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Migration Health Policies: Shifting the Paradigm from Exclusion to Inclusion*

Immigration has existed for many centuries, and has waxed and waned in response to international politics and economic and sociopolitical factors. The world migration landscape has undergone substantial changes in the past quarter century. The number of countries and population groups contributing to global mobility is steadily rising. The volume of migrants has more than doubled in the past 25 years, from 84 million in 1975 to 175 million in 2000. The International Organization for Migration (IOM) estimates that the number of international migrants in 2050 will be close to 230 million.¹

Migration is a major social phenomenon, with many complex linkages to economic, trade, labor, social, security, and health policies. In our new world order, an increasing number of migrating persons are likely caught in post-conflict or tenuous economic or political situations, and may have limited access to health care; they are therefore at great risk from infectious diseases and reproductive, mental, and other health problems. There is indeed a dynamic relationship and interdependence that exists between migration and health, and the needs of the various populations involved.

On one hand, receiving and host countries have needs that include:

- i. Protection of native populations from disease threats which may be introduced, imported, or propagated by migrating populations
- ii. Reduction of burden on publicly funded health and social services programs that might be required by migrants before and after resettlement

On the other hand, migrant populations have priorities that include:

- i. Need for timely and safe movement to resettlement communities
- ii. Access to appropriate medical treatments and health interventions, both to improve health during displacement and migration and to facilitate successful integration into resettlement communities
- iii. Protection of civil liberties

Clearly, one of the most important challenges we face today is developing policies that integrate migration and health needs of receiving and host countries and migrant populations.

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Migration and Health in Historic Context

The threat of introduction of contagious diseases through the movement of ships, cargo, and travelers was recognized as early as the 14th century, during the plague epidemic in Europe. Efforts to stop the spread of infection through travel and to prevent the spread of infectious diseases across international borders gave rise to the first formal system of quarantine. Other instances of the use of quarantine to prevent introduction and relocation of diseases through travel in Europe and the U.S. soon followed. Immigration and disease epidemics have also been historically linked. Beginning in the late 1800s, immigrant streams and even specific immigrant populations became associated with and were blamed for infectious disease outbreaks in the United States. Arriving immigrants were subject to quarantine, and quarantine practices were in some instances applied in a discriminatory manner, targeting the foreign-born and other poor minorities.

Over time, immigration, quarantine, and exclusionary immigration policies became closely interwoven in the United States. In 1891, U.S. immigration law made it mandatory that all immigrants coming into the U.S. be inspected by Public Health Service physicians. Increased anti-immigration sentiment culminated in the Immigration Restriction Act of 1924, which ended unrestricted immigration to the U.S. With the Public Health Service Act of 1944, U.S. Congress clearly delegated quarantine authority to the federal government for the first time, and required health screening for all potential immigrants overseas and at ports of entry--with an extensive list of medical conditions and diseases that might exclude or deny entry into the U.S. In summary, the U.S. as a receiving country has historically focused selectively on protecting against disease importation and costly post-migration utilization of health care resources through the use of quarantine and regulatory exclusion. This approach has led at times to discriminatory, inadequate, and ineffective migration health policies and programs.

Contemporary U.S. Migration Health Policy and Current Challenges

Major changes and improvements have been achieved in our approaches to migration and health issues in the past century. Yet, even today, global migration health policies are at least partially based on principles of regulatory exclusion. In the U.S., health assessments are required for all immigrants and refugees, and entry can be restricted or denied based on the identification of inadmissible conditions (including specified health conditions). Numerous challenges are associated with the use of an exclusionary paradigm in formulating migration health policy. First, such an approach poses ethical questions with regards to mandated screening and exclusion of migrants with specific health conditions. Second, a paradigm focused on assessment of individual migrants is inadequate to address potential public health risks for all populations involved. Third, exclusionary paradigms focused on inadmissible health conditions are limited in scope and flexibility and therefore ineffective in addressing constantly changing global health concerns. Last, policies based on regulatory exclusion fail to address the unique health needs of migrant populations, which can contribute to increased morbidity and mortality in migrant populations and strains on security and health-care systems in receiving and host countries.

U.S. Programs in Migration Health: Shifting the Paradigm from Exclusion to Inclusion

The U.S. has embarked on a program initiative aimed at achieving balance and integration between migration health needs of receiving and host countries and migrant populations, called the Enhanced Refugee Health Program. The program focuses on refugees for a number of reasons: 1) refugees comprise vulnerable populations, exposed to a variety of harsh environmental conditions and diverse disease exposures, with limited access to health care, 2) a unique opportunity exists to address refugee health concerns during required overseas health assessments, 3) the language and charge of the U.S. Refugee Act give more latitude to address conditions of public health concern among refugees, and 4) experiences can be applied to other migrant groups.

