

International Migration, Health and Human Rights



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Organization



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OFFICE OF THE HIGH COMMISSIONER

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PREFACE

Today, more than 214 million people are living outside their countries of origin. They have left their homes for a variety of reasons, including conflict, natural disasters or environmental degradation, political persecution, poverty, discrimination and lack of access to basic services and the search for new opportunities, particularly in terms of work or education.

One aspect of migration that is attracting renewed attention is the impact that it has on public health. Migrants may be subjected to multiple discrimination, violence and exploitation, all of which often directly affect their physical and mental health. In addition, migrants may have health problems that are not well known or understood in their new countries of residence. To compound this problem, legal and socioeconomic barriers impede access to health services in many cases; in cases where migrants do have access to health services, these may not be migrant-sensitive or culturally and linguistically appropriate.

Communities receiving large numbers of migrants face new challenges, such as increased diversity of the population and the consequent change in the cultural profile and health perspectives of its patients. This inevitably impacts the day-to-day work of health professionals. Current approaches to managing the health of migrants need to keep pace with the growing challenges associated with the complexity, volume, speed, diversity and disparity of modern migration flows to ensure that all migrants are able to realize their fundamental right to health.

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health has long been established in international human rights law. So, too, have the principles of equality and non-discrimination. It is therefore critical for national health systems and policies to address migrants' right to health, regardless of the legal status of the migrant. Doing so requires active collaboration across the different sectors and close cooperation between governments and the many non-state actors involved in the migration process.

In this publication, the World Health Organization, the Office of the High Commissioner for Human Rights and the International Organization for Migration explore the multifaceted health and human rights challenges that migrants face and report on recent developments in this area.

Our aim in producing this publication is to provide all stakeholders with a reference on key health and human rights issues in the context of international migration. We hope that it provides inspiration to policymakers to devise migration policies and programmes that are guided by public health considerations and human rights imperatives, with a view to protecting the human rights and improving the health of both migrants and the communities in which they live.

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INTRODUCTION

We live in an era of the greatest human mobility recorded in history. There are more people on the move today than ever before, with the total number of international migrants currently estimated at 214 million, most of whom move intraregionally.

Resolution on the health of migrants – a global commitment to improving the health of migrants

In order to promote the health of migrants, the member states of the World Health Organization (WHO) endorsed Resolution 61.17 on the Health of Migrants at its sixty-first World Health Assembly in 2008. In response to the Resolution, the WHO, the International Organization for Migration (IOM) and the Ministry of Health and Social Policy of the Government of Spain organized a global consultation on migrant health in Madrid, Spain in March 2010. The following priorities for action were identified:

1. **Monitoring migrant health.** Ensure the standardization and comparability of data on migrant health and support the appropriate disaggregation and assembling of migrant health information.
2. **Policy and legal frameworks.** Adopt national laws and practices that respect migrants' right to health based on international laws and standards; implement national health policies that promote equal access to health services for migrants; and extend social protection in health and improve social security for all migrants.
3. **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 health issues associated with migration; deliver migrant-inclusive services in a comprehensive, coordinated, and financially sustainable fashion.
4. **Partnerships, networks and multi-country frameworks:** Ensure cross-border and intersectoral cooperation and collaboration on migrant health.

(WHO (2010) Health of Migrants – The Way Forward. Report of a Global Consultation, Madrid, Spain).

In the last decade, protection of the human rights of migrants, including the right to health, has been increasingly recognized and has risen up the international agenda. In order to fulfil their legal obligations at the international and national levels, governments in many regions have acknowledged the need to integrate the health needs and vulnerabilities of migrants into their national plans, policies and strategies.

Accordingly, governments are showing an increased appreciation for the need to formulate health programmes and policies that address health inequities and remove access barriers to health facilities, goods and services. Despite these efforts, however, migrants continue to be overlooked in many countries, where access to health care often remains limited and conditional for them. This is particularly relevant during times of economic crises, when limited financial resources put pressures on health systems and policymakers may be in need of guidance in this area.

Additionally, there are various misperceptions about migrants around the world, one of which is that migrants place a heavy financial burden on the host society and the state's health system.

Empirical evidence, however, shows that migrants can be healthier than the native population, and it is actually the presence of structural constraints during the migration process and barriers in the country of destination that put them at a higher risk of adverse health. Misperceptions like this may lead to an increase in xenophobic attitudes and discrimination within the health-care system and can have a negative effect on migrants' health.

Excluding migrants from a rights-based approach to health is a blatantly poor public health practice, as it increases migrants' vulnerability, creates and amplifies discrimination and health inequalities, incurs higher health costs for migrants and is, in general, a violation of migrants' rights. On the contrary, addressing the health needs of migrants can improve health status and outcomes; facilitate integration; prevent long-term health and social costs; contribute to social and economic development; and, most importantly, protect public health and human rights.

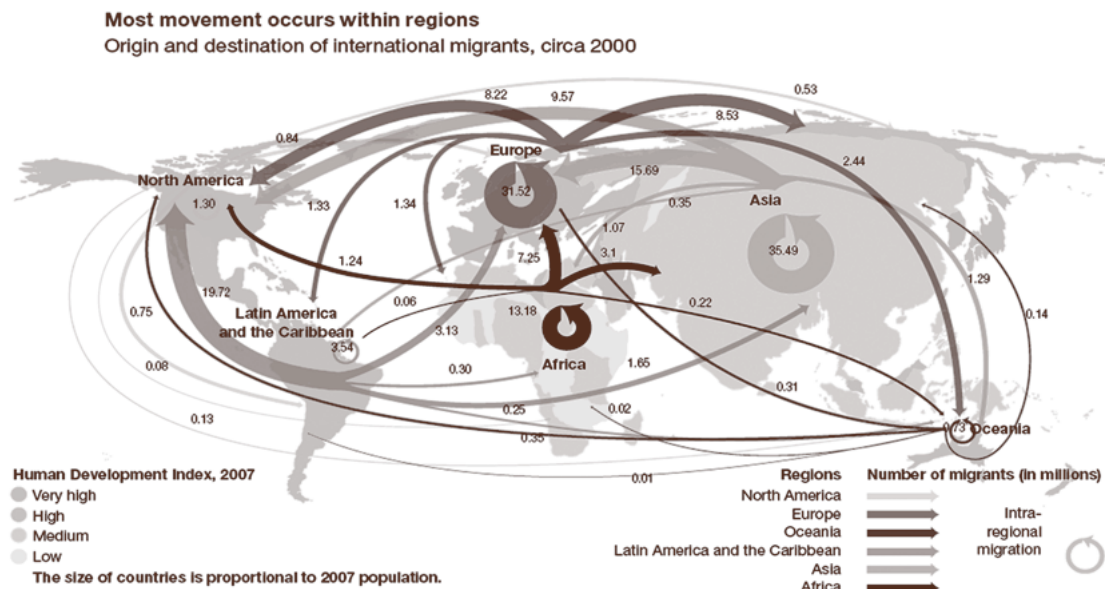
Given the complex interlinkages among the domains of human rights, health and international migration and the widely differing national and regional circumstances, this booklet does not try to make broad recommendations. Instead it reflects on the developments that have occurred over recent years and attempts to stimulate debate and bring attention to migration-related health matters by using a human rights-based approach. It argues that the realization of the rights of migrants is a sound public health practice that benefits all and provides new information, accomplishments and challenges with regard to international migration, health and human rights. It examines the effects of the migration process on migrant health, as well as the protection offered to migrants through human rights instruments. The publication does not focus in any way on the migration of health workers, but instead covers migrants in general, regardless of occupation, skill level and legal status during migration.

This publication devotes particular attention to the most vulnerable categories of migrants and conceptualizes vulnerability from two angles. The first is to view vulnerability as directly resulting from an inherent characteristic of the individual migrant or group (e.g. gender, age, disability, HIV status, lack of safety net and poor education). The second is to relate migrants' vulnerability to its fundamental structural causes (e.g. working and living conditions; lack of legal protection, including that in relation to the migrant's legal status in the host country; crime and conflict; language and cultural barriers; lack of formal and informal social protections offered during and after the migration process; and immigration detention).

The first section of this publication provides an overview of contemporary migration patterns, scope and trends. The second section discusses the human right to health and other relevant human rights in the context of health and migration. Section Three considers the various ways in which the health of migrants is affected throughout the course of the migration process, from the initial decision to move, during the journey itself, to reception in the new community and until the potential return. Examples illustrate the challenges faced by migrants, policymakers, health planners, international organizations and other stakeholders and demonstrate efforts and developments that can stimulate future approaches to improving the health of migrants. Annexes provide a glossary, as well as a list of international instruments relevant to the discussion on health, human rights and migration.

SECTION I. INTERNATIONAL MIGRATION: SCOPE AND TRENDS

Figure 1. Migration flows¹



There are far more international migrants in the world today than has ever been previously recorded. The growth in the number of migrants has remained proportional to the overall rise in world population, but what is noteworthy is that their total number has increased rapidly in the last few decades.² The 2010 IOM World Migration Report estimates that if migration continues to increase at the same pace as in the last 20 years, the number of international migrants worldwide could be as high as 405 million by 2050. Reasons for the significant increase in people's mobility around the world include globalization, low transportation costs, economic pressures, demographic trends (specifically, ageing societies worldwide and youth bulges in developing countries), environmental degradation, violence and human rights abuses (see Figure 1).

Almost half of all international migrants are women and girls, who are increasingly migrating independently and as main income earners. The International Labour Office (ILO) estimates the number of economically active migrants at 105.4 million; together with accompanying family members, they account for almost 90 per cent of the total number of international migrants.³

Migrants are often thought simply to be non-nationals within the territory of a host state. However, this does not take into account return migration, internal migration and internal displacement. Migration is a varied and complex phenomenon. It may be either uni- or multi-directional, and temporary or permanent. Attempting to understand migration through the

¹ UN Development Programme, *Human Development Report 2009 – Overcoming barriers: Human mobility and development*, 5 October 2009, available at: www.unhcr.org/refworld/docid/4ac9d10d2.html (HDR team estimates based on Migration DRC [2007] database.)

² The number of international migrants as a percentage of the global population has remained relatively stable over the last few decades, at around 2-3% of the world's population.

³ International Labour Office, *International Labour Migration: A Rights-Based Approach* (Geneva, 2010). Available from www.ilo.org/public/english/protection/migrant/download/rights_based_approach.pdf (p. 2).

spectrum of nationality alone can unintentionally exclude second- or third-generation migrants in the analysis and overlooks the fundamentally dynamic character of migration.⁴

Several migration-related economic and social factors – including aspects of migrant behaviour and health-related influences associated with migration – can persist long after nationality or a permanent residence permit is acquired.⁵ Similarly, some biological and genetic determinants of health may extend over generations regardless of nationality.⁶ This is why it is important to monitor migration health over time.

The focus of this publication is international, not internal, migration. International migrants may intend to stay for either a short or long period in the host country and may be in either a regular or irregular legal situation. The majority – not all – of such migrants are migrant workers and their families. The rest may be victims of trafficking in persons; children who migrate on their own or with their families and guardians; asylum-seekers and refugees, migrants who have been smuggled; or returnees. While acknowledging that these various categories of people will have varying protection statuses under international law, this publication refers to them collectively as “migrants.” Where different standards apply on the basis of legal status, the use of the term will be clarified.⁷

International migration connects communities, countries and regions, as well as various sectors of society. Any response to international migration and health requires close cooperation and collaboration among countries, as well as among sectors and related institutions involved in the migration process. Concerted global and regional efforts to arrive at coordinated approaches to international migration matters include, inter alia, the UN High-Level Dialogue on Migration and Development, the Global Forum on Migration and Development (GFMD), the Global Migration Group (GMG),⁸ regional migration regimes and regional consultative processes on migration (RCPs).

⁴ International Organization for Migration, *Migration and the Right to Health: A Review of International Law*. International Migration Law Series, No. 19, p. 22. (Geneva, 2009)

⁵ J. Landman and J.K. Cruickshank, A review of ethnicity, health and nutrition-related diseases in relation to migration in the United Kingdom, *Public Health Nutrition*, 4(2b):647–657.

⁶ A. Sharareh, B. Carina and W. Sarah, The health of female Iranian immigrants in Sweden: a qualitative six-year follow-up study, *Health Care for Women International*, 28:339–359.

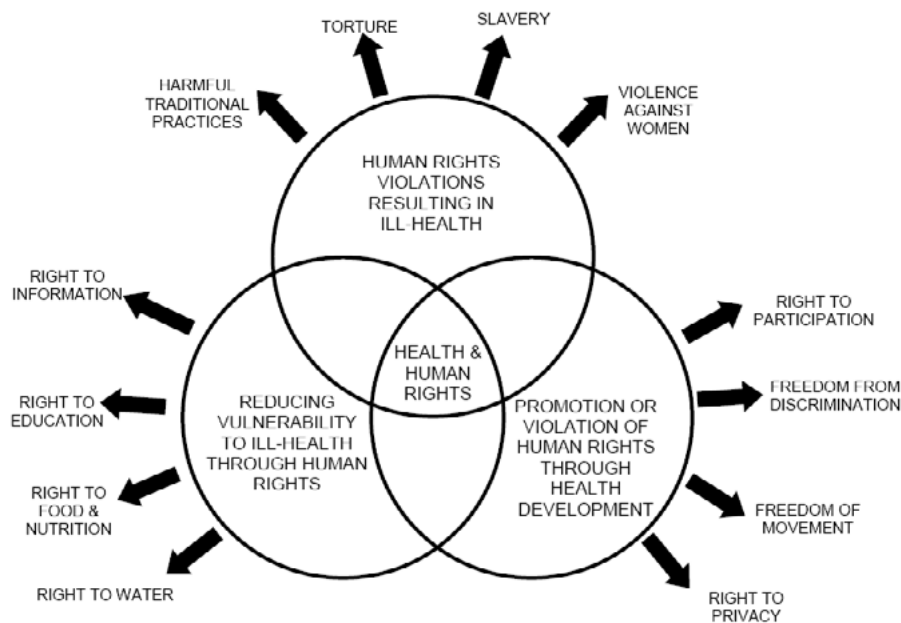
⁷ For further explanation regarding the terminology, see Annex I.

⁸ The Global Forum on Migration and Development (GFMD, www.gfmd.org) is a state-driven process that emerged after the 2006 UN General Assembly’s High-Level Dialogue on Migration and Development, which marked the culmination of more than a decade of international dialogue on the growing importance of the link between migration and development. The Global Migration Group (GMG, www.globalmigrationgroup.org) is an inter-agency group that, at the time of writing, is comprised of 16 members, including the organizations responsible for this publication. The role of GMG is to promote the development and wider application of relevant international instruments and norms relating to international migration and to encourage the adoption of more coherent and coordinated approaches to international migration.

SECTION 2. MIGRANTS AND THE RIGHT TO HEALTH

2.1 The human rights paradigm

Figure 2. Examples of linkages between health and human rights⁹



Human rights are universal and considered the birthright of every human being. Aimed at safeguarding the inherent dignity and equal worth of everyone, they are inalienable, interdependent and interrelated.¹⁰ Human rights are articulated as entitlements of individuals and groups, thereby creating obligations of action and non-action, particularly for states. There are different classes of human rights, encompassing the civil, cultural, economic, political and social.

Human rights are expressed and guaranteed by law in international instruments,¹¹ as well as in national constitutions and legislation. States assume obligations under international law to respect, protect and fulfil human rights. The obligation to respect means that states must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires states to protect individuals and groups against undue interference with the enjoyment of human rights by other individuals and entities. Lastly, the obligation to fulfil means that states must take positive action to ensure the enjoyment of human rights.

⁹ World Health Organization, "Linkages between health and human rights". Available from: www.who.int/hhr/HHR%20linkages.pdf.

¹⁰ If a human right is inalienable, this means that it cannot be waived or taken away. Human rights are considered interrelated because each one is closely related to and often dependent upon the realization of other human rights.

¹¹ The nine core international human rights treaties are as follows: the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the International Covenant on Civil and Political Rights (ICCPR); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); the Convention on the Rights of the Child (CRC); the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW); the Convention on the Rights of Persons with Disabilities (CRPD); and the International Convention for the Protection of All Persons from Enforced Disappearance (ICPED). For more details, see: www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx.

It is important to note that international migration – that is, the entry into and exit from a sovereign territory – is intimately related to legal and sociological notions of nationality and sovereignty. However, the Committee on Economic, Social and Cultural Rights (CESCR), which is the UN treaty body monitoring the implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR), has articulated that nationality must not be used as a ground for discrimination in relation to health care and other rights in the Covenant.¹²

Principle of non-discrimination

Different forms of discrimination create obstacles for the realization of the right to health and other rights of migrants. Most often, states use nationality or legal status as a basis to draw a distinction between persons who may and may not enjoy access to health-care facilities, goods and services. However, international human rights law provides that *all* persons, without discrimination, must have access to all fundamental human rights provided in the international bill of human rights. Therefore, migrants, regardless of their status, are protected by international human rights law.

The provision of the ICESCR (see Section 2.2 below) clearly expresses that the right to health obligates governments to ensure that “health facilities, goods and services are accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds” (emphasis added).¹³

States cannot limit the enjoyment of any human right and discriminate against non-nationals on the grounds of ‘race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.’¹⁴ The CESCR has explained that the reference to ‘other status’ indicates that this list is not exhaustive and that, therefore, other grounds of discrimination, such as nationality, that hinder migrants from exercising the right to health and other human rights must be equally prohibited.¹⁵

Some individuals, for example, irregular migrant women, may find themselves in extremely vulnerable positions if discriminated against on multiple grounds. These multiple layers of discrimination may compound and exacerbate the unequal treatment that migrants receive when accessing health services or seeking specific health-related information.

