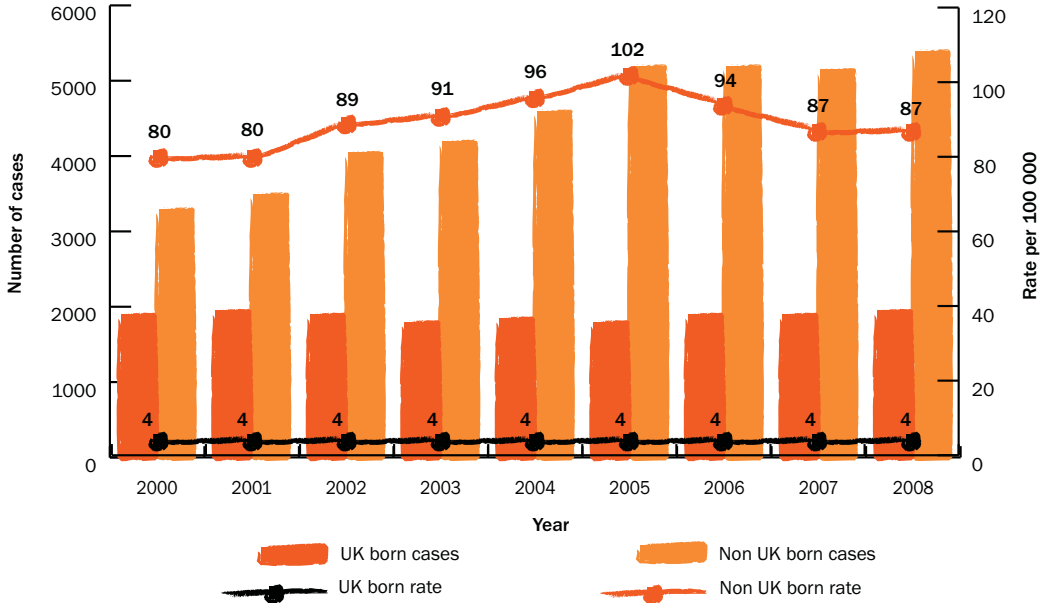
The first, as described above, is a consequence of the legal and administrative aspects related to the determination of citizenship, residency and immigration being national responsibilities. As countries have diverse backgrounds in regard to how they address issues of right of residency and citizenship, national differences in terminology and classification are to be expected. Coordinated international activities and agreements have helped harmonize approaches to some elements such as refugee determination, migrant labour and regional approaches to citizenship and residency as those exemplified by the European Union. Yet many differences remain at national level. An implicit consequence

of this factor is that the legal and administrative definitions and classifications used in the context of migration and immigration were for the most part developed in the absence of any considerations of population health.

While health impact and influences may extend across the entire spectrum of migration, travel and ethnic history, those influences may not be adequately reflected by national definitions or practices. For example, some countries collect and relate health information in terms of nationality or citizenship. This practice, while providing a frame of reference in terms of demographic legal status, is insensitive to the health effects resulting from the timing of the individual's arrival at their in their new destination. A migrant who arrived some 30 years ago from country X may be administratively classified similarly to a person from the same origin who has arrived within the past six months. Several, but not all, of the health characteristics of the earlier migrant are more likely to reflect those of the host population than those of the more recent arrival.

Other countries collect some health information in relation to place of birth. This practice provides a comparator that is not influenced by subsequent citizenship or residency formalities. The process has been use in the monitoring of some diseases and has been used to plan and amend policies and programmes to mitigate or control some diseases such as tuberculosis (Figure 2).

FIGURE 4. TUBERCULOSIS IN THE UNITED KINGDOM 2008[21]



A part of this dynamic has been a simple product of access. Organized or regular migration, including organized refugee resettlement activities, normally involves interaction with national governmental, legal or administrative sectors. This interface and interaction with officials facilitates the collection of information including health monitoring, if required or requested as part of the migration application process. While important in the context of health monitoring, it may have limited applicability to other migrant populations, particularly those acutely affected by crisis (environmental, social, political or conflict-related) or those migrating through irregular means where access to the populations themselves may be limited. Improved migration health monitoring will reduce elements of bias resulting from the over-representation of some population cohorts and increase the wider applicability and implications of migrant health observations.

The administrative terminology used to describe the legal or citizenship status of individuals or populations may have little epidemiological power in helping to define or describe migrant cohorts at increased risk for adverse health outcomes. Populations of migrants defined or aggregated on the basis of immigration status (refugee, immigrant, asylum seeker) may be composed of markedly diverse sub-populations comprised of communities and individuals at greater risk or need of medical

intervention.[22] Victims of trafficking or exploitation, forcibly displaced individuals and traumatized refugees are but a few examples. Even within specific administrative or legal classifications there can be great diversity in the social determinants of health depending on the situation. Immigrants, for example, depending location and situation, can encompass cohorts of wealthy, educated, employed individuals and communities relocating internationally as well as much less advantaged individuals and communities who may be subject to the health effects of poverty, limited education and poor employment. The social and economic differences present in the same administrative or legal migrant classification can be reflected in disparities in health characteristics and outcomes within the larger cohort. Depending upon the size of the more vulnerable groups, health indicators aggregated by immigration classification alone may mask or obscure groups or cohorts at risk.

The monitoring and evaluation of health metrics that account for the existing diversities in migrant populations will support improved migration health policy development. As demonstrated in other cross cutting health issues such as primary care, gender and health, the impact of chronic diseases and the control of international public health threats, the use of appropriate metrics and monitoring by WHO is a cornerstone in the development of relevant multinational and global health policies for use by Member States.

Monitoring the effects of modern migration

Traditional immigration/emigration

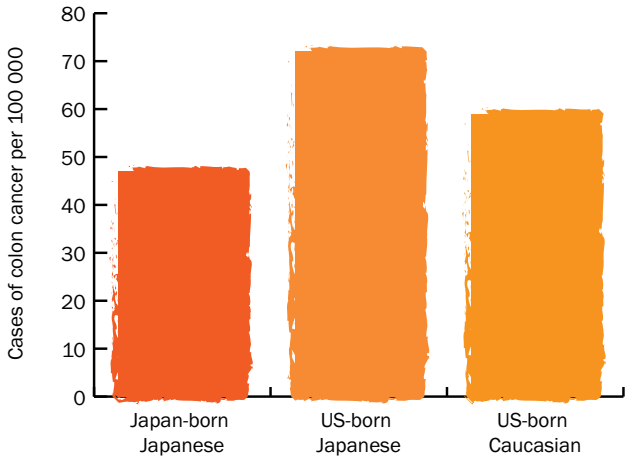
The second factor influencing the applicability and relevance of health information used to monitor migrant health is the consequence of the evolution of the process of modern migration itself. Several of the historical approaches to examining migrant health were developed in the context of the traditional immigration/emigration paradigm of migration. Migration was and in many situations is considered to be a unidirectional process where individuals and populations left a place of origin, permanently or for an extended period of time. That model was appropriate for many of the great historical migratory movements such as European population flows to the Americas, of the 19th and early 20th century, post conflict and "cold war" migration in Europe or the initial waves of migration from Asia and Africa following decolonization. It has been effectively used for the monitoring and study of the impact of long-term migration on certain health conditions such as malignancies, genetic disorders and some chronic infections in some locations (Figure 3).

In addition to the use of place of birth and immigration status some countries with multicultural or diverse population components have evaluated health indicators and outcomes by using determinants of race and or ethnicity as proxy variables for migration. These approaches while sometimes useful in quantifying or identifying differences in health outcomes can be complicated by serious methodological, ethical and conceptual factors. In many locations the volume and dynamics of modern migration test traditional or historical concepts of ethnicity. Communities with dual or multiple citizenship coupled with continuous modern global communication and information exchange and frequent travel patterns further complicate the use of race or ethnicity as surrogates for migration variables. The systematic comparability of health information collected in the context of race and/or ethnicity between different countries and regions is important but it may not always reflect the implications and influences of migration.

An important aspect of longitudinal studies of traditional migration is that they often transcended generations. The implications associated with the migration of genetic or biological health determinants extend long after the arrival of the first generation of migrants. Over extended periods of time, migrants can influence the epidemiology of previously rare or uncommon disorders or diseases at host or transit destinations. Examples are provided by the epidemiology of some malignancies[24] and genetically determined blood disorders such as thalassaemias.[25] The role and importance of health monitoring of this type remains but now extends to countries and regions not historically considered to migrant-receiving locations.[26] The children and grandchildren of migrants may manifest the genetic and biological determinants of their progenitor's place of origin but if monitoring is based on citizenship or nationality, they may not be included. Mitigating or managing these situations is a developing area of migration health but as noted above, monitoring these events can be complicated by data definitions. Understanding country populations as dynamic and changing communities

partly due to the integration of previously migrant communities, rather than close populations with specific unchanging characteristics, may help to understand the need for ongoing updating of health monitoring systems.

FIGURE 5. INFLUENCES OF MIGRATION ON CANCER RATES IN THE UNITED STATES, 1973–1986 (MODIFIED FROM REFERENCE[23]) (COLON CANCER FOR JAPANESE MIGRANTS BY PLACE OF BIRTH)



Modern patterns of migration

In several respects, modern global migration can be very different from the historical unidirectional model.[27] A considerable amount of current migratory activity involves temporary, return or in some cases circular migration. Millions of migrants may be permanent residents of different locations or countries from those in which they work or reside temporarily. Aspects of dual or multiple nationality and ease of travel have blurred both the concept and the functional aspects of citizenship, immigration and emigration. There are also population flows of irregular migrants between host and destination locations and into and out of regular migrant population groups. Recent geopolitical evolution may now allow for the return, travel and repatriation of refugees or displaced populations who may have been absent from their original homes for extended periods of time. Additionally, an important element of migrant health is related to the children and extended families of migrants who, while being routinely considered in the immigration/emigration paradigm, share health risks and determinants of migrant populations due to travel and cultural linkages. These cohorts, described as travellers who visit friends and relatives (VFR) are areas of current interest in the monitoring of aspects of the international spread of disease.[28]

It is clear that terminologies and classifications developed or implemented in the context of traditional unidirectional immigration often do not adequately reflect the more complex health implications of modern migration. Adequate and sensitive classification and data standardization will ensure that the health attributes and needs of vulnerable or high risk cohorts of migrants are more easily identified and described.

Sources of information

The collection and gathering of migrant health information can be derived from many sources. As noted, some Member States may collect health information or statistics on the basis of nationality, immigration status or right of residence. At national level, census information may use place of birth or citizenship as variables to estimate the size and demography of migrant populations. As noted above, these approaches result in the aggregation of what may be disparate sub-populations and small groups or communities that may be vulnerable but "lost" in the larger denominator. Aggregate census statistics of this type, however, if coupled with the time of arrival of new residents, can be useful in long-range health policy and programme planning.

Countries where health elements are a component of national immigration programmes may monitor some health indicators in migrant or foreign born populations as part of the immigration process. As described elsewhere, this activity can take place around the time of the application for admission, arrival at the new place of residence or granting of residency status and is frequently limited to specific disease or conditions according to national public health or immigration law. Examples include tuberculosis, some sexually transmitted infections, immunization status and serious chronic illnesses or conditions requiring extensive care. Some countries may collect and evaluate how, and for what reasons, migrants access or use health and medical services. Other countries may either systematically or less regularly monitor health surveillance or epidemiological information with respect to migrant status, ethnicity or place of birth. Often, studies of this type begin as a disease-based approach with the prevalence or incidence of an illness or a disease related to ethnicity or immigration status. The information collected from those undertakings provides an important window into migrant health[29] but extending the knowledge to other, wider venues can be problematic.

Depending on location, however, large numbers of migrants may access or utilize services in manners that are not systematically monitored or evaluated. Migrants may receive health services from public, private or civil society sectors or a combination of providers,[30] depending on their status, financial capacity or the nature of their illness (the treatment of diseases of public health importance, for example, may be treated through the public health care sector even though other conditions and illnesses are not). In other locations the provision of health-related services may be shared between national health, social service and civil society sectors. Common information-gathering tools, health surveillance systems and indictor definitions may be standardized between providers. The resulting diversity of patterns of access, care and monitoring complicates the collection of information and evidence to better support the planning and development of migrant-sensitive health policies, programmes and services.

Related monitoring variables

International comparability and data standardization notwithstanding, even at a "uniform" national level, migrant health monitoring and study is subject to a variety of epidemiological influences that must be considered in the interpretation of the data. One of the most important is the population against which the migrant cohort is being compared. Traditionally, this has involved using one of three comparators. Firstly, and perhaps most commonly, the health characteristics of migrant populations may be compared against those of the host population in which the migrant transits or resides. Secondly, migrant health elements may be compared between similar groups of migrants in other locations of transit or residence. Finally, health-related aspects of migrant cohorts can be contrasted to those of similar populations from the migrants' origin who did not migrate. Each approach can reveal important aspects of how the migratory process and its consequences affect and influence the health of migrants and of those with whom they have or currently live and work.

A further area of monitoring migrant health that requires attention relates to the importance of health information includes gender sensitive indicators that extend beyond aggregation according to sex. Gender norms and values and the complex interactions that affect many of the social and economic aspects of life between men and women affect health and health outcomes. The impact of these gender sensitive variables can be very important in some migrant populations. These influences may vary according to the stage of migration and some may be only manifest following migration and resettlement, particularly if there are gender-specific differences in the social or cultural environment between origin and destination. Monitoring the impact and outcome of these influences requires systematic attention to gender sensitive indicators as routine elements of migration health programmes and policies.

In addition, monitoring of migrant health in the modern context must consider an important and frequently underappreciated element – the rapid evolution of health conditions and influences in the environment in which migrants originate, transit, work or live. During the past three decades the determinants of health in many regions of the world where migrants originate have changed rapidly in terms of social and economic influences. Some of these changes, such as the decreasing incidence of many infectious disease or health outcomes for non-infectious diseases, have been positive. Others

such as the adoption of less healthy lifestyles or health risk factors (e.g. dietary and caloric alterations; use of tobacco, alcohol or other substances) associated with diseases of affluence that may accompany economic development may be reflected in adverse health outcomes. Whatever their impact however, they can affect the interpretation of comparative studies, particularly those examining the health of earlier migrant cohorts. The fact that recent macro-environmental changes may produce population health outcomes that do not follow historical patterns may limit the applicability and relevance of earlier or historical studies.[31]

One of the important global benefits that can result from the improved monitoring of migrant health will be the early recognition and appreciation of evolving health influences (both positive and negative) at migrant origin and transit locations. The knowledge gathered from metrics of this type can support integrated policies and programmes to mitigate or reduce the consequences of health disparities.

Clarifying and delineating health characteristics and outcomes directly associated with migration

A further challenge related to the monitoring of health of migrants is generated by the functional interface of processes of travel and migration. While travel is an integral portion of migration, the inverse is not always true. While migrant and other travellers do share some health influences and characteristics the accurate appreciation and monitoring of the migration-specific health aspects will be necessary to support and direct accurate focus on those migrant populations who may be at greatest need.[32] This is an important concept in the area of public health and the mitigation of the international spread of diseases. While some groups of migrants may be better studied or investigated as a consequence of administrative or legal requirements, the size of the population of international migrants is dwarfed by that of international travellers.[33]

There are two basic and important facets in migrant health. The first is that migrants share many common health influences and outcomes with other population groups. Factors affecting the social determinants of health, defined and understood globally, are equally applicable to migrants. Health monitoring activities and programmes to mitigate these effects frequently exist but they may not include migrant-relevant indicators such as origin, duration of residence or migration history. Improving monitoring in this context may simply involve the addition of "migrant-relevant" data elements to existing tools.

The second facet is the health influences and determinants directly related to or resulting from migration. These elements may apply specifically to migrants and may not be addressed in health programmes. Examples include geographic, biological or genetic determinants of health as well as specific elements of the migration process itself (forced or voluntary movement, for example). In this case, health monitoring may require the development of new and specific tools including the above noted-migrant relevant indicators as well as specific components reflecting the population at risk (i.e. genetically determined blood disorders, geographically isolated infections, ethnic and cultural aspects and travel patterns).

Global diversity in many of the economic and social determinants of health produces great disparities in the epidemiology of disease and the distribution of health outcomes. Health indicators and characteristics of populations living and working in these disparate environments and locations will reflect local health conditions and influences. Some of those indicators and determinants will accompany migrants when they move to a new destination similar to other travellers following the same route.[34] In this context migration simply provides an epidemiological window disclosing existing disparities and health inequities. The distinction is important as it is fundamental to the considerations of where best to address or mitigate the issue. For example, it has been suggested that addressing certain diseases of importance in some migrant populations, such as tuberculosis, would be more efficiently undertaken through disease control programmes in source countries as opposed to routinely screening immigrants.[35] It is important in this context to better document and to understand those health outcomes that are the product of pre-existing conditions from those that develop in response to or as a result of migration and exposure to adverse health determinants at the migrants' new place of residence.

Understanding and defining the health indicators and outcomes directly related to the migratory process will allow for the most effective and appropriate use of interventions, efforts and investment to improve and promote health.[36] Comparing migrant populations to host populations frequently reveals that not all of the health characteristics of migrants are adverse. As noted above, many migrants arrive at their new home with health indicators and determinants that exceed those of the host population.[37] Over time, due to the negative influence of some social and economic factors, these positive health indicators become less prevalent; a situation associated with future cost and service demand implications. Assisting migrant populations in maintaining these positive indicators and preventing their future deterioration will be facilitated by the improved monitoring of migrant health. Improved monitoring will support better health prevention in migrant populations.[38]

More systematic global migration health monitoring also has positive implications for some migrant source countries. Improved collection of health information for migrants from less developed regions can be used as a surrogate for population health indicators that source countries may not have the current capacity to obtain. Such information may be useful in health programme development in those locations.

IMPROVING THE MONITORING OF MIGRANT HEALTH

Many of the elements of the WHO resolution adopted by the WHA in May of 2008[39] will require the collaborative and integrated collection, analysis and interpretation of the empirical measurements of migrant health indicators and outcomes. There is a large amount of activity and investigation into the relationships between health and migration and an extensive collection of historical material that provides insight into these relationships. However, much of this material activity has been collected at national level and variations in definitions and data sets make international and aggregate comparisons difficult. Reducing these differences and developing more widely applicable indicators will greatly assist in improving the monitoring of the health of migrants.

To be effective, future policy development, health prevention and promotion programmes, and health interventions intended to improve and support the health of migrants, will need to be both population and evidence based. Those policies and guidelines should be based on metrics and analysis flowing from data elements that are wider in scope and context than those represented by administrative immigration or legal status context, citizenship or nationality. The complex social, cultural and ethnic components of migration mean that they will also need to encompass more than disease-based epidemiology. They will have to reflect the dynamic elements of the process of migration itself. Elements that include duration of residence both before migration and after arrival may need to be included in monitoring activities to account for the effects of acculturalization and evolving health environments at the migrant's place of origin. The long-term consequences of genetic and biological health determinants have implications for health monitoring that extends, sometimes for generations, beyond the process of migration and can influence the need for future health services. Collecting the information to monitor and support those initiatives will require comparative and standardized processes producing globally relevant and applicable conclusions necessary to support programme development and provide adequate health guidance for immigration and migration policies.

Needs for improved migration health monitoring
Improved standardization of metrics and indicators
Better monitoring of under-represented communities and migrant populations
Improved definition of metrics and indicators specifically related to migration v. those resulting from existing global disparities
Greater attention to aspects of health prevention and promotion in migrant populations
Improved economic analysis of current migration health interventions

WHO and its partners have already addressed similarly complex health issues such as the role and effects of gender, age, and primary health care; issues that are defined and influenced by economic, social and geographic disparity. Migrant health shares some of those characteristics and

will benefit from some of the lessons learned as those issues became monitored in a global fashion. Globally integrated approaches have been successfully used to address several health issues of international importance and many of the Organization's activities are already directed at reducing health disparities, a major factor affecting the health of migrants. At the international level, regional approaches to improving the monitoring of health indicators in migrant and ethnic populations exist.[40] Reflecting national activities in the area of migrant health some of them are disease- as opposed to migration-based and as such frequently include populations with diverse migrant backgrounds. As described above, there are complex methodological challenges related to the examination of health in terms of race and ethnicity. Some of the health influences are biological and genetic while others are social, economic and cultural. Others still may be the result of or directly influenced by the process of migration itself. One of the important areas of discussion for this consultation will be the need to identify best indicators that account for the effects of migration as well as the longer term health outcomes in migrants.

Traditionally, issues of migrant health have been approached in terms of a disease- or condition-based focus, or a migrant classification-based focus. Both approaches provide some insight into the relationships between health and migration but may not allow for monitoring the effects and influences of the process of migration itself. Framework-based approaches to the study of health and migration based on phases of the process have been considered.[41] Relating health indicators to the components of the migration; origin, movement, settlement and return, can provide the beginnings of a standardized matrix upon which the other related indicators and influences (examples include biological and genetic factors, socio-economic influences, access to care, cultural factors, environmental and other risks) can be related between locations and time. A similar matrix approach can be used to assess the effect of programmes and policies designed to improve migrant health.

Many of the principles and practices developed and utilized by WHO and member countries in those activities can modified and applied to monitoring the health of migrants. Work towards standardized information collection and analysis based on the results of this Consultation will be an important aspect of that activity. During this process, careful attention to one aspect of monitoring of migrant health will be required. Migrants may be subject to stigmatization and negative stereotyping for several reasons. Health and disease can be sensitive issues in certain situations and any activities associated with the monitoring of health outcomes in the context of migration must avoid negative associations related to health and migration. That is why it is important to consider the health outcomes and indicators that are simply associated with global disparities from those that are specifically associated with migration. The former are simply related to travel and global health disparities and can affect all travellers. The latter have more direct relevance for migrants. This attention reduces the possible stigmatization of migrants as disease carriers, especially in the context of health issues related to communicable or uncommon diseases. It is also important in terms of the collection and management of health information where privacy is important or where the fear of the consequence of the poor or abusive handling of data may complicate data gathering among certain groups of migrants. In this context, data aggregation and presentation must reflect high standards of privacy and protection of personal information.

The improved monitoring and analysis of the health elements related to or resulting from migration will be important for the development of applied migrant health policies and programmes. They will better and more early identify and define groups and communities at risk and will be essential to evaluating the impact of interventions and programmes to support the health of migrants.[42] They will also be necessary for the development of integrated and widely applicable guidelines and best practices for those involved in migrant health in countries from which migrants originate, transit through, settle permanently or temporarily or perhaps return to. Improved monitoring of migrant health will provide the tools and capacity for countries to better prepare for and respond to the health needs of migrants and others affected by migration. It has been demonstrated in other WHO supported activities that actions and responses are best supported when the necessary resources and information are prepared for collective integrated use. Improved monitoring of migrant health will support and strengthen many regional and global health and social initiatives, improving life and health for all migrants.

SUMMARY

It is apparent the health of migrants is a field of interest and importance at national and international levels. The size and demography of modern global migration ensure that the health aspects of migrant will retain their importance for the foreseeable future and will have global implications. Considerable efforts are under way to explore the relationships and implications of health and migration across the spectrum of diverse migrant populations, origins, transit locations and resettlement destinations. However, monitoring migrant health often remains subject to historical aspects of immigration/emigration that can limit opportunities for using the information beyond the local context in which it was gathered. Making this information more widely applicable and expanding global capacities to collect, interpret and evaluate migration health information will assist national and international migrant health programme and policy development.