The Enhanced Refugee Health Program utilizes a strategy encompassing both the required health assessment components included in U.S. immigration law, plus expanded components, which are tailored to specific refugee population needs and targeted to diseases of public health importance. This enhanced refugee health strategy also includes facilitating timely transmission for all population-based health and medical assessment data from overseas to U.S. health departments in resettlement communities through the development of electronic data transmission systems, and in the future, will strive to standardize follow-up and treatment of refugees after U.S. arrival. Since 1997, the U.S. CDC has undertaken enhanced refugee health programs for at least 7 large-scale, emergent movements of refugee populations. These programs have included components to address pre-departure treatment for malaria and intestinal parasites, enhanced tuberculosis and HIV diagnosis and treatment, appropriate immunizations, dental and mental health needs, and chronic diseases. In addition, some of the more recent programs have included enhanced surveillance for emerging infectious diseases. Other integral parts of the enhanced refugee health approach have been efforts to assess quality and build infrastructure for overseas health screening and interventions and to provide linkages to U.S. programs in host countries, such as Global AIDS Program (GAP), which can provide diagnostic and treatments services to refugees. Such efforts aim to reduce the burden placed on host country resources and to assure refugees access to needed health care services.

Migration Health Policies: Summary and Directions for the Future

The current Enhanced Refugee Health program aims to shift the migration health paradigm away from regulatory exclusion, and towards an integration of migration and health needs, and demonstrates that such an inclusive approach can lead to improved health status for all populations involved.^{2,3,4} Further refinements to the strategy are needed. Future directions to consider for achieving more integrated and effective migration health policies and programs include:

- i. Continued efforts to tailor our approaches to migration health, both to incorporate the unique needs of migrant populations and to provide flexibility to address emerging global health issues
- ii. Expanding the role of migration health assessments in protecting public health of migrants and of receiving and host countries. Priority areas should include:

- a. Support for delivery of essential preventive and treatment interventions, such as vaccinations and treatment for malaria and intestinal parasites
- b. Creation of effective surveillance systems for emerging infectious diseases
- c. Development of emergency response capacity
- d. Inclusion of components to address reproductive and mental health needs
- iii. Applying new information technology to secure electronic information exchange among numerous international and interagency partners and assuring real time communication of health data along the migration pathway.
- iv. Identification of sustainable funding to support migration health programs, in both receiving and host countries.
- v. Development of international and interagency partnerships to facilitate harmonization of policies and the integration of global migration and health issues.

Ultimately, health and migration are intimately linked and interdependent. Early investment in addressing and integrating the health needs of migrants and receiving and host communities will facilitate the migration process, improve migrant health and decrease associated morbidity and mortality, avoid long-term health resource and social costs, and protect global public health.

¹ IOM. *World Migration 2003: Managing Migration: Challenges and Responses for People on the Move*. International Organization for Migration, Geneva, Switzerland, 2003.

² Miller JM, Boyd HA, Ostrowski SH, Cookson ST, Parise ME, Gonzaga PS, Addiss DG, Wilson M, Nguyen-Dihn P, Wahlquist SP, Weld LH, Wainwright RB, Gushulak BD, Cetron MS. Malaria, Intestinal Parasites, and Schistosomiasis Among Barawan Somali Refugees Resettling to the United States: A Strategy to Reduce Morbidity and Decrease Risk of Imported Infections. *Am J Trop Med Hyg* 2000; 62(1): 115-21.

³ Geltman PL, Cochran J, and Hedgecock C. Intestinal Parasites Among African Refugees Resettled in Massachusetts and the Impact of an Overseas Pre-Departure Treatment Program. *Am J Trop Med Hyg* 2003; 69(6):657-662.

⁴ Posey DL, O'Rourke TO, Weinberg M, Cano M, Naughton M, Comans T, Liu Y, Lanciotti R, Roerig J, Marfin A, Bellini B, Cetron M, Maloney SA. Urgent Resettlement of Liberian Refugees to the United States, 2003: An Enhanced Refugee Health Response. Fourth European Conference on Travel Medicine: Travel and Safety. Rome, Italy, March 29-31, 2004.