State responsibility for non-discrimination includes ensuring equal protection and opportunity under the law, as well as in policies, programmes and everyday practices for the enjoyment of rights, such as the rights to health and social security.¹⁶ In addition, states are obliged to monitor the effects of their public health policies and actions and, more broadly, their social policies, to ensure that these are anchored in a system which does not allow inequalities in the enjoyment of human rights. In order to achieve this, states are compelled to gather disaggregated data on the realization of the rights to health, social security and education, among others. The indicators under study must include special measures that recognize the diversity of population groups and assist states in meeting their human rights obligations by eliminating all forms of discrimination.^{17,18}

¹² CESCR General Comment No. 20 on Non-Discrimination in Economic, Social and Cultural Rights (Art. 2, para. 2), E/C.12/GC/20, 2 July 2009, para. 30.

¹³ CESCR General Comment No. 14 on the Right to the highest attainable standard of health (Art. 12), E/C.12/2000/4, 11 August 2000, para. 12. The principle of non-discrimination when implementing health measures is also provided by the International Health Regulations (IHR) (2005) in Article 42, available at http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf.

¹⁴ ICESCR, Art. 2.2.

¹⁵ E/C.12/2000/4, para. 30.

¹⁶ WHO World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance: Health and Freedom from Discrimination. Geneva, WHO/SDE/HDE/HHR/01.2, p. 6. (2001).

¹⁷ E/C.12/2000/4, paras. 20 and 63.

¹⁸ E/C.12/GC/20, para. 41. For more details on human rights indicators, including on the right to health, see the OHCHR Report on Indicators for Promoting and Monitoring the implementation of Human Rights, 2008, HRI/MC/2008/3 and the OHCHR Report to the Economic and Social Council, 4-29 July 2011, E/2011/90.

Improving disaggregation of data on migration

Various reports stress that the failure to collect, analyse and use disaggregated data by age are major obstacles to the protection of migrant children. In 2009, the Special Rapporteur on the human rights of migrants expressed his concern about the dearth of accurate statistical information on the number of children involved in the international migration process.¹⁹ Similarly, a 2010 study by the Office of the High Commissioner for Human Rights (OHCHR) highlighted that the “lack of disaggregated data is one of many challenges in formulating and implementing child-sensitive migration policies.” The study specifically recommended that “States and other relevant stakeholders [...] prioritize the collection of age- and gender-disaggregated data on the human rights situation of children in the context of migration, while ensuring that such data-collection activities are not used for immigration enforcement purposes.”

(Study of the OHCHR on challenges and best practices in the implementation of the international framework for the protection of the rights of the child in the context of migration, A/HRC/15/29, paras. 7 and. 87(d), July 2010).

In order to respond to the growing demand for accurate, current and policy-relevant data, the United Nations Population Division of the Department of Economic and Social Affairs created the United Nations Global Migration Database. This database collects all publicly available data on international migrants and disaggregates the information according to age, as well as gender and country of birth and citizenship. Such information is vital in facilitating research and evidence-based policymaking.

(United Nations, Department of Economic and Social Affairs, Population Division (2008) United Nations Global Migration Database (UNGMD) available at: <http://esa.un.org/unmigration/index.aspx>).

One of the four priority areas agreed to for action at the Global Consultation on Migrant Health in Madrid, Spain, in March 2010 is to better “monitor migrant health.” All stakeholders at the consultation agreed that health information systems should be strengthened to collect and disseminate migrant health data, disaggregated by relevant categories. Equally important in this regard is to consider the ethical issues related to the collection of migrant health data and to avoid dealing potential harm to migrants during the collection of such data.

(WHO (2010) Health Of Migrants - the Way Forward, Report of a Global Consultation, Madrid, Spain).

2.2 The right to health

While several human rights treaties refer to the right to health, Article 12 of the ICESCR provides the most comprehensive articulation by recognizing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”²⁰

A key aspect of the right to health is that it contains both ‘freedoms’ and ‘entitlements.’

- **Freedoms** include, for instance, the right to be free from non-consensual and uninformed medical treatment, medical experimentation or forced HIV testing. Freedom from torture and

¹⁹ Report of the Special Rapporteur on the human rights of migrants, Jorge Bustamante, A/HRC/11/7, 14 May 2009, para. 20.

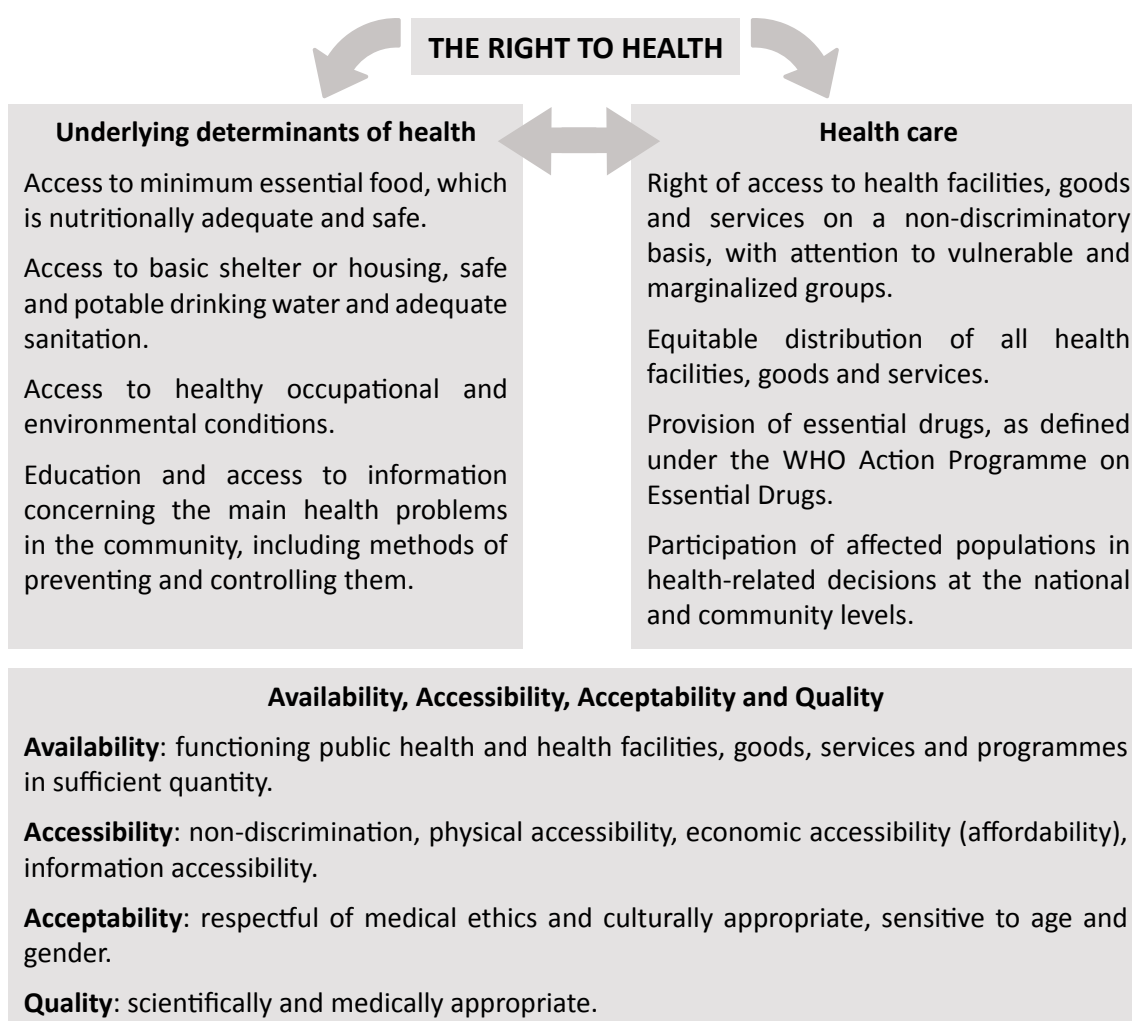
²⁰ In addition to the ICESCR, several core international and regional human rights treaties and national constitutions and laws recognize the right to health. CEDAW, CRC, ICRMW and CRPD are some of the main international human rights instruments for the protection of the right to health.

other forms of cruel, inhumane and degrading treatment is another important component of the realization and protection of the right to health.

- **Entitlements** result from the obligation of the state to provide adequate health services necessary for the realization of the highest attainable standard of health. Entitlements include the right to a system of protection (i.e. a system of prevention, treatment and control of diseases) on an equal basis for all and access to information and education about health (particularly that surrounding unhealthy or risky behaviour), essential medicines and sexual and reproductive health-care services.

The CESCR, in its General Comment No. 14, interpreted the content of the right to health.²¹ Accordingly, in order to comply with the above-mentioned entitlements and freedoms, states must make sure that health facilities, goods and services are available, accessible, acceptable, of good quality and applicable to all sectors of the population, including migrants.²² Figure 3 summarizes the essential components of the right to health.

Figure 3. The scope and content of the right to health according to CESCR General Comment No. 14²³



²¹ General Comments are interpretative documents that guide states and other stakeholders to clarify the scope and content of each right, as well as outline their obligations under specific articles of an instrument. They are developed by Committees entrusted to monitor states' compliance with the treaty body.

²² E/C.12/2000/4, para.12.

²³ Ibid.

Availability. Functioning public health and health-care facilities, goods and services must be available in sufficient quantities within a state and in a timely manner. The availability component of the right to health obligates states to ensure general supplies, as well as to avoid stock shortage. Specific essential medicines and vaccinations, for example, should be ordered in sufficient quantities to cover the needs of all, including migrants and their families. Further, the principle requires states to enlist and cater for specific essential medicines and goods that are particularly relevant to migrant populations.

Accessibility. The concept of accessibility includes several aspects that are related to the principle of non-discrimination, as follows:

- Non-discrimination ensures that health facilities, goods and services must be accessible to all sections of the population, including the most vulnerable and marginalized groups, in law and in practice, without discrimination on any ground. Many countries define their health obligations towards non-nationals in terms only of ‘essential care’ or ‘emergency health care.’ Consequently, migrants are generally inadequately covered by the host state’s health system and are, thus, often unable to afford health insurance, treatment or essential medicines.²⁴
- Non-inclusive health policies contravene the principle of non-discrimination set in the core human rights instruments. State governments should realize that by denying migrants access to primary health interventions, states are exposed to greater financial costs and public health risks, as medical conditions could become chronic and more expensive to treat if not dealt with early on. As stated by the Special Rapporteur on the human rights of migrants, “mere commitment to emergency care is unjustified not only from a human rights perspective, but also from a public health standpoint, as a failure to receive any type of preventive and primary care can create health risks for both migrants and their host community.”²⁵ It is therefore important to stress that the right to the highest attainable standard of physical and mental health also applies to migrants in an irregular situation.²⁶
- Physical accessibility refers to the provision of safe access for all sectors of the population – children, women, the elderly, persons with disabilities, adolescents, migrants and any other individual or group – without discrimination. Migrants often live and work in areas where services tend to be physically unavailable, as is the case of those performing domestic work in private households. In addition, migrant workers may – for a variety of reasons – be less able to request time off from their work to seek health care during the day. The location and opening hours of health facilities may, thus, constitute a problem for migrants.
- Access to information implies the right to seek, receive and impart health-related information in an accessible format, such as tailor-made campaigns and plain-language messages that speak to different groups of society. Migrants often face difficulties accessing information on health matters and available services, particularly if such information is not provided adequately by the state.²⁷
- Affordability (financial accessibility) guarantees that every person, regardless of their nationality or legal status, would have access to health goods and services, notwithstanding economic constraints. In order for health goods and services to be financially accessible, states should adopt special measures for persons in financial difficulties or in need of special assistance. These measures include the affordability of essential medicines and health insurance.

Acceptability. Health facilities, goods and services must be acceptable, meaning gender-sensitive, culturally appropriate and respectful of medical ethics. Migrant-sensitive health services may include interpretation, translated written materials and ‘cultural mediation’ in hospitals and health centres. Introducing these services can assist in tackling language and cultural barriers –

²⁴ OHCHR and WHO, *The Right to Health*, Fact Sheet No. 31, pp. 18-20 (Geneva, 2007).

²⁵ *Report of the Special Rapporteur on the human rights of migrants, Jorge Bustamante A/HRC/14/30*, para. 28.

²⁶ A/HRC/14/30, para. 34.

²⁷ A/HRC/14/30, para. 12.

both of which can have negative effects on care and prevention services, treatment plans and appropriate follow-ups – as well as avoid misunderstandings (e.g. when a patient relates his or her symptoms) or mistranslations, which may result in delayed care, clinically significant medical errors, or, as a worst-case scenario, death.²⁸

Quality. Health facilities, goods and services must be scientifically and medically appropriate and of good quality. There should be, among other things, trained health professionals at all levels, scientifically approved drugs, trustworthy laboratories, appropriate hospital equipment, adequate sanitation and safe drinking water.

²⁸ OHCHR Report to the Economic and Social Council, 1 June 2010, E/2010/89, paras. 34-35.

Health care for migrant children

The legal status of migrant parents may affect the access to health care by migrant children. Hence, where migrant parents are deprived of health care, their children are also likely to be deprived of such care. Even migrant children who are nationals of the host country may still face obstacles in accessing health care, particularly if their parents are migrants in an irregular situation and, therefore, are reluctant to seek health care for fear of their immigration status being detected. Similarly, many migrant children in an irregular situation are not enrolled in schemes that provide health care, regardless of their parents' ability to pay, because their parents are reluctant to approach social services due to the risk of being reported to the authorities.²⁹ In addition, certain laws, policies and measures may indirectly hamper irregular migrant children's access to health. For instance, in some countries, "a parent must be a regular migrant in order to obtain a birth certificate for [the] child, thus making access to health care difficult for children of migrants in an irregular situation."³⁰ A particular area of concern as regards the health of migrant children in an irregular situation lies in the area of childhood immunization. It has been reported that many such children are unable to gain access to vaccinations in a timely manner, which may cause long-term effects on their health.

(Study of the OHCHR on challenges and best practices in the implementation of the international framework for the protection of the rights of the child in the context of migration, A/HRC/15/29, 5 July 2010, para. 63).

The Committee on the Rights of the Child (CRC) has underlined in its General Comment No. 3 that "States parties must ensure that services are provided to the maximum extent possible to all children living within their borders, without discrimination, and that they sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live . . . The obligations of States parties under the Convention extend to ensuring that children have sustained and equal access to comprehensive treatment and care, including necessary HIV-related drugs, goods and services on a basis of non-discrimination."

(CRC General Comment No. 3 on HIV/AIDS and the rights of the child, CRC/GC2003/3, 17 March 2003, paras. 21 & 28).

Children affected by migration are invisible to policies and systems for protecting and promoting children's rights. In many countries of origin, transit and destination, social policies and programs do not take into account the conditions and needs of migrant children. The neglect is particularly evident in the case of children in an irregular situation, as national action plans and strategies on social exclusion, child poverty, early school leaving and health inequalities do not identify irregular migrant children as a target group.

(CRC Background Paper for the Day of General Discussion on The rights of all children in the context of international migration, 28 September 2012).

2.3 The interdependence of human rights

The full enjoyment of many human rights depends on the realization of the right to health. Likewise, the full realization of the right to health cannot be pursued without respect for and fulfilment of several other rights, such as the right to an adequate standard of living, the right to work and the freedom of expression. As the graph in Section 2.1 demonstrates, many links can

²⁹ F. Crépeau, C. Rousseu et al. (2010) Right and access to healthcare for undocumented children: addressing the gap between international conventions and disparate implementations in North America and Europe, *Social Science and Medicine*, 70(2):329-336.

³⁰ A/HRC/14/30.

be established between different human rights. While all rights are equally interdependent with the right to health, a few rights are analysed below to illustrate this interdependence in more detail.

The right to adequate food³¹

The right to adequate food derives from the right to an adequate standard of living. The right to adequate food is realized when every man, woman and child, alone or in community with others, has physical and economic access at all times to adequate food or the means for its procurement. The right to adequate food shall therefore not be interpreted in a narrow or restrictive sense which defines food as a minimum package of calories, proteins and other specific nutrients.³²

The quality and quantity of food have a direct impact on the health of individuals and are, therefore, essential aspects of a person's well-being. From a human rights perspective, the right to adequate food implies the "availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture."³³

Access to safe and adequate food and nutrition presents a number of complex and interrelated challenges for migrants. It is not, however, the case that all risks associated with nutrition are related to the lack of food.³⁴ Some are related to poor diets, poverty and the economic inaccessibility to (i.e. the high cost of) healthy foods. Unhealthy diets, in particular, have been associated with a range of health problems – including obesity-related illnesses such as diabetes and cardiovascular disease – among certain migrant groups.³⁵

Violations of migrants' right to food

Violations of migrants' right to food can take various forms and can impact their lives and health. One form of migrant domestic worker mistreatment that has been reported is food deprivation – the denial of food adequate in terms of quantity or quality - which results in weight loss, malnutrition and other health consequences.³⁶ In the context of detention, the Special Rapporteur on the human rights of migrants highlighted that detained migrants may lack or have limited access to food and noted, moreover, that failure to provide culturally appropriate foods to migrants may be a violation of the right to food.

(Report of the UN Special Rapporteur on the human rights of migrants, Ms. Gabriela Rodríguez Pizarro, E/CN.4/2003/85 (2002) para. 53).

³¹ OHCHR and FAO, *Right to Adequate Food*, Fact Sheet No. 34 (Geneva, 2010).

