



World Health Organization



International Migration, Health & Human Rights

Health & Human Rights
Publication Series
Issue No.4, December 2003



December 18



Office of Union



Office of the United Nations High Commissioner for Human Rights

Acknowledgements:

International Migration, Health and Human Rights was made possible by support from the Government of Italy and was written by Helena Nygren-Krug, Health and Human Rights Adviser, WHO, through a process of wide-ranging consultations. In particular, the following are thanked for their input, guidance and support: Colin Bailey, Franz Bauer, Veronica Birga, Christoph Bierwirth, Alisha Bjerregaard, Rachel Brett, Dominique Bush, Alex Capron, Manuel Carballo, Andrew Cassels, Andrew Clapham, Jenny Cook, Atti-la Dahlgren, Ayesha Dawood, Julie De Riviero, Myriam De Feyter, Nick Drager, Sarah Galbraith, Anne Gallagher, Kieran Gostin, Mariette Grange, Oliver Laws, Fernando González-Martín, Danielle Grondin, Mary Haour-Knipe, Katie Heller, Beatrice Loff, Sylvie Da Lomba, Tanya Norton, Lisa Oldring, Annette Peters, Ryzard Piotrowicz, Priti Radhakrishan, Jillyanne Redpath, Nathalie Rossette-Cazel, Barbara Stilwel, Julia Stuckey, Patrick Taran and Gianni Tognoni.

WHO Library Cataloguing-in-Publication Data**International migration, health and human rights.**

(Health and human rights publication series)

1.Transients and migrants 2.Refugees 3.Emigration and immigration 4.Human rights 5.Health status 6.Public policy
6.International cooperation I.World Health Organization II.Series.

ISBN 92 4 156253 6 (NLM classification: WA 300)

© World Health Organization, 2003

All rights reserved. Publications of the World Health Organization can be obtained from Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to Publications, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

International Migration, Health & Human Rights



World Health Organization

“Today’s real borders are not between nations, but between powerful and powerless, free and fettered, privileged and humiliated. Today, no walls can separate humanitarian or human rights crises in one part of the world from national security crises in the other.”

**Kofi Annan, UN Secretary-General,
in his acceptance speech upon receiving
the 2001 Nobel Peace Prize**

Preface

As we focus our efforts on reaching the health targets set in the Millennium Development Goals, it is important to understand the challenges to health in the context of globalization. Migration - the movement of people from one area to another for varying periods of time - constitutes one such important and growing challenge.

The work of the World Health Organization is guided by the principle that health is a fundamental human right to be enjoyed by every human being without discrimination. Vulnerable and marginalized population groups require priority attention. In the context of migration, these range from forced and undocumented migrants lacking access to basic health services to poor populations left behind by the “brain drain” as health professionals in poor countries migrate to richer ones.

WHO has explored the challenges to health and human rights in the context of international migration, together with the Instituto Mario Negri, the International Centre for Migration and Health, the International Labour Organization, the International Organization for Migration, the Office of the High Commissioner for Human Rights and other relevant actors, including key civil society organizations.

We hope this volume, *International Migration, Health and Human Rights*, Issue No.4 in our Health and Human Rights Publication Series, will serve as a useful tool to focus public attention on this important topic. We also hope that it can serve as a platform for stimulating debate among policy-makers to devise sound solutions informed by public health considerations and human rights imperatives.



Dr LEE Jong-wook
Director-General
World Health Organization
Geneva – December 2003



Foreword

People are increasingly on the move for political, humanitarian, economic and environmental reasons. This population mobility has health and human rights implications both for migrants and for those they leave behind. Migrants often face serious obstacles to good health due to discrimination, language and cultural barriers, legal status and other economic and social difficulties. At the same time, migration policies may have significant public health consequences. In many parts of the world, the migration of health professionals can be a serious impediment to the delivery of health care in countries of origin.

All human rights – including the right to health – apply to all people: migrants, refugees and other non-nationals. The International Covenant on Economic, Social and Cultural Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of mental and physical health. Recently, the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families entered into force, providing additional human rights protections for migrant workers. These and other provisions should be integral to migration and health policies, programmes and legislation.

We welcome an ongoing and informed discussion on the challenges for policy-makers in addressing these issues. We congratulate the World Health Organization and other partners for their valuable contribution to this process.