Two basic health monitoring components will be needed to accomplish this task. The first will be to ensure that existing programmes designed to improve the determinants of health are equally applicable to migrants, by recognizing their specific needs. Examples include health monitoring activities that support reducing the health effects of economic inequity, improving living standards and better access to health services. Needs in this regard are standardized use of health-relevant migrant definitions; examples of which may include place of origin, duration of residence of the migrant as well as indicators defining the cultural and linguistic capacity of service providers.

The second monitoring component reflects the need to better define the health indicators and elements directly related to or resulting from migration. Factors in this category may have the same significance for non-migrant populations and may include health indicators related to geographic origin, genetic or biological determinants of health in migrant populations that are different from those of host populations, the health effects of the migratory process itself and health vulnerabilities resulting from some aspects of migration such as the traumatization of refugees and displaced persons.

Together these activities will support the integration of migrant health into existing programmes and activities while ensuring that the specific health needs are recognized and addressed through a population health approach.

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Policy and legal frameworks affecting migrants' health

EXECUTIVE SUMMARY

Traditional approaches to manage the health consequences of migration are no longer considered sufficient or appropriate to address health needs of migrants. Policy approaches have not kept pace with growing challenges associated with the volume, speed, diversity and disparity of modern migration flows and do not sufficiently address the existing health inequalities, gaps in social protection, and determining factors of migrant health including barriers to access health services, goods, and facilities. Indeed, some policies and various practices may complicate access instead of facilitating it.

This chapter discusses policies and legislation that affect migrant health. It suggests that policies aimed at improving the health of migrants must span across sectors to reflect the interdisciplinary nature of the topic, and require harmonization among communities and countries involved in the migration cycle. Access to social protection schemes and migrant participation in policy development are also essential elements for coherent migrant health policy development. The chapter stresses that national legislation and practices should comply with international standards that set parameters for the respect of human rights, including health related rights. Additionally, it addresses the role, competencies and responsibilities of the various sectors and stakeholders in realizing the right to health for migrating persons throughout the various phases of the migration process. It underlines that States have the primary responsibility in protecting all those in their territory and under their jurisdiction, and should protect, respect and fulfil their rights. Major gaps in current policies and legislations that can negatively impact migrants' right to health are highlighted. The chapter furthermore provide examples of policies and national legislation that comply with international standards and public health principles and are followed by appropriate implementation measures.

OVERVIEW

This chapter aims to provide an introduction to the existing policy and legal frameworks on or affecting migrants' health. It also gives examples of practices. It argues that policies must span across sectors in order to adequately address the variety of situations in which migration can occur and the range of migrant health issues. The paper will first introduce the policy considerations raised by modern migration patterns and will then discuss three elements of past, current and developing policy: disease control, migration management and control, and legal norms. The paper will examine the responsibilities of states and stakeholders at each stage of the migration process and will provide recommendations for improving current practices. Finally, the paper will evaluate current concerted international efforts towards policy change.

Policy coherence across migration and health sectors presents numerous challenges. Traditional policies and regulations focus on disease control, emerging public health issues both globally and in the hosting community, and the cost implications of addressing migrant health needs. Others address issues of adaptation, integration, accessibility, acceptability and quality of health services for migrants and the human rights implication thereof. Policies tend to focus on immigrants rather than considering migration health beyond nationality and residence; they tend to focus on communicable diseases rather than lifestyle risk factors and preventive care. When focusing on migrant workers, policies and legislations may not adequately consider their dependents' health. Conflicting pressures created by policies and regulations in areas such as security, registration, profiling, labour or criminalization of migration,[1] migrants and health professionals are directly linked to migrant health.

Nationality or residence are frequently associated with elements of requirement or regulation, designed to control or balance the allocation of associated privileges or access to services. At the same time, population health policies and principles are based on fundamental concepts of universal access to preventive and clinical health and medical services, promotional, preventive or therapeutic.

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Unless they are addressed in a unified manner, these differences in approach can be counterproductive to overall national and global health goals.

The provision of health services to migrants who might not have routine access to them can produce beneficial outcomes. Access to care, particularly in terms of health promotion and disease prevention can reduce both the future demands for health care and also subsequent expenditures. Expedient access to therapeutic services can prevent the progression of disease to more advanced stages, which would require more expensive or involved treatment. Finally, in terms of public health, the early identification and mitigation of communicable diseases can significantly reduce subsequent costs and resource demands on health services.

Historically, with the exception of quarantine and infectious disease control elements, the health and immigration policies of many countries have developed independently. Based on traditional immigration patterns, it was frequently assumed that migrants who did not become permanent residents would reside only temporarily and then return to their normal place of residence. Those who were long-staying would acquire access to care as they formalized their residence. Modern migration, which can involve large numbers of irregular migrants[2] who may reside for long periods without routine access to health services, has altered the historical patterns in several locations. Policy attempts to control or manage migration now have to be balanced with policies designed to improve health and mitigate the health effects of inequity.

Responding to the patterns of modern migration requires coordinated policy development processes that involve both the health sector and those responsible for immigration policy. In some countries, consultations of this nature may not be commonly undertaken. Migration can result in situations where the local health impact or event was generated or created beyond the national boundary or jurisdiction. And yet migrant health policies, by nature, have to be global in context. While national immigration sectors may be more familiar with managing the domestic consequences of international events and situations, this is a policy approach that will need to become more integrated into the national health sector in nations with large migrant populations. This level of coordination has challenges of its own.

Policy coherence in the context of health and migration also highlights the effects of global health disparities which, through migration, present at national level. Policies which ensure that migrants receive similar levels of care to those available for the host population will reduce some of the health disparities and limits to care faced by many migrant populations and communities. In a similar vein, some nations are coordinating cross-border aspects of health care to accommodate the growing impact of migration. Countries with shared borders or significant international migrant flows have enacted policies to ensure sustained treatment, epidemiological surveillance and, in some cases, payments for the care of migrants moving between them.

There is a parallel series of policy issues and needs related to migrant health associated with the economic aspects of health care delivery. Polices that ensure or recommend care need to be accompanied by fiscal policy elements to pay for the care. There are several models in use in this regard. Central health budgets may be used to provide care to migrant residents who have no access. In other locations, insurance or payment is provided to migrants who register or identify themselves as being in need.

Independent of the delivery model, there are several policy challenges associated with care delivery and its cost. Some services are necessary to facilitate access and utilization of health care, including transportation to providers, and the availability of culturally and linguistically competent health services. The costs and funding for ancillary migration health programme elements of this type may extend beyond the health sector. In these situations, additional policy coordination is required between the migration/immigration sector and other national ministries or departments, civic municipalities and non-governmental organizations.

Polices to improve health service provision to migrants should also aim to include the involvement of migrants and migrant communities to ensure programme adequacy. The perspective provided by migrants, including their intimate understanding of the social, cultural, and linguistic aspects of health, is a necessary component of migration health policy development.

Policy coherence in migrant health has some implications that extend beyond national and regional borders. Aspects of what are considered essential, basic, routine or standard health care serv-

ices differ between countries and regions according a complex series of economic, domestic, social and political factors. The nature and type of basic services provided by counties to their domestic populations differ, as do methods of obtaining and paying for essential and non-essential services. Sustained disparities in care that are tolerated at national level can assume significant policy importance in terms of migration when individuals or communities move from more advanced levels of care to locations where care is less prevalent or available.[3] Adequately dealing with the interface between health and migration that occurs at the global/national level requires additional international policy coordination and coherence. Global policies and strategies directed at reducing health disparities should incorporate the impact of current and future migration demographics. At the same time, health policies in countries with large numbers of migrants will need to encompass global elements to mitigate the impact of domestic health challenges that originate beyond national borders.

Migration policies, health policies, and other policies affecting migrant health can only be viable and effective when they are based on a firm foundation of legal norms, and thus operate under the rule of law. International standards set parameters for the respect of human rights, including the right to health and health related rights, for the protection of migrants, and for respect of the sovereign interests of states. National legislation and practice must therefore comply with international norms, which provide a continuous framework of protection from human rights violations.[4]

BASIC ELEMENTS OF MIGRANT HEALTH POLICY AND LEGAL FRAMEWORK

The following section will outline three key elements of policy and legal frameworks affecting migrants' right to health: disease control, migration management and control, and norms.

Disease control elements

Policies, edicts and legislation designed to limit or mitigate the spread of infectious diseases represent some of the earliest recorded organized public health activities. Early religious texts in several cultures contain references to practices and procedures to be used to deal with travellers afflicted with certain feared diseases. The management of leprosy in medieval Europe is an example.

Faced with the threat of imported plague in the 14th century, regulatory processes were enacted to manage and control the arrival of goods and people from areas known or suspected to be disease affected. These processes of quarantine and isolation expanded globally in parallel with colonization, trade and migration. They were often driven by important international disease threats, such as cholera in 19th century and yellow fever and malaria in the 20th. They are distant progenitors of today's International Health Regulations (IHR).

Today, globalization, high-speed travel and growing international migration are recognized as factors influencing the international spread of some diseases of public health importance. While rare in occurrence, the outcome can be significant. Migrants from vulnerable environments may be at greater population-based or epidemiological risk of acquiring some of the diseases of public health importance. As a consequence, and because regulatory processes continue to be applied to those crossing international borders, migrants may also be at increased likelihood of being subject to the application of disease control legislation. Fundamentally based on principles of protecting the majority, quarantine, some disease control policies, and legislation can interfere with or limit an individual's rights. These components can include elements of voluntary and, in situations of lack of compliance, involuntary isolation or detention pending treatment or disease resolution. Ensuring that regulatory activities and policies meet the needs of migrants while avoiding discrimination is important for legal, humanitarian and public health reasons.

Migration management and control elements

While quarantine practices could be applied to all travellers, some nations receiving large volumes of international pilgrims or migrants have introduced specific immigration-related medical activities for these populations. Some of those migrant-specific health policies exist at international levels, such as those currently defined in Article 31 (1) (b) of the IHR.[5] More frequently, however, immigration-related health legislation is found at national level, since states have competency regarding, inter

alia, the determination of nationality, admission, residence of non-nationals, security/border control measures and detention.

Migrant health policies vary in relation to the characteristics of the migrants themselves. For example, health status may be used to determine fitness for work or entry for migrant workers. For regular immigrants, the health status or condition at the time of application may be a component of immigration selection and acceptance criteria. In most cases, policies exist to waive such health related entry requirements for refugees and others in need of international protection, except in conditions where communicable disease concerns are identified.

As it will be explained in depth later, state authority over entry, stay, expulsion and detention is limited by international law and international human rights law in particular.

Norms

Human rights approach to health[6]

Ensuring that human rights are fundamental components in the design, implementation and evaluation of health related policies and programmes provides the basis of a human rights approach to health. Furthermore, it guarantees that states are complying with their obligations under international human rights law and is often in line with their national Constitutions. Rights-based components include equality and non-discrimination, the active and informed participation of involved individuals and communities, a sustained focus on the most vulnerable and marginalized in society, and the existence and effectiveness of accountability mechanisms. The use of these normative standards and principles shapes both policy-making and action concerning health intervention at all levels. A human rights-based approach to programming would optimize a holistic and integrated process as well as health outcomes with a focus on the goals of health promotion and disease prevention.

The protection offered to migrants by International Law

Migrants are first of all human beings and hence right holders. States have to protect the human rights of migrants, including their right to health, regardless of their migration status.

There is, nevertheless, a disparity between the principles agreed to by governments and the reality of individual lives, which underscores the vulnerability of migrants in terms of dignity and human rights.[7] Migrants may face discrimination on multiple grounds and are particularly vulnerable to human rights violations.[8] Migrant workers are too often seen as exploitable and expendable, a source of cheap, docile and flexible labour, consigned to dirty, dangerous and degrading work or working conditions[9] and at a high risk for being victims of occupational accidents.[10] Irregular migrants, including irregular migrant workers, tend to belong to the most deprived sections of the population, and therefore their social protection deserves particular attention.[11] Victims of trafficking in persons often suffer from a multitude of physical and psychological problems.[12] Migrants are among the most vulnerable when sexual and reproductive health is analysed.[13] Asylum seekers constitute a particularly vulnerable section of the population due to pre-migration risk factors such as torture or other trauma, which may result in physical and mental problems. However, some other migrants, usually skilled workers who move to take up professional jobs in the formal sector, may have relatively few human rights problems.[14] Focusing on those with the greatest needs is one of the challenges of policy development in migrant health. The report by the World Health Organization (WHO) Secretariat supports action in this regard by highlighting that many "migrants' fundamental health needs are not always adequately met, thus raising concerns with regards to equity, social cohesion and inclusiveness".[15]

Human rights law is central to migrants' protection. Founded upon the inherent dignity and equal and inalienable rights of every human being, the principles of equality and non-discrimination[16] lie at the heart of international human rights law. In accordance with these principles and the provisions set out in the core universal human rights instruments, states have an obligation to protect the human rights of all individuals within their territory, including migrants, regardless of their migration status. Thus, the human rights of migrants are protected under all the core international human rights treaties.

In addition, many of the rights applicable to migrants are part of customary law and must be observed by all states and guaranteed to all persons.

Finally, human rights law also operates in combination with different areas of international law that have implications for the right to health of migrants.[17] Those other areas include aspects of labour, humanitarian and refugee law.[18] For instance, the International Labour Organization (ILO) standards that make up international labour law are intertwined with human rights law and include specific reference to migrant workers. These standards cover occupational safety and health.[19] The ILO has produced several instruments protecting the rights of all workers, including migrant workers, and four specific conventions and recommendations.[20] Migrant workers benefit from both specific provisions of the ILO instruments related to migrant workers as well as all the core international human rights treaties.

Health as a human right, human rights as migrants' right, health as migrants' right

Health as a human right for all was first enunciated at international level by the Constitution of the WHO. It was then reiterated in the Universal Declaration of Human Rights, Article 25; and in several legally binding international human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights,[21] Article 12; the International Convention on the Elimination of all Forms of Racial Discrimination,[22] Article 5; the Convention on the Rights of the Child,[23] Articles 24; the Convention on the Elimination of All Forms of Discrimination against Women,[24] Article 12; the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families,[25] Articles 28, 43 and 45; and the Convention on the Rights of Persons with Disabilities,[26] Article 25.

The central formulation of the right to health is contained in Article 12 of the International Covenant on Economic, Social and Cultural Rights. Article 12.1 recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", which is abbreviated to the "right to health". The scope and content of this specific right is based on general comment No. 14 of the Committee on Economic, Social and Cultural rights.[27] It includes the requirement that, within a country, health facilities, services and goods must be available in sufficient quantity, be accessible (including affordable) to everyone without discrimination, be culturally acceptable (e.g. respectful of medical ethics and sensitive to gender and culture) and be of good quality. The right to health also includes the underlying preconditions of health: an adequate supply of safe food, nutrition and housing, access to safe and drinkable water and adequate sanitation, safe and healthy working conditions, and access to health-related education and information. Moreover, the right to health embraces a wide variety of socio-economic factors indispensable to the achievement of health. It contains freedoms, such as the right to be free from non-consensual medical treatment and to be free from forced sterilization and discrimination, as well as entitlements, such as the right to a system of health protection.[28] Another important aspect is the participation of the population in all health-related decision-making at the community, national and international levels, including migrants.

Regional instruments have also proclaimed explicitly the right to health or they offer indirect protections through other health-related rights. Instruments in the African region include the African (Banjul) Charter on Human and Peoples' Rights, Article 16, and the African Charter on the Rights and Welfare of the Child, Article 14. In the American region there are the American Declaration on the Rights and Duties of Man, the American Convention on Human Rights, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women. Many EU Law and Council of Europe instruments enrich the right to health, including the now legally binding Charter of Fundamental Rights of the European Union of 2000, the European Convention on Social and Medical Assistance of 1953, the European Social Charter of 1961 (and Revised Charter of 1996), the Convention on Human Rights and Biomedicine of 1997. [29]

Many national constitutions and statutes recognize the right to health directly or indirectly.[30]

The relationship between health and other human rights

The right to health has a symbiotic relationship with many other rights, including human dignity, life, the prohibition of torture, privacy, access to information, and the freedoms of association, assembly and movement. The enjoyment of the right to health in practice can positively impact on

the realization of the above listed rights. Recognizing this, the African Commission on Human and Peoples' Rights has held that "enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realization of all the other fundamental human rights and freedoms".[31] Conversely, the failure to protect human rights can have adverse consequences for health.

Legal obligations

From a human rights perspective, states have to comply with the treaties' legal obligations to take concrete steps to the maximum of their available resources to ensure that all persons within their jurisdiction, including migrants, receive health care and also the underlying preconditions for health.

The aforementioned General Comment No. 14 on the right to health stipulates that one aspect of the obligation to respect the right to health is to refrain from denying or restricting the equal access of irregular migrants to preventive, curative and palliative health services.[32]

Yet while international human rights law places on states the responsibility to ensure that facilities, goods and services required for the enjoyment of economic, social and cultural rights, like to right to health, are available to all at affordable prices, it does not stipulate that services must be provided free of charge in all cases. Subsidized or free services should be provided in those circumstances where the enjoyment of human rights is at risk, and access to social security should have the aim of preventing people from living in desperate circumstances.[33]

Core obligations, such as non-discrimination, are subject to neither progressive realization nor resource availability.[34]

Governments have an obligation to protect individuals from the actions or omissions of third parties (for example non-state stakeholders, relatives or partners) that may have an impact on the right to health and other health-related human rights (e.g. do not discriminate).

Social security

In addition, compliance with a rights based approach to health care for migrants requires social safety nets based on legislation. Accordingly, the Committee on Economic, Social and Cultural Rights General Comment No. 19 asserts the particular rights of migrant workers in respect to the right to social security, of which health care is an element.[35] The Committee states that non-nationals should be able to access non-contributory schemes for income support, affordable health care and family support. The Committee has made it clear that all non-nationals, regardless of their migration status, are entitled to primary and emergency health care.[36] In addition, migrant works need to be able to obtain equal access to coverage and entitlement to benefits as national workers, maintain acquired rights when leaving the country, and benefit from the accumulation of rights acquired in different countries.[37]

Social security schemes take a variety of forms. Under contributory social security schemes covering both nationals and non-nationals, employers of migrant workers are required by law to contribute towards social security benefits for the worker, including health care for the worker and dependants. In other cases, countries have reached mutual agreements on the portability of social security benefits between countries partly to encourage the return of migrants to their home countries on retirement as well as to assure care when migrants travel back to their homes to visit family and friends. Some countries with high dependency on migrant labour but without social health insurance schemes, such as the oil producing countries, are now developing contributory social security schemes, covering health care and disability for the salaried workers. However, these schemes rarely cover the migrants' dependents.

The success of any social security scheme depends both upon employers' compliance and upon workers' knowledge of their rights. Furthermore, the process will fail to provide regular rather than ad hoc protection unless comprehensive legislative and policy developments clearly define the statutory extent of coverage, eligibility, governance and financing for all categories of migrant populations.

Protection mechanisms

States' compliance with treaty obligations is monitored by the United Nations Treaty Monitoring Bodies. As the International Catholic Migration Commission and December 18 highlighted, it is necessary that states produce reports that clearly identify the various categories of non nationals on their

territories, and the level of protection they are afforded. This would enable the Treaty Monitoring Bodies to give clear guidance to States parties as to how and in which area they should improve their performance.[38] The Treaty Monitoring Bodies' concluding observations on states' reports cover the topic of non nationals' access to health services.[39] The Treaty Monitoring Bodies' concluding observations on states' reports cover the topic of non nationals' access to health services.[40] They also argue for the application of relevant treaty provisions to irregular migrants. They have, for example, urged some States parties to take necessary legal and policy measures to ensure that irregular migrants and asylum seekers whose asylum applications have been rejected are provided with access to social security, health care and education.

Other international protection mechanisms are known as "special procedures". They are mechanisms established by the Commission on Human Rights and assumed by the Human Rights Council to address the human rights situation in a particular country or territory, a specific human right, or a particular human rights issues such as the right to health or the human rights of migrants.[41] For example, the mission to Sweden by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in 2006 and the subsequent report have augmented an existing movement advocating for irregular migrants' exercise of their right to health and pursuing relevant initiatives.

Regional bodies and courts are increasingly dealing with economic, social and cultural rights, including the right to health, often shedding light on the scope of these rights and playing an important role in their protection. For example, it appears from the European Court of Human Rights' case law that the denial of health care to irregular migrants may amount to an infringement of Article 3 (the right to be free from torture and degrading and inhuman treatment) of the European Convention for the Protection of Human Rights and Fundamental Freedoms. Additionally, according to the Case Law of the Court, a state's failure to provide effective access to health care for migrants in an irregular situation may also result in a violation of Articles 2 (right to life) and/or Article 8 (right to respect for private and family life).[42]

National courts are a critical means of ensuring that the state respects the human right to health. Administrative and political mechanisms complement judicial mechanisms of accountability.

STATES' RESPONSIBILITIES AND OTHER STAKEHOLDERS' ROLES THROUGHOUT THE MIGRATION PROCESS

The following section will examine the roles and responsibilities of states and other stakeholders in ensuring migrants' right to health at each stage of the migration process: entry, detention, stay in the country of destination, and eventual return.

Entry

Non-nationals have no general recognized right to enter another country. However, when states exercise their sovereign powers to deny admission or exclude migrants, they must do so in a manner consistent with international law, including the principle of non-discrimination. This principle requires states not to treat persons intending to enter or reside on their territory differently solely due to their health status unless there is an objective and reasonable basis for doing so.

Progress and challenges

One of the challenges in this area occurs at the interface of migration and public health. In rare situations health threats and risks to others may justify limits to personal autonomy, privacy and freedom.[43] Examples include processes to mitigate the spread or extension of diseases of great international public health importance such as highly pathogenic infections at risk of causing serious mortality or morbidity (i.e. extremely drug resistant tuberculosis or highly pathogenic avian influenza capable of human infection).[44] Migrants can be affected by these processes because of exposure related to their status, work or detention[45] or because they may be subject to immigration-associated medical assessment or screening. Ensuring that restrictions based on public health rationales are empirical, equitable and justifiable is crucially important for compliance with international law in these situations.

Progress has been made. For example, with effect from January 2010, the United States lifted the ban on travel and immigration by people living with HIV. The Mexican Federal Constitution explicitly prohibits discrimination on the basis of state of health (Article 1), which is reiterated in the Federal Prevention and Elimination of Discrimination Act (Article 4). Accordingly, HIV/AIDS detection standards cannot be used for purposes other than health protection (6.3.2), including for determining entry into and departure from the country for both nationals and foreigners (6.3.4) unless such a measure is in the national interest (General Population Act Article 38). Similarly, Lesotho's immigration laws and policies do not discriminate against entry of migrants living with HIV. Continuing this progress, the Joint United Nations Programme on HIV/AIDS (UNAIDS) set up an international task team to heighten attention to the issue of the so called HIV-related travel restrictions on international and national agendas and move towards their elimination.

Discriminatory legislation and/or practices still exist in many countries.[46] Many countries justify such a differentiation on the grounds of protecting public health and avoiding excessive pressure on national health care resources. Indeed, various regulations are imposed with the purpose of preventing the entry or residence of migrating persons with certain diseases or conditions. However, it is questionable whether these justifications are objective, empirical and reasonable in all cases.[47] For instance, the refusal to admit persons living with HIV on the grounds of preventing or mitigating the spread of the disease, is not a reasonable means of controlling the virus, since the virus is spread by specific behaviours rather than the mere presence of carriers and since the virus already is present in virtually every country.

Some of the policies related to migrant health can be associated with significant ethical and moral issues that extend beyond health and disease. These include the pregnancy screening of temporary female migrant workers to prevent the birth of children during the period of employment and the use of genetic technology to determine family relationships for immigration purposes.

Recommended directions

In order to conform with international human rights law, entry as well as residence restrictions based on health status should be applied on an individual basis, taking into account the real effect of excluding the applicant on public health grounds and the cost treatment would impose on the host state.