³² CESCR General Comment No. 12 on the Right to adequate food (Art. 11), E/C.12/1999/5, 12 May 1999, para. 6.

³³ *Ibid.*, para. 8.

³⁴ T. Dubowitz, D. Acevedo-Garcia et al. Life course, immigrant status and acculturation in food purchasing and preparation among low income mothers, *Public Health Nutrition*, 10(4):396-404.

³⁵ N. R. Kleinfeld. Living at an epicenter of diabetes, defiance and despair, *The New York Times*, 10 January 2006. Available from www.nytimes.com/2006/01/10/nyregion/nyregionspecial5/10diabetes.html?_r=1&emc=eta1; see also Mathews R. & Zachariah R. (2008) Coronary heart disease in South Asian immigrants: synthesis of research and implications for health promotion and prevention in nursing practice. *Journal Transcultural Nursing*, 19(3):292-99.

³⁶ See, for instance, Human Rights Council (HRC) 11th Session, Report of the Special Rapporteur on violence against women, its causes and consequences: Mission to Saudi Arabia, 14 April 2009, A/HRC/11/6/Add.3, para. 59.

The right to adequate housing³⁷

The right to adequate housing is derived from the right to an adequate standard of living, (article 11 of the ICESCR). The CESCR has underlined that this right should be interpreted as the right to live somewhere in security, peace and dignity. Protection against forced evictions and the arbitrary destruction and demolition of one's home is a core aspect of the right to adequate housing.^{38,39}

The enjoyment of the right to adequate housing is indispensable to human dignity and the realization of a wide range of basic rights and freedoms, in particular the right to health and other rights essential to the well-being of every individual. Housing conditions have a significant impact on the quality of life and the physical and mental health of individuals. Lack of adequate housing is correlated with several health problems, such as poor nutrition, mental health problems and substance abuse,⁴⁰ as well as serious diseases caused by the lack of safe drinking water and sanitation facilities.

Poor accommodation has been associated with adverse health outcomes related to accidents, injury and exposure to pollutants, toxins and cold stress (i.e. hypothermia). In addition, overcrowding and poor sanitation can be associated with the increased risk of respiratory, gastrointestinal and dermatological diseases.⁴¹

Access to adequate housing may be challenging for many migrants, especially irregular ones. In its General Comment on this particular right, the CESCR pointed out that “a disturbingly large gap” exists between the right and its implementation in many parts of the world.⁴²

In some countries, discriminatory national laws seriously impair migrants' right to housing. For instance, there are laws which impose civil or criminal penalties on landlords who rent out housing to irregular migrants.⁴³ Segregation and discrimination, including in the form of administrative obstacles and renting procedures, remains a major barrier to migrants' ability to exercise their right to housing. The CESCR has expressed concern that migrant families “are disproportionately concentrated in poor residential areas characterized by large, low-quality and poorly maintained housing complexes” and recommended “the effective implementation of existing legislation to combat discrimination in housing, including discriminatory practices carried-out by private actors.”⁴⁴ Furthermore, the Committee on the Elimination of Racial Discrimination (CERD) has firmly stressed that states must take measures to eliminate discrimination and “act to avoid segregation in housing.”⁴⁵

³⁷ For an overview of the right to adequate housing, see OHCHR and UN Habitat, *Right to Adequate Housing*, Fact Sheet No. 21 (Geneva, 2009). Available from www.ohchr.org/EN/PublicationsResources/Pages/FactSheets.aspx.

³⁸ CESCR General Comment No. 4 on the Right to adequate housing (Art. 11.1), E/1992/23, 13 December 1991.

³⁹ CESCR General Comment No. 7 on the Right to adequate housing: Forced Evictions (Art.11.1); E/1998/22, 20 May 1997.

⁴⁰ Australia Human Rights and Equal Opportunity Commission (2008) *Homelessness is a Human Rights Issue*, para. 6.2.

⁴¹ UNICEF, WHO, World Bank and UNPD. *Globalization and Infectious Diseases: Review of the Linkages* (Geneva, 2004), p.41.

⁴² E/1992/23, para. 4.

⁴³ “Equal rights for all migrants: A call for ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,” address by the UN High Commissioner for Human Rights, Ms. Navi Pillay (Geneva, 14 December 2011). Available from www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=11723&LangID=E.

⁴⁴ CESCR, 40th session, Concluding Observations of the Committee on Economic, Social and Cultural Rights: France, E/C.12/FRA/CO/3, 29-30 April 2008, para. 41(iii). Further numerous studies have highlighted how administrative obstacles and indirect forms of discrimination compel migrants to concentrate in impoverished areas and in substandard housing where overcrowding, lack of services including transportation and safe drinking water and sanitation, are the norm. See also, e.g. S. Braunschweig and M. Carballo, *Health and Human Rights of Migrants* (Geneva, WHO and International Centre for Migration and Health, 2002).

⁴⁵ ICERD, 64th session, General Recommendation No. 30 on Discrimination against non-citizens, CERD/C/64/Misc.11/rev.3, 23 February – 12 March 2004, para. 32.

The right to adequate housing goes beyond having a mere shelter. According to the Commission on Human Settlements, adequate shelter is defined as ‘adequate privacy, adequate space, adequate security, adequate lighting and ventilation, adequate basic infrastructure and adequate location with regard to work and basic facilities – all at a reasonable cost.’⁴⁶ Migrants are not only more likely to have less access to *adequate* housing, but are also more likely to be homeless. In the European Union (EU), migrants comprise around 20 per cent of the homeless population, and in Copenhagen, Denmark (an EU member state), as many as 33 per cent of the city’s homeless population are migrants.⁴⁷

The relationship between a migrant worker and his or her employer may further complicate the issue of access to adequate housing. For example, in some countries, employers are required to provide housing for the workers they hire from abroad. OHCHR has expressed concerns that in many situations, the type of housing provided by employers may be inadequate, even when the employer deducts a large portion of the worker’s salary as payment for the housing or when several workers share the same bed in turns, a phenomenon sometimes referred to as “hot beds.”⁴⁸

Similar concerns exist for migrant domestic workers who live in the house where they work. In addition to the lack of privacy, domestic workers in such settings often live in substandard accommodations where they are forced to sleep in hallways or closets. Moreover, given that these workers live in the house where they work, they may be compelled to remain on duty 24 hours a day, often without a day-off during the week. In many regions of the world, the exploitation of migrant domestic workers and their treatment even “reach the intensity of slavery or slavery-like conditions.”⁴⁹ Domestic migrant workers living in such settings – many of whom are women – may also be subjected to physical, psychological and sexual violence. Moreover, such workers are at risk of being evicted from the accommodation provided in connection to their work⁵⁰ and may have to put up with abuse from their employers to avoid becoming homeless. It has also been reported that migrant domestic workers are often unaware of available health services and facilities and, in some cases, are not paid for days taken as sick leave.⁵¹

The right to work and labour rights

Article 7 of the ICESCR states that everyone has the right to the enjoyment of just and favourable conditions of work, which include a safe and healthy working environment. The impact of inadequate working conditions on the health and well-being of an individual should not be underestimated. Migrant workers are among the most vulnerable workers in the world, often subject to exploitation, discrimination and abuse, lacking access to mechanisms for remedy and redress and in constant fear of deportation.

International human rights law and international labour law converge on the issue of migrant workers. For example, by adopting the 1998 Declaration on Fundamental Principles and Rights at Work, the member states of the ILO agreed to adhere to the principles in the eight core ILO Conventions (which address forced labour, the elimination of child labour, trade union rights

⁴⁶ UN General Assembly Global Strategy for Shelter to the Year 2000, Resolution adopted at the 78th Plenary Meeting, A/RES/46/163 19 December 1991.

⁴⁷ M. Carballo and M. Mboup, *International Migration and Health*, International Centre for Migration and Health, Paper prepared for the Policy Analysis and Research Programme of the Global Commission on International Migration (Geneva, 2005), p. 7.

⁴⁸ E/2010/89, paras. 36-40. Studies find that temporary and seasonal migrant workers face serious housing problems and tend to cluster in makeshift accommodation or shanty towns. There is a vicious cycle linking poor housing, hazardous working conditions, social disruption and the spread of diseases among migrant workers.

⁴⁹ OHCHR Europe Regional Office, *Rights of Migrant Domestic Workers in Europe* (Geneva, 2011), p. 5.

⁵⁰ Report of the Special Rapporteur on women and adequate housing, Mr. Miloon Kothari, E/CN.4/2006/118, 27 February 2006, para. 68.

⁵¹ EU Fundamental Rights Agency, *Migrants in an irregular situation employed in domestic work: Fundamental rights challenges for the European Union and its member states*, (Vienna, 2011), pp. 24-26.

and non-discrimination) even when they have not ratified the instrument in question.⁵² This Declaration seeks the elimination of a number of practices which directly impact on the mental and physical health of migrant workers. Among the practices that need to be eliminated are, for instance, forced or compulsory labour, child labour and discrimination in respect of employment and occupation. Furthermore, the Declaration recognizes the freedom of association and the effective recognition of the right to collective bargaining. The prohibition of discrimination on the basis of nationality ensures the full application of all labour protections to migrant workers and the consideration of health in the workplace.

Regional human rights systems and migrant workers

Regional human rights bodies have strongly supported the applicability of labour protection to migrants, including irregular migrants. As stated by the Inter-American Court of Human Rights: “On assuming an employment relationship, the migrant acquires rights as a worker, which must be recognized and guaranteed, irrespective of his regular or irregular status in the State of employment.”⁵³ In the case of *Siliadin v. France*, the European Court of Human Rights applied Article 4 of the European Convention on Human Rights, which prohibits slavery, servitude and forced or compulsory labour, regardless of the victim’s migration status. In the said case, the victim was an undocumented child migrant who was forced to work as a domestic worker without pay and no rest, under the promise of attaining regular status in France.⁵⁴

The right to social security

Article 9 of the ICESCR provides that “[t]he States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.” As the CESCR has noted, the right to social security encompasses the right to access and maintain benefits, whether in cash or in kind and without discrimination, in order to secure protection, inter alia, from (a) lack of work-related income caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member; (b) unaffordable access to health care; and (c) insufficient family support, particularly for children and adult dependents.⁵⁵

States cannot arbitrarily exclude migrant workers from social security and social protection schemes. The CESCR has established that the principle of non-discrimination on the basis of nationality applies equally to the right to social security. Further, the Committee elaborated that the right to social security includes contributory or insurance-based schemes such as social insurance, inter alia, as well as non-contributory schemes (for instance, universal or targeted schemes).⁵⁶

It is important to acknowledge that migrant workers are a valuable part of a country’s workforce and economy and, thus, may contribute to social insurance schemes by paying taxes. The CESCR has advised that when migrant workers have contributed to a social security scheme, they should be able to benefit from it or retrieve their contribution when they leave the country.⁵⁷ Article 27 of the International Convention on the Protection of the Rights of All Migrant Workers and

⁵² For more information on the international legal framework for the protection of migrant workers, see IOM, ILO and OSCE, *Handbook on Establishing Effective Labour Migration Policies, Mediterranean edition* (Geneva, 2007), pp. 27-37.

⁵³ Inter-American Court of Human Rights, *Juridical Condition and Rights of Undocumented Migrants*, Advisory Opinion OC-18/03, 17 September 2003, para. 134.

⁵⁴ *Siliadin v. France*, 73316/01, ECtHR, judgment of 26 July 2005, paras. 109-129.

⁵⁵ CESCR General Comment No. 19 on the Right to social security (Art. 9), E/C.12/GC/19, 4 February 2008, para. 2.

⁵⁶ *Ibid.*, para. 4.

⁵⁷ *Ibid.*, para. 36.

Members of Their Families (ICRMW) extends the right to social security to all migrant workers and members of their families.⁵⁸

A person's migratory status – that is, whether he or she is documented or undocumented – should not be a determining factor for inclusion in a state's social protection schemes, in order to address poverty and social exclusion.⁵⁹ The CESCR has clearly prescribed that “non-nationals should be able to access non-contributory schemes for income support, affordable health care and family support. Any restrictions, including a qualification period, must be proportionate. All persons, irrespective of their nationality, residency or immigration status, should be entitled to primary and emergency medical care.”⁶⁰ The Committee also noted the importance of establishing reciprocal bilateral and multilateral international agreements or other instruments in order to coordinate or harmonize contributory social security schemes for migrant workers.⁶¹

Efforts to enhance migrants' access to health services

A number of states are using innovative approaches to contributory social security schemes, employer-based health insurance and tax-based schemes to improve migrants' health and access to health services. For example, some countries of migrant origin that heavily rely on remittances, such as Sri Lanka and the Philippines, put in place insurance schemes for their overseas migrant workers. Several countries of destination, including Thailand, offer health services to certain categories of registered migrants and their families through a compulsory migrant health scheme. Brazil, Spain and Portugal are examples of countries that have adopted a policy of equal access to coverage for all migrants irrespective of their legal status. Other initiatives are led by trade unions and employees. For instance, in Argentina, employers of rural migrant workers contribute a percentage of their workers' salaries towards a special fund that covers social benefits, including health insurance. However, only a few cases of portable health-care benefits – such as those provided in the Moroccan-German agreement – exist. Despite the rarity of these cases, some migrants within the EU enjoy high standards of portability of health-care benefits. The above-mentioned efforts may have their limitations, but they at least recognize the need to ensure the health of migrants as a human right, as well as a good public health practice.

(GFMD 2010 Background paper Roundtable 2.1 “Reducing the costs of migration and maximizing human development”, Annex 1: Examples of global migrant health responses. Fourth meeting of the Global Forum on Migration and Development, held in Mexico 2010. Available from www.gfmd.org/en/docs/mexico-2010).

⁵⁸ Article 27 of the ICRMW provides that:

“1. With respect to social security, migrant workers and members of their families shall enjoy in the State of employment the same treatment granted to nationals in so far as they fulfil the requirements provided for by the applicable legislation of that State and the applicable bilateral and multilateral treaties. The competent authorities of the State of origin and the State of employment can at any time establish the necessary arrangements to determine the modalities of application of this norm.

2. Where the applicable legislation does not allow migrant workers and members of their families a benefit, the States concerned shall examine the possibility of reimbursing interested persons the amount of contributions made by them with respect to that benefit on the basis of the treatment granted to nationals who are in similar circumstances.”

⁵⁹ CESCR has clearly stated that “[t]he right to social security is of central importance in guaranteeing human dignity for all persons when they are faced with circumstances that deprive them of their capacity to fully realise their Covenant rights.” Ibid., para. 1 (emphasis added).

⁶⁰ E/C.12/GC/19, para. 37.

⁶¹ E/C.12/GC/19, para. 56.

The right to family life

The family is recognized as the natural and fundamental group unit of society in, inter alia, Article 23 of the International Covenant on Civil and Political Rights (ICCPR). Rights specific to children, such as the principle of family unity, the rights to a name, registration at birth and nationality, as well as the right not to be separated from their parents against their will, are protected under the Convention on the Rights of the Child (CRC), Articles 7, 8 and 9. The principle of the best interests of the child is derived from Article 3.1 of the Convention, and the Committee on the Right of the Child, in its General Comment No. 6, makes it clear that the best interests of the child should be the primary consideration, including in issues of family reunification. The ICRMW contains specific provisions protecting all individuals, and it also makes explicit reference to the family (e.g. in Articles 14 and 44).

Long-term separation from family members and loved ones may be associated with psychological problems, substance abuse, high-risk-taking behaviours, and other related adverse health outcomes.^{62,63} In relation to women and children migrants, such a separation may increase the risk of exploitation, violence and abuse.⁶⁴

Family ties are strongly connected to the physical and mental health of family members, in particular children, the elderly and those in situations of vulnerability. In the context of migration, social isolation caused by separation from family and social networks, job insecurity, difficult living conditions and exploitative treatment can have adverse effects on the mental health of migrants.

As mentioned above, the family is considered “the fundamental group unit of society”⁶⁵ in human rights law and is accorded “the widest possible protection and assistance.”⁶⁶ The Human Rights Committee (CCPR) recognizes that the term “family” may have diverse meanings among different states; thus, it emphasizes that the term is to be understood broadly and that it refers to different types and different membership compositions.⁶⁷ It has been established that family members may include more than those in the customary notion of a nuclear family, i.e. husband, wife and minor children. The ICRMW explicitly recognizes this principle in Article 4.⁶⁸

Respect for the right to family life requires not only that states refrain from actions resulting in family separation, but also obligates states to take positive measures to maintain the unity of the family and reunite family members who have been separated. For example, when family members are separated and reside in different countries due to political, economic or similar reasons, states are obliged to facilitate family contact and family reunification.⁶⁹

⁶² S. Maguire and K. Martin, Fractured migrant families: paradoxes of hope and devastation, *Family and Community Health*, 30:178-188.

⁶³ A. Mercer, G. Khanam et al. Sexual risk behaviour of married men and women who have lived apart due to the husband’s work migration, *Sexual Transmitted Diseases*, 34(5):265-73.

⁶⁴ United Nations Population Fund, *State of the World Population 2006: A Passage of Hope: Women and International Migration* (New York, 2006).

⁶⁵ Universal Declaration of Human Rights, Art. 16.3.

⁶⁶ ICESCR, Art. 10.1.

⁶⁷ CCPR General Comment No. 19 on the Protection of the family, the right to marriage and equality of the spouses (Art. 23), 27 July 1990, para. 2. The comment states that “[t]he concept of the family may differ in some respects from State to State, and even from region to region within a State, and...it is therefore not possible to give the concept a standard definition.”

⁶⁸ ICRMW, Art. 4 states that “[f]or the purposes of the present Convention the term ‘members of the family’ refers to persons married to migrant workers or having with them a relationship that, according to applicable law, produces effects equivalent to marriage, as well as their dependent children and other dependent persons who are recognized as members of the family by applicable legislation or applicable bilateral or multilateral agreements between the States concerned.”