Paul Hunt
UN Special Rapporteur
on the Right to Health



Gabriela Rodríguez Pizarro
UN Special Rapporteur
on the Human Rights of Migrants

Table of Contents

Section 1: Introduction to migration, health and human rights

- | | |
|---|----|
| 1 - Background and rationale | 7 |
| 2 - The human rights paradigm | 8 |
| 3 - Migration: magnitude and terminology | 9 |
| 4 - Why people migrate: “forced” and “voluntary” migrants | 10 |

Section 2: Health implications for those left behind

- | | |
|--|----|
| 5 - The “brain drain”: effects of migrating health professionals | 11 |
|--|----|

Section 3: Health implications for those on the move

- | | |
|---|----|
| 6 - Forced migration and the health implications | 15 |
| 7 - Detaining migrants and the health challenges this poses | 17 |
| 8 - Screening of migrants at the border | 18 |

Section 4: Health and human rights of migrants in the host country

19

Conclusion

29

Annex I: Main categories of migrants

30

Annex II: International legal & policy instruments relevant to health & migration

- | | |
|---|----|
| International human rights instruments | 32 |
| International legal norms specific to non-nationals | 34 |
| International conferences (policy commitments to ensuring the human rights of migrants) | 35 |

A guide to this publication

This publication provides an overview of some of the key challenges for policy-makers in addressing the linkages between migration, health and human rights. It recognizes that there is limited data available and thus does not provide a full picture. It attempts to provide a useful platform to stimulate action towards addressing migration and health in a comprehensive and human rights-sensitive way.

The *first section* explains why we are addressing the issue of migration and health and what is meant by doing this through a human rights framework. It then explores some of the terminology used and what is known about the magnitude of, and reasons for, migration.

The *second section* links the reasons that people migrate with the health and human rights implications of moving for the populations left behind. It focuses attention on the issue of migrating health professionals by highlighting relevant trends, financial implications and ongoing trade negotiations.

The *third section* considers the health implications for those on the move both in the context of public health as well as in relation to the health of the individual. It considers the various ways in which migration is managed, such as detaining and screening at the border.

The *last section*, section four, considers the health and human rights issues of migrants once in the host country. It focuses particular attention on the most vulnerable categories of migrants and highlights some of the key challenges to promoting and protecting their health.

Attached are annexes which provide a glossary as well as a list of international legal and policy instruments relevant to any discussion on health and migration.

Section 1:

Introduction to migration, health and human rights



©IOM/Chauzy 2003

This section explains why the issue of migration and health deserves to be addressed and what is meant by doing this through a human rights framework. It then explores some of the terminology used and what is known about the magnitude of, and reasons for, migration.

1- BACKGROUND AND RATIONALE

At the start of a new millennium, migration - the movement of people from one area to another for varying periods of time - has become more pronounced than ever before. Growing political instability coupled with the fact that economic growth is stagnating in a considerable number of countries means that uprooting and displacement - be it for political, environmental or economic reasons - will probably continue ⁽¹⁾ and become an even greater public health challenge.

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. ⁽²⁾ Health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. ⁽³⁾

The Constitution of the World Health Organization (1946)

The debate on health in the context of globalization to date has concentrated on the movement of goods and trade with some attention to people insofar as they provide services.

Relatively little attention has been paid by the international community to the most vulnerable population groups in the context of migration. Yet the magnitude of migration, both forced and voluntary, regular and irregular, suggests that unless attention is paid to these groups, there is a risk that in many settings individuals and groups will remain socially excluded and unable to benefit from the health and health care that is due to them as human beings. Efforts are required to maintain public health and social cohesion in an increasingly mobile world. In the absence of such efforts, migrants' capacity to contribute to host societies will be constrained.

Mindful of these concerns, the World Health Organization (WHO) brought together representatives of the following concerned international organizations during 2001-2003 to explore the issues and challenges of addressing health and migration from a human rights perspective. These organizations recognize that health issues for migrant populations represent a serious and important public health and human rights concern:

- the Ethical Globalization Initiative (EGI),
- December 18,
- the Instituto Mario Negri (IMN),
- the International Catholic Migration Commission (ICMC),
- the International Centre for Migration and Health (ICMH),
- the International Labour Office (ILO),
- International Organization for Migration (IOM),
- the Office of the High Commissioner for Human Rights (OHCHR) and
- the UN High Commissioner for Refugees (UNHCR).

⁽¹⁾ Huddled masses, please stay away. *The Economist*, 13 June 2002, at 29.

⁽²⁾ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

⁽³⁾ *Ibid.*

International organizations, human rights advocates, governments and NGOs are increasingly giving attention to the human rights aspects of migration, in particular the human rights of migrants other than refugees and asylum seekers. Increased ratifications by States of international treaties recognizing the human rights of migrants, renewed attention to the human rights aspects of migration in many national and international conferences, the appointment of a UN Special Rapporteur on the human rights of migrants and the recent entry into force of the UN Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (UN Convention on Migrant Workers) are visible manifestations of this new attention.