Detention[48]

Policies that governments use to deal with those found to have entered illegally, not having correct documentation to stay or pending deportation can have significant implications on migrants' health. Detention, either as a deterrent or control mechanism, can be associated with several adverse health outcomes, particularly for the already vulnerable. Psychological distress and despair, including deliberate self harm have been documented.[49] Prolonged and indefinite detention can lead to negative psychological results. The health needs of migrant detainees may often not be adequately appreciated, monitored or met, and detention itself can be profoundly damaging for their physical and mental health.

Progress and challenges

Alternative measures to detention have been successfully used by some countries. "In Slovenia, foreigners who are caught for the first time in an irregular status, or for whom there is no risk of absconding, are usually treated in open community centres where they are free to leave during the day."[50] In Italy, the detention of "unaccompanied" foreign minors is prohibited by law.

Alternatives to detention are not ubiquitous, however, and where migrants are detained, international standards ensuring their right to health should apply.

Recommended directions

As the former United Nations Special Rapporteur on the human rights of migrants recommended, infractions of immigration laws and regulations should not be considered criminal offences under national legislation. Governments should consider the possibility of progressively abolishing all forms of administrative detention.[51] [52] When migrants are detained, international standards[53] should

apply to help ensure that they are held in centres specifically designed for that purpose and in conditions which do not violate their human rights, including their right to health. Sufficient provision of health services and hygienic conditions, as well as adequate safety and security, are essential for the right to health of all detainees.

Stay

Barriers impeding access to health services, facilities or goods for migrants, in particular those in irregular situations, exist in a variety of forms and are practiced in many states. These include health providers' and migrants' lack of information regarding legislative measures concerning access by migrants, ambiguously or imprecisely defined entitlements, inappropriate implementation measures and insufficient funding, time-consuming administrative reimbursement procedures, any requirement on health service providers to report to the authorities the presence of irregular migrants, illiteracy, language problems or lengthy and complex application processes to obtain regular access to health care.

Progress and challenges

Access to health care

Some governments have developed and adopted a variety of policies and legislative approaches to meet the health needs of migrants and to comply with their legal obligations.

In Spain, for example, all migrants, including asylum seekers and irregular migrants, are entitled to the same health coverage and conditions as nationals. The only requirement to obtain an individual health card is register in the "local civil registry" (*padrón*). However, children and pregnant women do not have to register. In order to register in the civil registry, it is necessary to have a valid passport and provide proof of habitual residence. In addition, registration must be renewed every two years in order to retain the health card. A number of irregular migrants are unable to obtain health cards because they cannot comply with the registration's requirements, particularly with the requirement of proving habitual residence. In response, some regions have developed more welcoming systems in which undocumented migrants are provided with health cards without prior registration in the civil registry. In some of these regions, such as Comunidad Valenciana, the authorities directly provide a "solidarity card" and in others, such as Andalucía, municipalities, health departments, NGOs and trade unions have established partnerships and systems to make this possible.[54]

In Italy, under Article 34 "Health Care Assistance for the foreigners registered to the National Health Care Service" of the legislative decree n.286 of 25 July 1998,[55] non nationals have the obligation to register with the National Health Care Service, after which they are granted equal treatment and have the same rights and duties as any other Italian citizen. Health assistance is also granted to minor dependents living in Italy regardless of legal status. Children of non nationals registered with the National Health Care Service are entitled from birth to the same treatment conferred on any other Italian minor. Under Article 35 "Health Care Assistance for the foreigners not registered with the National Health Care Service" of the same decree, irregular migrants are entitled to urgent outpatient and hospital treatment or any other basic urgent treatments, even including long hospitalizations health cares, for disease and accidental injuries as well as protocol of preventive medicine to safeguard the individual and collective health. Preventive,[56] necessary[57] and urgent[58] treatments are expressly defined. Even when entitlements are clearly specified by law, wide access may be impeded by lack of awareness about rights.[59]

In Italy ensuring access to health services by migrants, regardless of their status, has produced important public health successes, in particular with respect to communicable diseases. For instance, Italy has observed among migrant populations reduced rates of AIDS since the introduction of highly effective antiretroviral therapy (1996); the stabilization of those infected with tuberculosis; and reduction of adverse outcomes in maternal and child health (e.g. low birth weight, perinatal and neonatal mortality).

The Committee on the Rights of the Child that monitors the implementation of the eponymous Convention noted with appreciation an initiative of Malaysia to provide all children of migrant workers with unrestricted access to health services.[60]

The Bahamas and Guyana provide universal access to health care with respect to HIV.[61]

In Canada, where health care delivery is a provincial responsibility, costs for health care for migrants not yet eligible for health insurance are paid for by a national programme.[62] The programme, administered by the Canadian immigration department, provides benefits for refugee claimants, resettled refugees, persons detained under immigration legislation, victims of trafficking in persons and the in-Canada dependants of these groups who are unable to pay for health care. Benefits are provided until the eligible migrants obtain provincial/territorial or private health plan coverage.

Although good practices exist, there is a tendency in some countries to restrict irregular migrants' entitlements to access health care and to look at health as an instrument serving immigration control purposes rather as a human right to protect.[63]

Additionally, barriers to access are faced by regular migrants. For instance, documented migrant workers in the Republic of Korea are able to independently subscribe to the National Health Insurance or to obtain subsidized corporate insurance through their employers. However, most migrants cannot afford the independent subscription, and most employers lack the economic incentives to provide subsidized insurance, since it is not compulsory. Finally, many documented migrant workers become undocumented after changing jobs more than three times, the maximum allowed; they are then illegible for the National Health Insurance.

Occupational health

Protection of the health and safety of migrant workers is critical. They have been explicitly identified as a vulnerable group.[64] ILO standards, as aforementioned, extensively cover occupational safety and health.[65] The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, together with the ILO Migration for Employment Convention, 1949 (C-97) and the ILO Migrant Workers (Supplementary Provisions) Convention, 1975 (C-143), offer the most comprehensive legal framework for defining national and international migration policy and apply to all stages of the migration process, including preparation for migration, departure, transit and the period of stay and employment in the states of destination as well as return to the country of origin. Adopted 20 years ago, the Convention suffers from a relatively low level of ratification, especially in countries of destination. Still, the number of State parties is steadily growing, reaching 42 as of today. An additional 16 states have signed but not yet ratified the Convention.[66]

Emergency care

It should be emphasized at the outset that mere commitment to emergency care is not legally permissible nor justified and reasonable from a public health perspective. From a legal perspective, the principle of non-discrimination proscribes "any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement… which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health." Thus, if non-migrants are granted health care beyond emergency care, it impermissibly discriminates against migrants to provide to them only emergency care. From a public health perspective, the failure to receive any type of preventive and primary care could create health risks for migrants and host communities. Additionally, the economic and social burden of non-access is ultimately greater than providing migrants, including irregular migrants, with access to all health services, while the benefits – both intangible and financial – contributed by migrants more than offset their use of health care.[67]

Health beyond nationality

Even after acquiring the nationality of the country of destination, migrants and subsequent generations may still experience barriers to realizing their right to health. Also, some biological and genetic determinants of health, as well as certain behaviourally influenced determinants, may extend over generations.[68] In this context, monitoring and studying the health implications and consequences of migration require a focus that goes beyond the legal boundaries of nationality and residence.[69]

Recommended directions

In the context of health, successful integration in the receiving country requires, inter alia, a comprehensive interpretation of migration health beyond infectious disease control. It should encourage preventive and curative efforts in a holistic approach to health that involves migrants' working and living in healthy conditions. Health services, goods and facilities should be provided for migrating persons' well-being and the fulfilment of their right to health, and for the health and wealth of affected communities.[70]

Ensuring that the right to health for all, including migrants, is formally recognized in national laws and that it is realized in practice is fundamental for its operation for those staying or residing in a given country. This can be achieved by defining entitlements; using appropriate implementation measures and sufficient funding; improving the scope and function of the existent public reimbursement schemes; eliminating requirements on health service providers to report to the authorities the presence of irregular migrants; and guaranteeing health care is appropriate to the needs and circumstances of individual victims of trafficking in persons regardless of their willingness to cooperate in criminal proceedings against traffickers.

Finally, it is essential to ensure that everyone, from migrants to health care providers to policy-makers, is aware of the right to health, the needs of migrants, and the resources available to them. Migrants must be made aware of and gain confidence in the health care systems of Member States as well as realizing the importance of preventive health care. Migrants should participate in health services delivery, policy design, programme planning and evaluation, and the health workforce should be trained about issues related to migration health. Also, researchers, policy-makers, and those involved in social and economic planning on migration health should have their awareness raised.

Return

Finally, the return of migrating persons to their country of origin may entail returning to an area with higher disease prevalence then the country where the migrant resided. The migrants' return could also entail the introduction of health conditions acquired during the migration process into the community of origin. For instance, data suggests that Haitian migrants were infected with HIV after their arrival in the Dominican Republic.[71]

Progress and challenges

Return conditions, as with entry and residence conditions, must not breach international law. For example, persons with life-threatening medical conditions who cannot continue with their treatment in their country of origin may not, at the risk of hastening death in distressing circumstances and thus causing inhumane treatment, be returned. In some locations, health status has, in fact, been considered a possible ground to limit sovereign power to expel a non-national.[72]

Assisting voluntary return and reintegration of people living with HIV or with other health conditions requiring treatment and support may be particularly problematic if specific conditions are not met. Recently, a report on the situation faced by a group of migrants living with HIV in the Netherlands evaluated conditions for sustainable return and reintegration and listed the following conditions as minimum ones: the necessary medical treatment is available and accessible; the returnee can acquire an income that is sufficient to cover regular expense for her/him and the family and to cover all costs related to medical treatment in the country of return; the returnee finds a place with a supportive social network and has the ability to cope with possible stigma from society as a whole. The report concludes that such conditions can be assessed only by taking into consideration the individual's specific situation and the context in which she or he would return.[73]

Finally, acquired conditions may become exposed long after return due to the latent period between occupational exposure and disease outcomes. Migrant workers can be exposed to hazardous chemicals or carcinogens at the workplace in the hosting country, and the symptoms of chronic poisoning or occupational cancer may develop after they return to their home country. For example, workers exposed to asbestos in construction sites of the hosting country in their thirties may develop lung cancer and mesothelioma in their sixties after returning to their country of origin.

Recommended directions

A case-by-case consideration of factors such as the availability and the physical and economic accessibility of treatment in the country of origin, as well as the presence of family or other support, must be taken into account in order to determine the legality of expulsion.

The country of origin should protect, respect and fulfil the right to health for all those in its territory and under its jurisdiction, including returnees.

The role of international organizations

As states have the primary responsibility in protecting, respecting and fulfilling the right to health for all, the involvement of international actors is only of a subsidiary nature. International actors will only engage in assistance measures related to the right to health, where states have not fully implemented the right to health. The ultimate aim of any international assistance programme is, in fact, building the capacity of the government to secure the enjoyment of the right to health and health related rights by all individuals on their territory or under their jurisdiction. Nevertheless, such efforts to develop the capacity of governments or non-governmental organizations do not preclude international actors, including WHO and IOM, from assisting in the health sector.

CONCERTED GLOBAL EFFORTS TOWARDS POLICY CHANGE

The growing global interest in and appreciation of the need to reorient policies in the migrant health domain can be illustrated by various recent health related UN initiatives of global importance. For instance, the United National General Assembly Special Session on HIV/AIDS (UNGASS) in 2001 called for developing and beginning by 2005 national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services.[74] In June 2009, following a thematic segment on "People on the move–forced displacement and migrant populations". the UNAIDS Programme Coordination Board requested the UNAIDS Secretariat and Cosponsors: to ensure that staff at global, regional and national levels facilitate the incorporation of mobile populations, including migrants and forcibly displaced persons, into regional and national AIDS strategies to achieve universal access to prevention, treatment, care and support services.

Relevant World Health Assembly (WHA) resolutions have addressed or included migrants' health considerations in recent years. For instance, WHA60.26 on "Workers health, global plan of action", urges Member States, among others, to work towards full coverage of all workers, including those in the informal economy, small- and medium-sized enterprises, agriculture, and migrant and contractual workers, with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries; WHA 61.17 on "Health of migrants", asks Member States for migrant sensitive health policies and practices, and requests WHO to promote migrant health in collaboration with other relevant organizations, and encourages interregional and international cooperation and dialogue; WHA 62.12 on "Primary health care, including health system strengthening", strongly reaffirms the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for strengthening health systems; WHA 62.14 on "Reducing health inequities through action on the social determinants of health" urges Member States, among others, to tackle the health inequities within and across countries; and WHA62.15 on "Prevention and control of multi drug resistant tuberculosis and extensively drug resistant tuberculosis", stresses the needs of vulnerable groups, such migrants, as well as the underlying social determinants of tuberculosis.

CONCLUSIONS

Considerations to reach policy coherence:

- Human rights based approach
- Equality and non-discrimination
- Active and informed participation of involved individuals and communities

- Sustained focus on the most vulnerable and marginalized in society, including irregular migrants
- Existence and effectiveness of accountability mechanisms
- Coordination and harmonization between countries of origin, transit and destination, as well as between relevant sectors
- Social protection, including health financing
- Broad spectrum of health issues, beyond infectious problems
- Awareness raising on "right to health" issues among all relevant stakeholders

Addressing migrant health is a necessary precondition to full realization of the benefits of migration for those who migrate and for both countries of origin and destination. "Sick people are more likely to become poor, and the poor are more vulnerable to disease and disability. Good health is central to creating the capabilities that the poor need to escape from poverty. In other words, good health is not just an outcome of development – it is a way of achieving development. The right to health has a vital role to play in tackling poverty and achieving development – it lies at the heart of our struggle for a fairer, more humane world."[75]

Migrant health is closely linked with the unequal distribution of socio-economic determinants including income status, housing, education, nutrition, employment. As a consequence, policy responses will be more effective if they reflect the multi-disciplinary nature of the topic and involve stakeholders from all relevant sectors. For instance, in 2007 the European Union (EU) Conference on Health and Migration in the EU: Better Health for All in an Inclusive Society, stressed the need for coherent immigration policies that incorporate health dimensions at EU and country level and promoted a "health in all policies" approach to migrant health. Such an approach could help avoid the development of contradicting policies and legislation within one country.

Not only should policies and strategies to address migrant health be multi-sectoral in nature, they also require multilateral cooperation and coordination among the communities or countries involved in the migration process. Migrants, by default connect communities or countries and their respective health environments. Harmonization of policies among countries is required to support the health of migrants and hosting communities throughout the migration process. Especially considering today's magnitude of circular migration flows, inter country and regional approaches facilitate uninterrupted treatment.[76]

This paper has shown that legislative and policy frameworks that relate to the health of migrants exist at international, regional and national levels. Some have argued that providing adequate health care and ensuring the preconditions of health decreases the cost implications of addressing migrants' health needs. The principles of health economics show that cost containment is achieved through timely and appropriate use of services, particular preventive services, and when utilization is not hampered by problems of accessibility. A human rights-based approach leads to the same end: the ultimate goal of enhancing the realization of the right to health – and other interrelated rights – requires legislative and policy development processes that consider the relationship of migration and the determinants of health. Accordingly, this paper has emphasized that there are existing legal and policy frameworks that address the issues of the accessibility of health services and the preconditions of health from the point of view of migrants' right to health. Consider, in light of the recommendations provided, whether the existing frameworks are effective and what can be done to strengthen their support of migrants' right to health.

NOTES

1 On 29 September 2008, the Council of Europe Commissioner for Human Rights (the Commissioner) issued a Viewpoint expressing his concern regarding the trend to criminalize the irregular entry and presence of migrants in Europe presented as part of a policy of migration management. He stated that "such a method of controlling international movement corrodes established international law principles; it also causes many human tragedies without achieving its purpose of genuine control" (http://www.coe.int/t/commissioner/Viewpoints/080929_en.asp, accessed 21 February 2010). Guild E. *Criminalization of migration in Europe: human rights implications*. Issue Paper commissioned and published by the Council of Europe Commissioner for Human Rights, 2009 (http://www.statewatch.org/news/2010/feb/coe-hamm-criminalisation-of-migration.pdf, accessed 21 February 2010).

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8 "Dissociation between nationality and physical presence has many consequences. As strangers to a society, migrants may be unfamiliar with the national language, laws and practice, and less able than others to know and assert their rights. They may face discrimination, and be subjected to unequal treatment and unequal opportunities at work, and in their daily lives. They may also face racism and xenophobia." Council of Europe. *The human rights of irregular migrants in Europe*, CommDH/IssuePaper1.

9 See note 4.

10 Occupational health and safety among migrants is essential as studies show a large proportion of all reported occupational diseases and accidents occur among migrating persons. Low-skilled migrants as well as irregular migrants are at a high risk of being victims of occupational accident while working in high risk jobs with poor supervision. This is the case for migrants working in mining, construction, heavy manufacturing and agriculture. In the agriculture sector, for example, chronic and unprotected exposure to pesticides and other chemical products is associated with high incidence of depression, headaches, neurological disorders and, in case of women, miscarriage. See: Human Rights Watch. *"Are you happy to cheat us?" exploitation of migrant construction workers in Russia*. New York, Human Right Watch, 2009. Bollini P. and Siem H. No real progress towards equity: health of migrants and ethnic minorities on the eve of the year 2000. *Social Science and Medicine*, 1995, 41(6):819-828. Ahonen EQ and Benavides FG. Risk of fatal and non-fatal occupational injury in foreign workers in Spain. *Journal of Epidemiology and Community Health*, 2006, 60:424-426.

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17 IOM. *Migration and the right to health: a review of international law*. International Migration Law Series No. 19, 2010.
18 *Idem*.
19 The ILO claims that its SAFEWORK unit has jurisdiction for over seventy Conventions and Recommendations pertaining to occupational safety and health. These topics range from subjects as diverse as maternity protection (1919) to maritime, workers' compensation, asbestos, benzene, and C 155 the Convention whereby member governments undertake to create regulatory frameworks to protect safety and health in the workplace. Additional Conventions and Recommendations concern safety and health or hygiene in specific branches of activity such as construction, mines, agriculture, commerce and offices.
20 Convention No. 97 of 1949 concerning Migration for Employment; Recommendation No. 86 concerning Migration for Employment (Revised 1949); Convention No. 143 of 1975 concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers; and Recommendation of 1975, No. 151 concerning Migrant Workers.
21 As of 11 February 2010, the Covenant has been ratified or acceded to by 160 States.
22 As of 11 February 2010, the Convention has been ratified or acceded to by 173 States.
23 As of 11 February 2010, the Convention has been ratified or acceded to by all States except for two.
24 As of 11 February 2010, the Convention has been ratified or acceded to by 186 States.
25 As of 11 February 2010, the Convention has been ratified or acceded by 42 States (http://www.migrantsrights.org/index.htm, accessed 21 February 2010).
26 As of 11 February 2010, the Convention has been ratified or acceded to by 79 States.
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Migrant-sensitive health systems

EXECUTIVE SUMMARY

Societies have become increasingly multi-cultural and multi-ethnic. The consequent increased diversity in health determinants, vulnerability levels and needs among society members is challenging the capacity of health systems to deliver affordable, accessible and migrant-sensitive services, and calls for a more migrant-sensitive workforce.

This chapter explains the progress made in the delivery of linguistically and culturally adapted services and the importance of migrant community participation in programme and services design. It discusses the role of primary health care in ensuring health needs of migrants are mainstreamed and sustained. Finally, it lays out attempts to transform health workforce training programmes to address cultural competence, knowledge of the epidemiological aspects of migrant health, awareness of administrative barriers to care; and the integration of migrants themselves as both health professionals and community liaisons.

OVERVIEW

Health systems are often challenged to meet the needs of migrants. Accessibility to and appropriate utilization of health services are often compromised by a lack of familiarity with enrolment processes and entry points, financial and structural barriers to receiving care, and discouraging or discriminatory treatment by staff. If migrants can access health services, they may find it difficult to communicate symptoms or understand treatment instructions due to language barriers, a situation frequently complicated by different cultural constructs of illness causation and management, or unfamiliarity with a formalized health system. A lack of appropriate training for health professionals means they may not be prepared to identify and manage the variety of health issues presented by migrants, including communicable diseases, inherited conditions, chronic diseases, nutritional deficiencies, and the effects of displacement, trauma, torture, or sexual abuse.[1]

Migrant sensitive health systems and programmes aim to consciously and systematically incorporate the needs of migrants into all aspects of health services financing, policy, planning, implementation, and evaluation. Globally, there is a broad range of models for this approach, from single-site interventions to comprehensive national policies. This chapter will outline some of the key elements of migrant sensitive health strategies, and offer examples of programmes and policies from many countries.

The concept of migrant sensitive health services is underpinned by broader efforts to understand and effectively respond to the needs of migrant, minority, and indigenous communities worldwide. Starting from research and practice based in the academic disciplines of medical anthropology and immigrant/tropical medicine, front-line health care providers and advocates for these populations have evolved models of care that better respond to the linguistic, cultural, social, religious, and health status differences that affect their ability to use mainstream health care systems. These efforts, and the theoretical concepts that accompany them, have been variously described under the labels of multicultural health, cultural competence, migrant-friendly, race equality, diversity-sensitivity, and health disparities reduction. Many of the factors influencing migrants' health status and utilization of health services have to do with their social circumstances, so that the discourse on multicultural health links up with that on the social determinants of health.

When health systems choose to respond to needs of migrants, they do so for a variety of reasons. On a practical level, front-line staff may recognize the pressures caused by changing demographics and begin to develop tailored programmatic responses that will make it easier for them to do their jobs. Migrant-serving community organizations often advocate for these changes, and can be supportive partners in illuminating migrant needs and offering expertise and complementary services. Given the particular health issues faced by migrants, including many communicable diseases, it is

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good public health practice to facilitate their access to information, facilities, and services. Human rights advocates recognize that undocumented migrants are in a particularly vulnerable position, due to perceived or actual discriminatory practices, fears related to interactions with authorities, and legal and financial barriers that impede their access to health care.

In some countries, policy frameworks both shape and respond to the realities posed by migrants at the health service delivery level. These policies are frequently motivated by persistent advocacy from migrant, minority or human rights organizations, and by findings from research and demonstration programmes that provide an outcomes-driven rationale for action. Going beyond basic articulations of rights to care, these documents often specify in detail how a health system should adapt its policies and service delivery to the needs of migrants. Among these are *The Amsterdam Declaration: Towards Migrant Friendly Hospitals in an ethno-culturally diverse Europe*;[2] the United Kingdom Race Relations Act and subsequent National Health Service implementation frameworks;[3] frameworks developed under the auspices of the Portugal Presidency of the Council of the European Union and the Council of Europe; and State and Federal laws, and health facility accreditation standards in the United States.[4 5]

Policy and practice have a synergistic relationship – sometimes practice is ahead of policy statements, and sometimes it is the reverse. In South Africa, for example, a recent examination of health access for migrants in the context of the 2008 xenophobia riots noted that an explicit right to health services exists for migrants, but there is widespread discrimination, delay, denial or inappropriate charges by health staff when migrants seek them.[6] Conversely, states may have a system of good practices related to service delivery for some migrants and at the same time have legal restrictions or harmful practices related to the care of asylum seekers and the undocumented, or those in detention or awaiting deportation.[7 8]

TYPES OF SERVICES THAT COMPRISE MIGRANT-SENSITIVE HEALTH SERVICE DELIVERY

Taking into consideration the unique needs and conditions presented by migrants in need of health services, a wide variety of programmes and interventions have been developed to help migrants access health services and to promote adaptations to migrant needs by mainstream health systems. These services (and the policy frameworks that support them) predominate in countries that have had historically high rates of immigration, such as Canada, Australia, New Zealand, the United States and the United Kingdom. However, a variety of innovative activities are also emerging from countries with more recent experience of large migrant populations. An excellent overview of this work in Europe is contained in the report on *Health and migration in the European Union*.[9 10] The following is a brief overview of different types of migrant sensitive health services, with a few examples to illustrate each.