⁶⁹ ICRMW, Art. 44 (In respect of migrant workers in a regular situation and members of their families); CRC, Art. 10.1.

The right to family life also entails the right of children to parental care. This right governs the obligations of states to ensure that children are not separated from their parents without due judicial process.⁷⁰ The principle of family unity has an important protective function for children in the context of migration, particularly in the situation of unaccompanied and separated migrant children; hence, states are also obliged to take special measures to trace and reunite parents with their unaccompanied or separated children.⁷¹ At the heart of these principles is the need to ensure that the best interests of the child are served and to guard against economic or social exploitation and abuse.

The right to seek, receive and impart information

Article 19 of the ICCPR states that “[e]veryone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.”

Ensuring that necessary information is both available and understood by diverse populations is an increasingly important consideration for public health planning and preparedness in countries with large groups of migrants.^{72,73}

Availability of health-related information, including that on sexual and reproductive health issues⁷⁴ such as family planning and sexually transmitted infections, is central to ensuring equality and non-discrimination in the access to health care for specific individuals such as women, adolescents and young adults, and persons living with HIV. Accessibility to health information should also include the right to seek and receive impartial information and professional opinions concerning health issues.⁷⁵

Improving the health of indigenous migrant workers in Central America by disseminating information

IOM has produced for the Ngöbe-Buglé indigenous population information, education and communication (IEC) materials on basic hygiene practices to prevent the spread of influenza-like illnesses. Every year the Ngöbe-Buglé population cross the border between Panama and Costa Rica to work in the agricultural sector. IOM involved cultural advisors in developing bilingual IEC materials in Spanish and in the indigenous Ngobere language to ensure the dissemination of culturally appropriate information to these migrant workers.

⁷⁰ CRC, Art. 9.1.

⁷¹ CRC General Comment No. 6 on the Treatment of unaccompanied and separated children outside their country of origin, CRC/GC/2005/6, 1 September 2005, Section VII.

⁷² S. Shiu-Thornton, J. Balabis et al. Disaster preparedness for limited English proficient communities: Medical interpreters as cultural brokers and gatekeepers. *Public Health Reports*, 122:466-471.

⁷³ Y. Pylypchuk J. Hudson, Immigrants and the use of preventive care in the United States, *Health Economics*, 18(7):783-806.

⁷⁴ One health issue which affects women and girls is the practice of female genital mutilation (FGM) in certain cultures. For more information, read on the IOM position on FGM at www.iom.int/jahia/Jahia/about-iom/organizational-structure/iom-gender/activities-best-practices/fgm/cache/offonce/; the factsheet from WHO at www.who.int/mediacentre/factsheets/fs241/en/; and the factsheet from OHCHR at www.ohchr.org/Documents/Publications/FactSheet23en.pdf.

⁷⁵ CESCR General Comment No. 14, para. 12(b).

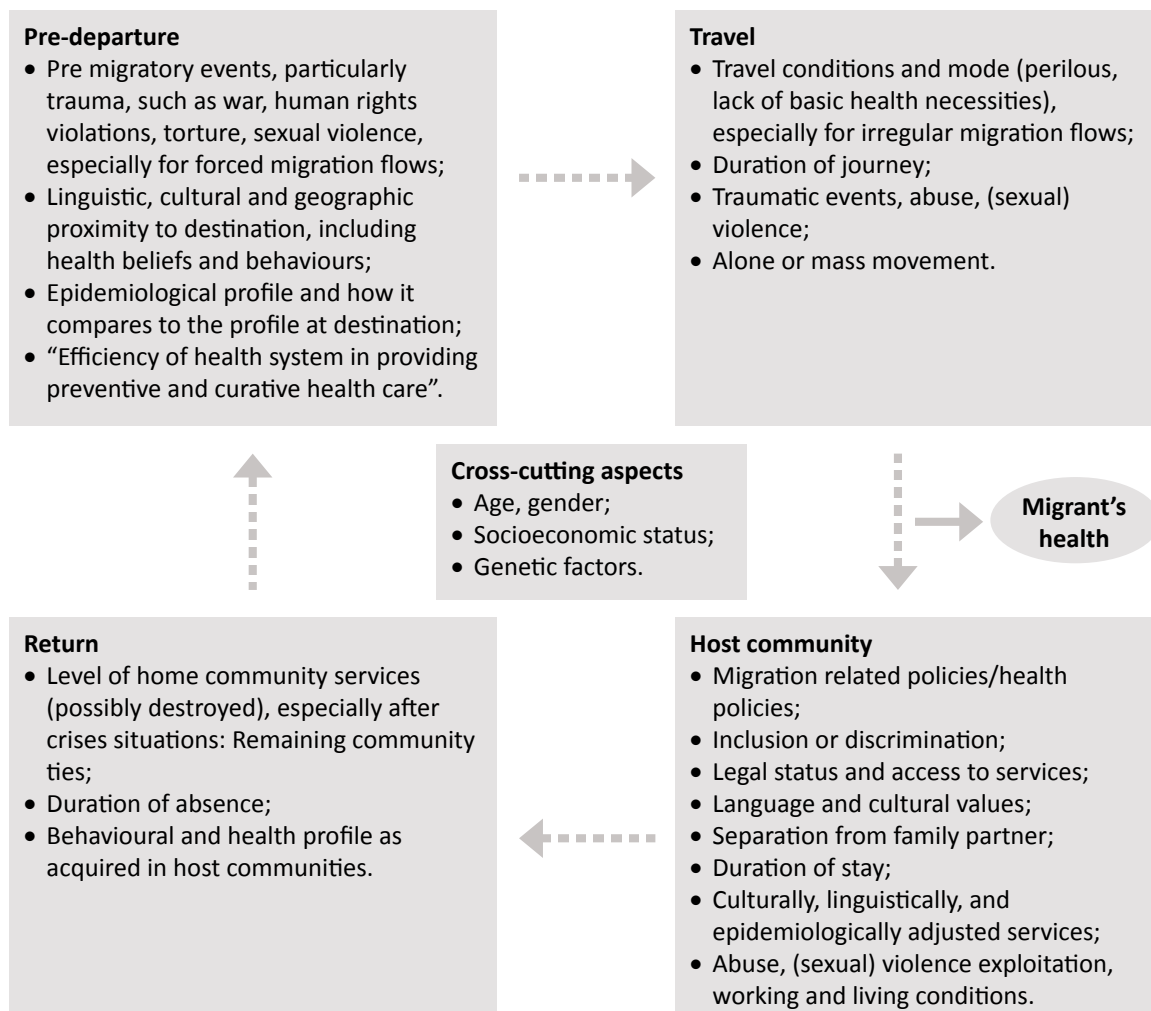
SECTION 3. HEALTH CHALLENGES OF THE MIGRATION PROCESS

This section provides a comprehensive review of implications of migration on public health, as well as on the health of the individual migrant. It focuses on the link between health and migration in various phases of the migration process and includes examples of challenges, as well as promising developments with regard to the protection of migrants' right to health.

The stages of the migration process

Conditions surrounding the migration process can increase migrants' vulnerability to ill health. Risk factors can be related to circumstances present before the departure, during travel, at the destination and while returning to the place of origin (Figure 4).

Figure 4. Aspects of the various migration stages that can affect migrants' health⁷⁶



⁷⁶ Adapted from B. Gushulak, J. Weekers and D.W. MacPherson, Migrants in a globalized world – health threats, risks, and challenges: An evidence-based framework. *Emerging Health Threats Journal*, published online 2010 March 31; and IOM, Migration and Health: IOM's Programmes and Perspectives: towards a multisectoral approach. Standing Committee on Programme and Finance, 2nd Session, SCPF/12 (Geneva, 2008).

Differences in health vulnerabilities among migrants

The risk of illness and adverse health outcomes is higher for certain migrant groups. Migrants originating from areas of poverty, those who are displaced by conflict or a natural disaster, vulnerable groups (e.g. people with pre-existing health conditions, unaccompanied migrant children, the elderly, the young and single-parent families) and those with limited educational, job and linguistic skills, are at greater risk of adverse health outcomes.^{77,78,79} Furthermore, migrants who are subjected to legal, economic and/or social exclusion (especially migrants in an irregular situation) can be disproportionately vulnerable to contracting disease and developing mental health problems resulting from poor living environments, exploitative working conditions and lack of access to health and social services.^{80,81,82,83}

Inequalities in health and access to quality care for migrant groups cannot be addressed by health systems alone. Social determinants of health cut across various sectors, such as education, employment, social security and housing, among others. All these have a considerable impact on the health of migrants.^{84,85,86} As recognized by the abovementioned human rights framework (Section 2), the right to health is closely related to and dependent upon a range of other human rights.

⁷⁷ B. Moynihan, M.T. Gaboury and K.J. Onken, Undocumented and unprotected immigrant women and children in harm's way, *Journal of Forensic Nursing*, 4:123-129.

⁷⁸ The United Nations Children's Fund (UNICEF), *Children in Immigrant Families in Eight Affluent Countries* (Innocenti Research Centre, Florence, 2009).

⁷⁹ WHO. *Health of migrants-The way forward: Report of a global consultation* (Geneva, 2010). Available from www.who.int/hac/events/consultation_report_health_migrants_colour_web.pdf.

⁸⁰ Comment (2010) on Migration and health: a dynamic challenge for Europe. *EuroHealth* 16(1).

⁸¹ The Platform for International Cooperation on Undocumented Migrant (PICUM), *Access to Health Care for Undocumented Migrants in Europe*(2007). Available from http://picum.org/picum.org/uploads/file_/Access_to_Health_Care_for_Undocumented_Migrants.pdf.

⁸² HUMA Network, *Access to Health Care for Undocumented Migrants and Asylum Seekers in 10 European Countries: Law and Practice*.

⁸³ HUMA Network *Access to healthcare for undocumented migrants in 11 European countries*.

⁸⁴ WHO, *The Tallin Charter: Health Systems for Health and Wealth* (Copenhagen, 2008).

⁸⁵ WHO Resolution 62.14 on Reducing health inequities through action on the social determinants of health, WHA62.14, 22 May 2009, Agenda item 12.5.

⁸⁶ WHO, *Social Determinants of Health*, Available from www.who.int/social_determinants/en.

Tuberculosis (TB) and migrants' rights

The TB and Human Rights Task Force of the Stop TB Partnership aims to protect and promote human rights in its pursuit of universal access to TB prevention, diagnosis and treatment. In one of its working documents, the task force stipulates the main human rights issues associated with TB with regard to migrants, refugees and internally displaced persons.

Migrants

- Migrants in an irregular situation often fall to the lower end of the social structure, where they may be at risk of TB due to poor housing, inadequate nutrition, lack of access to health facilities, information and services and/or exploitative working conditions;
- Migrants may be denied access to the diagnosis of and treatment for TB because of their legal status. They may avoid accessing health services for fear of deportation and delay seeking treatment because of the lack of education and information;
- Continuity of care is often unavailable to deportees.

Refugees

- Refugees have a high risk of developing TB associated with poor nutritional status and sanitation, crowded living conditions, insufficient access to care, education and information, and other coexistent illnesses. Ensuring appropriate TB treatment and control may be difficult because of, for example, changing emergency situations or the lability of a refugee population.

Internally displaced persons

- The prevention and diagnosis of TB, as well as the continuity of TB care, are often neglected in the context of protracted humanitarian emergencies.

(Stop TB Partnership TB Human Rights Task Force - WORKING DOCUMENT on TB and Human Rights, available at www.stoptb.org/assets/documents/global/hrtf/Briefing%20note%20on%20TB%20and%20Human%20Rights.pdf).

Gender-specific health vulnerabilities of migrants

In 2008, the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) directed its attention to the situation of women migrant workers, including their sexual and reproductive health. As noted in its General Recommendation No. 26 on women migrant workers, “[d]iscrimination may be especially acute in relation to pregnancy. Women migrant workers may face mandatory pregnancy tests followed by deportation if the test is positive; coercive abortion or lack of access to safe reproductive health and abortion services, when the health of the mother is at risk, or even following sexual assault; absence of, or inadequate, maternity leave and benefits and absence of affordable obstetric care, resulting in serious health risks. Women migrant workers may also face dismissal from employment upon detection of pregnancy, sometimes resulting in irregular immigration status and deportation.”

(UN Committee on the Elimination of Discrimination against Women, General Recommendation No. 26 on women migrant workers, CEDAW/C/2009/WP.1/, para. 18, 5 December, 2008).

Non-deportation of pregnant migrant workers in Israel

In a landmark ruling in April 2011, the Israeli High Court of Justice abolished a regulation allowing for pregnant migrant workers to be deported and declared it unconstitutional. Under the regulation, if a pregnant migrant worker was not employed, she could be deported during the first six months of her pregnancy. On the other hand, a migrant worker more than six months pregnant, regardless of her employment status, could not be deported until 90 days after giving birth. After the deportation, the women would be left with two choices, that is, either apply for a work permit for two years and return to Israel without her child, or stay in her home state. The Court stated that forcing women to choose between her family and work “involves serious infringement upon the workers’ constitutional rights under Israeli law.”

(See the *Migrant Rights* website, available at www.migrant-rights.org/2011/04/17/israeli-high-court-forbids-deportation-of-pregnant-migrant-workers/).

3.1 Pre-departure and at the border

Conventionally, migration management has been considered to fall within the scope of national sovereignty. This means that states have the power to control their borders; determine which non-nationals to admit to their territory and which ones to remove under certain circumstances; and to take necessary steps to protect public security.⁸⁷

Despite the sovereignty of nations, the power to manage migration must, however, be exercised with full respect of international law and, particularly, of international human rights law. When countries exercise their sovereign powers to deny admission to migrants, they must do so in a manner that is consistent with their obligations under international law, including adherence to the fundamental principles of non-refoulement and of non-discrimination. This latter principle requires states, inter alia, not to treat persons intending to enter or reside on their territory differently solely due to prohibited grounds, such as health or disability status, unless there is an objective and reasonable basis for doing so.⁸⁸ The Convention on the Rights of Persons with Disabilities (CRPD) defines discrimination on the basis of disability as “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”⁸⁹

⁸⁷ S. Vohra, Detention of irregular migrants and asylum seekers. In: R. Cholewinski, R. Perruchoud and E. MacDonald (eds.) *International Migration Law: Developing Paradigms and Key Challenges*, Asser Press, The Hague, Ch. 3.

⁸⁸ For guidance on the limitation and derogation provisions in the International Covenant on Civil and Political Rights, see Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, U.N. Doc. E/CN.4/1985/4. The Principles state that “[p]ublic health may be invoked as a ground for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individual members of the population. These measures must be specifically aimed at preventing disease or injury or providing care for the sick and injured.” And that “[d]ue regard shall be had to the international health regulations of the World Health Organization”. See also the Joint United Nations Programme on HIV/AIDS (hereafter UNAIDS)/IOM Statement on HIV/AIDS-related Travel Restrictions, Geneva, UNAIDS/IOM, 2004; UN, International Law Commission, *Expulsion of aliens: Memorandum by the Secretariat*, UN Doc. A/CN.4/565, 2006, para. 261 and paras. 392-400. (The memorandum lists some national laws that enumerate physical defects, mental illness or handicap or retardation as grounds for the refusal of entry or the expulsion of those non-nationals who suffer from the specified health condition). See also Human Rights Watch (2009) *Discrimination, Denial, and Deportation Human Rights Abuses Affecting Migrants Living with HIV*.

⁸⁹ CRPD, Article 2. The prohibition has been reaffirmed in CESCR, GC No. 14. See also, resolutions of the UN Commission on Human Rights, E/CN.4/RES/1997/33, E/CN.4/RES/1999/49 and E/CN.4/RES/2001/51 on the protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS).

In today's world of increased international mobility, public health risks in a specific geographic location can rapidly assume global relevance.⁹⁰ This was illustrated by the international spread, awareness and detection of and response to the influenza A(H1N1) pandemic in 2009.⁹¹ The fact that public health can be affected by human mobility was acknowledged as early as the 14th century during the plague epidemic in Europe. Formal systems of quarantine to stem the spread of infectious diseases through travel are part of the oldest border-entry requirements and predate immigration laws. Long-standing coordinated attempts at the international level to contain disease transmission were consolidated into the International Health Regulations (IHR), revised in 2005.⁹² The IHR recognize that there shall be no prejudice with regard to the rights persons have under applicable international law. The IHR have expressed that when applying health measures, affected travellers shall be treated by states "with respect for their dignity, human rights and fundamental freedoms."⁹³

Compulsory medical screening of migrants

Traditional approaches to health and migration frequently deal with specific diseases (primarily communicable diseases of public health interest, such as tuberculosis) that may be associated with the arrival of migrants.⁹⁴ Immigration-related medical screening, quarantine and isolation have been used in attempts to address the possible introduction of health threats.⁹⁵ Some countries with long-standing immigration programmes systematically screen applicants for permanent residency status and certain other categories of migrants, such as international students and migrant workers, for a variety of health conditions and illnesses.⁹⁶ Such screening or health assessment can take place before departure, upon arrival at the border or in the host country, as is the case with a change in visa status.

The most common justification offered for the systematic and compulsory screening of visa applicants is to ensure that the migration process does not endanger the health of the host population. Efforts in this area have focused on the control of cross-border transmission of infectious diseases. The disease burden of the migration process on the migrant population and the impact this might have on national health and social services have been another concern. In this case, attention is focused on chronic diseases requiring long-term treatment, often in countries that have state-supported national health insurance coverage. Several countries waive the costs associated with these health demands or considerations for refugees and those in need of international protection, but for other categories of migrants it can lead to exclusion from migration.^{97,98,99,100}

⁹⁰ B. Gushulak, J. Weekers and D.W. MacPherson. Migrants in a globalized world - health threats, risks, and challenges: An evidence-based framework, *Emerging Health Threats Journal*, published online 2010 March 31.

