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Future Capacity Needs in Managing the Health Aspects of Migration
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Future Capacity Needs in Managing the Health Aspects of Migration
FOREWORD

This paper is one of 19 background papers which have been prepared for the IOM, 2010 World Migration Report which is entitled the “Future of Migration: Building Capacities for Change”. The 2010 report focuses on likely future trends in migration and the capacities that will be required by States, regional and international organizations, civil society and the private sector to manage migration successfully over the coming decades.

Over the next few decades, international migration is likely to transform in scale, reach and complexity, due to growing demographic disparities, the effects of environmental change, new global political and economic dynamics, technological revolutions and social networks.

The 2010 World Migration Report focuses on capacity-building, first because it is good governance to plan for the future, especially during a period of economic downturn when the tendency is to focus on immediate impacts and the short-term period of recovery. Second, capacity-building is widely acknowledged to be an essential component of effective migration management, helping to ensure the orderly and humane management of migration.

Part A of the World Migration Report 2010 focuses on identifying core capacities in key areas of migration management. The aim is not to recommend “one size fits all” policies and practices, but to suggest objectives of migration management policies in each area, to stimulate thinking and provide examples of what States and other actors can do.

Part B of the World Migration Report 2010, provides an overview of the latest global and regional trends in migration. In recognition of the importance of the largest global economic recession since the 1930s, this section has a particular focus on the effects of this crisis on migrants, migration and remittances.

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INTRODUCTION

This paper presents the capacities required of governments and societies in order to promote health-care equity in a world that will continue to face increased migration trends. Focusing on the issue of international migration and the capacity needs of countries in effectively managing the health aspect of migration, it also briefly explores the challenges presented by internal migration (including urbanization) and other migration trends. Two diverse typologies of migrants – regular and irregular international migrants – are outlined to show how the context of migration acts as a social determinant of health-care access.

Existing activities and capacities in several countries are discussed, highlighting concrete examples that offer guidance to governments and other stakeholders, and future capacity needs are described within the following four main thematic areas:

1) advocacy to improve societal views towards migrants and migration in general
2) systematization of migrant health within governmental structures
3) enhancing strategic knowledge management capacity on migrant health
4) integrating and capacitating migrants as a force for positive social change.

I. HEALTH OF REGULAR AND IRREGULAR MIGRANTS: TRENDS, DETERMINANTS, RELEVANCE

Overview of migration trends

The drivers of international migration are diverse and complex, and the forms of migration are equally so. Societies are becoming more multicultural and multi-ethnic in nature, due to increasing migration, and these trends are expected to continue, underpinning the need to improve countries’ capacities to manage the health-related aspects of migration.

In 2010, the total number of international migrants is expected to reach 214 million (3% of the global population) (World Bank, 2009a). This includes 20–30 million irregular international migrants (ILO, 2004) and 16.3 million refugees (UNHCR, 2009); 26 million were internally displaced (IDMC, 2009). In 2009, there were approximately 740 million internal migrants (UNDP, 2009).

The United Nations (UN) estimates that half of the world’s population resided in urban areas in 2008. This is expected to increase to 70 per cent by 2050. Asia and Africa will see a doubling in urban growth during this timeframe (UNDESA, 2008). With increased movement to urban centres, disparities in access to health-care services and health outcomes are widening. Poverty levels are now increasing faster in urban than in rural settings. One third of urban-dwellers live in slums – which translates into one in six people globally – and the levels of urban poverty are particularly severe in parts of Asia and Africa. Poor health in urban centres is the result of unhealthy living conditions and sanitation, and lack of services such as health care, sewerage
systems and piped water (UNFPA, 2007). Living in these conditions with limited freedom of movement or access to basic health services are untold numbers of irregular migrants.

There are several factors driving the increase in migration. While many developing countries face significant labour surpluses due to young populations and few opportunities in the formal economy, the demand for labour will increase in high-income countries with declining workforces due to the demographic shift towards more aged populations. Migrants will continue to fill this gap, contributing towards international development through low labour costs, remittances and marketable skills. Migrant remittances increased from USD 68.6 billion in 1990 to USD 444 billion in 2008, with the proportion transferred to developing economies increasing from less than half in 1990 to over 70 per cent in 2008 (World Bank, 2009a, 2009b). For low-income countries, remittances accounted for 7 per cent of GDP in 2007 – an increase of 3 per cent since 2000 (World Bank, 2009a). In 2004, remittances were more than twice the monetary value of net official flows to developing countries and only second to foreign direct investment as a source of external finance for developing countries (IOM, 2005). Remittances are often utilized by families back home to fill crucial gaps in education and health care, thus helping to reduce some of the social disparities faced by migrants and their families (IOM, 2007a).

Climate change is also expected to have a major impact on migration and health in the coming years by flooding coastal areas and reducing availability of arable land and fresh water. By 2020, for example, crop yields are expected to drop by 50 per cent in parts of Africa (Brown, 2007). The worst-case scenarios are that, by 2050, 160 million could be displaced annually, increasing to over 420 million early in the 2100s. Competition over scarce water resources is already causing conflict in parts of Africa, and will result in involuntary migration due to lack of livelihood options and to conflict. These phenomena will also increase health challenges (e.g. diarrhoea, child mortality). Exacerbating this issue, warmer temperatures are facilitating the emergence or re-emergence of such vector-borne diseases as malaria in formerly temperate climes, and expanding the geographical area of exposure risk.

Irregular migrants comprise 10–15 per cent of migrants (ILO, 2004), and are defined as those who have illegally entered a country or who lack legal status in a transit or host country due to the expiry of their visa (IOM, 2007b). While many irregular migrants move to find employment or to join family members abroad, others are forced to move without asylum or are unable to gain refugee status. Irregular migrants are more likely to be abused by smugglers, marginalized from services, trafficked and exploited.

**Migration as a social determinant of health**

Migration is itself a fundamental determinant of health. The context in which migration takes place, together with individual factors such as gender, language, immigration status, and culture, have a significant impact on health-related vulnerability and access to services.

In increasingly multi-ethnic, multicultural and multilingual societies, the challenge posed to governments and their partners is to understand these social determinants of health and to develop more inclusive programmes and policies, with the goal of reducing health disparities and exclusion by promoting migrant-friendly health-care programmes.
These social determinants will now be addressed on three levels: the individual, the environmental, and the structural.

**Individual-level determinants**

Social determinants of health at the individual level are those issues over which a person may exert some direct influence, including health literacy, personal hygiene, rights awareness, language/cultural factors, legal status, psychological condition and coping skills, health-seeking behaviour, and health profile pre-departure.