Language services

Provision of interpretation services and language-appropriate written materials is often the first and most critical intervention implemented to improve the migrants' experience in the health care system. Research shows that language barriers have a negative effect on access to care and prevention services, adherence to treatment plans, timely follow-up, and appropriate use of emergency departments. Misunderstandings of symptoms or mistranslations have resulted in delayed care, clinically significant medical errors, and death.[11 12] From a clinical ethics and human rights perspective, accurate communication is essential to obtain consent for health interventions and treatment and to guarantee confidentiality and privacy about health information. In response to demonstrated needs and legal and accreditation requirements, ever-increasing numbers of United States hospitals and health systems use specially-trained medical interpreters in programmes with budgets that can reach beyond US$ 1 million per year. In the United Kingdom, many local health trusts have interpreter and translation programmes, and other localities around the world also use interpreter services organized by non-governmental organizations or private companies.

Culturally informed care delivery

Culturally informed health care delivery – also called culturally competent[13] or culturally sensitive care[14] – refers to the ability of a health care practitioner to acknowledge their own cultural backgrounds, biases, and professional cultural norms and to incorporate relevant knowledge and interpersonal skills related to the care of patients from different cultural backgrounds. In the case of migrant populations, this would also encompass being familiar with the health and social issues related to the experience of individual migrant groups. There are cultural, religious, social, and gender factors that come into play in the negotiation and implementation of treatment plans for a variety of general health issues, such as reproductive and child health, chronic disease management, aging and end-of life care; as well as specific issues that may affect migrant populations such as consanguineous marriages, female genital mutilation, and the effects of torture and trauma. In France, for example, the Government supported a multi-sectoral strategy to raise awareness about and reduce the prevalence of female genital mutilation among girls living in France.[15] Among the key points related to culturally informed care that emerged was that how a health professional raises the topic with a girl or her family is critical in facilitating a productive conversation. Similar efforts have been undertaken in Italy and Switzerland, and by several international organizations.[16]

Mental health issues among migrant populations, and unaddressed trauma, torture and integration issues, can have especially paralysing consequences on migrants trying to make a new life. Linguistic and cultural issues are particularly delicate in the context of mental health services. This is often complicated by the cultural differences in how mental health issues are perceived: in many countries, there are few formalized mental health services and those that exist are associated with the most serious disorders and a high level of societal stigma. 'Traditional' immigration countries have developed models of specialized expertise in dealing with the mental health concerns of migrants, and mental health systems have attempted to be more proactive in developing a cadre of mental health professionals who come from needed linguistic and cultural backgrounds. The State of New South Wales in Australia has recently issued the Multicultural Mental Health Plan 2008-2012, a strategic state-wide policy and service delivery framework for improving the mental health of people from culturally and linguistically diverse (CALD) backgrounds. The key actions outlined in the Plan are underpinned by several existing programmes, including the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, the Transcultural Rural Remote Outreach Project and the CALD Children and Families Mental Health Project.[17] In New Zealand, some specialized mental health services have been established, for example the "Refugees as Survivors" (RAS) centres, and "transcultural" teams that have clinicians partnering with ethnic peer support workers.[18] [19]

Culturally tailored health promotion, disease prevention, and disease support programmes

The concept of culturally informed care can be extended to population-based health programmes. A wide body of research demonstrates the efficacy of health promotion, disease prevention and disease support interventions that are designed with the linguistic, cultural, and educational characteristics of the target population in mind. The most successful programmes are often aimed at specific groups in a particular locale, and ensure participation of the target population in the intervention's design, implementation, and evaluation. The Innvadiab project, hoping to reduce the development of type 2 diabetes among Pakistani women living in Oslo, Norway, demonstrated that culturally adapted education has the potential to change Norwegian-Pakistani women's intentions and behaviour related to health diets.[20] *Promotores de salud* (community health workers) and primary care professionals often lead face-to-face health education campaigns among seasonal migrant workers in the Americas.[21] There are similar examples in many other countries, although like many interventions focused on migrants, these efforts are often short-term demonstration projects that falter after the initial funding period if they are not incorporated into regular public health service operations.

Institutional and community-based cultural support staff

A very effective model of care that directly addresses the linguistic and cultural issues posed by migrant populations is the use of cultural support staff, working both inside health organizations and in the community. They are variously called intercultural mediators, community health workers, or patient navigators, and are used in many countries and in a variety of contexts. Ideally drawn directly from migrant communities themselves, these cultural support staff can play a wide range of roles, such as interpreter, patient advocate, and health educator – and offer the added bonus of facilitating social integration for both the mediators and those they serve. In Hamburg, Germany, teams of intercultural mediators planned and conducted health events and community learning sessions, including an introduction to the German health care system. It is similar to programmes in 21 other German municipalities, funded by national umbrella of health insurers.[22] A programme in Belgium places 80 mediators in 62 hospitals around Brussels, where they provide interpretation services and patient support.[23 24]

ORGANIZATION- AND SYSTEM-LEVEL FRAMEWORKS FOR MIGRANT SENSITIVE SERVICES

There are many systems of care specifically organized to address the needs of migrants – some government sponsored, and many supported by civil society organizations. For refugees, starting at the pre-resettlement stage in-country, there are health programmes that provide health care services for short and long-term periods. Some health care systems and non governmental organizations say that their ability to deliver appropriate health services in the destination country would be greatly facilitated by better communication of patient-specific health information from the sending countries. Upon arrival, there may be a short transition period of government-sponsored screening and other health services for asylum seekers and regular migrants, but after this point they must successfully navigate the regular health system (if they are eligible), or depend on free-standing migrant health programmes (often run by non governmental organizations on limited budgets). It is important to recognize that in some countries asylum seekers and those with refugee status are a specialized and sometimes more privileged group than migrants overall, especially undocumented migrants (including failed asylum seekers).

Primary health care: barrier or gateway for migrants?

Recent activity on strengthening primary health care within health care systems[25] has relevance to improving health services for migrants. Addressing health inequalities by moving towards universal coverage and putting people at the centre of service delivery are two goals that speak directly to some of the access limitations experienced by migrants. Primary care services should be the primary entry point for most, if not all, health care services, and eligibility and financing systems should account for migrants.

But too often primary care providers are not friendly to or actively discourage migrants from seeking services. Health care providers are often unfamiliar with the epidemiological profiles of migrant groups and feel unprepared to manage the complex psychosocial issues that affect migrants. Migrants may be referred away by primary care providers to non governmental organizations or private providers, even when migrants are entitled to access public services. While migrants may sometimes prefer to access community services from organizations they trust, this practice can compromise continuity and quality of care, puts an unfair burden on non governmental organizations who are often not reimbursed for the health services they provide, and allows government agencies to side-step care obligations. Although the situation varies from country to country, migrants often experience financial barriers in seeking primary care, where they may be required to pay user fees or full cost of services, as differentiated from other residents. These barriers are almost always more pronounced for irregular migrants.[26]

Whether caused by social, structural or financial barriers, it is clear from a variety of studies that migrants do not use health care in a way that allows them to maintain optimum health status. A study of the health status and social situations of newborn children in two Portuguese communities with large migrant populations shows higher levels of morbidity for both mothers and babies, along with

higher use of emergency rooms instead of local primary care services.[27] This suggest a strong need for education and outreach to migrant women about timely and appropriate use of different health services.

One response to these challenges is the concept of a dedicated primary care service for asylum seekers in Leicester, United Kingdom. Designed to address the difficulty of mainstreaming asylum seekers into regular health system, this programme allows for a gradual adaptation while delivering services particularly needed by migrants in one place. These include screening, mental health assessments, reproductive health services, a health visitor programme for child health, health promotion, and language support.[28]

Improving the overall capacity of the health system to respond to migrants: practice and policy

Specialized expertise in dealing with complex needs of migrants is essential, but no substitute for improving the overall accessibility of mainstream health services. There are many examples of locality-specific attempts to bring more coherence and a systematic approach to migrant sensitive health services. In Spain, the Migrant-Friendly Health Centres programme was undertaken by a non governmental organization in partnership with five hospitals and 33 primary health centres in the Catalonia public health system. The focus was on offering intercultural mediation services and making intercultural adaptations to the facilities' services, products and routines.[29] Similar efforts in Norway, through their migrant friendly hospital network, have addressed language accommodations, training for staff, and multi-faith religious accommodations in hospitals. Another effort resulted in an increased local authority subsidy for general practitioners in a municipality with 70% refugees and immigrants.[30]

The key to long-term improvements in the delivery of care to migrants lies in formal systems of migrant sensitive services and policies in mainstream health organizations, as opposed to ad hoc, short term individual projects. These strategies must engage health staff from all disciplines and areas of responsibility, and address all levels of health planning, service delivery, management, and governance. For example, as an outgrowth of the United Kingdom Race Relations Act requirements, the 22 Health Boards of Scotland now have an audit framework to support progress on race equality outcomes for service users, communities and staff. The framework addresses a range of highly specific targets and success indicators in the areas of organizational readiness, demographic investigations, access and service delivery, human resources and community development and involvement. The strategy specifically defines Black and Minority Ethnic as including asylum seekers, transitional populations (students, seasonal workers, gypsies/travellers) and tourists.[31 32]

In Thailand, the multi-partner Migrant Health Project emphasized four key organizational strategies to improving services for migrants: building the capacity of health service providers and migrant communities to identify the health needs of migrant and provide migrant friendly services, developing a health information system, identifying possible financing options to run sustainable and equitable services for migrants, and documenting models that could be replicated in similar settings.[33]

The Australian State of New South Wales has had a long-standing commitment to address the needs of culturally and linguistically diverse populations, including refugees, through policy statements and funding for migrant sensitive services at the state health department level. A recent strategic planning document speaks to promoting the "effective use of the health care interpreter service by all clinical staff and assist multicultural health state-wide services to extend their coverage in line with the settlement patterns of new arrivals and refugees".[34]

In 2000, the United States Department of Health and Human Services issued national standards for culturally and linguistically appropriate health services (CLAS), addressing health care organization practices related to staff-patient interactions, staff development, community involvement, data collection, and administration.[35 36] With the exception of previously mandated language access provisions, the standards did not have the force of law. But they did become a benchmark for a wave of voluntary efforts by health care providers, and provided the impetus for subsequent state laws[37] and accreditation standards for hospitals[38] and health plans.[39]

Research and data collection to monitor and plan for migrant needs

A critical component of designing and implementing migrant sensitive health systems is having the data to monitor migrant health needs, service utilization and ongoing health status. What data to collect is a complex and often controversial topic – for example, country of origin, period of residence, race, ethnicity, preferred language – and legal and operational barriers exist in many countries. Nevertheless, many countries and health care systems are experimenting with ways to collect and use this data for the purposes of planning and tracking. The Valencia Health Agency in Spain has a population information system that allows the collection and matching of data about nationality, residence, insurance status, and various health indicators to permit analysis in relation to each distinct cultural or national group, with the aim of recognizing any public health issues deriving from a particular group and addressing their repercussions for the service delivery system.[40] In the United States, the Institutes of Medicine have recently called for standardization of how data related to patient race, ethnicity and preferred language are collected, with the intent of using this information to design interventions aimed at the reduction of health disparities among different population groups.[41]

There is a great need for additional research on migrant health status and needs, and on the effectiveness of interventions aimed at them.[42] In additional to traditional study approaches, community-based participatory action research (CBPR) focuses on topics of importance to communities with the aim of combining knowledge and action for social change to facilitate integration, improve community health and eliminate health disparities. In Toronto, Canada, the Access Alliance Multicultural Community Health Centre sponsored a study examining the mental health of newcomer female youth and found that participants gained a sense of empowerment from having "a forum in which their voices are acknowledged and heard".[43]

PREPARING THE HEALTH WORKFORCE TO ADDRESS MIGRANT ISSUES

Migrant sensitive service programmes have no chance of success if the clinical, service delivery, and administrative staff of health care systems do not understand the unique health and social needs of migrants, have the knowledge and skills to deal with them, and support the value of these interventions. In order to properly respond to both migrant individuals and communities, clinicians and public health planners need to be aware of the unique epidemiological profiles of migrant groups' countries of origin, how migrant health status can change (often for the worse) after many years of acculturation, and how both these factors are affected by social, educational, and economic status. Specific training, both during the course of undergraduate health professions education as well as in post-degree continuing education, is emerging as a critical component of clinical training to ensure that migrant needs are adequately met.

In addition to the clinical and epidemiological content related to diagnosing and managing prevalent illnesses affecting migrant streams, training on how to respond effectively to sociocultural issues is essential Often labelled cultural competence training, courses range widely in both length and content, and are still mostly optional. Responding to the large numbers of foreign nationals working in Qatar, the Weill Cornell Medical College, with the Hamad Medical Corporation, has implemented a cultural competence training programme for medical students to prepare them to work with diverse populations and to support the effective use of its medical interpretation programme.[44] In other areas, cultural competence training or standards are being required. In New Zealand, the Health Professional Competency Assurance Act of 2003 requires that professional registration bodies set standards of cultural competency, clinical competency and ethical standards and to ensure that practitioners meet those standards.[45] United States medical students are required to demonstrate an understanding of the health concerns, beliefs and communication needs of diverse populations, and six states have mandated cultural competence continuing education for physicians.[46 47]

It is equally important for health care systems administrative staff to receive training on non-discrimination and the rights of migrants seeking care. As shown in the South Africa example above, reception staff in a health care organization are often the first point of contact and they can create substantial barriers to accessing services if they purposefully discourage or discriminate against migrant patients, or inadvertently do so because they cannot communicate across language differences.

The need for education about the needs of migrants is especially important for health care managers, because they influence policies and budgets for health care facilities, and set the tone and standard of behaviour for all staff.

In a corollary development, attractive opportunities are emerging to draw on the linguistic and cultural knowledge of immigrants themselves to enhance the ability of health systems to deliver migrant sensitive care (not withstanding the complicated issues of deliberately recruiting health service workers from countries where there are professional shortages). By supporting the requalification of migrant health professionals in destination countries, these efforts also speed up the integration and social adjustment of migrants in their host countries. In Portugal, with funding from a national foundation, Jesuit Refugee Services assisted immigrant physicians and nurses by facilitating their professional integration through many complicated stages of administrative procedure and academic requalification.[48] A similar effort in the United States, the multi-state Welcome Back programme, has helped more than 2000 migrant health professionals move towards requalification or employment in the health sector.[49]

When professional requalification is not possible (or during the requalification process), many programmes have also taken advantage of the linguistic, cultural and clinical knowledge possessed by migrant health professionals by employing them as intercultural mediators, health educators, and medical interpreters or translators. With or without health care credentials, trained migrant community members are ideal facilitators and intermediaries between migrants and health care programmes and services.

ISSUES THAT NEED ATTENTION AND TOPICS FOR AN OPERATIONAL ACTION FRAMEWORK

The last few years have seen a significant upsurge in attention to the health needs of migrants. Documentation of good practices, policy frameworks, research findings, and the effects of health inequalities have increased both in depth and breadth. In some countries, the dialogue about these issues has evolved over time and is "maturing"; in other regions the parameters of discussion are just being set. In a global context, we can say that migrant health as a commonly accepted concern is still emerging. There are many opportunities to advance the agenda.

One significant gap in most countries is the lack of coordinated action to comprehensively address migrants needs within the context of existing health programmes. This includes removing legal and financial barriers to the system, acknowledging that the special needs of some migrants may require additional resources to address, and making an explicit commitment to adjustments within the system that will improve delivery of care. In place of the scattershot approach to funding one-time demonstrations or short-term projects, consistent funding for migrant sensitive services must be put in place, and the results of successful demonstrations must be integrated into regular service delivery systems.

These is a great need for comprehensive and accurate information about migrant health characteristics and for a higher level of awareness about how to address them. Advocates for migrant health services have done an excellent job of documenting needs and potential interventions, but the mainstream health care providers and policymakers are still largely uninformed. This information should be integrated into health worker education and made a part of professional societies' meetings and agendas. Coordinated systems for collecting and analysing data related to migrants and their health needs and status are still mostly lacking, and a prerequisite for effective planning and evaluation of the quality of care.

Similarly, many recommendations and action frameworks on migrant health have been discussed and promoted in particular regions, but still wait to be implemented. For other regions, the dialogue must be broadened or initiated. In all areas, lasting change will only come from engaging political and other sectoral stakeholders beyond health, supported by information about the policy advocacy and implementation strategies that have worked in countries with successful programmes. It will be difficult in many cases to separate discussions about increasing access to health care systems and insurance from the highly polarized debates about the terms of residence for migrants and their access to social benefits in destination countries. There must be a frank discussion about the broader societal costs of poor migrant health.

From the health implementation perspective, it is also critical to identify and package key elements of migrant sensitive health systems for inclusion in other important health agendas, including primary health care reform, initiatives related to major disease programmes (e.g., HIV, TB, malaria, non communicable diseases), population-specific programmes (maternal and child health, aging), and quality improvement programmes, including patient-centred care and patient safety. Global networks and regional/professional communities of practice can be used to document and share best practices.

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Networks, partnerships and multi country frameworks on migrant health

EXECUTIVE SUMMARY

Migration, by definition, connects communities and countries or regions as well as various sectors in society. Therefore, the management of migrant health requires close cooperation and collaboration among countries, as well as among sectors and related institutions involved in the migration process.

This chapter reviews examples of existing global, regional, and inter-regional platforms and processes on migration and social/economic development that connect countries and/or regions of origin, transit and destination. A synthesis of these network models and outcomes illustrates the complexities and accomplishments of integrating health into non-health dialogues as well as migration into health-related processes. Multi sectoral partnerships on migrant health need support and strengthening. In particular, additional civil society and private sector involvement are key to reach effective responses to better access to services for migrants and to enhance migrant health. Notwithstanding some existing good examples of multi sectoral and institutional partnerships related to selected aspects of migrant health, there is a need to identify key platforms and institutional networks that can drive needed comprehensive partnerships on migrant health beyond disease specific approaches, and that account for the different typologies of migrants and their widely varying levels of vulnerabilities and needs.

OVERVIEW

Sustained by persisting unbalanced distribution of resources and opportunities, as well as by natural and man-made disasters migration has grown in size and scope and has become a major feature of the post cold-war era of globalization.[1] To date, with a few exceptions, the "health of migrants" agenda has not received adequate attention and support in national, regional and global health frameworks, nor in relevant networks and platforms on migration and development. Traditionally the association between human mobility and health has mainly been seen in light of the potential cross-border spread of communicable diseases and the need to protect the public. The emergence of global health challenges such as the HIV/AIDS epidemic, SARS, the re-emerging of tuberculosis, avian influenza, H1N1 and the threat of bio-terrorism, have increasingly fostered global, regional and bilateral cooperation, including among actors outside the health sector.

As we come to understand that the migration process itself can be a determinant of ill health for migrants and migrant-hosting communities, the paradigm has progressively shifted from one of migrants as possible culprits of disease-spreading to one that recognizes migrants, particularly the most marginalized, as being vulnerable to negative health outcomes of mobility.

In 1990, the International Organization for Migration (IOM), with the support of the World Health Organization (WHO), organized a Conference on Migration Medicine.[2] Since then there has been sustained advocacy and research that has contributed to the progressive growth of a global Migration and Health agenda. In June 2001, the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, tasked governments "to develop and begin to implement national, regional and international strategies to facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services".[3] The focus on migrants' vulnerability to HIV was broadened and in several regions, migrants' right to health was discussed broadly (see Section 2 and 3 of this paper). More recently, the 2007 Portuguese European Union (EU) Presidency had a strong focus on migrant health, and paved the road to the adoption of a resolution on "Health of Migrants" by the Sixty-first World Health Assembly in 2008.

There is now increased international agreement that global health is a tool for development and that excluding vulnerable populations from national health programmes hurts marginalized populations, such as migrants, and host populations alike. Yet the translation of this principle into

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effective policies and programmes requires broad partnerships and networks of debate, advocacy and exchange that have not yet been put in place at country, regional or global level. Migrant health is multi-sectoral in scope, encompassing not only labour, the economy, health, education etc, but also civil society, academia and the private sector. As such, it is critical to identify the various platforms that address the health of migrants within and beyond the health sector.

This paper is divided up in the following different sections:

1. Multi-country frameworks to address migrant health;
2. Regional economic communities (RECs) action on migrant health;
3. Global, bi-regional and regional consultative processes on migration;
4. International, inter-regional and regional networks and partnerships;
5. Regional health networks and partnerships;
6. Challenges and recommendations.

MULTI-COUNTRY FRAMEWORKS TO ADDRESS MIGRANT HEALTH

The Sixty-first World Health Assembly 2008 urges Member States and WHO to, among other things, engage in bilateral and multilateral cooperation (Resolution 61.17 on Migrant Health). This paper will give a non-exhaustive overview of some examples of international and regional cooperation on migrant health between countries of origin, transit and destination.

There are many multi-country frameworks in place but it is difficult to assess how effective they are in addressing the challenges that migration poses on the health needs of migrants and host communities.. As the migration process connects countries of origin, transit, destination and return, it is futile for countries to have a purely national approach to migration and health. Through bilateral and multi-country dialogue, health responses should be harmonized and continuity of treatment for diseases such as tuberculosis and AIDS, as well as preventive measures such as vaccinations, should be ensured across borders. This dialogue can be facilitated by health ministries and other health agencies at bilateral and regional level forums. Another way of addressing migrant health regionally is to include it in the agenda of regional economic communities (RECs) and regional consultative processes (RCP).

Partnerships between source-, transit-, receiving and return- countries are a first step towards addressing the health of migrants and host communities. But partnerships are required at multiple levels: from local and grassroots level, to the inter-state level; between public and private sectors; between agencies, and including migrants and diaspora associations.

REGIONAL ECONOMIC COMMUNITIES (RECS) ACTION ON MIGRANT HEALTH

There are some 20 RECs globally (see Annex B) and they are gaining importance with increased inter-regional and extra-regional mobility and population movement. RECs are seen as useful mechanism to address joint challenges in a particular region, whether the issue is political, economical, social, health or migration management. RECs have started to address the issue of health as a regional issue as there is increasing recognition that migrants have health needs and vulnerabilities and there is a need for increased collaboration and coordination between countries that are linked by migration.

RECs' attention to health issues are mainly related to the major migration and epidemiological trends of relevance for their respective region. Most RECs would agree that there is a need to harmonize health protocols, health responses and standardization of access to health for non-nationals within a region to make the health response more effective. Some of the key developments in the migrant health domain within the context of RECs are listed below.

Africa

The Southern African Development Community (SADC) has developed a Draft Policy Framework on Population Mobility and Communicable Diseases in 2008. The Policy Framework would provide guidance to the SADC governments on the protection of the health of cross border mobile populations with regard to communicable diseases and to provide guidance on the control of communica-

ble diseases as people move across borders. The framework has not yet been adopted by the SADC member states.

The Intergovernmental Authority on Development (IGAD) in Eastern Africa hosts refugees, internally displaced people (IDPs) and different types of migrants in an irregular situation. Some of these populations are very vulnerable to ill health and often fall outside national health programmes. IGAD has focused mainly on HIV so far, through their Regional HIV/AIDS Partnership Programme (IRAPP). One of the goals of IRAPP is to contribute to the reduction of HIV infections among cross border and mobile populations and to mitigate the socio-economic impact of the epidemic in the IGAD region. Major achievements for the IRAPP to date include the harmonization of protocols and standardization of referral system and research conducted in mobile population settings.