⁹¹ M. A. Miller, C. Viboud, M. Balinska and L. Simonsen, The signature feature of influenza pandemics – Implications for policy, *New England Journal of Medicine*, 360:2595-2598; see also, C. Fraser, C. A. Connelly CA, S. Cauchemez et al., Pandemic potential of a novel strain of influenza A(H1N1): Early findings, *Science*, 324:1557-1561.

⁹² WHO, The International Health Regulations, second edition (IHR, entered into force in 2007 and legally binding on 194 countries). The regulations aim at preventing the international spread of diseases while limiting unnecessary restrictions on the free movement of travellers. Available from http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf.

⁹³ *Ibid.*, Art. 32.

⁹⁴ H. Blumberg, G. Migliori, O. Ponomarenko and E. Heldal, Tuberculosis on the move, *The Lancet*, 375:2127-2129.

⁹⁵ M. Cetron and P. Simone, Battling 21st-century scourges with a 14th-century toolbox. *Emerging Infectious Diseases Journal* 10(11): 2053-54. Available from www.cdc.gov/ncidod/eid/vol10no11/04-0797_12.htm.

⁹⁶ T.A. Arcury and S.A. Quandt, Delivery of health services to migrant and seasonal farm workers. *Annual Review of Public Health*, 28:345-363.

⁹⁷ IOM, *Migration Health Service Medical Manual, 2001 Edition* (Geneva, International Organization for Migration, 2001).

⁹⁸ United States Center for Disease Control and Prevention (CDC), *Medical examinations of immigrants and refugees*. Available at: www.cdc.gov/immigrantrefugeehealth/exams/medical-examination.html.

⁹⁹ Australian Department of Immigration and Citizenship, *Health Requirements for Visa Applicants*. Available at: www.immi.gov.au/allforms/health-requirements/.

¹⁰⁰ United Kingdom Border Agency. *Health screening for Visa Application*, available at: www.ukvisas.gov.uk/en/howtoapply/tbscreening/; and Citizenship and Immigration Canada. *Guidelines about medical exams*. Available at: www.cic.gc.ca/english/information/medical/index.asp.

The compulsory health screening of migrants has been criticized as a human rights violation by expert bodies.¹⁰¹ The justification for such mandatory screening has also been questioned, given the complexity and diversity of contemporary migration flows and the fact that diseases may be latent, that is, present but not manifesting symptoms. The important public health aspects of migration are based on the diversity of the migrant populations themselves and the social determinants of migrants' health, extending well beyond the legal and temporal processes of changing one's residence.¹⁰²

Some screening practices (such as those already mentioned) might have a limiting effect on a person's human rights and even pose ethical and moral questions. Examples of such practices include pregnancy screening of female temporary migrant workers, to prevent situations wherein children are born during the period of employment, and the use of DNA testing to determine family relationships for immigration purposes.^{103,104}

In the case of highly infectious diseases such as severe acute respiratory syndrome, which pose an immediate threat to the health of the general public, screening at departure may be an effective measure to protect public health.¹⁰⁵ Medical screenings – if done with the appropriate human rights safeguards and, particularly, if supported by adequate pre- and post-arrival health services and community-based interventions – can contribute to addressing the health needs of migrants and host communities alike.

ILO Recommendation No. 200 on HIV/AIDS, 2010 (in particular, paragraphs 25, 27 and 28)

“25. HIV testing or other forms of screening for HIV should not be required of workers, including migrant workers, jobseekers and job applicants.

27. Workers, including migrant workers, jobseekers and job applicants, should not be required by countries of origin, of transit or of destination to disclose HIV-related information about themselves or others. Access to such information should be governed by rules of confidentiality consistent with the ILO code of practice on the protection of workers' personal data, 1997, and other relevant international data protection standards.

28. Migrant workers, or those seeking to migrate for employment, should not be excluded from migration by the countries of origin, of transit or of destination on the basis of their real or perceived HIV status.”

Denial of entry, stay and residence due to HIV status

Some countries¹⁰⁶ have specific restrictions on entry, residence and stay based on HIV status, with some even imposing a complete ban on HIV-positive people for any reason or length of stay. Besides being discriminatory, these travel restrictions have no public health justification

¹⁰¹ Committee on Migrant Workers (CMW) General Comment No. 1 on migrant domestic workers, CMW/C/GC/1, 23 February 2011, para. 22.

¹⁰² H. Hogan, R. Coker et al., Screening of new entrants for tuberculosis: Responses to port notifications. *Journal of Public Health*, 27:192-95; R. Coker, Compulsory screening of immigrants for tuberculosis and HIV. *British Medical Journal*, 328:298-300; B. Gushulak, K. Pottie et al. Migration and health in Canada: Health in the global village. *Canadian Medical Association Journal* 183(12):E952-8.

¹⁰³ J. Taitz, J. Weekers and D. Mosca D. DNA and immigration: The ethical ramifications. *Lancet*, 359:794.

¹⁰⁴ Human Rights Watch, *Exported and Exposed; Abuses against Sri Lankan Domestic Workers in Saudi Arabia, Kuwait, Lebanon, and the United Arab Emirates* (New York, 2007).

¹⁰⁵ P. Spiro, The legal challenges SARS poses, *CNN FindLaw*, 29 April 2003. Available at: <http://edition.cnn.com/2003/LAW/04/29/findlaw.analysis.spiro.sars>.

¹⁰⁶ For more information, see the country listings of the Joint United Nations Programme on HIV/AIDS (UNAIDS) at www.unaids.org/en/media/unaids/contentassets/documents/priorities/20110620_CountryList_TravelRestrictions_en.pdf.

whatsoever because HIV is not transmitted by the mere presence of a person with HIV or by casual contact. In addition, such restrictive measures may deter people from coming forward to use HIV services. People living with HIV can lead long and productive lives that contribute to host states' economies.¹⁰⁷

In 2008, with the aim of drawing attention to and ending the discriminatory practice of HIV-related restrictions on entry, stay and residence, UNAIDS convened the International Task Team on HIV-Related Travel Restrictions. The team included governments, civil society, networks of people living with HIV and international organizations and urged states to fulfil the equal rights of people living with HIV to the freedom of movement and the freedom from non-discrimination.^{108,109}

During the last couple of years, much progress has been made towards breaking down migration barriers to people with HIV. For instance, in January 2010, the United States removed HIV-related entry restrictions, overturning a policy that had been in place since 1987.¹¹⁰ China and Namibia have also since removed similar restrictions.^{111,112}

UN Secretary-General urges for an end to discrimination against people living with HIV

“Six decades after the [Universal Declaration of Human Rights] was adopted, it is shocking that there should still be discrimination against [...] individuals living with HIV. This not only drives the virus underground, where it can spread in the dark; as important, it is an affront to our common humanity. [...] I call for a change in laws that uphold stigma and discrimination, including restrictions on travel for people living with HIV.”

(Ban Ki-Moon, UN Secretary General, United Nations High Level Meeting on AIDS, June 2008).

European Court of Human Rights finds travel restrictions on people living with HIV to be discriminatory

In the landmark judgment of *Kiyutin v. Russia* adjudicated by the European Court of Human Rights in 2011, the Court found that refusing to grant a residence permit to a foreign national solely on the basis of HIV status amounts to unlawful discrimination. This is the first time the Strasbourg Court expressly recognized the protection of people living with HIV under Article 14 (non-discrimination) of the European Convention on Human Rights. Further, this is the first time any international or regional human rights adjudicative body condemned HIV-related restrictions on entry and residence as inherently discriminatory and, therefore, unlawful.

(Case Kiyutin v. Russia, Application no. 2700/10, judgment 10 March 2011).

¹⁰⁷ UNAIDS and IOM, *Statement on HIV/AIDS-related Travel Restrictions* (Geneva, 2004).

¹⁰⁸ UNAIDS, Mapping of restrictions on the entry, stay and residence of people living with HIV, UNAIDS/09.20E/JC1727E, May 2009.

UNAIDS (2009) *Denying Entry, Stay and Residence Due to HIV Status*, 3rd edition; and UNAIDS (2008) *Report of the International Task Team on HIV related travel restrictions: Findings and recommendations*, UNAIDS/09.19E/JC1715E.

¹⁰⁹ The European AIDS Treatment Group and the International AIDS Society, Global Database on HIV-Related Travel Restrictions is an Initiative of the German AIDS Federation. For details on the Global Database, see www.hivtravel.org.

¹¹⁰ Human Rights Watch, US: Obama Announces End to HIV Travel Ban, 30 October 2009. Available at www.hrw.org/news/2009/10/30/us-obama-announces-end-hiv-travel-ban.

¹¹¹ WHO, WHO commends China on lifting entry and travel restrictions for HIV-positive people, WHO Media Centre, 27 April 2010. Available at www.who.int/mediacentre/news/statements/2010/hiv_20100427/en/index.html.

¹¹² UNAIDS, Namibia lifts travel ban for people living with HIV, press release issued 8 July 2010. Available from www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2010/july/20100708prnamibia/.

3.2 Travel and transit

The migratory journey itself directly affects the health of many migrants. The health risks in this phase of the migration process are particularly significant for migrants in an irregular situation, refugees and displaced persons. Physical and environmental threats, hunger, lack of access to basic services and exposure to violence (including sexual violence) and trauma frequently accompany the movement of migrants, some of whom travel for long periods of time before reaching a safe haven. As a matter of fact, this phase of the migration process is associated with high risks of death and morbidity at both land and sea borders.¹¹³ The ones most at risk – women, children, trafficked persons and the poor – are at the greatest disadvantage.^{114,115}

Travel-related health risks

“A 16-year-old-girl crossed into South Africa from Zimbabwe with her two aunts and four men. When the group was at a farm about 30 kilometres south of Musina, they slept in the bush. At dawn they were ambushed by a group of violent, infamous gangs called *guma-gumas*. As she was running, the young girl tripped and fell. One of the *guma-gumas* then searched her and took her money. He then proceeded to violently rape her. Her genitalia were bruised. She was infected with a sexually transmitted infection (STI). She cannot sit up straight and can hardly walk. She has missed her period and could be pregnant from the rape. She said she could not go to the hospital for fear of being deported.”

(Hjalmarsson S. (2009) *MSF Nurse and Project Coordinator in Musina, South Africa. Médecins Sans Frontières, “No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa”*).

Immigration detention

Detention refers to the restriction on the freedom of movement, usually through enforced confinement, of an individual by government authorities. There are two types of detention: criminal detention, which is utilized for punishment of a committed crime, and administrative detention, which is utilized to guarantee that another administrative measure (such as deportation) can be implemented. In many states, migrants are subjected to administrative detention, including while they wait for a decision on their admission to or removal from the host state or for a determination of their asylum claim.¹¹⁶

Migrants who are detained can be vulnerable to violations of their rights to food and health. According to the UN High Commissioner for Human Rights and the former Special Rapporteur on the human rights of migrants, Ms. Gabriela Rodríguez Pizarro, detained migrants have a right to adequate and culturally acceptable food.¹¹⁷

¹¹³ Human Rights Watch (2009) *Hostile Shores: Abuse and Refoulement of Asylum Seekers and Refugees in Yemen*, New York; IOM (2008), *Irregular migration from West Africa to the Maghreb and the European Union: An Overview of Recent Trends*, Migration Research Series No. 32; Médecins Sans Frontières, (2009) *No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa*.

¹¹⁴ A. Tsutsumi, T. Izutsu, A.K. Poudyal et al, Mental health of female survivors of human trafficking in Nepal. *Social Science & Medicine*, 66:1841-47.

¹¹⁵ Inter-agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (Washington, DC, 2010). Available from: www.iawg.net/IAFM%202010.pdf.

¹¹⁶ Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, 3 June 2010, A/HRC/14/20/Add.4, paras. 82-99. Available from www.ilpa.org.uk/data/resources/14148/12.01.30-ILPA-to-UN-Special_Rapporteur_Human_rights_migrants-detention.pdf.

¹¹⁷ E/2010/89, para. 44 and E/CN.4/2003/8, para. 53.

The long-term detention of asylum-seekers has been associated with mental health problems.¹¹⁸ The Special Rapporteur on the Human Rights of Migrants has noted that the “[M]ental and physical health of migrant detainees is often neglected. Doctors and nurses are not always available and may not have the authority to properly treat their patients, inter alia, when they need hospitalization. Furthermore, reproductive health care for women, especially pregnant women, is not available in all places of detention. Substandard detention conditions may potentially amount to inhuman or degrading treatment, and may increase the risk of further violations of economic, social and cultural rights, including the right to health, food, drinking water and sanitation.”¹¹⁹

Health implications of migrant detention

In detention or reception centres throughout Europe, numerous children or young adults have committed suicide and countless others have harmed themselves. The neglect of physical and mental health needs has been cited as a contributory factor to these tragedies.

(European Race Audit (2010), Accelerated removals: A Study of the Human Cost of EU Deportation Policies).

Further, some countries detain and deport HIV-positive or pregnant migrants, posing a range of health and human rights questions.^{120,121}

Given the high risk of human rights violations in detention, international human rights mechanisms have encouraged states to use immigration detention as a last resort and to actively explore the use of non-custodial measures in the first instance. The UN Working Group on Arbitrary Detention has voiced concern regarding immigration detention:

“... considers that immigration detention should gradually be abolished. Migrants in an irregular situation have not committed any crime. The criminalization of irregular migration exceeds the legitimate interests of States in protecting its territories and regulating irregular migration flows.

If there has to be administrative detention, the principle of proportionality requires it to be the last resort. Strict legal limitations must be observed and judicial safeguards be provided for. [...]

During country missions, the Working Group has sometimes witnessed unacceptable substandard conditions of detention in overcrowded facilities that affect the health, including the mental health, of irregular migrants, asylum-seekers and refugees, and increase the risk of a whole range of further violations of human rights, i.e. of economic, social and cultural rights.”¹²²

¹¹⁸ K. Robjant and R. Hassan R, Mental health implications of detaining asylum seekers: a systematic review. *The British Journal of Psychiatry*, 194:306-312.

¹¹⁹ Report of the Special Rapporteur on the human rights of migrants, Francois Crepeau, 2 April 2012, A/HRC/20/24, paras 25 and 26.

¹²⁰ H. Venters, J. McNeely and A. Keller, HIV screening and care for immigration detainees, *Health and Human Rights*, 11(2):89-100.

¹²¹ UN Joint Programme on HIV/AIDS (UNAIDS), *Denying Entry, Stay and Residence Due to HIV Status*. The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), which supplement the Standard Minimum Rules for the Treatment of Prisoners, provide that account shall be taken of the distinctive needs of women prisoners, inter alia, the accommodation of women prisoners shall have the facilities and materials required to meet women’s specific hygiene needs; the health screening of women prisoners shall determine, inter alia, mental health-care needs, including post-traumatic stress disorder and risk of suicide and self-harm; the reproductive health history of the woman, including current or recent pregnancies, childbirth and any related reproductive health issues; and sexual abuse and other forms of violence that may have been suffered prior to admission.

¹²² UN HRC, *Report of the Working Group on Arbitrary Detention, Mr. El Hadji Malick Sow*, A/HRC/13/30, 15 January 2010, paras. 58-61.

Respecting migrant rights while managing borders and public health



Between 2007 and 2010, IOM Brussels managed a project entitled “Increasing Public Health Safety Alongside the New Eastern European Border Line” (PHBLM). This project aimed to minimize public health risks, build capacity for border management and public health staff, and facilitate the realization of the right to health of migrants.

As part of the PHBLM project, guidelines on the health of migrants in detention were developed, aimed mainly at border officials and health professionals. The guidelines give specific recommendations on how to:

- improve those living conditions of migrants in detention centres that can impact their physical and mental health;
- address the occupational health issues of border officials/immigration staff working in immigration detention centres;
- enhance access to health care for migrants in detention.

(IOM and the Andalusian School for Public Health (2010) Guidelines for Border Management and Detention Procedures involving Migrants: A Public Health Perspective).

3.3 Host communities

The degree of vulnerability in which migrants find themselves in the host community depends on a variety of factors, ranging from their legal status to the overall living and working environment. These factors also affect migrants’ access to health. As societies have become increasingly multicultural and multi-ethnic, the capacity of health systems to deliver affordable, accessible and migrant-sensitive quality services has been challenged.¹²³ Governments and health-care providers have a critical role to play in reorienting the competencies of a public health workforce to improve the health of all people.¹²⁴

Occupational health and safety

Many migrant workers are employed in high-risk and hazardous sectors such as mining, agriculture and construction. These kinds of work usually involve long hours and hard physical labour, which can result in fatigue and increase the risk of occupational accidents.¹²⁵

Studies demonstrate that occupational accident rates are higher among migrant workers than nationals. In 2009 the Sri Lanka Bureau for Foreign Employment received 12,061 complaints from overseas migrant workers, out of which 2,594 (17%) were about ‘sickness and harassment’; the deaths of 333 Sri Lankan migrant workers were also reported in the same period.¹²⁶ Another study conducted in Austria found that some 30 per cent of migrant workers were at high risk of accidents and injuries in the workplace, compared with only 13 per cent of Austrians.¹²⁷ In Denmark, data from the National Board of Industrial Injuries show a relatively higher frequency

¹²³ For more information, see an assessment of the health systems and the right to health in 194 countries carried-out in 2008 and published in the Lancet, available at www.who.int/medicines/areas/human_rights/Health_System_HR_194_countries.pdf.