Illiteracy and/or the inability to read and speak the local language hinders awareness-raising and education, and has an impact on communication with health-care providers. It can also prevent migrants from becoming more aware of their health issues and of their basic human rights.

Cultural differences between migrants and health-care providers can pose additional challenges. A classic example is the case of a young Hmong child in California who was diagnosed with severe epilepsy (Farrar et al., 1997). Her immigrant parents saw her as having a special gift for interacting with the spiritual world; they believed that her seizures were explained by spirits catching her and making her fall. In contrast, instead of addressing the spiritual realm, her health-care providers dealt with her medical condition of epilepsy. Despite great efforts on the part of the child’s parents and her health-care providers to provide the highest level of care, the inability to understand one another’s cultural perspectives tragically led to permanent mental impairment for the child.

Finally, migration can have a psychosocial impact, as individuals must adapt to the combination of loneliness and separation from social support systems, while adapting to new and difficult situations in a foreign land. Gender-based violence and forced displacement, whether related to environmental catastrophe or violence, can also have lasting psychosocial effects.

**Environmental-level determinants**

Environmental-level determinants include contextual factors that directly impact one’s vulnerability in terms of health, but that must be addressed through community or systemic actions. They are largely related to living and working conditions, accessibility and “migrant-friendliness” of services, and the attitudes of host communities towards migrants.

Migrants tend to fill key roles in the formal or informal economy that are undesirable for the local population. Such occupations tend to be dirty, dangerous or degrading (the “3 Ds”), and are found in such sectors as agriculture, fisheries, sex work, mining, construction, maintenance and domestic work.

In these and other sectors, crowded living conditions and the lack of basic sanitation place migrants at risk of contracting preventable diseases. Sub-standard workplace safety policies and practices further expose migrants disproportionately to preventable morbidity and mortality.
It is not uncommon for employers to actively keep migrants confined to prevent them from accessing the outside world. This creates an environment conducive to exploitation and abuse (including rape), and prevents migrants gaining access to health-care services, legal assistance and social support. Those commonly affected include domestic workers, sex workers and factory workers, among others.

Migrants (especially women) with irregular immigration status are particularly vulnerable to sexual abuse, sometimes perpetrated by the police or other authorities who can threaten the individual with arrest.

Even in the formal economy, migrants working legally under temporary contracts tend to be abused, with fundamental rights denied. Furthermore, while international and host-country workers receive social benefits as part of their compensation packages, migrants rarely receive even basic access to health insurance.

Social integration is a major determinant of the health status of migrants – both for the individual who has a place to go for assistance, as well as at the community level. Migrant-sending and -receiving communities may be particularly vulnerable to the impact of natural disaster and other emergencies. During crisis situations, the ability of communities to cope is largely influenced by the strength of community-level social structures. In communities affected by outmigration or where migrants tend to be isolated, the social fabric is less resilient than in communities less affected by migration. This can constrain emergency responses, and is often neglected in the development of risk mitigation strategies.

Vulnerabilities can be exacerbated by negative attitudes towards migrants who may have less access to limited services than citizens. Negative and condescending attitudes of service providers can hinder communication with migrant clients, negatively impacting the quality of care. Xenophobia occasionally leads to acts of violence that specifically target migrants.

**Structural-level determinants**

Important structural-level determinants of migrant health include poverty, the policy environment surrounding migration (including the health aspects), as well as the availability of strategic information to guide policy development, priority-setting and programming.

Health systems discriminate against migrants through ignorance or lack of inclusion. The systemic “invisibility” of migrants in programming, routine health data collection and research is a major obstacle to improving national and international understanding of the issues, to changing public perceptions, to harmonizing and strengthening policies, and to developing more inclusive and effective health-care systems.
Countries also struggle with competing policy-related interests in three interrelated areas: a) law and security; b) economic development; and c) health and human rights (see figure 1). The inability to find long-term solutions to the complex challenges presented by these competing interests often puts health-care service providers in difficult situations. For example, countries may temporarily grant amnesty to irregular migrants when their contribution to the economy is important, relative to other national interests, yet those in charge of law and security may fear that, by offering access to health-care services, this would legitimize irregular migration or serve as a pull factor. At the local level, those offering health-care services to irregular migrants on deontological and public health grounds are sometimes undermined by immigration police making arrests at the front gate. Often, “gentlemen’s agreements” must be reached between officials at the local level, in contravention of official policy, in order to serve the needs of migrants and the community as a whole.

Furthermore, negative public opinion towards migrants may render any evidence-based policy decisions politically impossible. For example, host societies often protest at any “special treatment” given to people who illegally cross borders.

As governments tighten policies and procedures related to immigration, more migrants are likely to end up in irregular situations. Fearing arrest and/or exploitation, irregular migrants have a tendency to distrust host government institutions, regardless of whether they seek to deport them or offer assistance – by, for example, providing health-care services.

In addition, since migrants are excluded from health insurance schemes, they usually pay for their health care out of their own pockets. As services are expensive, migrants tend to forego basic primary care (e.g. prenatal care for pregnant women) and often delay seeking care until health conditions have progressed to an advanced stage. This ultimately leads to higher costs for migrants and the health-care system, while increasing the risk of permanent disability or death.
Importance of migrant health promotion: rights, conventions, resolutions

A series of international conventions and resolutions recognize the right to health of all human beings, including migrants. Some of these are described below.

The 1948 Constitution of the World Health Organization has enshrined in “all people the fundamental right to the highest attainable standard of physical, social, and mental well-being”. In 1978, the Alma-Ata Declaration reaffirmed that primary health care is a fundamental human right. The 2000 United Nations Millennium Declaration and 2001 UN General Assembly Special Session (UNGASS) on HIV/AIDS further oblige the international community to ensure that migrants can exercise their universal right to health.

Several international covenants and conventions specifically affirm all migrants’ fundamental right to health. The International Covenant on Economic, Social and Cultural Rights (ICESCR) grants every individual the right to enjoy the best attainable state of physical and mental health. The International Covenant on Civil and Political Rights (ICCPR) and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), both prohibit discrimination based on race, colour, sex, language, religion, political views or their opinion, national or social origin, property, birth or other status. The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families was ratified by 20 countries, and entered into force in 2003, guaranteeing migrants their basic human rights, including the right to health. Yet, although countries usually do not deny life-saving emergency care to foreigners, there are no minimum standards of care for migrants that meet both widely accepted international ‘health in all policies’ and sound public health practices serving the best interests of all.