In terms of migrant health, the East African Community (EAC) has mainly focused on the link between HIV and mobility. An example of this is the "HIV and AIDS Cross Border Regional Transport Corridor Stakeholders" meeting, organized in October 2008, in partnership with IOM and UNAIDS in Arusha, Tanzania. During this meeting it was agreed that the EAC should establish a regional coordinating mechanism on HIV and most at risk populations in East Africa involving National Aids Councils and other national and regional stakeholders and international collaborating partners.

Asia

In October 2003, APEC (Asia-Pacific Economic Forum) established the Health Working Group (HWG) to address health-related threats to economies' trade and security, focusing mainly on emerging infectious diseases. During its first meeting in 2008, the following areas were identi-fied as priorities:

- preparedness for and response to public health threats, including avian and human pandemic influenza and vector-borne diseases;
- combating the spread of HIV/AIDS in the APEC region;
- improving health outcomes through advances in health information technology.

Some key achievements of the HWG include:

- APEC Action Plan on the Prevention and Response to Avian and Influenza Pandemics;
- Guidelines on pandemics and HIV/AIDS – namely, the APEC functioning economies in times of pandemic guidelines and the Guidelines for creating an enabling environment for employers to implement effective workplace practice for people living with HIV/AIDS;
- The HWG held a capacity building seminar on "Social Management Policies for Migrants to Prevent the Transmission of HIV/AIDS" in Hanoi in September 2008.

Health and Population Activities is one of the seven areas of cooperation under the South Asian Association for Regional Cooperation's (SAARC) Regional Integrated Programme of Action which is pursued through the Technical Committees. Relevant strategies that SAARC adopted are the Regional Strategy on HIV/AIDS (2006-2010), by SAARC and UNAIDS which includes a focus on migrants and the SAARC Regional Strategy for TB/HIV Co-Infection, by SAARC (Tuberculosis Centre) and the Canadian International Development Agency (CIDA).

Europe

European Union

Since 2006, migration health has received increased attention within the EU. A number of events, activities and policies were developed and implemented including:

- The Conference Health and Migration in the EU: better health for all in an inclusive society was organized in Lisbon in September 2007 under the Portuguese EU Presidency with the support of the European Commission and the collaboration of member states. The Conference conclusions comprise reflections on current migration health concerns and recommendations for various levels including transnational and country-based best practices.
- The conference conclusions subsequently informed a text on health and migration presented by the Portuguese Presidency for discussion at the Employment, Social Policy and Health

and Consumer Affairs Council (EPSCO) in December 2007, which was finally adopted (Council Conclusions on Health and Migration in the EU (15609-07)).[4]

- The EU has included consideration to migrants in their health policies, examples include the *EC Communication on Reducing Health Inequalities (October 2009)* and the *EU HIV/AIDS Strategy (2009-2013*).
- The EU Advisory Group on Migration and Health was created on an ad hoc basis in early 2007 to support the Portuguese EU Presidency (July–December 2007) priority of health and migration. It gathered representatives from EU Member States' Ministries of Health. The European Centre for Disease Prevention and Control (ECDC), the Council of Europe, WHO and IOM were also members. Subsequently, the Expert Group on So-cial Determinants and Health Inequalities was formed which also considers migrant health issues from the health inequalities perspective.

Below are a few examples of projects that are (co)funded by the EU focusing on migrants' health:[5]

- The AMAC Project (Assisting Migrants and Communities: Analysis of Social Determinants of Health Inequalities) is a partnership between the government of Portugal, the European Union and IOM (2008-2009). The AMAC project focused on priority health issues affecting migrant and mobile communities across Europe such as mental health, maternal and child care, care for the elderly as well as legislation and research in the field, bioethics and training for health professionals. Through three multi-stakeholder workshops and a European-level multi-sectoral consultation that took place in Lisbon in September 2009, AMAC fostered synergies amongst ongoing initiatives in the field, identified good practices for improved migrants' access to healthcare and furthered the migration health policy agenda in Europe.
- The project Increase Public Health Safety Alongside the New Eastern European Border Line (PHBLM) is being implemented by a network of different partners including public health and migration authorities of the Governments of Hungary, Poland and Slovakia, and with the participation of Romania in selected activities; IOM; the University of Pécs; the Andalusian School of Public Health; the European Centre for Disease Prevention and Control (ECDC), Frontex, and WHO Euro. This collaboration developed evidence-based guidelines for public health in border management and detention procedures, identified recommended structural changes to health/public health services in the targeted border sectors, and developed multidisciplinary training materials for health professionals and border guard staff, amongst others.
- MIGHEALTHNET: Information network on good practices in health care for migrants and minorities in Europe. The project aims to stimulate the exchange of knowledge on migrant and minority health through the development of interactive databases in each of the participating countries.[6]
- Healthcare in "NowHereLand": Improving services for undocumented migrants in the EU. This project aims at improving the level of health protection for the people of Europe by addressing migrants' and immigrants' access, quality and appropriateness of health and social services as important wider determinants for health focusing on health care services for undocumented migrants as an especially vulnerable group, an increasing public health risk and a group providing difficulties for healthcare providers and health policy.[7]
- Migrant and Ethnic Health Observatory (MEHO): The main objective of MEHO is to develop indicators to monitor the health status of immigrant/ethnic minority groups in Europe.[8]
- EUGATE: Best practices in access, quality and appropriateness of health services for immigrants in Europe. EUGATE aims to provide a European-wide definition of what is meant by "migrant", explore legislation, policies and finding arrangements relating to migrants and minorities, investigate organization and utilization of services, describe evaluation and monitoring methods, and identify and compare models of best practice. It aims at developing a tool kit for improving access, quality and appropriateness of health and social services for migrants and ethnic minorities.[9]

- Improving Access to Health Care for Asylum Seekers and Undocumented Migrants in the EU (HUMA Network). The project aims to enhance the EU general population' health, by improving asylum seekers' and undocumented migrants' access to health care.
- TAMPEP: European Network for HIV/STI prevention and Health Promotion among Migrant Sex Workers. A Network of community-based service providers, public health and social services cooperating in 26 EU countries; main objective being the decreased of HIV vulnerability of migrant and mobile sex workers across Europe.[10]

Central and South America

Within the Community of Andean Nations (CAN),[11] and among the organs of the Andean Integration System, the *Convenio Hipólito Unanue* (CONHU) is dedicated to health. The CONHU holds yearly meetings of the ministers of health of the Andean Area (REMSAA for *Reuniones de Ministros de Salud del Area Andina*), as well as other health ministers fora on different health topics, such as the Forum on Health Sector Reform.

Within the Caribbean Community (CARICOM)/Caricom Single Market and Economy (CSME),[12] the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) was established at the February 2001 Meeting of the CARICOM heads of state and endorsed by the Nassau Declaration on Health 2001. PANCAP aims to scale up the response to HIV/AIDS in the region. PANCAP's membership includes member countries, United Nations agencies, bilateral and multilateral organizations, regional and international organizations, networks of people living with HIV/AIDS, academic institutions, the private sector, and faith-based organizations.

The Caribbean Regional Strategic Framework for HIV/AIDS (2002-2006) has a strong focus on migrants and mobile populations. In addition to receiving more than 20 million visitors from abroad each year, Caribbean people themselves are in general very mobile, travelling from island to island and outside the region for work, study and family reasons. Because mobility is often linked to increased risk of HIV infection, the characteristics of the population movements that make up such an important part of Caribbean life need particular attention.

GLOBAL, BI-REGIONAL AND REGIONAL CONSULTATIVE PROCESSES ON MIGRATION

There is currently no single overarching regime governing migration at the global level as many governments, especially those of destination countries, place much importance on retaining sovereign discretion over the numbers and groups of non-nationals entering their territory and the conditions under which they enter, and are wary of a formal global structure on migration.

Global migration initiatives

There have been some successful global efforts on migration, most ambitiously the Berne Initiative, 2001-2005, the Global Commission on International Migration (GCIM), 2003-2005, which was quickly followed in 2006 by the United Nations General Assembly-hosted High Level Dialogue on International Migration and Development, and by the Global Forum on Migration and Development (GFMD), which by late 2009 had held three meetings (Brussels, Philippines, Athens). Health has not, as yet, featured high on the agenda of the GFMD, although some member states have discussed migrants' access to health services in the different Roundtables that form part of the GFMD. The GFMD is an important forum where governments of migrant sending and receiving countries meet every year. Advocacy efforts should focus on this forum to raise the issue of migrant health.

The Global Migration Group (GMG) is an inter-agency group[13] bringing together heads of agencies to promote the wider application of all relevant international and regional instruments and norms relating to migration, and to encourage the adoption of more coherent, comprehensive and better coordinated approaches to the issue of international migration. The GMG is particularly concerned with improving the overall effectiveness of its members and other stakeholders in capitalizing upon the opportunities and responding to the challenges presented by international migration. Apart from sustaining the inter-agency cooperation in the field of international migration, the Group

also contributes to the Global Forum on Migration and Development (GFMD). WHO is not a member of the GMG.

So far, the GMG has not focused much on migration health, except in a few seminars: Migration, Braindrain and Caregiving Report, UNITAR Migration & Development Series Seminar, organized jointly with IOM, UNFPA, and the MacArthur Foundation on 6 March 2009; and HIV, AIDS and Migration, Report, UNITAR/UNFPA/IOM Key Migration Issues, Series, 26 May 2006.

Bi-regional meetings on migration

There are also some inter-regional dialogues on migration which are taking place with increasing frequency, such as the 5+5 Dialogue (Regional Ministerial Conference on Migration in the Western Mediterranean) and MTM (Mediterranean Transit Migration Dialogue) (see Annex A). As far as can be assessed, migrants' health has not been discussed during these dialogues.

Regional consultative processes (RCPs)

Motivated mainly by the recognition that few, if any countries, can unilaterally manage migration, regional consultative processes on migration (RCPs) emerged in many regions of the world, most significantly in the middle to late 1990s (see Annex A).

RCPs are inter-state fora for addressing migration. As most migration has historically taken place in a regional or inter-regional context, smaller, informal gatherings of countries with an interest in common migration patterns were formed to provide a venue and opportunity to come together, understand each others' perspectives, and identify common solutions.

RCPs are recurring regional meetings of countries dedicated to discussing migration. They vary greatly in their composition, history, purpose and organizational frameworks, but they do share the following principal characteristics:

- They are informal and non-binding;
- RCPs were purposefully created to deal with migration issues only;
- They are processes, not one-off events;
- Most RCPs are not officially associated with formal regional institutions.

As the main topic of discussion for RCPs is migration, health has not been an immediate focus for the agenda. However, some RCPs, such as the Puebla Process, 5+5 dialogue, MIDSA, and IGAD have been focusing their discussions on the links between migration and health, or consider migration and health one of their priorities.

> The Migration Dialogue for Southern Africa (MIDSA) held its second session on migration and health in June 2009 in Dar es Salaam: "Promoting Health and Development: Migration Health in Southern Africa". The meeting was attended by representatives from ministries of Health, Home Affairs and National AIDS Councils in an effort to facilitate inter-sectoral dialogue on migrant health challenges in Southern Africa, and formulated recommendations to promote the health of migrants in the region.

INTERNATIONAL, INTER-REGIONAL AND REGIONAL NETWORKS AND PARTNERSHIPS

There is increased acknowledgement that exclusively national, vertical health responses are not having the desired effect of facilitating migrants' access to health services. Integrating health into non-health programmes, networks and meetings can be an effective approach to raise awareness on migrants' health. A few examples are listed below:

The International Federation of the Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian organization and the unique network of National Societies, covering almost every country in the world, is the Federation's principal strength. During its Seventeenth General Assembly in November 2009 it adopted the Policy on Migration. The present policy on migration expands the scope of, and replaces the Federation policy on refugees and other displaced people. It

addresses the needs and vulnerabilities of, among others, labour migrants, stateless migrants, irregular migrants, as well as refugees and asylum seekers. The policy aims to address the humanitarian concerns of migrants in need throughout their journey, providing assistance and protection to them, uphold their rights and dignity, empower them in their search for opportunities and sustainable solutions, as well as promote social inclusion and interaction between migrants and host communities. While not specifically focused on health, health is integrated in this policy on migration.[14]

The Global Partnership on HIV and Mobile Workers in the Maritime Sector was launched in 2009. It is an initiative among seven international organizations and global networks: IOM, the International Transport Workers' Federation (ITF), the International Committee On Seafarers' Welfare (ICSW), the International Labour Organization (ILO), the International Maritime Health Association (IMHA), the International Shipping Federation (ISF), and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The overall objective of the global programme is to contribute to a reduction in the number of new HIV cases among seafarers.[15]

The International Steering Committee for the Campaign for Ratification of the Migrants Rights Convention (ICRMW, 1990)[16] is a network among international and regional civil society organizations and concerned intergovernmental organizations committed to promote respect for migrants' human rights and dignity. Its purposes are to advocate for the universal ratification of the 1990 United Nations Convention for the protection of the rights of all migrant workers and members of their families; to place the Convention in the context of advancing human rights; to project a broad profile of support for the Convention and the Global Campaign; and to facilitate cooperation and information sharing among different actors in the Global Campaign. Migrants' right to health is on the agenda of the committee and included in the recently launched Twentieth Anniversary Global Campaign of the Migrants Rights Convention.

Another example is the Asia-Europe meeting (ASEM), which is a vital forum for dialogue between Europe and Asia on a variety of topics. One of the topics is migration. So far, health has not been addressed in these migration meetings, although they would offer an opportunity to mainstream health on the discussions related to migration.

Iberoamericana (SEGIB) is the international organization of the Ibero-American Community of Nations composed of the 22 Spanish and Portuguese speaking countries from Latin America and Europe. It provides institutional and technical support to the Ibero-American Conference which culminates every year with the Ibero-American Summit of Heads of State and Government. As such, it promotes multilateral and horizontal cooperation in the framework of the Conference through actions in policy and the social, cultural and economic areas.

International migration and its link with development and human rights is a field of strategic relevance for SEGIB. The common heritage of these 22 nations and the bi-regional dimension of the community they form, which includes origin, transit and destination countries for migration, generate a space conducive to partnerships and multi-country frameworks. Progress has been made in the area of migration through the adoption of a number of agreements which implementation is ongoing. In the area of health, SEGIB follows-up the "health networks" created in the framework of the Ibero-American Health Ministries Conference, which include education and research, medical drugs, nicotine and smoking, social protection in health, public policy and migration.

The Community of Portuguese Language Countries (CPLP) is the intergovernmental organization for friendship among lusophone (Portuguese-speaking) nations where Portuguese is an official language (Portugal, Brazil, Angola, Cape Verde, Guinea-Bissau, Mozambique, São Tomé and Príncipe and East Timor). The Portuguese-speaking countries are home to more than 223 million people located across the globe. Because of its historic ties and shared language there will be a natural flow of migration between these countries. This forum might be a useful platform where migrant health could be discussed.

The Council of Europe has established an Expert Committee of Experts on Mobility, Migration and Access to Health Care (SP-MIG). This group has a specific mandate to further the development of the processes launched by the 2006 *Recommendations of the Committee of Ministers to member states on health services in a multicultural society*, and the *Bratislava Declaration on Health, Human Rights and Migration* (2007).

In the first semester of 2010, the Council of Europe will approve non binding but goal setting recommendations on improving access and health care for people on the move in Europe. The recommendations will focus on 1) improving knowledge about migrants and their situation; 2) migrants' state of health; 3) entitlement to care.

In West Africa, the WAHO (West African Health Organization), as a specialized agency of the Economic Community of West African States (ECOWAS), signed a Memorandum of Understanding with IOM's Regional Office for West and Central Africa in November 2009 to strengthen regional and cross border health responses to migrants and mobile populations and their host communities.

REGIONAL AND GLOBAL HEALTH NETWORKS AND PARTNERSHIPS

Many regional health networks and partnerships focus on disease surveillance, containment of infectious diseases and the impact of mobility in this regard, rather than on migrants' health per se. A few other networks advocate for migrants' equal right to access health care. Examples of both approaches include:

The South east Europe (SEE) health network[17] was founded in Sofia, Bulgaria, in April 2001 and is a political forum set up to coordinate, implement and evaluate the commitments of the Dubrovnik Pledge (2001) and its regional projects for developing health policy and services. In April 2009, the ministers of health that are part of the SEE health network further strengthened their regional cooperation on public health issues by signing the MOU on the future of the South-eastern Europe health network. The main purpose of the network is to provide leadership and to sustain project ownership by the countries in the region. The network comprises both representatives from the ministries of health of its member countries and representatives of intergovernmental organizations and is supported by a secretariat run jointly by the Council of Europe and the WHO regional office for Europe.

WHO is facilitating different technical networks, such as the Task Force on Migrant-Friendly and Culturally Competent Hospitals, which has been set up within the framework of the WHO Regional Office for Europe's Health Promoting Hospitals Network.

The Mekong Basin Disease Surveillance (MBDS) started in February 1999 when delegates from all countries of the Mekong Basin agreed to start collaborating on disease surveillance (Cambodia, the Lao People's Democratic Republic, Myanmar, Viet Nam, Thailand and the Yunnan Province and Guangxi Zhuang Autonomous Region of China). The general objective is to strengthen national and Mekong sub-regional capabilities in disease surveillance and response to outbreaks of priority diseases, so that they can be effectively controlled. Priority diseases are vaccine preventable diseases, e.g., malaria, dengue haemorrhagic fever and dengue fever, cholera, and other outbreaks. The MBDS has three objectives:

1. Strengthen sustainable national capacity in disease surveillance, outbreak investigation and responses;
2. Strengthen health manpower development in field epidemiology;
3. Establishment of a sub-regional surveillance network.

In 2005, a number of countries agreed to develop the project EpiSouth**,** a network for communicable diseases in Southern Europe and Mediterranean countries[18] whose aim is to create a framework of collaboration on epidemiological issues in order to improve communicable diseases surveillance, communication and training across the countries of the Mediterranean and the Balkans. This project aims to translate data into appropriate action, and disseminate information between countries that will facilitate early detection of cases and a cross-border, harmonized and prompt response to effectively contain the spread of diseases. As of June 2009, the EpiSouth Network counts 26 countries (nine EU and 17 non-EU), which have identified and appointed two focal points each, plus seven representatives from collaborating institutions.

The Global Health Cluster has been active since the beginning of the implementation of the United Nations Humanitarian Reforms in September 2005. WHO and partners[19] work at global, regional and country levels to improve the effectiveness, predictability and accountability of humanitarian health action to people who are forced to migrate following natural disasters or conflict.

It should be noted that humanitarian assistance to people who are displaced by force is also provided by non-governmental organization networks outside of the Global Health Cluster, such as Médecins Sans Frontières and other non-governmental health agencies.

The Binational Health Week (BHW) is one of the largest mobilization efforts of federal and state government agencies, community-based organizations, and volunteers in the Americas to improve the health and well-being of the underserved Latino population living in the United States and Canada. It encompasses an annual week-long series of health promotion and health education activities that include workshops, insurance referrals, and medical screenings.[20] Participants discuss migrants' health challenges and explore collaborative strategies to enhance the health and conditions of this population. Topics to be addressed include global health and migration, chronic and emergent diseases of mobile populations, occupational health and safety, access to health services, workforce development, and the health of vulnerable people, including those with disabilities and agricultural workers.

CARAM Asia[21] is a non governmental organization in Special Consultative Status with the Economic and Social Council of the United Nations. It is an open network of NGOs and community-based organizations. The CARAM Asia network is involved in action research, advocacy, coalition building and capacity building with the aim of creating an enabling environment to empower migrants and their communities to reduce all vulnerabilities including HIV and enhance their health rights globally.

The Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia and southern China (JUNIMA)[22] brings together governments, the ASEAN Secretariat, leading non governmental organization networks, and the United Nations family, to promote the right to health and universal access to HIV prevention, treatment, care and support for mobile and migrant populations in South-East Asia and southern China. The work of JUNIMA is focused in three strategic areas: 1) intellectual leadership and production of strategic Information; 2) policy and advocacy on the right to health and HIV services; and 3) multi-stakeholder and multi-country mechanisms.

In an effort to eliminate HIV-related entry, stay and residence restrictions, UNAIDS convened in 2008 the International Task Team on HIV-related Travel Restrictions**.** The Task Team includes individuals from governments, civil society, networks of people living with HIV, United Nations system and other international organizations. It advocates for the equal rights of people living with HIV to freedom of movement and non-discrimination. The Task Team illustrates how multilateral efforts can take on complex and inter-connected problems posed by the AIDS epidemic and generate a movement for practical solutions.

CHALLENGES AND RECOMMENDED DIRECTIONS

Challenges

Some challenges have been identified with regard to addressing migrant health through multi-country regional and global frameworks, partnerships and networks:

- Some multi-country, regional and global consultations have defined a set of recommendations in the migrant health field, but there are no mechanisms to enforce these recommendations. Also, it is difficult to assess the real impact these consultations have had as they usually lack mandatory reporting mechanisms. Often, the recommendations remain without action plans or budgets.
- RECs, RCPs and global consultations such as the GMG and GFMD focus on migration and involve government representatives of Ministries of Interior or Home Affairs. Health stakeholders are not well integrated or absent from the discussions and action plans.
- There is a lack of multi-country or multi-sectoral partnerships on migrant health that include the entire spectrum of actors and/or sectors that have a stake in migrants' health. An exception is with regard to HIV and migration/mobility which many governments have recognized as a multi-sectoral issue in need of a multi-sectoral response. Most countries experiencing a high burden of HIV have multi-sectoral National AIDS Councils in which different sectors and stakeholders are represented.

- Multi sectoral partnerships between civil society and government actors rarely discuss migrant health. The private sector is often absent from the partnerships, while employers are a key stakeholder. They hire both irregular and regular migrants as employees. Access to health insurance and minimum adherence to safe occupational standards are relevant in this regard.
- There is a need to unpack the different typologies of migrants, i.e. migrants in an irregular situation, regular (labour) migrants, people displaced by conflict or natural disasters etc. All have different health vulnerabilities and need different responses by different actors. For instance, while assistance including health is well regularized for some legal migrant groups and refugees, migrants in an irregular situation are mainly assisted through civil society networks who provide more acceptable and accessible forms of assistance, compared to formal health care mechanisms.
- With regard to regional meetings, strategic frameworks and consultations on migrant health, there has been a narrow focus on HIV/AIDS, usually excluding other important topics such as mental health, sexual and reproductive health, and other communicable diseases such as TB.

Recommended directions

- Governments and other stakeholders should be encouraged to establish and support ongoing and regular migration health consultations across sectors (labour, migration, and health) and among countries of origin, transit and destination.
- Coordination and information-sharing along migration routes and throughout the migration process is urgently needed; this may require consultative processes on migration health involving countries from different regions.
- Global and regional consultative processes focused on migration that do not regularly include health (e.g. GFMD, GMG, RCPs), should be leveraged to address health matters, such as improved working conditions of migrant workers, in order to promote and protect their health. This may imply considering structural issues that impact on migrants' health, such as regularization of immigration status and occupational health and safety.
- RECs and RCPs should assist member countries to harmonize national policies and laws that respect the rights of migrants and improve access to health promotion, prevention, care and treatment for all migrants, regardless of their immigration or residence status.
- RECS and RCPs should make available technical support in order to disaggregate health data concerning migrant populations, enhance national and international surveillance of migrant populations' (including undocumented migrants) health and mechanisms for confidential data exchange.
- Governments and other relevant actors should advocate for a stronger focus on migrant health within REC and RCP meetings and harmonization of approaches to migrant health within and between regions.
- Global health funding mechanisms, such as the GFATM, should support regional initiatives on migrant health.
- Multi-country partnerships should be undertaken to make existing health services more migrant-sensitive (e.g. culturally appropriate, interpretation available, removal of barriers within the system, etc.). Whenever possible these actions should be coordinated along migration routes and among sending and receiving countries
- There is a need for a small number of stakeholder, i.e. governments, international organizations and civil society actors, to join efforts to develop and coordinate an operational plan to implement the WHA resolution recommendations.