¹²⁴ D. McDaid, S. Merkur, P. Mladovsky, L. Kossarova and A. Sato, Migration and health: a dynamic challenge for Europe, *Eurohealth* 16(1):i.

¹²⁵ M. Flyvholm, Results from a Danish intervention project on immigrants in the cleaning trade, *Barents Newsletter on Occupational Health and Safety*, 14(2):46-47 (Helsinki, 2011). Available from www.ttl.fi/en/publications/electronic_journals/barents_newsletter/Documents/BarentsNewsletter2_2011.pdf.

¹²⁶ Sri Lanka Bureau of Foreign Employment, *Annual Statistical Report of Foreign Employment* (Colombo, 2009).

¹²⁷ European Foundation for the Improvement of Working and Living Conditions (Eurofond), *Employment and Working Conditions of Migrant Workers* (Dublin, 2007).

of notified musculoskeletal diseases among immigrants, compared with the rest of the Danish population. These differences can, to a large extent, be explained by the fact that immigrants are mainly employed in occupations with a high risk of work-related injuries and diseases. For immigrants in the cleaning trade, it was found that the lack of understanding of the Danish language is the largest occupational safety and health problem.¹²⁸

It is commonly reported that migrants, particularly those in an irregular status, endure dangerous working conditions for fear of drawing attention to themselves and losing their jobs or being deported. Furthermore, migrant workers are often not allowed to form and join trade unions, which may be an additional obstacle to raising concerns about their health and safety in the workplace.

Health hazards of migrant workers in the United States

“Occupational health hazards are another key problem disproportionately impacting the USA immigrant sector . . . [W]ork-related accidents are one of the biggest problems immigrants have because [immigrants] do risky work nobody else wants to do and don’t have insurance coverage because employers do not offer it.”

(Xochitl Castaneda, Director of the University of California’s Health Initiative of the Americas program (Bi-national Health Week in October 2010)).

Improving migrants’ knowledge of safe and healthy work routines in the cleaning trade in Denmark

The Danish National Research Centre for the Working Environment implemented a three-year project (2007–2010) to develop and implement practical methods and tools for efficiently communicating risks to immigrants, who, being employed in cleaning, may have difficulties with gaining solid knowledge on safe and healthy work routines. The interventions initiated were based on knowledge and experiences gained through field studies, in which two anthropologists carried-out participant observation and semi-structured interviews with immigrant cleaning assistants. Managers in the cleaning business report general communication difficulties, particularly when giving instructions to immigrants.

(Flyvholm M. (2011): Results from a Danish intervention project on immigrants in the cleaning trade, 14 Barents Newsletter on Occupational Health and safety, pp. 46-47, available at: www.arbejdsmiljoforskning.dk/en/nyheder/arkiv/2007/new-research-project-less-attrition-among-immigrants-in-the-cleaning-trade).

In addition to occupational hazards, sexual exploitation in the workplace has been widely reported by returning migrant workers.¹²⁹ At the workplace in the host country, the problem of sexual harassment is often left unaddressed. Women fear retaliation, for example, where their income, as well as that of their dependent family members’, may be at stake. With limited financial means or bargaining power, there may be little recourse for female workers who have experienced sexual harassment.¹³⁰

¹²⁸ M. Flyvholm 2011, op. cit., Results from a Danish intervention project on immigrants in the cleaning trade, *Barents Newsletter on Occupational Health and Safety*, 14(2):46-47.

¹²⁹ Human Rights Watch, *World Report 2010*, p. 346 (New York, 2010).

¹³⁰ K. Embrey Coming up on the season: Migrant farmworkers in the Northeast. *Resources for Teachers Grade, Cornell Migrant Program*. Available at www.migranthealth.org/index.php?option=com_content&view=article&id=38&Itemid=30.

Sexual harassment of migrant domestic workers

The issue of sexual harassment and abuse of migrant domestic workers has been noted by the former Special Rapporteur on the human rights of migrants, Jorge Bustamante, in his report in 2010, in which he noted that “[f]emale migrant workers engaged in domestic services are one of the most vulnerable groups of migrant workers. There appears to be a widespread pattern of physical, sexual and psychological abuse of migrant domestic workers, who are also often exposed to health and safety threats without being provided with adequate information about risks and precautions. Further, their vulnerability is heightened by the lack of domestic legal mechanisms recognizing or protecting their rights. Consequently, they are often excluded from health insurance and other important social and labour protections.” The vulnerable situation of domestic migrant workers was further highlighted by the Committee on Migrant Workers (CMW) in their General Comment No. 1 on migrant domestic workers.^{131,132}

(See Report of the Special Rapporteur on the human rights of migrants, Jorge Bustamante A/HRC/14/30, 16 April 2010, para. 30).

Lack of awareness and information about entitlements and services

Even when domestic legislative provisions guarantee access to health services, lack of awareness among migrants and health professionals of migrants’ rights and entitlements may impede the use of health service and, therefore, the realization of the right to health. In many countries, inadequate general health education and the lack of information about available services are two main reasons why migrants do not utilize preventive health services and treatment effectively.

Studies carried-out in a number of Western European countries show that rates of maternal mortality and morbidity, as well as of infant mortality, are higher among immigrant women than among women from host communities.¹³³ The reasons behind this disparity include lower levels of awareness about and the consequent disuse of relevant services and entitlements, such as pre- and postnatal care and contraceptives. In Portugal, where primary care services are available to all, a study of the health status and social situation of newborn children was carried-out in two communities with large migrant populations. The study demonstrated higher levels of morbidity among both mothers and babies, in addition to a higher use of emergency rooms. These findings suggest a need to reach out to migrants and educate them on the availability and appropriate use of health services.¹³⁴

Legal barriers to accessing health services

Legal status is one of the most important determinants of the degree to which migrants access health services in a country. Laws and policies which prevent migrants from accessing social services, including health services, are often based on the view that it would be expensive for taxpayers to shoulder the costs of health services for all, that is, including irregular migrants. Furthermore, it is argued that excluding this particular group from receiving social benefits would deter future irregular migration. There is no empirical evidence to prove this claim, however.

¹³¹ Committee on the Protection of the Rights of all Migrant Workers and Members of Their Families (CMW) General Comment No. 1 on Migrant domestic workers, CMW/C/GC/1, 23 February 2011, para 1.

¹³² International Federation for Human rights report to CEDAW on the situation for migrant domestic workers in Bahrain, available from www.fidh.org/IMG/pdf/bchr Bahrain42.pdf and the Migrant Forum in Asia’s report to CEDAW on the situation for women migrant workers in the United Arab Emirates available at www2.ohchr.org/english/bodies/cedaw/docs/ngos/MigrantForumAsia_UAE_45.pdf.

¹³³ M. Ackerhans and F. Staugard F. (eds.), *Health issues of minority women living in Europe*, Report from meeting in Göteborg, Sweden, 11-12 November 1999, (Brussels, European Commission, 2000).

¹³⁴ Machado M et al. Equal or different? Provision of maternal and child health care to an immigrant population. Health and migration in the European Union: better health for all in an inclusive society. Lisbon, Instituto Nacional de Saude Doutor Ricardo Jorge, 2009.

Nonetheless, in recent years a number of countries have continued to follow this misguided logic and have barred even regular migrants from accessing social benefits, including public health services.

Under human rights law, governments are obliged to promote and fulfil the health of every person within their respective territories. In practice, however, access to health services for migrants in an irregular situation remains limited in many countries.¹³⁵ In these settings, irregular migrants may be eligible for emergency treatment; nonetheless, in various countries this acute type of care is only provided at migrants' own expense, which means that many are unlikely to seek treatment or delay treatment until they are seriously ill.¹³⁶ As mentioned above, mere commitment to emergency care is unjustified not only from a human rights perspective, but also from a public health standpoint.

Studies have found that in some cases, migrants, especially those in an irregular situation, try to solve their health problems through self-medication or by referring to sub-quality care by non-professionals within their community.¹³⁷

European Parliament's recommendation on affirmative action to reduce health inequalities

In 2008, the European Parliament made concrete recommendations to the EU member states to tackle pervasive health inequalities and respond to the health challenges of the most vulnerable groups, which includes irregular migrants. Among these recommendations are the calls on the following:

- "...on the Commission and Member States to press ahead with their efforts to tackle socio-economic inequalities, which would ultimately make it possible to reduce some of the inequalities relating to health care; furthermore, on the basis of the universal values of human dignity, freedom, equality and solidarity, calls on the Commission and Member States to focus on the needs of vulnerable groups, including disadvantaged migrant groups and people belonging to ethnic minorities;
- ...on the Member States to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare; calls on the Member States to assess the feasibility of supporting healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation;
- ...on the Member States to take account of the specific health protection needs of immigrant women, with particular reference to the guaranteed provision by health systems of appropriate language mediation services; those systems should develop training initiatives enabling doctors and other professionals to adopt an intercultural approach based on recognition of, and respect for, diversity and the sensitivities of people from different geographical regions; priority must also be given to measures and information campaigns to combat female genital mutilation, including severe penalties for those who practice it."

(European Parliament resolution of 8 March 2011 on Reducing Health Inequalities in the EU, 2010/2089(INI) paras. 4-6) (emphasis added).

¹³⁵ In 2010 the Doctors of the World and the Health for Undocumented Migrants and Asylum seekers network (HUMA) launched a declaration aiming at a non-discriminatory access to health care in the EU. The declaration has been signed by more than 140 organizations, including seven European health organizations and to view their requests see HUMA network's website, available at www.huma-network.org/Activities-of-the-network/European-declaration.

¹³⁶ PICUM (2007) *Access to Health Care for Undocumented Migrants in Europe*, available at: http://picum.org/picum.org/uploads/file_/Access_to_Health_Care_for_Undocumented_Migrants.pdf.

¹³⁷ Barimah K. & van Teijlingen E. (2008) The use of traditional medicine by Ghanaians in Canada. *BMC Complementary and Alternative Medicine* 8.

Council of Europe adopts recommendation on mobility, migration and access to health care

In November 2011, the Committee of Experts of the Council of Europe adopted Recommendation CM/Rec (2011)13 on mobility, migration and access to health care.

It recommends that governments of member states, while keeping due regard to their specific national, regional or local structures and respective responsibilities, and in partnership with all other relevant organizations involved in improving, maintaining and restoring health, carry-out the following tasks:

- i. “in accordance with national legislation regarding the collection and use of personal data, collect information on the demographic, social, educational and economic characteristics of migrants and their legal situation in the host country;
- ii. systematically monitor migrants’ state of health and investigate the causes of discrepancies;
- iii. review all policies and practices affecting migrants’ living and working conditions in order to minimize risks to their health;
- iv. having regard to the organization, general principles and financial capacities of their social security system of the member state concerned, provide migrants with adequate entitlements to use health services and ensure that these entitlements are known and respected;
- v. promote knowledge among migrants about issues concerning health and the health system, and take measures to increase the accessibility of health services;
- vi. overcome language barriers by appropriate measures, including interpreting services and access to translated information materials wherever necessary;
- vii. improve the adaptation of health service provisions to the needs, culture and social situation of migrants;
- viii. improve the integration of health care with other social services for migrants;
- ix. promote appropriate training and education programmes;
- x. stimulate high-quality research on all aspects of health services for migrants;
- xi. harmonize efforts to promote the health of migrants at European level;
- xii. foster a closer relationship between migrants and health services, involving them in all activities concerned with their health;
- xiii. support the widest possible dissemination of the recommendation and its explanatory memorandum, where appropriate accompanied by a translation;
- xiv. take necessary steps to implement the guidelines contained in the appendix to this recommendation, in collaboration with health professionals, professional bodies, and all governmental and non-governmental agencies concerned with migrant health.”

(Recommendation CM/Rec(2011)13 of the Committee of Ministers to Member States on mobility, migration and access to health care. Adopted by the Committee of Ministers on 16 November 2011 at the 1126th meeting of the Ministers’ Deputies. Available at <http://bit.ly/rKs2YD>).

Too rarely do primary health-care services serve as the entry point to the destination country’s health system for migrants, particularly those in an irregular situation. Migrants, especially those in an irregular situation, may instead be referred to NGOs or private providers, creating ‘parallel’ health systems. Examples of such NGOs or private providers include the Caritas Migrants Centre in Lebanon, which uses mobile clinics to provide free care and insurance to vulnerable groups;¹³⁸ and South Africa’s Médecins Sans Frontières (MSF), which provides primary health services to

¹³⁸ ILO, Luckanachai N. & Rieger M. (2010) *A Review of International Migration Policies*. Programme for the Study of Global Migration, Graduate Institute of International and Development Studies, Geneva.

Zimbabwean migrants in the border town of Musina and in Johannesburg where many migrants, including irregular migrants, are residing.¹³⁹ While migrants may sometimes prefer to access community services provided by organizations they trust, this practice can compromise the continuity and quality of care, puts a high burden on NGOs and can allow government agencies to sidestep legal obligations.

An important factor which may deter irregular migrants – and members of their families, whatever their status – from seeking care and treatment is the fear that health providers may have links to immigration authorities.¹⁴⁰ Such links, if they exist, compromise the commitment of health professionals to respect the right to privacy of those seeking care. Such connections further impair the professional ethical duty and foremost obligation to provide patients with the best care possible. To prevent this from happening, some countries have laws forbidding reporting. Article 35.5 of the Italian Consolidated Immigration and Foreigners' Status Act, for example, states that "access to health facilities by foreigners who are in breach of the residence legislation shall not lead to any report being made to the authorities except when such report is mandatory, in the same way as for Italian nationals".¹⁴¹

Medical care for undocumented migrants in Korea

In March 2012, the Metropolitan Government in Seoul, Korea, announced that it will provide medical aid to undocumented migrant workers in Seoul who are not entitled to social security and health insurance. The aid is expected to cover surgery costs, hospital charges (up to a certain amount), interpretation and nursing services for up to a month, depending on the patient's condition. Nursing services are expected to be available in languages other than Korean, such as Chinese, Thai and Mongolian. The rationale behind this development is that the Government recognizes that undocumented migrant workers contribute to Korea's economy and should, therefore, also benefit from health benefits, regardless of their irregular migratory status.

*Lee Woo-Young, "Medical support for undocumented migrants", *The Korea Herald*, 7 March 2012. Available from www.koreaherald.com/national/Detail.jsp?newsMLId=20120307001296.

Linguistic barriers to accessing health services

Language barriers have a negative effect on the access to care and prevention services, adherence to treatments and timely follow-ups. Misunderstanding, for example, when a migrant patient describes his or her symptoms, and incorrect translations may result in delayed care, clinical errors and even death. From a human rights perspective, accurate communication and, if necessary, the use of professional interpretation services, are essential when obtaining consent for health interventions and treatment and guaranteeing confidentiality and privacy about health information.¹⁴²

At the 8th Conference of European Ministers of Health on People on the Move: Human Rights and Challenges for Health Care Systems in 2007, the Bratislava Declaration was adopted. The

¹³⁹ Médecins Sans Frontières, , *No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa*, p. 12.

¹⁴⁰ Wolff H. & Epiney M. (2008) Undocumented migrants lack access to pregnancy care and prevention. *BMC Public Health*, 8:93.

¹⁴¹ See Article 35 of the Decree- Law No. 286 of 25 July 1998 (Decreto Legislativo n. 286, 25 Luglio 1998, Testo Unico delle disposizioni concernenti la disciplina dell'immigrazione e norme sulla condizione dello straniero, Gazzetta Ufficiale n. 191 del 18 agosto 1998 – Supplemento Ordinario n. 139).

¹⁴² Flores G. (2005) The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review*, 62(3):255-299; US Department of Health and Human Services Office of Minority Health (2000) *Assuring Cultural Competence in health Care: Recommendations for National Standards*, available at http://minorityhealth.hhs.gov/Assets/pdf/checked/Assuring_Cultural_Competence_in_Health_Care-1999.pdf.

Declaration explicitly recommended that language barriers to migrants' access to health care be removed.

The European Commission report entitled "Quality and fairness of access to health services" specifically considers linguistic differences as a serious difficulty in the interaction of migrants with health providers.¹⁴³ A survey of health services in Oslo, for example, indicated that health professionals tended to settle for the most readily available solution to communicate with their patients, that is, they use their patients' families and friends as interpreters, even though they may not be proficient in Norwegian.¹⁴⁴

Abolishment of subsidies for interpretation and translation services in the Dutch health system

In 2011, the Netherlands abolished subsidies for interpretation and translation services in health care despite advocacy efforts by health professionals, intergovernmental organizations and NGOs. These individuals and organizations advised the Dutch government not to abolish these important services, arguing that this would lead to decreased access to adequate health care and a subsequent increase in the risk to human health and the health of migrants in particular. Abolishing the subsidy for interpretation and translation services, they highlighted, will especially affect poor migrants, particularly those who have recently arrived in the Netherlands and have not fully integrated yet and, as such, do not speak the Dutch language and are unfamiliar with the Dutch health-care system. It was also highlighted that poor communication can lead to misdiagnosis, ineffective consultation visits, unnecessary examinations and incorrect treatments. In addition, migrants who cannot speak Dutch postpone their visit to the doctor as much as possible; this can have adverse consequences for both individual and public health.

(For more information, see http://mighealth.net/nl/index.php/Decision_of_Dutch_Ministry_of_Health_to_abolish_subsidies_for_translation_and_interpretation).