In May 2008, the World Health Assembly passed resolution 61.17 on the health of migrants, calling upon Member States to take comprehensive action in promoting the health of migrants. The resolution builds upon the increased recognition of the importance of health in the broader context of migration and development, and the need to overcome health disparities in achieving the Millennium Development Goals.

Promoting migrant health in an increasingly globalized world

Migrants rarely live in isolation, but rather with their compatriots during transit, with host communities upon arrival, and with their home communities upon return. Disease vectors and pathogens can affect anyone; therefore it is in the interest of society as a whole to promote equitable access to health care for migrants, regardless of their immigration status.

In an increasingly globalized world, the spread of communicable diseases is inevitable and, unlike human beings, diseases know no borders. The scale is significant, with 2 million people crossing international borders each day, and 1 million travelling from developing to industrialized countries each week (French, 2000). This is not a new phenomenon. In the past, migration promoted the spread of pandemics such as smallpox, which significantly shaped the course of present-day geopolitics (Watts, 1997). More recently, we have seen the emergence and/or re-emergence of infectious diseases, including dengue, SARS, H1N1, filariasis, West Nile Fever and
polio. Drug-resistant strains of pathogens are emerging at an unprecedented rate and spreading within and between countries.

Never before has migrant health been so crucial an issue in international development. In an interdependent world, with increasing flows of capital, goods and people, communicable diseases have the potential to rapidly spread between countries. Strengthened international cooperation will be required in order to effectively manage the health aspects of migration. In the past, the solution was simply to attempt to keep sick people from crossing borders, ignoring the root of the problem. Furthermore, the speed, volume and scope of modern international movement and interconnectivity of people diminish the efficacy of border control-based strategies. Ensuring equitable access to health information and services for migrants therefore warrants stronger international action.

Indeed, given existing and projected future migration trends, it is clear that society is becoming increasingly heterogeneous, resulting in a diversity of health profiles. This is a particularly complex issue in urban settings. A stark example has been cited in relation to the health disparities in closely neighbouring areas along a particular stretch of the London Underground. With each of the eight successive stops from Westminster to Canning Town, life expectancy of a male child decreases by nearly one year – from 77.7 to 71.6 years.¹

A central issue in migrant health involves ensuring equitable access to health information and services (see textbox 1). Most economic migrants are in the prime of their productive lives and their health can deteriorate due to the conditions faced during migration and the inability to access basic health-care services.

Social barriers to health can, in turn, have significant consequences for receiving countries in terms of the cost of treating preventable conditions, the re-emergence of diseases (including vector-borne or water-borne diseases in cross-border settings), and the rapid emergence of drug-resistant malaria and tuberculosis.

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**Textbox 1: Case study of the impact of health inequities in a border community**

Mae Sod is a town in western Thailand on the main border crossing with Myanmar. The district comprises approximately 107,000 Thais and at least 100,000 migrants of mainly irregular immigration status. In August 2009, just 20,000 irregular migrants were registered and, thus, covered through the Compulsory Migrant Health Insurance Scheme (CMIS). The district has 200 factories employing migrants, in addition to those employed in shops, restaurants, households, brothels, farming and other trades. Significant daily cross-border movement takes place between Mae Sod and the sister town of Myawaddy on the Myanmar side. North and south of town, the Karen ethnic group predominates, with family groups crossing for temporary or permanent stay – many of these are Stateless (holding neither Thai nor Myanmar nationality). Large numbers of Karen and Myawaddy residents cross over to Mae Sod to seek health care at the district hospital, returning home in the evening.

As allocation for health-care funding in Thailand is based upon the official count of Thai citizens, and with few migrants paying into and benefiting from the CMIS, the district hospital runs an annual deficit of about USD 1.5 million. The hospital averages 90 per cent capacity, with corridors filled with inpatients – many of whom are migrants suffering from preventable conditions due to poor health-care access. This is confirmed by 2007–2009 hospital data showing that migrants comprised just 17 per cent of out-patients, but comprised a more significant 32 per cent of in-patient stays of five or more days. Sepsis caused by self-induced abortion among migrant women is a leading cause of mortality.

Emerging drug resistance and re-emerging communicable diseases are a major public health challenge due to the weaker health-care system across the border in Myanmar, high levels of mobility, and poor access to health services by migrants. In a 2008 study, 75 per cent of tuberculosis cases were found in non-Thais, with migrants comprising 70 per cent of MDR TB cases (Hemhongs et al., 2008). Drug-resistant *Plasmodium falciparum* malaria has existed along the border since the 1980s. While artemisinin derivatives have worked in combination with mefloquine in the area since 1992 (Carrara et al., 2009), resistance to the modern artemisinin combination therapies is occurring along Thailand’s eastern frontier with Cambodia (Dondorp, 2009), posing a looming threat to communities along the Myanmar border. Filariosis, also known as elephantiasis, was nearly eradicated in the district by the mid-1990s, but sustained cross-border flows of people (and mosquitoes) have thwarted eradication efforts. Formerly confined to low-lying forested areas inhabited by the Karen, in the 1990s an abundant urban mosquito was discovered to act as a vector for transmission in towns (Swaddiwudhipong et al., 1996). A 1999 study of 654 Myanmar factory workers in Mae Sod found 4.4 per cent infected with *W. bancrofti*, the filariasis parasite (Triteeraprapab and Songtrus, 1999).

In response to these significant challenges, the Ministry of Public Health has partnered with IOM since 2001 on the Healthy Migrants – Healthy Thailand programme, and greatly increased collaboration with NGOs and research institutes in promoting the health of migrants and communities along the border (IOM and MOPH Thailand, 2009). Under the management of Mae Sod District Hospital, and in partnership with IOM, several migrant community health posts have been established, training and employing persons from the migrant community to offer basic primary care, together with hospital staff. Migrant community health workers have been appointed to work in the public health structures at the community level, thus bridging migrants to available services and campaigns. Owners of factories employing migrants have been engaged and health volunteers deployed. The challenge now is to sustain the momentum created by these efforts.
Description of existing capacities, gaps and future capacity needs

In order to reduce health disparities for the benefit of migrants, host communities and origin communities alike, preventative and curative health services need to be made available and accessible to migrants. Governments will need to take a more systematic view towards managing the health dimension of migration. Migrant health needs to become better understood, with increased partnerships across sectors and with migrants themselves. Capacity needs to be concurrently developed within individuals, at the community and policy levels. Health systems will need to build their capacity to become more migrant-friendly.

Furthermore, increased collaboration between countries is required to address the transborder dimension of health and mobility. This includes greater bilateral collaboration and an expanded role for regional and global intergovernmental bodies as well as global consortiums concerned with specific aspects of migrant health.