ANNEX A. OVERVIEW OF PRINCIPAL REGIONAL CONSULTATIVE PROCESSES ON MIGRATION (RCPS), (AS OF APRIL 2009)*

RCP	Year	Governments
Söderköping Process or CBCP (Cross Border Cooperation Process)	2001	Belarus, Estonia, Hungary, Latvia, Lithuania, Moldova, Poland, Romania, Slovakia and Ukraine (Total: 10).
Budapest Process	1991	Albania, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia-Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Ireland, Italy, Kazakhstan, Kyrgyzstan, Latvia, Liechtenstein, Lithuania, Luxembourg,), Malta, Moldova, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, the United Kingdom and Uzbekistan (Total: 49) . • Chair: Turkey • Co-Chair: Hungary
Puebla Process (Regional Conference on Migration)	1996	Belize, Canada, Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama and the United States (Total: 11). • Current Presidency Pro-Tempore: Guatemala
SACM (South American Conference on Migration)	1999	Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Surinam, Uruguay and Venezuela (Total: 12). • Current Presidency Pro-Tempore: Uruguay (Presidency Pro-Tempore alternates every year between sub-regions, i.e. Southern Cone and Andean)
5+5 Dialogue (Regional Ministerial (Conference on Migration in the Western Mediterranean)	2002	Algeria, France, Italy, Libya, Malta, Mauritania, Morocco, Portugal, Spain and Tunisia (Total: 10). • Current President: transitioning from Portugal to Libya
MTM (Mediterranean Transit Migration Dialogue)	2003	Algeria, Egypt, Lebanon, Libya, Morocco, Syria and Tunisia, otherwise referred to as the Arab Partner States (APS); the 27 EU Member States and Norway, Switzerland and Turkey, called European Partner States (EPS) (Total: 37). • New Partner States for specific activities: Cape Verde, Ethiopia, Ghana, Mali, Niger, Nigeria, Senegal.
MIDWA (Migration Dialogue for West Africa)	2000	Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Ghana, The Gambia, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo (Total: 15).
MIDSA (Migration Dialogue for Southern Africa)	2000	Angola, Botswana, Comoros, Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe (Total: 16).
IGAD-RCP (Inter-governmental Authority on Development - Regional Consultative Process on Migration)	2008	Djibouti, Ethiopia, Kenya, Somalia, Sudan and Uganda (i.e. IGAD Member States) (Total: 6). (Eritrea temporarily suspended its membership)
Bali Process (Bali Process on People Smuggling, Trafficking in Persons and Related Transnational Crime)	2002	Afghanistan, Australia, Bangladesh, Bhutan, Brunei Darussalam, Cambodia, China, DPR of Korea, Fiji, Hong Kong SAR,** India, Indonesia, Iran, Iraq, Japan, Jordan, Kiribati, Laos PDR, Macau SAR,** Malaysia, Maldives, Mongolia, Myanmar, Nauru, Nepal, New Caledonia (France), New Zealand, Pakistan, Palau, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Sri Lanka, Syria, Thailand, Timor-Leste, Tonga, Turkey, Vanuatu, Viet Nam (Total: 41 + Hong Kong SAR and Macau SAR). • Co-Chairs: Australia and Indonesia • Thematic coordinators: (i) Policy Issues and Legal Frameworks: New Zealand (ii) Policy Issues and Law Enforcement: Thailand • IOM and UNHCR have participant status.

RCP	Year	Governments
APC (Inter-Governmental Asia-Pacific Consultations on Refugees, Displaced Persons and Migrants)	1996	Afghanistan, Australia, Bangladesh, Bhutan, Brunei Darussalam, Cambodia, China, Fiji, Hong Kong SAR,** India, Indonesia, Japan, Kiribati, Lao PDR, Macau SAR,** Malaysia, Micronesia, Mongolia, Myanmar, Nauru, Nepal, New Caledonia (France), New Zealand (until 2003), Pakistan, Papua New Guinea, the Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Sri Lanka, Thailand, Timor-Leste, Vanuatu and Viet Nam. (Total: 32 + Hong Kong SAR and Macau SAR). • Current Chair: Samoa
Colombo Process (Ministerial Consultation on Overseas Employment & Contractual Labour for Countries of Origin in Asia)	2003	Afghanistan, Bangladesh, China, India, Indonesia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand and Viet Nam (Total: 11). • Current Chair: Bangladesh
Abu Dhabi Dialogue (Ministerial Consultations on Overseas Employment and Contractual Labour for Countries of Origin and Destination in Asia)	2008	11 Colombo Process countries (Afghanistan, Bangladesh, China, India, Indonesia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand and Viet Nam). 9 Asian destination countries (Bahrain, Kuwait, Malaysia, Oman, Qatar, Saudi Arabia, Singapore, United Arab Emirates and Yemen) (Total: 20). • Current Chair: United Arab Emirates
IGC (Inter-Governmental Consultations on Migration, Asylum and Refugees)	1985	Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Netherlands, New Zealand, Norway, Spain, Sweden, Switzerland, the United Kingdom and the United States (Total: 17). • Current Chair: Switzerland

* Reflects minor corrections made in July 2009 and October 2009
** Special Administrative Region of China

Annex B. List of regional economic communities (RECs)

RECs	Countries
Andean Community of Nations (CAN)	Bolivia, Colombia, Ecuador, Peru (Venezuela announced its withdrawal from the Andean Community in 2006, but must still complete the necessary procedures); Associate Members: MERCOSUR Member States were granted associate membership in 2005. Observers: Mexico and Panama
Arab Maghreb Union (UMA)	Algeria, Libya, Mauritania, Morocco and Tunisia
Asia Pacific Economic Cooperation (APEC)	Australia, Brunei, Canada (not a participant in the ABTC), Chile, China, Hong Kong SAR,* Indonesia, Japan, Malaysia, Mexico (participate in the ABTC on a partial basis), New Zealand, Papua New Guinea, Peru, the Philippines, Russia (not a participant in the ABTC), Singapore, Republic of Korea, Taiwan (China), Thailand, the United States (participate in the ABTC on a partial basis) and Viet Nam.
Association of Southeast Asian Nations (ASEAN)	Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Viet Nam.
Caribbean Community (CARICOM) / Caricom Single Market and Economy (CSME)	Full Members:* Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago; Associate Members:** Anguilla, Bermuda, British Virgin Islands, Cayman Islands, the Turks and Caicos Islands.
Common Market for Eastern and Southern Africa (COMESA)	Burundi, Comoros, Democratic Republic of the Congo, Djibouti, Egypt, Eritrea, Ethiopia, Kenya, Libya, Madagascar, Malawi, Mauritius, Rwanda, Seychelles, Sudan, Swaziland, Uganda, Zambia and Zimbabwe.
Commonwealth of Independent States (CIS)	Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Ukraine and Uzbekistan; Associate member: Turkmenistan.
Community of Sahel-Saharan States (CEN-SAD)	Benin, Burkina Faso, Central African Republic, Chad, Comoros, Côte d'Ivoire, Djibouti, Egypt, Eritrea, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Libya, Mali, Morocco, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo and Tunisia.
East African Community (EAC)	Burundi, Kenya, Rwanda, Tanzania and Uganda.

RECs	Countries
Economic Community of Central African States (ECCAS)	Angola, Burundi, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of the Congo, Equatorial Guinea, Gabon and Sao Tomé and Principe.
Economic Community of West African States (ECOWAS)	Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.
European Economic Area (EEA)	European Union Member States, Iceland, Liechtenstein and Norway.
European Free Trade Association (EFTA)	Iceland, Liechtenstein, Norway and Switzerland.
European Union (EU)	Austria, Belgium, Bulgaria, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Malta, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and United Kingdom.
Inter-Governmental Authority on Development (IGAD)	Djibouti, Ethiopia, Kenya, Somalia, Sudan and Uganda (Eritrea temporarily suspended its membership with IGAD in April 2007).
NORDIC Common Labour Market	Denmark, Finland, Iceland, Norway and Sweden.
North American Free Trade Agreement (NAFTA)	Canada, Mexico and the United States.
Southern African Development Community (SADC)	Angola, Botswana, Democratic Republic of the Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.
Southern Common Market (MERCOSUR)	Argentina, Brazil, Paraguay, Uruguay and Venezuela. Associate Members: Chile, Bolivia, Colombia, Ecuador and Peru.
South Asian Association for Regional Cooperation (SAARC)	Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

* Haiti and the Bahamas are full member countries of CARICOM, but are not party to the CSME. Montserrat is still waiting for approval from the United Kingdom with regards to the Revised Treaty of Chaguaramas

** Associate members are not party to the CSME. All associate members are either United Kingdom territories or autonomous with special relationship with the United Kingdom

NOTES

1 The total number of international migrants is expected to reach 214 million in 2010, which will comprise 3% of the global population. This includes 20-30 million irregular international migrants and 16.3 million refugees. 26 million were internally displaced. In 2009, there were approximately 740 million internal migrants.(WB 2009).

2 International Seminar on Migration Medicine (IOM, February 1009, Geneva).

3 Paragraph 50 of the *Declaration of Commitment*, see http://www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/; http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf.

4 Conclusions on Health and Migration in the EU (15609/07) adopted during the EPSCO (Employment, Social Policy, Health and Consumer Affairs) Council on 5-6 December 2007 following a debate focusing on inclusion of migrant health issues into national policies, access to health care for migrants, difficulties in the field encountered by member states and suggestions to share knowledge and lessons learnt on effective intervention (http://register.consilium.europa.eu/pdf/en/07/st15/st15609.en07.pdf) Notice of adoption of conclusions in the ensuing press release (p. 21): http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/97445.pdf (More info http://www.migrant-health-europe.org).

5 http://mighealth.net/eu/index.php/1._Projects_co-funded_by_DG_SANCO

6 http://mighealth.net/index.php/Main_Page

7 http://www.nowhereland.info/

8 http://www.meho.eu.com/

9 http://www.eugate.org.uk/index.html

10 http://tampep.eu/

11 http://www.comunidadandina.org/ and http://www.conhu.org.pe.

l2 www.caricom.org and http://www.caricom.org/jsp/projects/pancap.jsp?menu=projects

13 ILO, IOM, OHCHR, United Nations Conference on Trade and Development, UNDP, United Nations Department of Economic and Social Affairs, UNESCO ,UNFPA, UNHCR, UNICEF, United Nations Institute for Training & Research, the United Nations Office on Drugs and Crime, the World Bank, UN Regional Commissions.

14 http://www.ifrc.org/Docs/pubs/who/policies/migration-policy-en.pdf
15 More info at seafarers@iom.int
16 International Convention on the Protection of the rights of all migrant workers and members of their families (ICRMW), http://www.migrantsrights.org/committee.htm.
17 http://www.euro.who.int/stabilitypact/network/20040611_1. The members of the South-eastern Europe (SEE) Health Network includes the ministries of health of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Montenegro, Romania, Serbia, and Macedonia,
18 http://www.episouth.org/
19 As of the end of 2009, there are 36 partners of the Global Health Cluster: African Humanitarian Action, the American Refugee Council, CARE, the Catholic Relief Service, the Centers for Disease Control, Columbia University, Concern Worldwide, DFID, ECHO, the Emergency Relief Agency, FAO, Handicap International, Harvard Humanitarian Initiative, Help Age International, the International Federation of the Red Cross and Red Crescent, IOM, the International Centre for Migration and Health, the International Council of Nurses, the International Medical Corps, the International Rescue Committee, the Johns Hopkins University Center for Refugee and Disaster Response, Marie Stopes International, Médecins du Monde, Merlin, Save the Children UK, Save the Children USA, Terre des Hommes, UNFPA, UNHCR, UNICEF, the United States Bureau of Population Refugees and Migration, the United States Office of Foreign Disaster Assistance, the World Association for Disaster and Emergency Medicine, the Women's Commission for Refugee Women and Children, WHO and World Vision International.
20 BHW main partners include the Secretariats of Health and Foreign Affairs of Mexico, and the Ministries of Foreign Affairs of Guatemala, El Salvador, Honduras, Colombia, Ecuador and Peru, as well as the Institute for Mexicans Abroad, the Mexican Social Security Institute, California's Department of Public Health, The California Endowment, California HealthCare Foundation, US-Mexico Border Health Commission, *Consejo de Federaciones Mexicanas de Norte América* (COFEM), and the Health Initiative of the Americas, a programme of the School of Public Health at the University of California at Berkeley.
21 http://www.caramasia.org/
22 http://www.hivmobilitysea.org/junima/

PART 5

BACKGROUND MATERIALS

Glossary on selected migration terms

Definitions in the field of migration are rarely universally accepted. They are often vague and can even be controversial. This glossary provides definitions of selected commonly used terms in the migration field that are used throughout this document. It is by no means an exhaustive list of terms and of sources of definitions in the migration field, and it does not set any standards.

Asylum-seeker

Asylum-seekers are persons who have left their country of origin seeking safety from persecution or serious harm, have applied for asylum in another country, and are awaiting a decision on their application. They hope to obtain refugee status or protection on other humanitarian grounds in order to benefit from the legal protection and material assistance which is an automatic part of such protection. If the application is rejected after consideration and after all possible appeals, the applicant's right to asylum is dismissed and the State usually tries to remove or deport them, sometimes after detention. Not every asylum-seeker is a refugee, but every refugee is initially an asylum-seeker (IOM, *Glossary on migration* 2004; UNHCR, *Master glossary of terms*, 2006).

Displaced person

A displaced person is a person who flees his/her State or community due to fear or dangers other than those which would make him/her a refugee. A displaced person is often forced to flee because of internal conflict or natural or manmade disasters (IOM, *Glossary on migration*, 2004).

Internally displaced person

Internally displaced persons are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border (UN, *Guiding principles on internal displacement*, 1998).

Immigrant

A non-national who moves into a country for the purpose of settlement (IOM, *Glossary on migration*, 2004).

Internal migrant

Internal migrants move but remain within their country of origin (e.g. rural to urban migration) (IOM, *Glossary on migration*, 2004).

Irregular migrant

Someone who, owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorized to remain in the host country. The preferred term is "migrant in an irregular situation" (IOM, *Glossary on migration*, 2004).

Migrant

At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without intervention of an external compelling factor. This term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family (IOM, *Glossary on migration*, 2004). Please note that throughout the discussion document text, a broader interpretation of the term migrant has been applied for ease of reference.

Migrant worker

A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national (Art. 2(1), International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990).

Migration

Migration refers to any process of moving of people, either across an international border, or within a country, either permanently or on a temporary basis, whatever its causes (IOM, *Glossary on migration*, 2004).

Refugee

A "refugee" is a person who meets the eligibility criteria under the applicable refugee definition, as provided for in international or regional refugee instruments, under UNHCR's mandate, and/or in national legislation. Article 1 of the 1951 Convention Relating to the Status of Refugees defines a refugee as a " person who owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country..." (UNHCR, *Master glossary of terms*, 2006).

Smuggling

The procurement , in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a State Party of which the person is not a national or a permanent resident (Art. 3(a), UN Protocol against the Smuggling of Migrants by Land, Sea and Air, supplementing the United Nations Convention against Transnational Organized Crime, 2000).

Victim of trafficking

Victims of trafficking are individuals who are victims of the crime of trafficking in persons. Trafficking is "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" (Art. 3(a), UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the UN Convention Against Transnational Organized Crime, 2000).

Usage of migration-related terminology

There is a lack of universally accepted definitions and consistency in the use of terminology to describe migration, and especially those who migrate. A "refugee" is an example of internationally recognized terminology. Definitions for migrant worker, internally displaced persons and stateless persons also exist at the international level. Terminology used to describe other groups of migrating persons, often refer to different populations depending on setting and jurisdictions. The descriptions below explain how some essential terms have been used throughout this document and the Consultation process. These descriptions should therefore not be perceived as agreed-upon international definitions – they solely clarify how the authors of the background documents of the Consultation have agreed to use them.

Migration

In this document and throughout the consultation proceedings the term "migration" refers to any process of moving of people, either across an international border, or within a country, either permanently or on a temporary basis, whatever its causes (also see the glossary).

Travel for the purpose of business, tourism or to visit relatives and friends, is not considered "migration" and has been otherwise specified as such where necessary.

Migrant

There is no universally accepted definition of "migrant". The term migrant is usually understood to cover persons moving to another country or region to, for instance, better their material or social conditions and to improve the prospects for themselves or their family (see also the glossary).

Migration today involves migrants in regular and irregular situations, as well as asylum seekers, victims of trafficking, refugees, displaced persons, returnees and internal migrants. *For ease of reference*, they are all referred to as "migrants" in this document. As mentioned earlier, health determinants, needs and vulnerability levels can vary greatly among the different migrating populations.

Migrant children, second and further generations

Biological and genetic determinants of health, as well as health behaviours, may extend over generations. The children and grandchildren of migrants can face health challenges, needs or vulnerabilities related to the migration of their (grand)parents. Also the health of children left behind by migrating family members can be affected by the migration of their parents. The health of migrants' children or second- and later generations is a relevant health topic associated with migration. However, migrants' children (who themselves did not migrate) and further generations are *not* considered "migrants".

Keynote addresses

Jorge Bustamante[1]
Special Rapporteur on the Human Rights of Migrants

This paper was prepared as requested by the organizers of the Global Consultation on Migrant Health. It is based on the fulfilment of the wide mandate of the Special Rapporteur for the human rights of migrants which covers all rights including economic, social and cultural rights of migrants. The mandate brings not only his expertise in the area, but also adds of certain practical values in his working methods to the discussion of rights to health to migrants. This includes:

- The reporting and fact finding responsibility the Special Rapporteur can bring attention to the challenges faced by migrants in accessing health and other entitlements by calling for enhanced protection of migrants at the national and international level.
- Further highlight, the human rights implication of health and migration to the international community deriving with governments, the United Nations human rights Council and NGOs. The practical results of the Special Rapporteur´s visits to countries in fulfilment of the mandate has been used to raise awareness and dialogue on human rights issues related to health at the local and national level, both within and between a large range of domestic stakeholders.
- On of the greatest and vastest of international human rights mechanisms is that they allow individuals and NGOs to lodge complaints of file reports of human rights abuses. In this regard, it provides an opportunity for the mandate to legitimately interview in view to providing protection for migrants.
- The Special Rapporteur has served to monitor national systems to ensure equality and non discrimination in the application of right to health for migrants. In this regard, the upcoming thematic report of the Special Rapporteur on migrants will focus on the rights to health and to adequate housing for migrants. It will also include the reference to some good practices in the area.

Human rights approach to migration and health

In relation to health and migration, a rights-based approach means integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of migration and health-related policies and programmes. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all. The principle of equality and freedom from discrimination is central, including discrimination on the basis of sex and gender roles. Integrating human rights also means empowering vulnerable groups, ensuring their participation in decision-making processes which concern them and incorporating accountability mechanisms which they can access. Mental disability and mental health care have been neglected in the discourse around health, human rights, and equality.

The right to health

In the age of globalization, the health dimension of migration and what the human right to health means in this context are key areas of concern for the international community. The right to health is a long established norm in international human rights law, and its scope and content[2] are well-defined in law. The normative foundations[3] of this right goes back to 1946 constitution[4] of the World Health Organization which stated in its preamble that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human …" In so doing, it asserted the fact that a right to health is fundamental[5] to the enjoyment of other human rights and for living a life in dignity. Its development in international human rights law started with its inclusion in the international bill of rights[6] and further reference made to in context of racial discrimination[7] and in relation to children,[8] to women[9] and migrant workers.[10]

The right to health is not a guarantee of a right to being healthy, but rather *a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health*,[11] which spans *"a wide range of socio-economic factors that promote conditions in which promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment"*.[12] It stipulates a system of entitlement to health care protection including health systems, facilities and products based on availability, accessibility, acceptability and quality[13] as core components of the right.

The application of the right to health to *non-citizens* or *migrants* is entrenched in the principle of non-discrimination provided of Art. 2(2) of the ICESCR.[14] Further, the ESCR Committee expressly confirmed the States' obligations to ensure equal access to preventive, curative and palliative health services by all persons, "including prisoners or detainees, minorities, *asylum seekers* and *illegal immigrants*".[15]

This basic principle of non-discriminations constitutes an important starting point, although, in practice, many industrialized destination countries justify restricting migrants' access to these rights on the grounds that they need to protect their welfare systems from abusive claims and, increasingly, as a means of deterring irregular migration.

Health conditions of migrants

Most migrants are vulnerable to poor health by virtue of their often low socio-economic status, the process of migration and their vulnerability as non-citizens in the new country. Studies in a number of OECD countries have found that while migrants initially gain benefits in improved health conditions from migration, such benefits diminish over time, partly due to the exposure to the adverse working, housing and environmental conditions that often characterize low-income groups in industrial countries.[16] Many migrants are often employed in "the three D jobs" (dirty, degrading and dangerous) in mostly informal, un- or lightly regulated sectors of economies where there is little respect for labour and other protection. Typically, such work is labour intensive, temporary or seasonal work which has significantly higher occupations hazards for migrants than for citizens.

Mental health of migrants is also an issue of concern, as social isolation caused by separation from family and social networks, as well as job insecurity and difficult living conditions can adversely affect their mental health.[17] While better economic opportunities may result in positive effects on migrants' mental health, other reports indicate higher incidence of stress, anxiety and depression for migrants than residents.[18] A study of mental health of women migrants also shows that mental health of migrant domestic workers may be jeopardized by exploitative treatment, enforced cultural isolation, undermining of cultural identity and disappointment in not achieving expectations.[19]

The processes of migratory movement may also have a significant negative impact on the health of migrants before they arrive in the host country. The stricter restriction for entry to richer northern countries has increased the use of clandestine, unofficial and dangerous entry. For instance, vulnerable groups of migrants, such as refugees, or victims of trafficking and people smuggling, may have been exposed to sexual and gender-based violence, greater vulnerability to ill health and diminished ability to exercise informed choices concerning their health in countries of origin or in transit. According to the WHO, exposure to risk associated with population movements also raises migrants' vulnerability to psychosocial disorders, drug abuse, alcoholism and violence. In addition, limited access to health care during the transit and early insertion phases of migration increases the resultant burden of untreated non-communicable conditions.[20]

Challenges of access to the right to health for migrants

A considerable gulf exists between the rhetoric of the universal application of human rights and the enjoyment of these rights in practice. Access to and the level of health care for migrants varies enormously depending on the state in focus and status of immigration status.[21] Most countries, particularly those with nationalized health systems, link access to non-emergency access to health to the immigration status of migrants. While activists have favoured a broad interpretation of the right to health applicable to all irrespective of the their residential or citizenship status, host states have been

less willing to apply such a definition, fearful that such a move will defeat migration control policies and place a heavy burden on health and other social services.

On the whole, access to health care and associated entitlements are often linked to the immigration status of migrants. Thus, regular migrants satisfying certain conditions have entitlements which may be comparable to citizens of host states, although there may be differences in entitlements between long-term and short-term migrants.[22] A study on the access to health care in several host states indicates that access to health care ranges from emergency care to expansive health coverage for all, including for irregular migrants. Within this range are included, the payment for preventative and primary health care, including urgent or emergency care and free medical service on certain restricted grounds.[23]

While states have developed different criteria for what constitutes urgent healthcare, the Special Rapporteur is concerned about its application as well as a lack of coherent definition amongst states of what constitutes emergency care. In the view of the WHO, mere commitment to emergency care is not justified and reasonable from a public health standpoint, as a failure to receive any type of preventive and primary care could result in the creation of a health risk for both migrants and their host community.