Cultural barriers to the health service access

Culturally informed health-care delivery, also referred to as 'culturally competent' or 'culturally sensitive care,' is the ability of health-care practitioners to acknowledge their own cultural backgrounds, biases and professional cultural norms and to incorporate relevant knowledge and interpersonal skills in the care of patients from different cultural backgrounds. In the context of migration, cultural competency implies being familiar with the health, social, cultural, religious and gender-related issues regarding the experience of migrants.¹⁴⁵ From a human rights perspective, cultural competency directly corresponds with the *acceptability* element of the right to health (see Section 2). Accordingly, health services, goods and facilities should tackle cultural barriers that may have negative effects on the access to health care for migrants.

Health providers need to be mindful that a migrant may fail to disclose that an alternative or traditional medicine commonly practiced in the migrant's home country was used before he or she sought their help, thus hindering effective diagnosis and treatment.

¹⁴³ Huber, M., Stanicole A., Bremner J., & Wahlbeck K (2008) *Quality in and Equality of Access to Healthcare Services*, European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities, Luxembourg.

¹⁴⁴ Norwegian Directorate of Health (2009) *Migration and Health: Challenges and Trends*. Oslo; Lewis G. (ed) The Confidential Enquiry into Maternal and Child Health (CEMACH) (2007) *Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer 2003-2005*, Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London.

¹⁴⁵ College of Nurses of Ontario (2004) *Practice guideline: Culturally Sensitive Care*, Ontario. www.nipissingu.ca/faculty/arohap/aphome/NURS3036/Resources/41040_CulturallySens.pdf.

Culturally sensitive mental health promotion for migrants

Providing effective mental health care to migrants may be challenging given the cultural differences and language barriers. This is why in 2008, the State of New South Wales in Australia issued the Multicultural Mental Health Plan 2008-2011, 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 issues outlined in the plan were 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. Despite significant achievements, however, the CALD programme ceased in 2011.

(Australian Department of Health (2008) Mental Health and Drug and Alcohol Office. The Multicultural Mental Health Plan 2008-2012, available at: www.health.nsw.gov.au/policies/pdf/2008/pdf/PD2008_067.pdf).

Migrant-sensitive health professional workforce

Migration results in a diversity of patients' health perspectives, beliefs, cultures and linguistic backgrounds, thereby changing the day-to-day work of health professionals. It also presents epidemiological challenges that are placing new demands on health professionals. Increasingly, health workers find themselves treating patients whose symptoms they may not be familiar with or fully understand. This may cause delayed or deferred care and lack of appropriate preventive services, which may be associated with progression of disease and illness and the subsequent need for more extensive and costlier treatment and intervention.¹⁴⁶ In order for health services to be sensitive to the needs and rights of migrants, it is important that managerial, clinical and administrative staff be able to comprehend the health and social requirements of migrants.¹⁴⁷

Health professionals' attitudes as potential barriers to access

The attitudes of health workers and other staff working in health facilities and the quality of their migrant sensitivity training are important factors that determine whether migrants would be able to utilize health services efficiently. In South Africa, several studies found that health staff are engaged in widespread discrimination against migrants, such that migrants routinely reported that they experienced delays and denials and were charged inappropriately when they attempted to use health services.

*(Human Rights Watch, No Healing Here: Violence, Discrimination and Barriers to Health for Migrants in South Africa (New York, 2009).
J. Vearey, Migration, access to ART, and survivalist livelihood strategies in Johannesburg, African Journal of AIDS Research, 7(3):361-74.*

¹⁴⁶ See Romero-Ortuño R. (2004) Access to health care for illegal immigrants in the EU: should we be concerned? *European Journal of Health Law*, 11:252-253; Agyemang C., Addo J., et al. (2009) Cardiovascular disease, diabetes and established risk factor among populations of Sub-Saharan African descent in Europe: a literature review. *Globalization and Health* 5.

¹⁴⁷ Seeleman C. Suurmond J, Stronk K. "Cultural competence: A conceptual framework for teaching and learning". *Medical Education*, 2009:43(3):229-237.

Cultural competency training for health professionals

In response to the high numbers of migrants working in Qatar, the Weill Cornell Medical College, with the Hamad Medical Corporation, implemented a cultural competence training programme for medical students to prepare them for working with diverse populations. Such training also aims to support the effective use of a medical interpretation programme.

In six U.S. states, medical students are required to demonstrate understanding of the health concerns, beliefs and communication needs of diverse populations. These states also have mandated cultural competence continuing education for physicians.¹⁴⁸

WHO (2010) Health Of Migrants- the Way Forward, Report of a Global Consultation, Madrid, Spain).

In New Zealand, the Health Practitioners Competence Assurance Act 2003 requires that professional registration bodies set standards for cultural and clinical competency and ethical practice and ensure that practitioners meet those standards.

(Bacal K., Jansen P. & Smith K. (2006) "Developing Cultural Competency in Accordance with the Health Practitioners Competence Assistance Act," 33(5) NZ Family Physician).

Guidelines for implementing migrant-sensitive health professional workforce programme

A migrant-sensitive health professional workforce requires new competencies. According to IOM's Assisting Migrants and Communities (AMAC) project, such a workforce needs to:

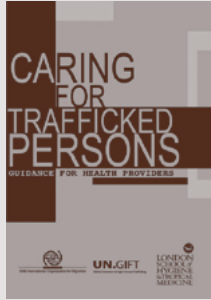
- have appropriate intercultural competence, language and communication skills;
- know how to manage change, cultural diversity and values;
- be sufficiently knowledgeable of other cultures and customs to be able to develop professional practice with respect to the autonomy, beliefs and culture of the patient;
- understand migrant health determinants and be able to contribute to reduce social and health care inequalities;
- recognize the disease profile of migrants and its epidemiology;
- manage competently the clinical manifestation of disease in different ethnic and population groups;
- know the rights of migrants to health services;
- be able to advise migrants on how to access and what to expect of health services.

(IOM (2009) Developing a Public Health Workforce to Address Migrant Health Needs in Europe, Background paper for Assisting Migrants and Communities project).

¹⁴⁸ See Landers S. (2009) Mandating cultural competency: should physicians be required to take courses? *American Medical News*, available at: www.ama-assn.org/amednews/2009/10/19/prsa1019.htm; see also US Department of Health and Human Services Office of Minority Health, available at www.thinkculturalhealth.hhs.gov/index.asp.

Health providers caring for victims of trafficking

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



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 UN Global Initiative to Fight Human Trafficking and led by IOM and the London School of Hygiene & Tropical Medicine, the handbook provides practical, non-clinical advice to help a concerned health provider understand the phenomenon of human trafficking, recognize some of its associated health problems and consider safe and appropriate approaches to providing health care for trafficked persons. This essential tool is available in various languages.

(IOM (2009) *Caring for Trafficked Persons: Guidance for Health Providers* (Geneva, 2009). Available from http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=1&products_id=510).

3.4 Return

In addition to peace agreements, post-conflict or post-disaster stability in areas of the world from which people were previously displaced, return migration is being facilitated by globalization and the greater ease and affordability of international travel. Moreover, the global economic crisis has led to a reduction in job opportunities in many host communities, encouraging many migrants to go back to their home countries. The increased enforcement of immigration controls in recent years has also led to deportations and voluntary return migration, raising the number of migrants returning to their countries of origin.

Health conditions that migrants acquired during their stay in host communities may surface upon their return to their home countries.¹⁴⁹ This is often the case for migrants who have suffered from exploitation and abuse in their host communities and may be at risk of deteriorated mental health and other adverse health conditions.¹⁵⁰ Thus, effective reintegration mechanisms that address the health of returning migrants should be introduced by countries of migrant origin.

Countries of origin should not only be concerned about the health of returning migrants, but must also consider the health of members of the families who have been left behind. Studies indicate that the physical and mental health of family members, particularly children, are often negatively affected by long-term separation.¹⁵¹

¹⁴⁹ Cortés, R. (2007) *Global report on Migration and Children: Children and Women left behind in Labour sending Countries: An Appraisal of Social Risks*, available at www.childmigration.net/files/Rosalia_Cortes_07.pdf.

¹⁵⁰ UNPD/IOM/UNIFEM/ et al. (2008) *HIV Vulnerabilities of migrant women: From Asia to the Arab States*. Colombo, UNDP Regional Centre in Colombo.

¹⁵¹ Fletcher-Anthony W. (2008) *Post-Immigration West-Indian Parent-Child Relationships*, Paper presented at Working Group on childhood and migration, Emerging Perspectives on Children in Migratory Circumstances, June 20-21, Drexel University, Philadelphia University.

The IOM ‘Children Left Behind Project’ in Ukraine

The Children Left Behind Project, funded by the Italian Ministry of Foreign Affairs, addresses the psychological and developmental problems of children of Ukrainian migrant workers, many of whom migrated to Italy to work in private households and look after elderly people. As a result, Ukrainian schools have taken on the function of developing the children’s ability for reflection and self-assessment and are providing them with effective tools to help them understand their identity and their role.

(For more information, see www.childrenleftbehind.eu/?page_id=1329).

Migrants returning temporarily to their communities of origin to visit friends or relatives can be at increased risk of acquiring health problems that are common in their countries of origin. Many migrants return to their home countries with children who were born and who may have lived only in their respective host countries. While migrant parents may have acquired natural immunity to diseases due to exposure prior to migration, their children may lack this natural protection.¹⁵²

Need to address prevention in case of return

In May 2010, the United Kingdom deported a woman and her UK-born child to Cameroon without the child being vaccinated against yellow fever. The mother’s appeal for her child’s vaccination against the disease prior to deportation was rejected. A letter from the UK Border Agency stated that the detention centre had no obligation or facility to provide the yellow fever vaccine. Furthermore, the letter stated that the health-care manager at the detention centre has “confirmed that the vaccine can be given on arrival in Cameroon and would be effective straight away.” This statement was made in clear contrast with the UK practices for its nationals, as all travelers are advised to obtain yellow fever vaccination 10 days before travel, in order to achieve adequate levels of immunity. In fact, vaccination certificates will only become valid 10 days after immunization.

*(The UK’s continued shameful neglect of migrants’ health, *The Lancet*, 376(9751): 1437-1512).*

Expulsion and health care in countries of origin

Although the state decides on matters regarding the entry and stay of migrants on its territory, it should keep in mind several substantial and procedural guarantees surrounding expulsion. The state has to consider, for example, principles such as non-refoulement, best interests of the child, health status of the migrant and family unity. (The fundamental principle of non-refoulement prohibits states from returning any person to a country where he or she would be at risk of persecution, torture or other serious human rights violations.) In addition to these principles, the EU’s Return Directive from 2008 provides that the state has to take account of the state of health of the third-country national concerned in relation to expulsion.¹⁵³ In the context of health, an important question arises under human rights law of whether returning persons to countries where they may not have access to adequate health services constitutes inhumane or degrading treatment.

Issues regarding the expulsion of migrants have been examined in a variety of cases by the European Court of Human Rights. The Court has held that persons with life-threatening medical

¹⁵² Angell S., Cetron M. et al. (2005) Health disparities among travelers visiting friends and relatives abroad. *Annals of Internal Medicine*, 142:67-72.

¹⁵³ Directive 2008/115/EC, art. 5(c).

conditions or terminal illness who cannot continue treatment in their country of origin may not be returned, as this would hasten death in distressing circumstances. This, in turn, would amount to a form of inhumane treatment contrary to Article 3 (the right to be free from torture, inhumane and degrading treatment or punishment) of the European Convention on Human Rights.¹⁵⁴ In another case, the Court extended the reach of Article 3 of the Convention to cases of severe mental illness.¹⁵⁵ However, the most recent jurisprudence of the Court appears to suggest that this principle only applies under exceptional circumstances.¹⁵⁶ Therefore, 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 members or other support networks, must be taken into account in order to determine the legality of the expulsion.

Some national courts have held that migrants suffering from severe medical conditions cannot be expelled where such an expulsion would constitute a violation of human rights.¹⁵⁷

Voluntary return of people with health conditions

It must be noted that the feasibility of the voluntary return of persons living with HIV or other health conditions may depend on the specific conditions in the country of origin.

An IOM report on the situation faced by a group of migrants living with HIV in the Netherlands listed the following as constituting the minimum conditions for sustainable return and reintegration: The needed medical treatment is available and accessible.

- The returnee can acquire income sufficient to cover both regular expenses and all costs related to medical treatment.
- The returnee can find a supportive social network that would enable him or her to cope with possible stigma from society as a whole.¹⁵⁸

¹⁵⁴ *D. v. United Kingdom*, 146/1996/767/964, ECtHR, 2 May 1997; See also *BB v France*, RJD 1998-V, ECtHR, 9 March 1998.

¹⁵⁵ *Bensaid v. The United Kingdom*, Appl. No. 44599/98, ECtHR, 6 May 2001.

¹⁵⁶ See *Karara v Finland* Application No 40900/98, 29 May 1998, *SCC v Sweden* Application No. 46553/99, 15 February 2000, *Henao v the Netherlands* Application No. 13669/03, 24 June 2003, *Ndangoya v Sweden* Application No. 17868/03, 22 June 2004, and *Amegnigan v the Netherlands* Application No. 25629/04, 25 November 2004. In all cases, the applications were found to be inadmissible.

¹⁵⁷ See PICUM (2009) *Undocumented and Seriously Ill: Residence Permits for Medical Reasons in Europe*. Brussels.

¹⁵⁸ See IOM (2009) *Health, Hope and Home? The Possibilities and Constraints of Voluntary Return for African Rejected Asylum Seekers and Irregular Migrants Living with HIV in the Netherlands*, The Hague.

CONCLUSIONS

This booklet has reviewed the relevant human rights laws that provide protections for migrants irrespective of their legal status. Furthermore, it has pinpointed and analysed the factors or determinants which may impair or prevent the full enjoyment of the right to the highest standard of health possible for migrants. By giving examples of concerns or encouraging developments in the area, this publication aims to direct states and health providers towards good public health practice that ensures equality and non-discrimination, is aligned with human rights and affords migrants their rights. Lastly, this booklet aspires for a world where state migration governance is harmonized with human rights standards.

Health is a human right and the right to health is indispensable to the exercise of other human rights, that is, it is also closely related to and dependent upon the realization of, among others, the rights to housing, food, social security, work and family. The right to health is equally tied to the key principle of non-discrimination, which recognizes the “inherent dignity” of every human being, locals and migrants alike. This principle guarantees that human rights apply to everyone, irrespective of nationality, race, colour, sex or other status.¹⁵⁹ Accordingly, states have an obligation to protect and promote the rights of migrants without discrimination of any kind. Furthermore, states are equally obligated to eliminate any discrimination that takes place in their respective territories. The principles of non-discrimination and equal treatment of all, including migrants, are applicable to elements of the right to health, such that states must ensure that health facilities, goods and services are available, accessible, acceptable and of good quality. These obligations fall upon all states parties to the relevant treaties enshrining the right to health, be they countries of origin, transit or destination.

Migrants make significant economic and social contributions to sending and receiving countries. However, many migrants, especially those in an irregular situation, have little or no access to health and social services that they contribute to, although they may be exposed to health risks, such as exploitation, dangerous working and substandard living conditions.

Despite migrants’ increased vulnerability and existing firm grounds for their social rights in international law, in practice many states constrain the effective and full realization of the right to health of migrants, particularly those in an irregular situation. These practices include excluding migrants and their families from national health systems, providing inadequate health coverage by limiting migrants’ access to emergency care and denying admission and residence to migrants with health conditions. In addition, there is the observed lack of health workers’ cultural competency, health worker training on migrants’ rights and health issues, occupational safety for migrants, health services for returnees and involvement of health professionals in migration control, as well as the excessive use of immigration detention as a tool of migration management. These abovementioned issues not only hamper a state’s compliance with its human rights obligations but are also considered poor public health practice. Denying migrants the right to health leads to their marginalization, increases their susceptibility to ill health and fuels health inequalities. Further, the lack of financial and legal protection in accessing health services means that many migrants are likely to postpone seeking treatment until they are seriously ill and have to seek costly emergency treatment. Such delays would inevitably have long-term effects on the health of migrants. The exclusion of migrants from health services will ultimately create a financial burden on the host country and may pose a public health risk to host communities.

¹⁵⁹ The list of grounds set out above is non-exhaustive.

A holistic and inclusive approach to the right to health calls for the inclusion of migrants' health needs and vulnerabilities in states' national plans, policies and strategies. Such national actions should address health inequities, barriers to the access to health care and other factors that impact migrants' health, including the social determinants of health. As a good public health practice, primary health services should be the principal entry point for most health services. This, coupled with the principle of non-discrimination, inevitably obligates states to form eligibility policies and financing systems that are inclusive of all, including migrants. Furthermore, from a human rights perspective, governments should foster the independence of the health profession. Health professionals' commitment should first and foremost be to their patients and to upholding health as a human right. Efforts should also be made to ensure that public policy and law promote the access of all persons to basic preventative and curative health care and clearly disassociate such access from the enforcement of immigration law. Finally, countries of origin should include effective reintegration mechanisms that address the health of returning migrants.

ANNEX I. GLOSSARY

International Migration is the movement of a person or group of persons across an international border. It is a population movement encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, migrant workers, and persons moving for other purposes, including study and family reunification (see *Glossary on Migration*, IOM, 2011).

At the international level, no universally accepted definition for ‘migrant’ exists. The United Nations defines a migrant as an individual who has resided in a foreign country for more than one year irrespective of the causes, voluntary or involuntary, and the means, regular or irregular, used to migrate. Under such a definition, those travelling for shorter periods as tourists and businesspersons would not be considered migrants. However, common usage includes certain kinds of short-term migrants, such as seasonal farm-workers who travel for short periods to work planting or harvesting farm products (see *Glossary on Migration*, IOM, 2011).

A **migrant worker** is 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 (Article 2.1, International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families [ICRMW], 1990).