The following four capacities are required to cope with increasing migration:

1) Advocacy to improve societal attitudes towards migrants and migration in general

Many people are reluctant to accept the reality that migration is a structural feature of a globalized world in the post-cold-war era and that, with increased migration, societies are becoming more heterogeneous. The reality is that migration has always existed and it has had a major impact on the world in which we live. In the coming decades, migration is expected to increase in scale and relative importance. Therefore, the integration of migrants into society, and the engagement of migrants in such domains as health promotion, will benefit everyone in society.

Migrants are frequently seen as poor and unskilled, rather than a significant reservoir of positive social capital. Negative perceptions have the effect of marginalizing migrants from society and preventing them from accessing basic health services, which results in poorer health outcomes for migrants and their host communities alike.

The real health risks of migration are those resulting from exclusion, denial, neglect and marginalization. Although States reserve the right of sovereignty in framing their migration policy, based on shared societal values and needs, it is important to include within the formative discourse a discussion of universal human rights and widely-accepted public health principles.

To address these societal-level challenges, several steps can be taken. First, balanced, fact-based advocacy is required to describe migration holistically, highlighting the positive effects of migration and reversing the common misperceptions. Societies should be encouraged to undergo a process of dialogue in order to consider the evidence for integration and to develop more inclusive public health policies. Furthermore, there is a need for expanded international platforms that offer opportunity for dialogue between
the various actors, including civil society, migrant networks, academia, intergovernmental organizations, the private sector and State governments.

Sensitization of society and policymakers can take place through more appropriate use of strategic information, targeted fact-based advocacy, and engagement of the media. In addition, school curricula could include modules on the benefits of migration and multiculturalism (see textbox 2).

**Textbox 2: Improving societal understanding and promoting integration of migrants in the European Union**

As European societies become more multicultural, there is a growing need to raise awareness and promote understanding of the many reasons that people choose, or are forced, to leave their own countries.

*An Educational Toolkit about Migration and Asylum in Europe*

Produced jointly by the European Union, IOM and the UNHCR, *Not Just Numbers* is a toolkit that assists teachers and other educators in engaging young people aged 12–18 in informed discussions about migration.


**2) Systematization of migrant health within governmental structures**

A top capacity need for governments is that of establishing functional mechanisms to comprehensively manage the health aspects of migration. Specific examples of capacity needs include the following:

a) *Coordinating units on migrant health*

Several governments have established a coordinating unit for migrant health within the health or other line ministry, as well as at the community level. The coordinating units are accountable for leading the development and implementation of migrant health-related policies, strategies and financing schemes. The units facilitate coordination within and between governments. They also strengthen collaboration between the various stakeholders and other relevant sectors (immigration, social welfare, labour, education, etc), including migrant networks, the private sector and NGOs. Coordinating units gather and share strategic information, and establish models of migrant-friendly service delivery.
b) Policy and strategy development

Policy coherence is crucial to developing effective and sustainable means of balancing and meeting the health needs of migrants and hosting societies. This involves reviewing policies related to health, immigration, security, finance and labour, among others.

Several countries have established national policies or strategies specifically addressing the health of migrants arriving or in transit, or for their own nationals living abroad.

Frequently, however, health sector policies and/or strategies are not in harmony with those in other sectors, or administrative procedures and implementation mechanisms are not fully in line with adopted integration policies. Multisectoral dialogue and harmonization are not sufficiently sought or maintained, and migrants often fall through the cracks. Moreover, global and country health policies and systems are still based on service delivery strategies conceived for static populations, rather than being adapted to reflect increasing internal and transnational mobility.

To effectively promote health equity, countries will need to increase their efforts to reach a balance between competing national interests and long-term strategies.

This is a challenge. Thailand, for example, has developed three strategies related to migration health, including a Master Plan on Mobility and HIV, the Migrant Health Strategy, and the Border Health Strategy. The main challenge affecting the efficacy and sustainability of these strategies is the lack of an overarching national plan on how to deal with the significant demand for migrant labour from neighbouring countries. Memorandums of understanding have been developed with neighbours for the regularization of migrant labour, including source-country issuance of passports to prospective migrants and applications for Thai work permits/visas. Although this process is beginning to have an effect, the vast majority of migrants still travel without travel documents. Migrants’ access to universal health coverage is contingent upon Cabinet resolutions that allow for the registration of migrants and entry into the Compulsory Migrant Health Insurance Scheme; however, with competing national interests, the policy environment changes from year to year. There are periods when no registration is allowed and periods when existing registrants are able to renew their coverage or new registrations are allowed. In the absence of an overall plan, practical challenges are inevitable. For example, it took five years of discussions and lobbying across ministries for a migrant-registration category to be successfully established, allowing health facilities to hire migrants who could assist in health promotion.

With respect to skilled health workers in developing countries, policies and strategies are needed to encourage domestic employment, protect health workers abroad, and facilitate reintegration. This includes improving working conditions at home, offering
incentives for work in more remote areas, developing agreements with receiving governments for the protection of worker rights, and devising strategies to facilitate workers’ re-entry into the workforce, while taking into account the knowledge and skills gained abroad.

c) Building a more migrant-friendly health workforce

The capacity of health workers to engage with migrant clients in an effective and culturally-sensitive manner requires strengthening. This can be implemented through the integration of sensitivity trainings into the curricula of health professionals, workshops on effective interpersonal communication, client testimony, anthropological research and feedback sessions, international exchange visits, and other means. Health policymakers and administrators could also potentially benefit from training and sensitization.

Cultural mediation is an important capacity need among medical practitioners working in increasingly heterogeneous societies. The cultural competence of healthcare providers needs to be strengthened, as does the use of cultural mediators in the medical field. A model employed in a large hospital in the United States involved a doula\(^2\) support programme, employing Somali doulas to assist in caring for Somali women during the perinatal period. Nursing staff were more comfortable working with Somali patients enrolled in the programme, the incidence of caesarean sections was reduced, and patients expressed satisfaction with the programme (Dundek, 2006).

Up to half of the trained health professionals from several developing countries are working in the industrialized world, but rarely are these medically and culturally competent professionals recruited to serve the needs of their compatriots living abroad. Governments could identify mechanisms for regularizing the temporary placement of health professionals abroad for the purpose of serving migrants’ needs.

Persons who have been trafficked have specific needs in terms of physical, psychological and emotional health care and support, shelter, protection, re-integration and, potentially, assistance in seeking redress through legal channels (see textbox 3). The health aspects include physical and emotional trauma, sexual and reproductive health issues, disability and infectious diseases. Increased capacity is urgently required to ensure that functioning systems are in place to address the needs of trafficked persons, while respecting their rights. Referrals need to be carefully managed in order to respect the choices and privacy of survivors and to avoid stigma. Social-service providers and law-enforcement agencies need to have increased understanding of the health aspects of trafficking, and to know how to deal effectively with such cases. Likewise, health-care providers need to know how to identify suspected cases of trafficking, to offer the appropriate medical care, and to refer individuals to the appropriate practitioners for assistance.