In developing countries, the reality of resource constraints often casts shadows on the ideal of granting health care access to migrants. In some countries, non-nationals may not be able to access life saving antiretroviral medication, because facilities deny treatment on the basis of "being foreign" or not having a national identity document.[24] Such rule does not only limit the ability of irregular migrants to seek non-urgent but also important physical and mental health care, as well as health prevention and health promotional activities. Reports suggest that given the limited access to health care, migrants often self medicate and use health services at a later stage in the progression of their ailments than members of the host community.[25] In this regard, experts opined that given the relatively small proportion of irregular migrants and their underutilization of services, providing them with free preventive and primary care rather than with delayed emergency intervention may actually lower the costs of the health system. Ultimately, the denial of access to preventive and other care may lead to an inefficient and costly use of other services such as emergency care.[26]

The right to health for migrant women

Women currently make up about one half of the world's migrant population[27] and in some countries, as much as 70 or 80%.[28] The number of female migrants has surpassed their male counterparts in some sectors, due to the increase in the demands for gender-neutral or gender-specified roles in service industries. As the CEDAW Committee pointed out, migrant women face specific challenges in the field of health throughout the migration cycles. Migrant women, for example, may be subject to sex- and gender-based discrimination such as mandatory HIV/AIDS or other testing without their consent, as well as sexual and physical abuse by agents and escorts during transit.[29] In host states, many are employed in relatively unskilled jobs within the manufacturing, domestic service or entertainment sectors, often without legal status and little access to health services. They are often subject to exploitation and/or physical and sexual violence by their employers or clients.[30] They may be particularly vulnerable to HIV and have few alternative employment opportunities.[31]

The sector in which women migrant workers dominate is domestic services. A report[32] on domestic migrant workers found that 50 to 75% of the legal migrants leaving several East Asian countries are women, most of whom work as domestic migrant workers in the Middle East and parts of Asia. Women migrant workers engaged in domestic services are one of the most vulnerable groups of migrant workers, as their work is often undervalued as informal work. As a consequence, they are often exempted from health insurance and other important social and labour protections.[33] Nevertheless, they are often exposed to health and safety threats without being provided with adequate information about risks and precautions. Given the lack of health care, they tend to seek care late when they do have problems. Many of these women migrant domestic workers are particularly vulnerable as a result of their immigration status and lack of legal mechanisms recognizing or protecting their rights within domestic legislation makes them outside the protection of the law.

Further, reports indicate that migrant women often experience different and more problematic pregnancy and gynaecological health issues, compared to the host population.[34] Many arrive from countries with poor reproductive health care including family planning, and with little knowledge or experience in such services. Consequently, the rate of unwanted pregnancies among migrant women is high, and requests for abortion by migrant women tend to be three to four times higher than in host populations. There is persistent discrimination against pregnant women, which effectively forces women to undergo abortion as they may face dismissal from employment and deportation, should they refuse to do so.[35]

In view of the specific health risk to which migrant women are exposed, States have a responsibility to ensure the provision adequate, appropriate and specialized medical assistance for this group. Particular concern is raised in relation to irregular pregnant women and girl children who are charged for services rendered other than emergency basis. Indeed, there is growing recognition of the far reaching impact of good health during pregnancy and childhood on adult health.

On immigration detainees, the Special Rapporteur received reports of wilful and malicious denial of proper medical treatment detainees are entitled to by law and regulation while in the custody of the national authorities. This is, particularly, worrying in relation to children and to women's health issues[36] and victims of torture. The denial of reproductive rights for the sexually assaulted or officials not informing detainees of their options if they become pregnant are serious breach of human rights. Further concerns are expressed about the mental health of migrants[37] in detention, on the detrimental effect that detention has on migrant's mental health and the lack of adequate resources to treat mental health ailments whiles in detention.

The right to health for migrant children

The right of the child to the enjoyment of the highest attainable standard of health[38] places obligations on State to make every effort "to ensure that no child is deprived of his or her right of access to such healthcare services" by providing them with "necessary medical assistance and healthcare" and "appropriate pre-natal and post-natal healthcare for mothers" among others. However, the Special Rapporteur notes with regret the vast discrepancies between international human rights norms and their actual implementation in the field of healthcare for migrant children, particularly irregular and unaccompanied migrant children. The long lasting consequences of inadequate care on development as well as the State duty of protection of the most vulnerable requires an urgent attention to access to healthcare for children.

The Special Rapporteur received reports that poor working and economic conditions for migrant adults affect the general health and welfare of their children, including giving birth to premature babies, increasing the risk of serious illness or death.[39] In general, the constraints on the rights of adult migrants immediately have an adverse impact on the rights of their children, and in a long term, may inhibit their development.[40] Where parent migrants are deprived of health care, it is most likely that their children also do not enjoy access to health care.

The Special Rapporteur is also concerned about laws, policies and measures which hamper irregular migrant children's access to health. For instance, the Special Rapporteur notes that in some countries, a parent must be a regular migrant in order to obtain a birth certificate for her child, thus making access to health care difficult for children of irregular migrants.

The Special Rapporteur is encouraged to learn of several schemes for low-income irregular children and providing care regardless of ability to pay or immigration status. This notwithstanding, he is concerned that many irregular children are still not enrolled on such schemes and may not be receiving health care benefits available to them because their parents are reluctant to approach the social services' for fear of their irregular status being discovered and/or due to limitations imposed by their immigration status. In many cases, challenge remains to ensure the enjoyment by irregular migrants of healthcare at the national level in law and practice without exposing them to the threat of immediate detection and expulsion.[41]

The Special Rapporteur also notes that pre-natal care and services after birth and early childhood are essential to prevent or mitigate many long-term disabilities and associated costs.[42] Preventive care is also an important element of health care in the case of children. Underutilization of preventive care

is also associated with poorer health outcomes such as longer stays in hospitals, more acute health crises, and higher mortality rates.[43]

The Special Rapporteur expresses particular concern about the administrative detention of children under immigration acts for the purposes of immigration control. In this connection, he recalls his earlier statements[44] that "laws should include such children's rights principles as detention as a last resort" and that "States should therefore include alternative measures to detention and express the priority of these measures in their legislation." He notes with concern that children suffering from serious medical conditions and the mentally ill were routinely kept in detention despite guidelines stating clearly they should not be. He would also like to mention that the health concerns associated with the placement of children in detention is further exacerbated by denial of urgent medical treatment, the high risk of serious harm among children and children being handled violently. Further, there is a failure to properly diagnose the mental health of children as well as inadequate access to counselling and other assistance.[45] In this regard, the Special Rapporteur reiterate the need for States to pay more attention to the mental health implications of detaining children as well as the psychological effects of detention on children.

NOTES

1 The sole responsibility of the author and not of the Human Rights Council of the United Nations.
2 Committee on Economic Social and Cultural Rights General Comment 14 in relations to Article 12 of the convention on the right to highest attainable standard of health.
3 For an in-depth analysis of the conceptual foundations of the human rights to health see: Riedel E. The human right to health: Conceptual foundations. In Clapham A, Robinson M. *Realising the right to health*. Swiss Human Rights Book Vol. 3, 2009.
4 Constitution of the World Health Organization (Off. Rec. Wld Hlth Org., 2, 100) can be found at: http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf.
5 Declaration 1, Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, http://www.searo.who.int/LinkFiles/Health_Systems_declaration_almaata.pdf. See also page 1 of Fifty-First World Health Assembly. WHA51.7. Agenda item 19. 16 May 1998 ... World Health Declaration: http://www.emro.who.int/mei/pdf/topic/phc/healthforall_resolution.pdf
6 Article 25(1) of the Universal Declaration of human rights (UDHR). Further, the clearest enunciation of this right is in Article 12 of the International Covenant on Economic Social and Cultural rights.
7 Article 5, Convention on the Elimination of all Forms of Racial Discrimination.
8 Article 24, Convention of the Right of the Child.
9 Article 12, Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).
10 See article 28 and 43 of International Convention on the Protection of Rights of all Migrant Workers and Members of their Families.
11 Paragraph 9 of CESCR General Comment 14 in relations to Article 12 of the Convention on the Right to Highest Attainable Standard of Health.
12 Paragraph 4 CESCR General Comment 14 in relations to Article 12 of the Convention on the Right to Highest Attainable Standard of Health.
13 CESCR General Comment 14 in relations to Article 12 of the Convention on the Right to Highest Attainable Standard of Health.
14 See also para. 34 of ICESCR General comment 14 *ibid,* and General comment No. 20: UN Committee on Economic, Social and Cultural Rights (CESCR). For an EU regional perspective on the prohibition based on national origin, see International Federation of Human Rights Leagues (FIDH) V France Complaint No. 14/2003 3 Nov. 2004 para. 32.
15 General Comment 14, Para 34 (emphasis added).
16 UNDP. *Human Development Report 2009. Overcoming barriers: Human mobility and development*. Available at http://hdr.undp.org/en/reports/global/hdr2009/
17 Human Development Report, 56.
18 Human Development Report, 56.
19 Anbesse B, Hanlon C, Alem A, Packer S, Whitley R. Migration and mental health: A study of low-income Ethiopian women working in Middle Eastern countries. *The International Journal of Social Psychiatry*. Brookmans Park: Nov 2009. Vol. 55, Iss. 6.
20 Health of Migrants, report of the Secretariat, World Health Organisation, Sixty-first World Health Assembly, A61/12, 7 April 2008.

21 PICUM. *Access to health care for undocumented migrants in Europe*, 2007 (http://www.picum.org/sites/default/files/data/Access%20to%20Health%20Care%20for%20Undocumented%20Migrants.pdf).
22 For instance, in the republic of Ireland, entitlement to full or limited health services is based on residency and an "intention to remain in Ireland for a minimum period of one year" is required for entitlement to health care. Immigrant Centre of Ireland and Independent Law Centre Submission to the Special Rapporteur on the human rights of migrants on access to economic and social rights by migrants-particularly, the enjoyment of the right to adequate standard of living (art 11 of IESCR) and the right to health(article 12 IESCR) for undocumented migrants in Ireland, January 2010.
23 See note 21.
24 Human Development Report, 57.
25 Human Development Report, 57.
26 Arnold, Chalmers, et al., 2008; BMA, 2008
27 CEDAW General Recommendation No. 26.
28 Varia N. Globalization comes home: Protecting migrant domestic workers' rights. In *Human Rights Watch World Report 2007*.
29 *para 17. The Committee on the Elimination of Discrimination against Women, General recommendation No. 26 on women migrant workers, December 2008, CEDAW/C/2009/WP.1/R*
30 See e.g. the cases of trafficked migrant women in South Korea in Amnesty International. *Disposable Labour: Rights of migrant workers in South Korea*. London: Amnesty International, 2009.
31 *UNAIDS policy brief : HIV and international labour migration*. UNAIDS, ILO, IOM, June 2008.
32 See note 28.
33 UNICEF briefing note, 12.
34 *The challenge of migration and health*. International Centre for Migration and Health Feature Article 2007.
35 CEDAW General Recommendation para. 18
36 Human Rights Watch. *Detained and dismissed. Women's struggles to obtain health care in United States immigration detention*. Human Right Watch, March 2009 (http://www.hrw.org/en/reports/2009/03/16/detained-and-dismissed).
37 Physicians for Human Rights And The Bellevue/NYU Program for Survivors of Torture. *From persecution to prison: The health consequences of detention for asylum seekers*. Boston and New York City, Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture, June 2003.
38 Art. 24 of Convention of the Rights of the Child (CRC).
39 See Amnesty International report in note 30.
40 UNICEF briefing note 12.
41 Cholewinski R. *The human and labour rights of migrants: Visions of equality*. 22 Geo. Immigr. L.J. 177.
42 Ruiz-Casares M et al. Right and access to healthcare for undocumented children: Addressing the gap between international conventions and disparate implementations in North America and Europe. *Social Science & Medicine*, Jan 2010, 70(2):329-336.
43 See note 42.
44 See para. 43 and 60 of 2009 Annual Report of the Special Rapporteur on the human rights of migrants. A/HRC/11/7.
45 The Children's Commissioner for England's follow up report to: The *arrest and detention of children subject to immigration control*, February 2009.

Enrique Iglesias
Secretary General, Ibero-American General Secretariat

I would like to praise and underline as good practice the timely initiative and goals of this Global Consultation, the results of which will be presented at the next World Health Assembly:

- Take stock of the actions undertaken since the adoption of the Resolution
- Reach consensus on priority areas
- Outline an operational framework to aid governments in managing migrant health
- And consolidate a working technical network, with appropriate areas of action.

I am pleased to address these representatives of countries, international organizations and civil society, thus underscoring our commitment to address the global challenge posed by the complex relationship between international migration and health.

This challenge, which is also an ethical one, is part of the broader framework linking international migration, development and human rights, in its twin aspect of civil and political rights, on the one hand, and economic, social and cultural rights, on the other.

WHO and IOM, guided by these principles, have pioneered the incorporation of migrant health into the political and international cooperation agenda as a matter of urgency. In addition, they have helped to revolutionize the manner in which these issues are addressed, and have developed innovative public practices to improve migrants' access to health.

I am also pleased to see this Global Consultation occurring in Spain, a country that illustrates in equal measure the problems and the promise of international migration, where the human rights and integration of migrants have been and continue to be of great concern in Spain's policies and programmes.

Health, understood not only as the absence of illness, but as a state of complete physical, mental and social well-being, is a fundamental human right irrespective of race, sex, religion and origin. The international community has clearly indicated the comprehensive nature of this right, and today there exists a broad range of international instruments that reaffirm the right of migrants to health care. These instruments have been widely ratified and are binding on signatories.

Nevertheless, in what Castles and Miller have called the "age of migration", migratory flows are one of the principal modes of interaction between countries. Alongside the noteworthy achievements that have been made in addressing this complex issue and recognizing the many contributions that migration makes to countries of origin and host countries alike, many challenges remain for States, international organizations and civil society. Migration also throws down a challenge to democracy in our countries, because it exposes serious shortcomings in our capacity for plurality and inclusion. Migrant health is one such challenge.

We should consider the need for "social education" on this issue, in terms of promoting attitudes that strengthen pluralism, inclusion and respect for diversity. No doubt this requires a deepening of the democratic foundations of societies and a search for equality.

Troublingly, past events have shown us that for various reasons immigrants still experience serious difficulties in accessing health care. This is especially true in the case of undocumented migrants, for whom migratory status is one of the greatest barriers to comprehensive health.

As we noted at our Ibero-American Meeting on Migration and Development, although the concept of a citizenry has historically served to make people equal before the law as entities capable of possessing rights and duties, the irony is that now citizenry is often used to discriminate and prevent the exercise of basic human rights such as the right to health.

At the Ibero-American Summit held in Santiago, Chile, in 2007, under the watchword of social cohesion, the Heads of State and Government agreed that access to health care and ensuring the well-being of persons and peoples fosters a sense of belonging to the community and positive integration, thus making health an important component of social cohesion.

The various aspects of the international migration-health nexus, for example:

- control of chronic and contagious diseases,
- mental and reproductive health problems,
- understanding beliefs and cultures with regard to health,
- analysis of the processes of protection and resilience,

- access to high-quality services without discrimination,
- public policies on comprehensive health,
- harmonization of regional and international policies,

illustrate the complex challenges facing us in the broader context of development and human rights.

The global economic crisis has made the migratory situation even more complex, by exacerbating the conditions of vulnerability which are associated with many migrants. That is why we must endeavour to address these vulnerabilities and guarantee migrants' rights, so that the already precarious living conditions of many of these migrants do not deteriorate further.

The challenge in this situation is not to move backwards, thinking as in decades past that restrictive and unilateral measures are the appropriate response to a transnational issue affecting all countries in different ways.

Accordingly, the Ibero-American Secretariat General, in accordance with the mandates of the Ibero-American Heads of State and Government at their XVIII and XIX Summits, is organizing a second meeting of the Ibero-American Forum on Migration and Development in El Salvador on 22–23 July. The Forum will have the following central themes:

- reporting progress on migration, development and human rights in the Ibero-American community
- the impact of the crisis on migration and development
- and the responses in terms of policies and programmes in Ibero-America.

This event will be organized in close collaboration with IOM and ECLAC, under the co-auspices of other international organizations.

Human rights, migration and health will be one of the items on the agenda of this forum, and its primary goal will be the passage from agreements to action.

Thank you very much.

ANNEXES

Consultation agenda

DAY I Wednesday 3 March 2010	
08:30–9:00	Registration
09:00–9:30	WELCOME REMARKS • Juan-Fernando Martínez-Navarro, Dean, National School of Public Health, Spain • Carlos Segovia, Deputy Director-General of International Research Programmes and Institutional Relations, Health Institute of Carlos III, Ministry of Science and Innovation Research, Spain • José Martínez Olmos, General Secretary for Health, Spain • Davide Mosca, Director Migration Health Department, IOM • Daniel López-Acuña, Director Strategy, Policy and Resource Management, Health Action in Crises, WHO
9:30–9:45	KEYNOTE ADDRESS • Jorge Bustamante, Special Rapporteur on the Human Rights of Migrants
9:45–10:15	SETTING THE SCENE Migration is a fact of life and Governments increasingly see the need to address health issues associated with migration. In 2008, Governments requested WHO to develop a Secretariat Report and a Resolution on the health of migrants which was endorsed by the Sixty-first World Health Assembly in May 2008. This Resolution asks Member States for migrant sensitive health policies and practices and requests WHO to promote migrant health, in collaboration with other relevant organizations and encourages interregional and international cooperation. This session provides the background to the Consultation, how its content is linked to the Resolution and, moreover, how governments increasingly recognized the need for a paradigm shift in the way to think about health and migration; terminology issues will be explored and objectives and methodology of the Consultation clarified. • Chair: Alberto Infante Campos, Director of Professional Planning, Cohesion of the Spanish National Health System and High Supervision, Ministry of Health and Social Policy, Spain • Speakers: Daniel López-Acuña, Director Strategy, Policy and Resource Management, Health Action in Crises, WHO and Davide Mosca, Director Migration Health Department, IOM • Questions
10:15–10:45	Coffee Break
SESSION I. MONITORING MIGRANTS' HEALTH	
10:45–11:15	The lack of agreed definitions and consistency in use of terminology to describe migrants and denominators greatly hampers the study of health outcomes associated with migration, and consequent evidence- and population- based programme- and policy design. This session refers to efforts to overcome the monitoring challenge and explores possible directions that take into account underrepresented groups, prevention and health promotion, access to services, and economic aspects. Identifying and defining migrants by universal-health-associated criteria as opposed to demographic status or administrative or legal status, could be helpful to overcome the current limitations in analysing health outcomes of migrants or comparing studies among migrant populations. • Chair: Raj Bhopal, Professor of Public Health, University of Edinburgh, UK • Speaker: Brian Gushulak, Research Consultant, Migration Health Consultants, Inc. • Discussant: Katrin Kohl, Deputy Director Division of Global Migration and Quarantine, Centers for Disease Control, USA • Rapporteur: Alex Leventhal, Director International Relations, Ministry of Health, Israel • Questions
11:15–13:15	4 breakout groups with proposed questions to guide the discussion 1. What needs to be monitored and measured to result in meaningful information for improving the health of migrants? 2. How to improve migrant health monitoring and standardized information collection, using what sources of data, or making better use of which surveillance systems? 3. How to overcome existing difficulties in the monitoring of migrants' health and who, what stakeholders, can be instrumental in solving them? • Moderators; Janet Roberts, Executive Director, Canadian Society for International Health (CSIH), Canada; Jonathan Suk, Expert, Social and Environmental Determinants, European Centre for Disease Prevention and Control (ECDC), Sweden; Bernardus Ganter, Adviser, Health Security and Environment/ International Health Regulations, WHO; Hashim El Mousaad, WHO representative for Jordan and Head of Mission • Rapporteurs: Joanna Vearey, Researcher, Forced Migration Studies Programme, University of the Witwatersrand, South Africa; Charles Agyemang, Senior researcher, Academic Medical Centre, University of Amsterdam, Netherlands; Jane Jones, Head of Travel and Migrant Health Section, Centre for Infections, Health Protection Agency, UK; Jennifer Hirsch, Associate Professor, Department of Sociomedical Sciences, Colombia University, USA

13:15–14:30	Lunch Break
14:30–15:30	Plenary reporting from the groups by the rapporteur for session I, followed by a discussion • Chair: Raj Bhopal, Professor of Public Health, University of Edinburgh, UK • Speaker: Brian Gushulak, Research Consultant, Migration Health Consultants, Inc. • Discussant: Katrin Kohl, Deputy Director Division of Global Migration and Quarantine, Centers for Disease Control, USA • Rapporteur: Alex Leventhal, Director International Relations, Ministry of Health, Israel
SESSION II. POLICY AND LEGAL FRAMEWORKS AFFECTING MIGRANTS' HEALTH	
15:30–16:00	Traditional approaches to manage the health consequences of migration have not kept pace with growing challenges associated with the volume, speed, diversity and disparity of modern human global movements. This session explores how policies and legislations in place determine the availability, level and nature of health services for migrants. It also addresses the role and responsibilities of the various sectors and stakeholders in realizing the right to health for migrating persons throughout the various phases of the migration process. Major gaps in current policies and legislations that can negatively impact migrants' health are highlighted. The session furthermore clarifies desired policy and legal provisions that comply with international standards and public health principles and are followed by appropriate implementation measures. • Chair: Isabel de la Mata, Principal Advisor with Special Interest in Public Health, Health & Consumers, EC, DG SANCO • Speaker: José Pereira Miguel, President, National Health Institute, Portugal • Discussant: Pia Oberoi, Migration Advisor, Research and Right to Development, OHCHR • Rapporteur: Patrick Taran, Senior Migration Specialist, ILO • Questions
16:00–16:30	Coffee break
16:30–18:30	4 breakout groups with proposed questions to guide the discussion 1. What are known practices and lessons learned with respect to policies that enhance the health of migrants? 2. What are known practices and lessons learned with respect to legislations that enhance the health of migrants? 3. What are known practices and lessons learned in the area of social protection in health (including financing health) that enhance the health of migrants? • Moderators: Bruel I Carreras Antoni, Coordinator General, Spanish Red Cross, Spain; Matthew Jowett, Senior Health Financing Specialist, WHO Office for Health Systems Strengthening, Barcelona , Spain; Sara Collantes Mateos, Deputy Coordinator of the Health for Undocumented Migrants and Asylum Seekers Network (HUMA); Chanvit Tharathep, Director, Bureau of Health Service System Development, Ministry of Public Health, Thailand • Rapporteurs: Caitlin Wiesen-Antin, Asia & Pacific Regional HIV/AIDS Practice Leader & Programme Coordinator, UNDP; Kumanan Rasanathan, Technical Officer, Department of Ethics, Equity, Trade and Human Rights, WHO; Elena Torta, Coordinator / Senior Advisor, Médecins Sans Frontières, Belgium; Roman Romero-Ortuño, Specialist Registrar, St James's Hospital, Ireland
DAY II Thursday 4 March 2010	
9:00–10:00	Plenary reporting from the groups by the rapporteur for session II, followed by a discussion • Chair: Isabel de la Mata, Principal Advisor with Special Interest in Public Health, Health & Consumers, EC, DG SANCO • Speaker: José Pereira Miguel, President, National Health Institute, Portugal • Discussant: Pia Oberoi, Migration Advisor, Research and Right to Development, OHCHR • Rapporteur: Patrick Taran, Senior Migration Specialist, ILO
SESSION III. MIGRANT SENSITIVE HEALTH SYSTEMS	
10:00–10:30	The increased diversity in health determinants, vulnerability levels and needs among society members is challenging the capacity of health systems to deliver affordable, accessible and migrant-sensitive services and calls for a more migrant-sensitive workforce. This session explains the progress made in the delivery of linguistically, culturally adapted services and the importance of migrant community participation in programme and services design. The session discusses the role of primary health care in ensuring health needs of migrants are mainstreamed and sustained. Finally, the session lays out attempts to transform educational programmes towards a more migrant-sensitive health workforce that addresses cultural competence, knowledge of epidemiological aspects of migrant health, awareness of administrative barriers to access health services; and the importance of programmes for non medical staff working with migrants. • Chair: Harald Siem, Senior Advisor, Secretariat International Health, Norwegian Directorate of Health • Speaker: Julia Puebla Fortier, Executive Director, Diversity Rx-Resources for Cross Cultural Health Care • Discussant: Khaled Abu Rumman, Director of Chest Disease and Migrant Health Directorate, Ministry of Health, Jordan