Family members of the migrant worker are defined to include common-law spouses, dependent children and other dependent persons (see Article 4 of the ICRMW).

Migrant workers and members of their families are considered (a) **documented or in a regular situation** if they are authorized to enter, to stay and to engage in a remunerated activity in the state of employment, pursuant to the law of that state and to international agreements to which that state is a party. (b) They are considered **non-documented or in an irregular situation** if they do not comply with the conditions provided for in subparagraph (a) (Article 5 of the ICRMW).

More generally, a **migrant in an irregular situation** is a person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. The definition covers, inter alia, those persons who have entered a transit or host country lawfully but have stayed for a longer period than authorized or subsequently taken up unauthorized employment (also called ‘unauthorized/ clandestine/ undocumented migrant or migrant in an irregular situation’). The term ‘irregular’ is preferable to ‘illegal’ because the latter carries a criminal connotation and is seen as denying migrants’ humanity (see *Glossary on Migration*, IOM, 2011). With that in mind, the UN General Assembly adopted a resolution requesting “the United Nations organs and the specialized agencies concerned to utilize in all official documents the term ‘undocumented or irregular migrant workers’ to define those workers that illegally enter another country to obtain work” (UN General Assembly Resolution 3449, 2433rd Plenary Meeting, 9 December 1975).

Victims of human trafficking are those persons recruited, transported, transferred, harboured or receipted, by means of threat or use of force or other forms of coercion, abduction, fraud, deception, abuse of power or of their position of vulnerability, or of the giving or receiving of payments or benefits to acquire their consent to be under the control of another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs (see Article 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).

Asylum-seekers are individuals seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum-seeker (see *Master Glossary of Terms*, UNHCR, June 2006).

A **refugee** is a person who meets the eligibility criteria under the applicable definition, as provided for in international or regional refugee instruments under UNHCR's mandate and/or in national legislation (see *Master Glossary of Terms*, UNHCR, June 2006).

ANNEX II. INTERNATIONAL INSTRUMENTS AND MECHANISMS RELEVANT TO HEALTH AND MIGRATION

International human rights instruments

The Universal Declaration of Human Rights (UDHR) is a milestone document in the history of human rights proclaimed by the United Nations General Assembly on 10 December 1948 as a common standard of achievements for all peoples and all nations. It sets out, for the first time in history, fundamental human rights to be universally protected. The principle of universality of human rights has since then been reiterated in numerous international human rights treaties, declarations and resolutions.

In 1966, the provisions of the UDHR were codified into two different legally binding instruments: the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). These two covenants, together with the UDHR, form the International Bill of Human Rights.

The ICESCR, in its Article 12, provides the most authoritative articulation of the right to health in international human rights law. The 160¹⁶⁰ states parties to the ICESCR “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. The ICESCR includes several other rights essential to the realization of the right to health, including the rights to food, housing, safe and healthy working conditions and education. All these rights should be exercised without discrimination as to, inter alia, race, sex, national or social origin.¹⁶¹

The principle of the progressive realization of economic, social and cultural rights set forth in ICESCR Article 2, recognizing constraints due to the limits of available resources, do impose on states the obligation to move as expeditiously and effectively as possible towards the full realization of rights.

The ICCPR recognizes several rights which are integral to the realization of the right to health, such as the rights to information, privacy, freedom of movement and security of persons. The ICCPR requires states to guarantee the rights recognized in the Covenant to all individuals within their territory and subject to their jurisdiction, without distinction of any kind (article 2.1).

The human rights treaty bodies, which are committees of independent experts that monitor implementation of the core international human rights treaties, have looked into migration and health issues. Questions regarding migrants’ health have included the following:

The Committee on Economic, Social and Cultural Rights, the body of independent experts that monitors implementation of the ICESCR, adopted, in May 2000, General Comment No. 14 on the right to the highest attainable standard of health, setting the criteria for the full enjoyment of the right to health. According to ICESCR (GC) No. 14, the right to health is the right to the enjoyment of a variety of facilities, goods, services and conditions – that must be available, accessible, acceptable and of good quality – necessary for the realization of the highest attainable standard of

¹⁶⁰ For updates on ratification and for a detail list of all states parties to the various international human rights treaties see: <http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en>.

¹⁶¹ See arts.12, 11, 7, 13 and 2(3).

health.¹⁶² In ICESCR No. 20 on non-discrimination and economic, social and cultural rights, the Committee restated that the Covenant rights apply to everyone, including non-nationals, regardless of legal status and documentation. Nationality should not bar access to Covenant rights, such as the right to health.¹⁶³

Furthermore, the Committee has recognized, in its GC No. 15 on the right to water, that the right to water is a human right as interpreted from Articles 11.1 and 12 of the Covenant.¹⁶⁴ According to the Committee, water should be seen as a social and cultural good, in contrast to a merely economic one¹⁶⁵ and states parties are under an obligation to ensure that the right to water is enjoyed without discrimination.¹⁶⁶ Additionally, states parties should give special attention to those individuals and groups who have traditionally faced difficulties in exercising this right, including women, children, minority groups, indigenous peoples, refugees, asylum-seekers, internally displaced persons, migrant workers, prisoners and detainees.

The Human Rights Committee, the body overseeing the implementation of the ICCPR, noted that “[i]n general, the rights set forth in the Covenant apply to everyone (...) irrespective of his or her nationality.”¹⁶⁷

The following instruments appear in order of their entry into force:

Under the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD, adopted in 1965, entered into force in 1969), states parties undertake to eliminate all forms of racial discrimination. Moreover, as stated by the Committee on the Elimination of Racial Discrimination, in its General Recommendation No. 30 on discrimination against non-citizens, states parties have to ensure that all legislative guarantees against racial discrimination apply to everyone, regardless of their migration status or nationality.¹⁶⁸

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW, adopted in 1979, entered into force in 1981) applies to all women, citizens and non-citizens alike. CEDAW includes provisions for states parties to eliminate discrimination against women in the field of health care, including those related to family planning, pregnancy, confinement and the post-natal period, granting free services, including adequate nutrition during pregnancy and lactation where necessary.¹⁶⁹

The Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT, adopted in 1984, entered into force in 1987) applies to any individual who has been subjected to torture within the jurisdiction of each state party. No person shall be expelled, returned or extradited to another state if there is reason to believe that the individual in question would be subjected to torture.¹⁷⁰

¹⁶² CESCR, *General Comment No. 14 on the Right to the Highest Attainable Standard of Health (art 12)*, E/C.12/2000/4, 11 August 2000, paras. 12 and 34.

¹⁶³ CESCR, *General Comment No. 20 on Non-discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)*, E/C.12/GC/20, 2 July 2009.

¹⁶⁴ E/C.12/2002/11, para. 3.

¹⁶⁵ E/C.12/2002/11, para. 11.

¹⁶⁶ E/C.12/2002/11, para. 13.

¹⁶⁷ CCPR, *General Comment No. 15 on the position of aliens under the International Covenant on Civil and Political Rights*, 1986, para. 1.

¹⁶⁸ ICERD, 64th session, *General Recommendation No. 30 on Discrimination against Non-Citizens*, CERD/C/64/Misc.11/rev.3, 2004, para. 7.

¹⁶⁹ CEDAW art. 12.

¹⁷⁰ CAT, art. 3.

The Convention on the Rights of the Child (CRC, adopted in 1989, entered into force in 1990), which has achieved almost universal ratification, includes the right of the child to the highest attainable standard of health. Moreover, it provides a framework of protection applicable to all children: “States parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child’s or his or her parent’s or legal guardian’s race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.”¹⁷¹

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW, adopted in 1990, entered into force in 2003) recognizes the right of *all* migrant workers and their families to emergency medical care, and the right of *documented* migrant workers and their families to equality of treatment with nationals and to access to health services.¹⁷² Article 81.1 of the ICRMW ensures that migrant workers and their families remain under the protection of more favourable rights or freedoms granted by virtue of domestic law or any other international treaty, such as the ICESCR.

The most recent instrument is the Convention on the Rights of Persons with Disabilities (CRPD, adopted in 2006, entered into force in 2008), which recognizes the rights of persons with disabilities to liberty of movement and the freedom to choose their residence on an equal basis with others, including, among other things, the access to immigration proceedings.¹⁷³

The Human Rights Council

The Human Rights Council is an inter-governmental body within the UN system made up of 47 states and created by the UN General Assembly in 2006, with the main purpose of addressing situations of human rights violations and making recommendations on them. The UN Special Procedures – the general name given to the mechanisms (extra-conventional) established to address either specific country situations or thematic issues in all parts of the world – established by the former Commission on Human Rights, were assumed by the Council.

There are several UN Special Procedures particularly relevant to the promotion and protection of the health and human rights of migrants. It is worth specifically mentioning the work of two mandate holders – the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the Special Rapporteur on the human rights of migrants.

The functions of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health are:

- to gather, request, receive and exchange information, from all relevant sources, on the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, as well as policies designed to achieve the health-related Millennium Development Goals;
- to develop or initiate a regular dialogue and discuss possible areas of cooperation with all relevant actors;
- To report on the status, throughout the world, of the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and on developments relating to this right, including on laws, policies and good practices most

¹⁷¹ CRC, arts. 2 and 24.

¹⁷² ICRMW, arts. 28, 43, 45 and 81.

¹⁷³ CRPD, art. 17.

beneficial to its enjoyment and obstacles encountered domestically and internationally to its implementation;

- To make recommendations on appropriate measures to promote and protect the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, with a view to supporting states' efforts to enhance public health;
- To submit an annual report to the Human Rights Council and an interim report to the General Assembly on its activities, findings, conclusions and recommendations.¹⁷⁴

Another mechanism for dealing with the health and human rights of migrants is the Special Rapporteur on the human rights of migrants. The mandate calls for the Special Rapporteur:

- To examine ways and means to overcome the obstacles existing to the full and effective protection of the human rights of migrants, recognizing the particular vulnerability of women, children and those undocumented or in an irregular situation;
- To request and receive information from all relevant sources, including migrants themselves, on violations of the human rights of migrants and their families;
- To formulate appropriate recommendations to prevent and remedy violations of the human rights of migrants, wherever they may occur;
- To promote the effective application of relevant international norms and standards on the issue;
- To recommend actions and measures applicable at the national, regional and international levels to eliminate violations of the human rights of migrants;
- To take into account a gender perspective when requesting and analysing information, and to give special attention to the occurrence of multiple discrimination and violence against migrant women;
- To give particular emphasis to recommendations on practical solutions with regard to the implementation of the rights relevant to the mandate, including by identifying best practices and concrete areas and means for international cooperation;
- To report regularly to the Council, according to its annual programme of work, and to the General Assembly, at the request of the Council or the Assembly.

Other international instruments and mechanisms

Several conventions delineating specific international standards for occupational health and safety have been elaborated and widely ratified under the auspices of the International Labour Organization (ILO). Such conventions provide standards for the protection of health in employment and, thus, are specifically applicable to migrant workers and other non-nationals (such as refugees) engaged in remunerative employment or occupation.

The ILO Convention No.155 concerning Occupational Safety and Health (adopted in 1981, entered into force in 1983) prescribes the progressive application of comprehensive accident prevention measures in the workplace and the adoption of a coherent national policy on safety and health, while establishing both the responsibility of employers for making work and equipment safe and without risk to health and the duties and rights of workers. Moreover, there are numerous Conventions that are specifically related to various sectors of economic activity and various types of dangerous equipment or agents, such as ILO Convention No. 167 concerning Safety and Health in Construction (adopted in 1988, entered into force in 1995).

Two specific instruments that provide for the protection of the basic labour and human rights of migrant workers and promote interstate cooperation on labour migration have been elaborated by the ILO. ILO Convention No. 97 concerning Migration for Employment (Revised) (adopted

¹⁷⁴ HRC, 4th session, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Paul Hunt, 2007, A/HRC/4/28.

1 July 1949 and entered into force 22 January 1952)¹⁷⁵ covers individuals who migrate from one country to another with a view to working for an employer. The ILO Convention No. 143 concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers (adopted in 1975, entered into force in 1978)¹⁷⁶ obliges states parties to respect the basic human rights of all migrant workers irrespective of their legal status.

Article 13 of the ILO Convention concerning Decent Work for Domestic Workers of 2011 states that: “1. Every domestic worker has the right to a safe and healthy working environment. Each Member shall take, in accordance with national laws, regulations and practice, effective measures, with due regard for the specific characteristics of domestic work, to ensure the occupational safety and health of domestic workers. 2. The measures referred to in the preceding paragraph may be applied progressively, in consultation with the most representative organizations of employers and workers and, where they exist, with organizations representative of domestic workers and those representative of employers of domestic workers”. Since 1926, the ILO has had a Committee of Experts, whose role is to provide an impartial and technical evaluation of the States parties of their application of international labour standards and the ratified conventions.

One of the first international instruments recognizing the right to health is the WHO Constitution (entered into force 7 April 1948), which established the World Health Organization. The Constitution recognizes that health is not merely the absence of disease or infirmity, but a state of complete physical, mental and social well-being and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition.

The International Health Regulations (2005) (IHR) are an international legal instrument that is binding on 194 countries and which entered into force on 15 June 2007. The IHR aims to prevent the international spread of diseases, while limiting unnecessary restrictions on the free movement of travelers. During public health emergencies of international concern or in connection with specific public health risks, measures affecting travel may be recommended to avoid the international spread of disease. Health information, basic examinations and vaccination documentation may be requested of a traveler by states. At the same time, under the IHR, states are required to treat travelers with respect for their dignity, human rights and fundamental freedoms; as such, travelers’ personal data must be kept confidential.

Finally, on 24 May 2008, the World Health Assembly Resolution 61.17 on the Health of Migrants was adopted.

Regional instruments and mechanisms relevant to the right to health

At the regional level, human rights treaties and monitoring and accountability mechanisms, for example, the African Commission on Human and Peoples’ Rights, the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, and the European Committee of Social Rights, play an important role in protecting the human right to health.¹⁷⁷

For the Americas, the American Declaration of the Rights and Duties of Man (1948) refers to the “right to preservation of health” in Article XI. The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, also known as the Protocol of San Salvador (adopted 1988, entered into force in 1999), provides for the right to health and the right to a healthy environment in Articles 10 and 11, and other health-related

¹⁷⁵ ILO, Migration for Employment Convention (Revised), 1949. The Convention is accompanied by Recommendation (No.86) concerning Migration for Employment (adopted in 1949).

¹⁷⁶ ILO, Convention concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers, 1949.

¹⁷⁷ Supra footnote 29, p. 35.

rights, such as social security, in Article 9. The regional mechanisms are the quasi-judicial Inter-American Commission on Human Rights and the judicial Inter-American Court of Human Rights, which, together, make up the Inter-American System of Human Rights. The Inter-American Court has considered the situation of undocumented migrants in its Advisory Opinion OC 18/03 of 17 September 2003.

In Europe, the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR, adopted in 1950, entered into force in 1953) does not specifically set out a right to health; however, it contains provisions related to health, such as the right to life, the prohibition on torture and inhumane and degrading treatment or punishment, and the right to respect for private and family life. The ECHR is enforced by the European Court of Human Rights, a judicial accountability mechanism. Another European instrument, the European Social Charter (adopted in 1961, revised in 1996), specifically sets out the right to health in Part I, Article 10 and Part II, Article 11. The Charter's application is monitored by the European Committee of Social Rights.¹⁷⁸ The European Convention on Social and Medical Assistance (not a human rights instrument as such) of 1953 and the Convention on Human Rights and Biomedicine of 1997 also offer elements for scope and content of the right to health in Europe. The now legally binding Charter of Fundamental Rights of the European Union of 2000 sets out the right of everyone to access preventive health care and to benefit from medical treatment. Although this right applies "under the conditions established by national laws and practices," it should be read in conjunction with the overall objective of the Treaty on European Union, which specifies that "a high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities".

Another charter that explicitly refers to the right to health is the African Charter on Human and Peoples' Rights ("Banjul Charter," adopted in 1981, entered into force in 1986), specifically in its Article 16. The Charter also refers to the physical health of the family in Article 18. The judicial enforcement mechanism for the Charter is the African Court on Human and Peoples Rights, which was established by the Protocol to the African Charter on Human and Peoples Rights and ratified by 26 African Union States. Similar to the European accountability mechanisms, the African human rights enforcement framework provides for a quasi-judicial mechanism, the African Commission on Human and Peoples' Rights.

Article 39 of the Arab Charter on Human Rights (adopted on May 22, 2004, and entered into force on March 15, 2008) recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health the right of citizens to free basic health services and to have access to medical facilities without discrimination of any kind. The Charter obligates state parties to take steps to realize this right by taking such actions as developing basic health services and guaranteeing free and easy access to centres that provide these services, regardless of geographical location or economic status; reducing the mortality rate through disease control by prevention and cure; promoting health awareness and health education; suppressing harmful traditional health practices; providing basic nutrition and safe drinking water for all; combating environmental pollution and providing proper sanitation systems; and combating smoking and the abuse of drugs and psychotropic substances.

¹⁷⁸ In 2004, the Committee held that "legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter" (International Federation of Human Rights Leagues [FIDH] v. France, decision of 8 September 2004). In 2010, the Committee concluded that there was a violation of Articles 16, 19, 30 and 31 of the Revised European Social Charter in a case alleging that the so-called "emergency security measures" and an overall racist and xenophobic discourse in Italy had resulted in unlawful campaigns and evictions leading to homelessness and expulsions disproportionately targeting Roma and Sinti migrants. The case also considered social exclusion in access to health services and sanitary and healthy housing. (Centre on Housing Rights and Evictions [COHRE] v. Italy, decision of 25 June 2010).



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