\(^2\) A doula is “a woman experienced in childbirth who provides advice, information and emotional support to a mother before, during and just after childbirth” (Merriam-Webster’s Medical Dictionary, 2002).
Caring for trafficked persons: guidance for health providers

For many trafficked persons, the physical and psychological aftermath of a trafficking experience can be severe and enduring. Health providers may come into contact with trafficked persons at different stages of the trafficking process and at different stages of their recovery. For health practitioners, diagnosing and treating trafficked persons can be exceptionally challenging. The informed and attentive health-care provider can play an important role in assisting and treating individuals who may have suffered unspeakable and repeated abuse.

Caring for Trafficked Persons brings together the collective experience of a broad range of experts from international organizations, universities and civil society in addressing the consequences of human trafficking. Developed with the support of the United Nations Global Initiative to Fight Human Trafficking (UN.GIFT), and led by IOM and the London School of Hygiene & Tropical Medicine, the handbook provides practical, non-clinical advice to help concerned health-care providers understand the phenomenon of human trafficking, recognize some of the associated health problems, and consider safe and appropriate approaches to providing health care for trafficked persons.

The handbook was released in 2009 and is available for download free of charge through http://www.ungift.org/docs/ungift/Steering-committee/CT_Handbook.pdf.

d) Migration health financing

Building the capacity to establish and implement financing options to meet migrants’ health needs is also necessary, with such financing being used to increase the health literacy of migrants, provide primary health care, and ensure access to more advanced care.

Options for covering the costs of migrant health care include engaging the private sector in extending health insurance and/or allowing migrants to pay into the government health insurance schemes of host countries.

Other innovative schemes include harnessing migrants’ remittance flows (see textbox 4) to support the health of migrants and their families back home, or to facilitate migrants’ access to the benefits of the national health scheme of their country of origin while working abroad (see textbox 6).
The project Salud a su Alcance (Health within Your Reach) offers low-cost health services in Guatemala to the families of migrants living in the United States. The project is a partnership between the Government of Guatemala, IOM, Microfinance International (MFI), and Empresa Promotora de Servicios de Salud (EPSS).

IOM facilitates the project, EPSS offers health services to remittance recipient populations through its medical service network that covers 147 municipalities nationwide, and MFI generates funds from the fees charged for health services to Guatemalans living in the United States.

Thailand launched its Universal Health Coverage Scheme (also known as the “30-baht scheme”) in 2002. The country hosts approximately 2 million irregular migrants from neighbouring countries, as well as internationally displaced populations and Stateless persons, and is working to identify viable financing schemes to promote equitable access to health services.

Currently, only registered migrants are covered by the Compulsory Migrant Health Insurance Scheme, which leaves out the majority of those requiring services. There are also questions about the sustainability of the scheme, given the policy and logistical challenges involved in registering large numbers of irregular migrants in line with ad-hoc Cabinet resolutions.

With funding through the UN Trust Fund for Human Security (UNTFHS), and in partnership with WHO, IOM and the Health System Research Institute undertook a study in 2009 that offered recommendations to the Ministry of Public Health and National Health Security Office for financing future health-care schemes.

The report is available on IOM’s online bookstore:

Too often, global health-financing mechanisms aimed at promoting the achievement of the Millennium Development Goals in low-income countries neglect the needs of migrants and mobile populations, as addressing these needs would mean using resources from health funds designated for nationals. With considerable movement of third-country nationals between low-income countries and from low-income to industrialized countries (as regular or irregular migrants), it would be in the interest
of both donor countries and countries receiving overseas development assistance to also consider the health needs of migrants.

In contrast, among industrialized migrant-hosting and transit countries, ‘health for all’ is facilitated through the adoption of policies and practices that specifically address the needs of marginalized and poorly-covered sub-groups of the population.

e) Establishing sustainable and innovative delivery structures that engage migrants

Given that the marginalization of migrants typically prevents them from accessing health care, capacity must be built for the provision of services through mechanisms that are accessible, affordable and meaningful for migrants.

Since the social barriers to health equity are determined by how one migrates and the conditions faced, it is important to ‘unpack’ these social determinants in order to appropriately develop health-care programmes.

Training and deploying migrants within governmental structures is one way of delivering health-care services. Migrant health workers, migrant health volunteers and translators can act as a bridge between marginalized communities of migrants and the services available to them.

Participatory community mapping can be undertaken jointly by health-care providers and migrant communities in order to delineate population demographics, identify available social resources, and find vulnerable households in need of assistance. Maintaining family health folders and bilingual health records for mothers and children, and encouraging migrant involvement in the development of educational materials are additional options that have been deployed in Thailand and elsewhere.

Successful delivery models can include a migrant reception desk at hospitals (see photo above), mobile clinics that reach remote areas or elusive groups of irregular migrants, and the establishment of health posts in migrant communities. In some places of employment, migrant health volunteers have been trained and supported to facilitate practitioner referrals and improve health literacy. “Health Corners” have been established in factories, offering access to basic commodities such as condoms and health information materials.
Governments will also need to engage NGOs, private health insurers, private health-care providers, and other stakeholders in order to facilitate equitable access to services. Health promotion can also be improved through increased access to information technology.