	• Rapporteur: Maria Lourdes Marin, Executive Director, Action for Health Initiatives Inc., CARAM, Philippines • Questions
10:30–10:45	Coffee break
10:45–12:45	4 breakout groups with proposed questions to guide the discussion 1. What are the key elements and actions for creating migrant sensitive health systems? 2. What are the key elements and actions for developing a migrant sensitive workforce? 3. What strategies exist to unite public and non-public health providers to better serve migrants, including private sector responsibilities, and to develop quality referral systems and adequate financing for NGOs and other providers? • Moderators: Xiaojiang Hu, Professor, School of Development and Public Policy, Beijing Normal University, China; Atti-La Dahlgren, Scientific Collaborator, International and Humanitarian Medicine, Geneva University Hospitals, Switzerland; David Ingleby, Professor, European Research Centre on Migration and Ethnic Relations (ERCOMER), Utrecht University, Netherlands; Louis Loutan, Head, Division of International and Humanitarian Medicine, Geneva University Hospitals, Switzerland • Rapporteurs: Edward Zuroweste, Chief Medical Officer, Migrant Clinicians Network, USA; Otoe Yoda, Social Policy Specialist, Social and Economic Policy Unit, UNICEF Innocenti Research Center, Italy; Peter Decat, Project Coordinator, International Centre for Reproductive Health, University of Gent (WHO Collaborating Center), Belgium; Walter Devillé, Chairperson, Section on Migrant Health, European Public Health Association (EUPHA), Netherlands
12:45–14:00	Lunch Break
14:00–15:00	Plenary reporting from the groups by the rapporteur for session III, followed by a discussion • Chair: Harald Siem, Senior Advisor, Secretariat International Health, Norwegian Directorate of Health • Speaker: Julia Puebla Fortier, Executive Director, Diversity Rx-Resources for Cross Cultural Health Care • Discussant: Khaled Abu Rumman, Director of Chest Disease and Migrant Health Directorate, Ministry of Health, Jordan • Rapporteur: Maria Lourdes Marin, Executive Director, Action for Health Initiatives Inc., CARAM, Philippines
SESSION IV. PARTNERSHIPS, NETWORKS AND MULTI COUNTRY FRAMEWORKS ON MIGRANT HEALTH	
15:00–15:30	Migration by default connects communities and countries or regions as well as various sectors in society. Therefore, the management of migrant health requires close cooperation and collaboration among countries as well as among sectors and related institutions involved in the migration process. This session analyses the extent to which migrant health is addressed in existing international and inter-regional platforms and processes on migration and social and economic development. Albeit existing good examples of multi-sectoral and institutional partnerships related to some aspects of migrant health, there is a need to identify key platforms that can drive the needed comprehensive partnership on migrant health beyond disease-specific networks that account for the different typologies of migrants and their widely varying levels of vulnerabilities and needs. • Chair: Manuel Carballo, Executive Director, International Centre for Migration Health & Development (ICMHD), Switzerland • Speaker: Houssam Muallem, Senior Officer, Programme Support on Migration, International Federation of Red Cross and Red Crescent Societies • Discussant: Innocent Modisaotsile, Project Coordinator, Directorate of Social and Human Development and Special Programs, Southern African Development Community Secretariat • Rapporteur: Graeme Hugo, Professor of Geography, University of Adelaide, Australia • Questions
15:30–15:45	Coffee break
15:45–17:30	4 breakout groups with proposed questions to guide the discussion 1. What kind of regional and global networks and partnerships can be supported or developed to better address migrant health? 2. How can migrant health be incorporated into country-, regional-, and global major influential platforms to strengthen dialogue among sectors? 3. What are the upcoming concrete near future events to focus on in this context and who, what stakeholder, can take the lead? • Moderators: Mabvuto Kango, Senior Health Officer, Division of Health, Nutrition & Population, Department of Social Affair, The African Union Commission, Ethiopia; Åsa Nihlén, Technical Officer, WHO EURO; Jintana Sriwongsa, Senior Officer, Health & Communicable Diseases Division, Association of Southeast Asian Nations (ASEAN), Indonesia; Suresh Idnani, President, International Maritime Health Association (IMHA), India • Rapporteurs: Roumyana Petrova, Senior Regional Migration Health Manager for Europe, IOM Brussels; Els Klinkert, Senior Advisor, Programmatic Priorities and Support Division, UNAIDS;George Benjamin, Executive Director, American Public Health Association (APHA), USA; Maria Cecilia Acuña, Health systems and services specialist, Pan-American Health Organization (PAHO)

17:30–18:30	Plenary reporting from the groups by the rapporteur for session IV, followed by a discussion • Chair: Manuel Carballo, Executive Director, International Centre for Migration Health & Development (ICMHD), Switzerland • Speaker: Houssam Muallem, Senior Officer, Programme Support on Migration, International Federation of Red Cross and Red Crescent Societies • Discussant: Innocent Modisaotsile, Project Coordinator, Directorate of Social and Human Development and Special Programs, Southern African Development Community Secretariat • Rapporteur: Graeme Hugo, Professor of Geography, University of Adelaide, Australia
DAY III Friday 5 March 2010	
CONSOLIDATING ELEMENTS FOR THE OPERATIONAL FRAMEWORK	
9:30-11:15	The group reports from the four sessions will provide the basic elements for the operational framework for member states and stakeholders, of which an outline will be presented and discussed in a plenary working session for final commenting. • Chair: Danielle Grondin, Director General of the Policy Integration, Planning, Reporting and International Directorate, Public Health Agency of Canada • Rapporteurs for the four sessions: Alex Leventhal, Director International Relations, Ministry of Health, Israel; Patrick Taran, Senior Migration Specialist, ILO; Maria Lourdes Marin, Executive Director, Action for Health Initiatives Inc. CARAM, Philippines; Graeme Hugo, Professor of Geography, University of Adelaide, Australia • Discussion
11:15-11:30	Coffee break
11:30-12:30	KEYNOTE ADDRESS • Enrique Iglesias, Secretary General, Ibero-American General Secretariat CLOSING REMARKS • Davide Mosca, Director Migration Health Department, IOM • Daniel López-Acuña, Director Strategy, Policy and Resource Management, Health Action in Crises, WHO • Alberto Infante Campos, Director of Professional Planning, Cohesion of the Spanish National Health System and High Supervision, Ministry of Health and Social Policy, Spain
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Resolution WHA61.17 on the Health of Migrants

The Sixty-first World Health Assembly,
Having considered the report on health of migrants;1
Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue on the multidimensional aspects of international migration and development (New York, 23 December 2003);
Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;
Recognizing that the revised International Health Regulations (2005) include provisions relating to international passenger transport;
Recalling resolutions WHA57.19 and WHA58.17 on international migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;
Recognizing the need for WHO to consider the health needs of migrants in the framework of the broader agenda on migration and development;
Recognizing that health outcomes can be influenced by the multiple dimensions of migration; Noting that some groups of migrants experience increased health risks;
Recognizing the need for additional data on migrants' health and their access to health care in order to substantiate evidence-based policies;
Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;
Mindful of the role of health in promoting social inclusion;
Acknowledging that the health of migrants is an important public health matter for both Member States and the work of the Secretariat;
Noting that Member States have a need to formulate and implement strategies for improving the health of migrants;
Noting that policies addressing migrants' health should be sensitive to the specific health needs of women, men and children;
Recognizing that health policies can contribute to development and to achievement of the Millennium Development Goals,

1. CALLS UPON Member States:
(1) to promote migrant-sensitive health policies;
(2) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;
(3) to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
(4) to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
(5) to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;
(6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
(7) to train health professionals to deal with the health issues associated with population movements;
(8) to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;
(9) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

2. REQUESTS the Director-General:

(1) to promote migrants' health on the international health agenda in collaboration with other relevant international organizations;

(2) to explore policy options and approaches for improving the health of migrants;

(3) to analyse the major challenges to health associated with migration;

(4) to support the development of regional and national assessments of migrants' health status and access to health care;

(5) to promote the inclusion of migrants' health in the development of regional and national health strategies where appropriate;

(6) to help to collect and disseminate data and information on migrants' health;

(7) to promote dialogue and cooperation on migrants' health among all Member States involved in the migratory process, within the framework of the implementation of their health strategies, with particular attention to strengthening of health systems in developing countries;

(8) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations and considering the impact of other policies;

(9) to encourage the exchange of information through a technical network of collaborating centres, academic institutions, civil society and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;

(10) to promote exchange of information on migrants' health, nationally, regionally, and internationally, making use of modern information technology;

(11) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

Eighth plenary meeting, 24 May 2008

Health of Migrants Report by the Secretariat. Sixty-first World Health Assembly (A61/12)

MIGRATION FLOWS AND THE GLOBALIZED WORLD

1. The volume of population movements, whether voluntary or forced, is increasing. Their impact – either as outpourings or influxes – is attracting considerable interest at regional, national and subnational levels, and from governments, civil society and the media.
2. Migration can be defined as "a process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes".[1] Migrants themselves encompass the overlapping categories of migrant workers and their families, long-term and short-term immigrants, internal migrants, international students, internally displaced people, asylum seekers, refugees, returnees, irregular migrants and victims of human trafficking.
3. According to United Nations estimates, 120 million of the approximately 175 million migrants worldwide are migrant workers and their families. Documented and undocumented workers have a different status and, therefore, varying levels of access to basic social services. Though the majority of migrant workers are men, more women and children are becoming international labour migrants, thus rendering them more vulnerable to human trafficking.
4. A large proportion of migrants globally move through legal channels, and their migration does not necessarily have negative health impacts. Some of them, however, will have difficulty in accessing health care. The migration process itself, may have negative health implications for migrants, in particular among subgroups such as vulnerable migrants, trafficked persons, refugees and smuggled migrants, involving demonstrated health risks. Improved definition of the populations under consideration is necessary to allow the health status and access to health care of the various subgroups of migrants to be analysed in greater depth.
5. Migration may require humanitarian responses, especially to substantial displacements resulting from natural disasters or conflicts within or between countries. It also poses challenges to the organization and delivery of effective and culturally sensitive social services. Migrants' fundamental health needs are not always adequately met, thus raising concerns with regard to equity, social cohesion and inclusiveness. There is also a strong association between population movements and the spread of disease. For all the above reasons, migrants' health is becoming an increasingly important public health matter, for Member States and for the work of the Secretariat. Consequently this report addresses two distinct but related issues: the health needs of vulnerable migrants and the public health implications of migration.

Basic principles of a public health approach to the health of migrants

6. A population health approach is necessary in order to align strategies, policy options and interventions for improving health outcomes among particular subgroups of migrants. Several basic principles influence the development of a public health approach for migrants. The main public health goal is to avoid disparities in health status and access to health services between migrants and the host population. The second, closely associated, principle is to ensure migrants' health rights. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions, which are the basic health entitlements of the host population. The third principle, associated with migrations resulting from disaster or conflict, is to put in place lifesaving interventions so as to reduce excess mortality and morbidity. The fourth principle is to minimize the negative impact of the migration process on migrants' health outcomes. Together, these four princi-

1 *Glossary on Migration*, International Migration Law Series, International Organization for Migration, 2004.

ples may be taken as the basis for a policy framework for defining public health strategies for migrants.

Determinants associated with the health of migrants

7. Population movements generally render migrants more vulnerable to health risks and expose them to potential hazards and greater stress arising from displacement, insertion into newenvironments and reinsertion into former environments.
8. Recent migrants often have to deal with poverty, marginality and limited access to social benefits and health services, especially during the early stages of insertion into a new environment (either inside or outside their country of origin or return). For their part, low-skilled and seasonal migrant workers are often concentrated in sectors and occupations with high levels of occupational health risks. Family members, including children, may also be involved in this work and thus exposed to these risks.
9. Victims of human trafficking, especially women and children, are particularly vulnerable to health problems and are more likely than other groups to suffer from communicable and noncommunicable diseases, as well as from mental health problems.
10. Migration, when triggered by disaster or conflict, food insecurity, disease, or climate change and other environmental hazards, is closely linked both to the destruction of livelihoods and, often, to disruptions to the health system.
11. Health inequities arise largely as a result of discrimination, inequalities in income, and unequal access to education, employment and social support networks, to all of which disadvantages vulnerable immigrant or refugee populations and trafficked persons are disproportionately prone. While equal access to health care is important, so too are health promotion and disease prevention measures, which are often overlooked when discussing the health of migrants.
12. Interventions that address the social determinants of health are possible through intersectoral actions that target the causes at societal level. Hence these economic, political, social and environmental determinants of migrants' health underline the importance of developing intersectoral policies, including those aimed at reducing the risk of disasters that can influence both the migration process and its most serious health consequences.

Health issues stemming from migration

13. Health information on migrants' health and on their access to health services is scarce. Few country health information systems disaggregate data in a way that permits analysis of the main health issues either found among migrants or resulting directly from migration. Qualitative studies call attention to migrants' different perceptions of health and of approaches to health-seeking behaviour, which indicate that quantitative studies should be complemented with qualitative studies – though again, the relevant data are limited.
14. An important health dimension is the health risks that migrants carry with them and the public health implications. Migrants travel with their epidemiological profiles, their level of exposure to infectious agents, their genetic and lifestyle-related risk factors, their culture-based health beliefs, and their susceptibility to certain conditions. Also, they carry the vulnerability present in their original communities. If, for instance, immunization coverage is low in the country of origin or return, the original population risk will be carried to the destination country until coverage of migrants reaches the same level as that for the host population. Similarly, if the prevalence of a given communicable disease or any neglected disease is higher in the country of origin or return, there is an increased likelihood among migrants of being affected by the condition and/or transporting it across borders.
    Conversely, when diseases have a high prevalence in destination countries, migrants may become affected and take them back to their country of origin or return. There is also evidence that certain noncommunicable diseases, such as hypertension, cardiovascular diseases, diabetes and cancer, are an increasing burden on migrant populations and impose considerable demands on health systems of destination countries.

15. Some destination countries perform health assessments for prospective documented migrants, or have provisions imposing certain health conditions that may prevent documented migrants from entering the country. This issue poses a challenge in defining public health preventive and treatment measures that adhere to basic human rights. The challenge is even more complicated in dealing with undocumented migrants and forced internal or international migration, since there are no mechanisms to detect health conditions prior to migration.
16. Communicable diseases and sexually transmitted infections are often viewed from a single perspective: the risk migrants bring when entering (or transiting) a country. However, vulnerability must be addressed at all stages of the migration process. Moreover, the differences among migrants – in their patterns of movement, and in their socioeconomic and migratory status – must also be considered.
17. Exposure to risks associated with population movement raises migrants' vulnerability to psychosocial disorders, drug abuse, alcoholism and violence. In addition, limited access to health care during the transit and early insertion phases of migration increases the resultant burden of untreated noncommunicable conditions.

Migrants and health systems

18. The foregoing health issues highlight the challenges faced by national health systems. There is a need to reach out to migrants and address their special vulnerabilities and health-care needs. The response entails targeting interventions to reduce migrants' health risks and launching or strengthening programmes and services that are "migrant sensitive", that is, which include care that takes cultural, religious, linguistic and gender needs into consideration, and which offer guidance to migrants on how to deal with their new national health system.
19. In addition, there is the challenge of securing equitable access to health services for migrants. Ensuring such access may take many different approaches depending on the organization and financing of each health system. The aim is to promote financial protection mechanisms to prevent excessive expenditures among already economically vulnerable groups. Consideration should be given to providing sustained health insurance between countries of origin or return, transit and destination, especially for temporary migrants and irregular migrants whose legal status prevents their accessing health services. In certain countries, the rapid influx of migrants over short periods of time constitutes a particular challenge for national health systems.
20. Few workplaces employing migrants provide basic occupational health services, and few migrants benefit from national social security compensation or rehabilitation schemes for occupational disease or injury. Preventing such disease or injury requires the overhauling of working conditions in high-risk sectors as well as the introduction of culturally sensitive approaches to the provision of health and safety training and information in multicultural work settings. Furthermore, the workplace could be used as an entry point for health services delivery and to convey public health messages to migrant workers and their families.

Strategies for improving the health of migrants

21. Member States facing migration challenges have an increasing need to formulate and implement strategies to improve migrants' health. Regional and global strategies can also supplement country-specific activities. Governments must ensure coherence between national policies for health, employment and migration. Further, intercountry collaboration is required to assess and subsequently tackle occupational risks and their health consequences before, during and after migrants' period of work, both in their country of origin or return and destination.
22. Among the possible strategies for improving the health of migrants are the following:
    - **advocacy and policy development:** promoting migrant-sensitive health policies that adhere to the principles of a public health approach aimed at improving the health of mi-

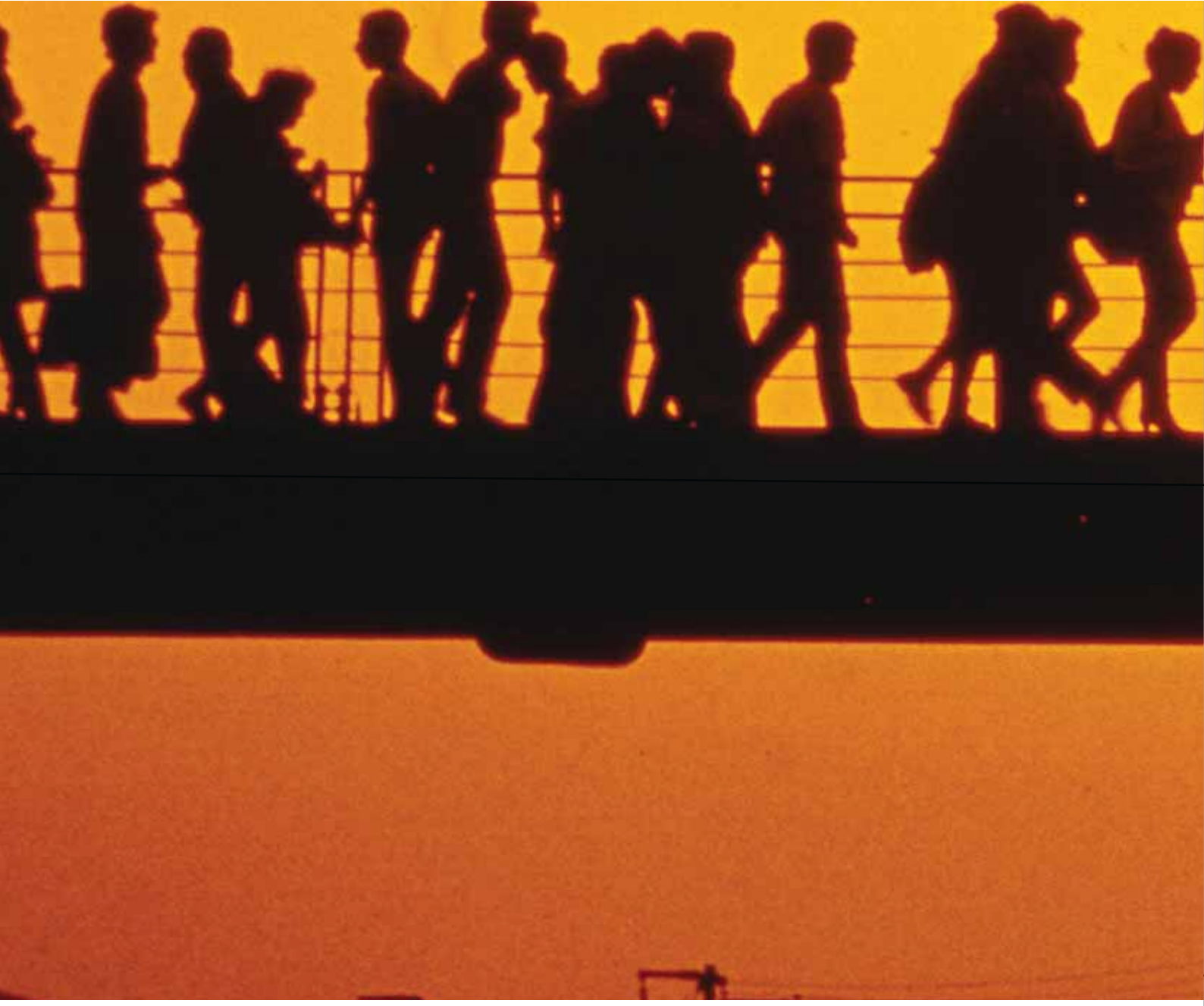
grants; advocating migrants' health rights; promoting equitable access to health protection and care for migrants; developing mechanisms to enhance social protection in health and safety for migrants; raising awareness of, and promoting international cooperation on, migrants' health in countries of origin or return, transit and destination; encouraging collaboration among health, foreign affairs and other concerned ministries in all countries involved; strengthening interagency, interregional and international cooperation on migrants' health with emphasis on eveloping partnerships with other organizations such as UNHCR and the International Organization for Migration; and promoting cooperation for health policies among central and local governments as well as among representatives of civil society

- **assessment, research and information dissemination:** assessing the health of migrants and trends in migrants' health; identifying and filling gaps in service delivery to meet migrants' health needs; disaggregating health information by gender, age and origin and by socioeconomic and migratory status; encouraging health and migration knowledge production, including both quantitative and qualitative studies; documenting and disseminating best practices and lessons learnt in addressing migrants' health needs in countries of origin or return, transit and destination; and disseminating good practices such as migrant-friendly hospitals to other regions of the globe
- **capacity building:** sensitizing and training relevant policy-makers and health stakeholders involved with migrants' health in countries of origin or return, transit and destination; promoting increased cultural, religious, linguistic and gender sensitivity associated with migrants' health among health service providers, and training health professionals in addressing the health aspects associated with population movements; creating a network of collaborating centres, academic institutions and other key partners for furthering research into migrants' health and for enhancing capacity for technical cooperation; and training health professionals about diseases and pathologies that prevail in the country of origin or return
- **service delivery:** initiating or reinforcing migrant-friendly public health services and health care delivery methods for migrants with special needs; strengthening health promotion and disease prevention initiatives to reach out to migrants in the community; establishing minimum standards of health care for all vulnerable migrant groups (particularly women, children, undocumented or irregular migrants, asylum seekers, refugees and victims of human trafficking); and publicizing existing services.

23. The Executive Board discussed an earlier version of this report at its 122nd session in January 2008. It also extensively discussed a draft resolution proposed by several Member States, before adopting resolution EB122.R5.

ACTION BY THE HEALTH ASSEMBLY

24. The Health Assembly is invited to consider the draft resolution contained in resolution EB122.R5.



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