<table>
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<tr>
<th>Textbox 6: The Mexican Comprehensive Strategy for Immigrant Health: reaching across sectors and across borders to promote health</th>
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<tr>
<td>Twenty million Mexicans (15% of the population) are living abroad – the vast majority in the United States. Of these, an estimated 55 per cent are irregular migrants, and a similar proportion lack access to Mexico’s universal health insurance programme Seguro Popular.</td>
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<tr>
<td>Challenges posed to the Mexican Government include: how to offer health insurance to citizens abroad; how to link diaspora communities with services available to them; and how to facilitate referral and continuity of care for Mexicans moving between communities in the United States and Mexico. Under the Comprehensive Strategy for Immigrant Health, a number of solutions are under way and planned.</td>
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<tr>
<td>First, the Ventanillas de Salud (Health Information Booth) programme is active in 30 consular sections, with an additional 10 planned. The programme comprises a network of information centres that increase awareness and use of health services, as well as providing health information to Mexicans living in the United States. The programme engages local migrant networks, NGOs and government institutions to facilitate referral to available services.</td>
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<tr>
<td>The Vete Sano, Regresa Sano (Leave Healthy, Return Healthy) programme is a communication programme that promotes healthy behaviour in light of the social challenges faced by migrants. Guidelines are developed and training is provided for key migrant groups and service providers on accessing comprehensive care throughout the migration process. One programme repatriates gravely ill migrants from the United States back to health facilities in Mexico. Another programme involves strengthening migrants’ health on the border with the United States, particularly in remote areas beyond the reach of Mexican consulates. Health campaigns are carried out within Mexico and bi-nationally.</td>
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<td>Forthcoming 2010–2012 programmes include affiliation of migrants living in the US State of Colorado to Seguro Popular (a pilot insurance scheme in Washington State), provision of basic primary care through 6,500 clinics with a telephone outreach component, extension of Ventanillas de Salud to offer medical consultations by telephone and offering discounts on medicine and lab tests, and an addiction treatment and prevention programme for migrants.</td>
</tr>
<tr>
<td>Further information is available at: <a href="http://www.saludmigrante.salud.gob.mx">www.saludmigrante.salud.gob.mx</a></td>
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</table>
Standard quality of care and equity principles need to be observed even when the health care of migrants is delegated to parallel unofficial charity networks of health-care providers. The involvement of NGOs and faith-based organizations should not be seen as the “default system”, but as a planned inclusive mechanism for which governments remain accountable to global and national health frameworks and to the public. The capacity to enlist the contribution of the civil society is therefore a critical capacity to be built within national migration and health programming.

f) International and transborder health systems

As migrants are increasingly moving across borders for employment, immigration, human security and other reasons, strengthening the transborder dimension of health systems is a major capacity requirement (see textbox 7). In this domain, three key factors need to be addressed.

The first is the surveillance and control of communicable diseases that are increasingly carried via international air travel. This is of particular significance for business travellers, tourists, exchange students and immigrants. A substantial body of expertise has been developed around this phenomenon through dealing with outbreaks such as SARS and H1N1, and through “fit-to-travel” health assessments for prospective migrants. Nevertheless, additional capacity is required in the detection of diseases during and prior to travel. With the persistent threat of emerging drug resistance, increased capacity will be required in research and versatile laboratory techniques – especially in developing countries. Increased emphasis will be required on pre-departure health assessments (which can be packaged together with health orientation sessions) for longer-term travellers such as students, seasonal international and low-skilled workers.

The second is the need to strengthen health systems in border areas. Particularly in the developing world, border sites are frequently far from the heart of a country’s main urban centres, and they tend to exhibit weak health infrastructures. This is compounded by large cross-border flows and a largely unregulated private sector filling the service provision gap. Clients pay out of their own pockets for whatever medication they can afford, whether or not the treatment meets international standards. Counterfeit drugs are also a major challenge. Surveillance and control of communicable diseases between countries sharing borders is a public health priority – particularly with the emergence of ACT-resistant malaria in parts of South-East Asia and the emergence of multi-drug and extensively drug-resistant tuberculosis. Increased health literacy and primary care is required in certain border locations. Governments on both sides of borders need to work together in dealing with border area populations as a single community. This will entail increased collaboration on surveillance, development of common standard operating procedures and therapeutic schemes, continuity of care, and targeting of programmes for the heterogeneous populations living in border sites. For many countries, it requires that the central levels of government offer clear policy guidance and operating
procedures for cross-border collaboration at the local level. Bureaucratic inefficiencies need to be overcome, including the need for high-level formal permission for every cross-border policy meeting or for sharing surveillance data across borders.

**Textbox 7: Transborder collaboration to tackle malaria: the Lubombo Spatial Development Initiative**

Funded through the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and a number of other partners, the Lubombo Spatial Development Initiative (LSDI) is a trilateral partnership aimed at reducing malaria incidence in the border areas of South Africa, Swaziland and Mozambique.

The Lubombo area is largely underdeveloped, but has high potential for mining, tourism and agriculture. The General Protocol for the LSDI was signed by Heads of State in 1999 with the goal of developing the region into a globally competitive economic zone. A malaria protocol was signed the same year.

Malaria is seen as a significant obstacle to development, with high prevalence in the shared border areas. Migration could potentially re-introduce malaria and spread resistance to control agents in both mosquitoes and parasites.

The focus of the initiative was limited to a set of achievable priorities – namely, research and surveillance, vector control and parasite control. The initiative was also able to direct the capacity of the more developed malaria programmes of Swaziland and South Africa towards Southern Mozambique, where greater capacity was needed. In the process, malaria incidence was greatly reduced in all three countries, protecting 6 million individuals from malaria.

**Textbox 8: Increasing Public Health Safety along the New Eastern European Border (PHBLM)**

This international initiative aims to minimize public health risks for irregular migrants, build capacity for border management and public health staff, and facilitate migrants’ access to health care as a fundamental human right.

PHBLM is a collaborative effort involving public health and migration authorities of the governments of Hungary, Poland and Slovakia, and with the participation of Romania in selected activities. Partners include the University of Pécs, the Andalusian School of Public Health, the European Centre for Disease Prevention and Control (ECDC), Frontex, and WHO Europe.
The programme began with analysis and documentation of the public health situation related to border management and detention. Based on this comprehensive assessment, a migrant health database is being developed, together with evidence-based operational procedures on public health in border management and detention. Recommendations have been developed for making structural changes to public health services in targeted border areas, and multidisciplinary training materials are under development for both health professionals and border management staff on issues of health and protection. Coordination between governments and institutions is facilitated, as is the development of a comprehensive public health and border management training package that can be adapted to suit local needs.

The third factor relates to the capacity needed to assist largely mobile populations (e.g. truck drivers, sex workers, commercial fishermen, nomads, etc.) in accessing services at the appropriate times and locations. Individuals’ health records need to be available in facilities along the main migration routes using smartcard or other technology – or carried on the person as a “health passport”. Treatment guidelines need to be harmonized between countries so that medical prescriptions can be appropriately refilled. Communication strategies and programme monitoring and evaluation systems must encompass the migration route instead of being boxed within individual countries or held within non-governmental organizations.

To better address the transborder dimensions of health, it will be important to build the capacity of regional economic communities and intergovernmental bodies to increase collaborative efforts. Technical human resources are particularly required so that sufficient effort can be devoted to advocating programming and mobilizing national counterparts who are busy with other tasks.

In addition, the way that donors, international partners and governments work with stakeholders to facilitate development of transborder health programming should be more closely examined, since establishing bilateral and multi-country initiatives requires up-front financial and time investment to ensure the inclusion of stakeholders and the political commitment of countries. Many transborder partnerships fail to materialize due to the difficulty of focusing on achievable priorities based on empirical evidence, rather than on the special interests of development partners and donors. Moreover, any proposed programme must fill gaps not met by country programmes, complement national strategies, and clearly show the added value of regional or cross-border approaches (GFATM, 2008). Many regional initiatives place too much emphasis on regional coordination aspects, expecting the country-level resources to cover other essential aspects, which rarely happens. Countries need sufficiently committed focal points to influence and harness country-level resources for the implementation of regionally-coordinated initiatives.

The Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand have, furthermore, underscored the importance of global health as a fundamental, yet neglected, aspect of foreign policy. In the Oslo Ministerial
3) Enhancing strategic knowledge management capacity on migration health

Migrants are largely invisible to national and international decision makers, and tend to be lumped together as a single typology in a way that dismisses the diverse nature of migration and its inherent impact on health service provision. With migration increasing, there is an urgent need to remove the cloak of invisibility that denies migrants their right to health. Migrants do not live in isolation from the rest of society, and the lack of data on migrants’ health should not be used as an excuse to take no action or seen as an indication that no problems exist.

Further research and scaling up are required in several areas, including identification of the differentials in health access and the outcomes by typology of migration, with comparison to non-migrant populations. Another key area is epidemiological and operational research related to communicable diseases and the emergence of drug resistance – particularly with respect to tuberculosis and malaria. The social determinants of health that affect migrants need to be delineated in order to identify effective means of promoting health. Evaluation and impact assessments need to be undertaken on national and regional programming, and compiled as a synthesis of effective practices. Perhaps most importantly, cost-benefit analyses are urgently required in order to sensitize policymakers, donors and societies to the costs of inaction.

To meet the growing need for strategic knowledge on migration health, significant capacity is required in a number of areas. Universities and intergovernmental organizations need to continue to build the capacity of young researchers in the field of migration health. National health surveillance systems need to be refined in order to capture data on such basic issues as nationality and immigration status, while avoiding the risk of stigma and misrepresentation of data that can fuel xenophobia and discrimination. Functional mechanisms are required for the exchange of epidemiological data between countries.

In addition, census data need to capture the population sizes and demographics of migrants in order to affect policy decision-making.

International research consortiums need to be established and/or strengthened to identify and address the major thematic areas of migration health research, to develop

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3 See [http://cat.inist.fr/?aModele=afficheN&cpsidt=18673146](http://cat.inist.fr/?aModele=afficheN&cpsidt=18673146)
partnerships within and between countries for addressing these data needs, and to effectively interpret and disseminate findings. (See textbox 9 for an example of one such consortium.)

**Textbox 9: Reproductive Health Outcomes and Migration (ROAM): an international research consortium**

Established in 2004, ROAM is an international collaboration that aims to coordinate and harness global research expertise on reproductive health issues faced by migrant women. The collaborators recognize that, globally, migrant women often face disparities in reproductive health access and outcomes, as compared to native-born populations.

ROAM was initiated by researchers from McGill University and McGill University Health Centre in Canada, and La Trobe University in Australia, as a means of analysing the existing data available globally, developing a core set of definitions and indicators, and prioritizing areas for future research. This led to a broader international collaboration on migration and reproductive health with investigators from the European Perinatal Epidemiology Network. Since the inaugural workshop in Siena, Italy, in 2005, ROAM has expanded to include 33 researchers from 13 countries. All collaborative members are self-selected researchers interested in migration and reproductive health. IOM is also a partner, assisting with internships for research development.

The initial phase of ROAM work focused on three main components: 1) identification of all potential migration indicators cited in the literature and determination of whether perinatal health outcomes differ, in accordance with these migration indicators; 2) standardization of migration indicators, their definitions, and their reporting categories for the purpose of international comparability; 3) comparison of perinatal outcomes for migrants from a single source country living in a variety of receiving countries (e.g. for Somali-born women living in various countries).

Furthermore, capacity is required to strengthen the ability to analyse migration health data within and between countries. Meta-analysis of international migration data across countries is currently hampered by lack of standard definitions for “migrant” and by the lack of a common set of health indicators. A 2008 international study of migration and perinatal health surveillance identified the need to capture in routine surveillance such data as country of birth, immigration status, and time since arrival (Gagnon et al., 2008).

Finally, increased capacity is required in effectively communicating health data to decision-makers and society at large.

4) **Integrating and capacitating migrants as a force for positive social change**

The international community largely overlooks the fact that migrants are a significant source of social capital, which can be harnessed to build healthier, more socially
integrated communities. Migrants must be de-victimized, empowered and engaged as a force for positive social change.

Migrants can be engaged as an integral component of the health response, as a first access point for primary care and referral, and as community health educators. They can also help to improve sanitation and living conditions. Governments should involve migrants in community participatory mapping and situational assessments, as well as in community disease surveillance.

In many countries, migrants serve as a bridge between marginalized migrant communities and the health services available to them. Migrant associations require increased technical and financial support in giving migrants a voice in international dialogue and advocacy, in facilitating service access, and in establishing community revolving funds that cover gaps in paying for health care, funerals, transport and other emergency needs.

Textbox 10: With Migrants, for Migrants (MiMi): intercultural health in Germany

Developed by the Ethno-Medical Centre, this programme was launched in 2003 as a pilot in four cities in Germany with large migrant populations. Implemented in cooperation with private health insurance associations and governmental agencies at the federal and local levels, the programme engages migrants in overcoming the social and economic constraints to accessing health information and services. Considered to be experts in their own cause, migrants are empowered to make the health system more accessible to migrants and to increase health literacy.

Integrated immigrants living legally in Germany are trained in a core list of activities and certified as multilingual intercultural health mediators who lead community-based health activities. A Health Guide, produced in 16 languages, describes the German health system in a straightforward manner, and provides health information targeted to the needs of migrants. Eighty health-related organizations have been involved in producing and regularly updating the guide.

In partnership with BKK Bundesverband (Federal Association of Health Insurance Companies), the media are utilized to raise awareness of the programme and improve networking. The founder of MiMi, Ramazan Salman, was awarded Social Entrepreneur of the Year in 2008.

city needs in the empowerment and engagement of migrants. There is a need for sustainable mechanisms to ensure that migrant health programming is included within government health budgets. National standards are also required – for example, in the development of training curricula and trainings. Models such as one-stop facilities offering a number of health and social services should be implemented, documented and disseminated. In some countries, these facilities provide information on how to legally and safely migrate and how to prevent communicable and non-communicable diseases, as well as raising awareness of trafficking in persons and fundamental human rights, and providing referrals to other services.

Where migrants are poorly integrated into society and/or poorly organized, they are particularly vulnerable to the impacts of natural disasters and disease outbreaks. In an environment that fosters social cohesion and integration, however, migrants are able to mitigate risks, become involved in surveillance activities, and build communities that are resilient to the effects of acute or recurring emergencies (see textbox 11).

Textbox 11: Engaging migrants in emergency and disease outbreak preparedness and response

Social cohesion is vital when preparing for emergencies or disasters, and for response and recovery. As migrants are frequently marginalized within society, they are particularly vulnerable. IOM therefore advocates the empowerment of migrants and the inclusion of migrants within national plans on disaster and pandemic preparedness and response.

IOM strengthens capacities at all levels of society for engaging migrants in disaster and pandemic preparedness and response. Activities undertaken by IOM and partners include social mobilization campaigns, distribution of information targeted at migrants, and facilitation of trainings of multisectoral partners in project sites in Africa, Asia and Latin America.

Communication and counselling skills are an important coping mechanism in the event of a disaster. IOM has therefore worked with migrants to develop a manual for building these skills in migrant communities. The manual has also been translated into Spanish, French, Russian and Arabic.

IOM also facilitates the inclusion of migrant communities in simulation exercises to ensure that migrants are included in humanitarian crisis preparedness plans.

Countries that host migrants are developing and integrating national strategies that promote integration, as a means of promoting health (see textbox 12).
In 2009, foreigners comprised 10 per cent of the total population of Spain. In fact, the financial contribution of foreign workers towards Spain’s social security system has increased annually from 2.3 per cent in 1999 to 9.8 per cent in 2006. Spain’s rapid influx of migrants has created challenges in the provision of health and social services, in spite of a policy of universal access to health services for migrants who register with their local municipality.

The Strategic Plan for Citizenship and Integration 2007–2010 (Plan Estratégico de Ciudadanía e Integración) includes specific objectives and programmes/activities in cross-cutting areas that aim to improve the social inclusion of migrant groups in multiple sectors, thus addressing socioeconomic factors that can influence well-being. The Plan’s key elements are:

- reception, mediation and basic services
- participation and association
- preventive policies in the area of socioeconomic health determinants, especially for children, young people and women
- reinforcement of policies and services for:
  - education, health and social services
  - economic promotion and the job market
  - culture, leisure and sports
  - housing
- training of professionals in cross-culturalism
- transfer of knowledge and best practices
- reinforcement of the tertiary sector and its operating capacity.

Each region of Spain has a specific plan adapted to the local migrant typologies and needs. For example, 20 per cent of the province of Almería’s population is foreign-born and the province has worked for 20 years to normalize access to health services for migrants. Concrete examples of the work in Almeria include sensitization and training of health professionals, engagement of multiple sectors, community mobilization, and the promotion of equitable access to health services.

Summaries of the plan can be downloaded from:
CONCLUSION AND RECOMMENDATIONS

This paper described the importance of managing migration health in the context of an increasingly globalized and interdependent world where migration is a fact of life. As migration has played a role in fostering more heterogeneous societies, this has resulted in health disparities that impact society as a whole.

The issue of whether to provide irregular migrants with access to health services is no longer a matter for debate; it is clearly in everybody’s best interest to ensure that migrants (regardless of their immigration status) have equitable access to affordable and meaningful health services.

The key issue then is how to strengthen health systems within and between countries so as to promote the health of migrants and, furthermore, what capacity will be required in order for governments to effectively address migration-related health challenges in the future. Minimum standards in accessing health should be elaborated for all migrants, weighing the rights and dignity of migrants in light of the best interest of the host society, and the costs and benefits of inclusive approaches.

A number of capacity-building needs have been described, with some practical examples offered.

The importance of understanding the specific typologies of migration is paramount, in order to address the social health determinants faced by migrants. There is a need for a new generation of researchers who are fluent in the issues of migrant health. National health surveillance systems need to be re-examined in the light of the heterogeneity of societies, so as to identify health differentials, trends and emerging threats, such as drug-resistant diseases. Research is required to facilitate advocacy and policymaking, including evaluations, effective practice documentation, and cost-benefit analyses of taking action on migrant health. International research consortiums are required to coordinate and conduct multi-country comparative studies that foster evidence-informed debate.

Health is also a gateway to furthering the debate on the integration of migrants into society. Migrants should no longer be envisioned as socially disadvantaged recipients of assistance, but rather engaged and empowered to play a vital role in community health. By working to integrate migrants and to reduce marginalization, communities become more cohesive and thus resilient in the face of crises and emerging health threats.

Mobilization of migrants within government health programmes should not be seen as a luxury but as a core component of functioning health systems, and budgeted as such. Harnessing the social capital of migrants in promoting health is likely to lead to significant cost savings, as the need for treatment of preventable diseases and adverse health conditions such as abortion-related sepsis and maternal deaths would be greatly reduced. Furthermore, healthy labour forces have less turnover and lead to a more productive business sector.

Similarly, the cultural competence of health-care providers should be strengthened to meet the needs of increasingly diverse communities. The diaspora can be engaged either within communities or through the regulated international recruitment of health workers to meet the
needs of fellow citizens abroad. Cultural mediators can likewise be deployed to improve the quality of care. Such actions should be routinely included in government health budgets and could potentially lead to net cost savings.

A key challenge facing countries is that of tackling the transborder dimension of health. Increased human capacity is required within developing countries to carry forward the international health agenda, including the harnessing of donor and national resources towards transborder health programming. Bilateral and regional initiatives will need to be evidence-informed, prioritized and of manageable scope, while complementing gaps in national responses.

Highly complex, but possibly key to the development of effective and sustainable responses to the growing challenges of migrant health, is the review and harmonization of national policies related to immigration, labour, security, economic development and social welfare. Well-managed migration will set a more stable framework within which to couch the health sector response.

Multisectoral partnership and a global alliance of stakeholders are required in order to advance advocacy, inform debate, and address multiple platforms of migration dialogues in the quest for policy coherence in migration and health.

Finally, coordinating units and trained cadres on migrant health are required to act as the driving force of change within governments. These units should be empowered with a clearly-defined mandate, appropriately resourced, and accountable for effecting measureable achievements.

In summary, the issue of migrant health is central to socioeconomic development and will gain unprecedented importance in the years to come. Governments and their partners in the international community have begun to recognize the importance of addressing the health of migrants and affected communities. The future paradigm requires that governments take stock of the lessons learned to date, identify their specific capacity needs, and forge a more systematic approach towards managing the health aspects of migration.
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