This report represents an initial contribution towards defining what is inevitably a long-term concern. It describes some of the complex public health issues posed by migration through a human rights framework and in the context of current migration patterns. Moreover, it seeks to highlight the highly variable nature of vulnerability as well as some of the main challenges that migration poses for health policy-makers globally.

In light of the complexities of the issues involved, any response to international migration today must be comprehensive - addressing both the “push” and “pull” factors that determine the nature and direction of migration.⁽⁴⁾ This report provides a modest contribution towards building a better understanding of the required overall picture. Its intent is first and foremost to demonstrate the need for further attention, research and elaboration of policy approaches.

Investing in improving health in poor countries is not a question of altruism but of long-term self-interest. For example, it has been shown by mathematical modelling for hepatitis B that the resources needed to prevent one carrier in the United Kingdom could prevent 4,000 carriers in Bangladesh of whom, statistically, four might be expected to migrate to the UK. Thus, it would be four times more cost-effective for the UK to sponsor a vaccination programme against hepatitis B in Bangladesh than to introduce its own universal vaccination programme.⁽⁵⁾



©IOM/Chauzy 2003

2- THE HUMAN RIGHTS PARADIGM

Human rights are legally guaranteed protections for individuals and groups against actions that interfere with fundamental freedoms and human dignity.⁽⁶⁾ These rights encompass a full range of civil, cultural, economic, political and social rights and apply universally.

The international human rights framework provides an ideological construct as well as clearly articulated and widely accepted legal notions for legislative and practical responses in the realm of health and its determinants. Respect for the basic human rights of all persons in society offers an essential and equitable basis for addressing and resolving the tensions that arise when groups with different interests interact.

International human rights instruments explicitly recognize that human rights, including specific health-related rights, apply to all persons - migrants, refugees and other non-nationals. Many provisions are recognized as applicable to all migrants, regardless of legal status. The denial of these rights carries a high risk that non-nationals will be socially excluded and unable to benefit from health services, with potentially severe consequences both for themselves and for their host and home communities.

In short, a human rights approach to the complex issues around migration requires that the human rights implications of any migration policy, programme or legislation be addressed. More proactively, it requires that a human rights

(4) For further explanation of the push/pull factors, see Section 1(4).

(5) Gay NJ, Edmunds WJ. Developed countries could pay for hepatitis B vaccination in developing countries. *British Medical Journal*, 1998, 316:1457.

(6) Office of the High Commissioner for Human Rights, United Nations Staff College Project. *Human Rights: A Basic Handbook for UN Staff*. Geneva, United Nations, 2001, at 3.



©IOM/Lowenstein-Lom 1999

framework be used to consider legislative, policy and programme options. In other words, human rights would be an integral dimension of the design, implementation, monitoring and evaluation of migration policies and programmes.

3- MIGRATION: MAGNITUDE AND TERMINOLOGY

The term “international migration” encompasses a wide range of population movement, the reasons for that movement and the legal status of migrants, which determines how long they can stay in a host country and under what conditions.

Approximately 175 million people, or 2.9% of the world’s population, currently live temporarily or permanently outside their countries of origin.⁽⁷⁾ This figure includes migrant workers, permanent immigrants, refugees and asylum seekers but it does not account for the growing irregular or undocumented movement that is coming to characterize migration everywhere.

Twenty million African workers live and work outside of their countries of origin and by 2015 one out of ten African workers will be living and working outside his or her country.⁽⁸⁾

A distinction is made between **regular** and **irregular (documented and undocumented) migrants**. Regular or documented migrants are those people whose entry, residence and, where relevant, employment in a host or transit country has been recognized and authorized by official State authorities. Irregular or undocumented migrants (sometimes referred to inappropriately as “illegal” migrants/immigrants) are people who have entered a host country without legal authorization and/or overstayed authorized entry as, for example, visitors, tourists, foreign students or temporary contract workers.

There is also a distinction made between “**voluntary**” and “**forced**” migrants. Voluntary migrants are people who have decided to migrate of their own accord (although there may also be strong economic and other pressures on them to move). These include labour migrants, family members being reunified with relatives and foreign students. Forced migration refers to “movements of refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects”.⁽⁹⁾

(7) *World Migration Report*. Geneva, International Organization for Migration, 2003.

(8) *ILO calls for Change in Migration Policies in Southern Africa*, 29 November 2002. Geneva, International Labour Organization, 2002. (Press Release). (<http://www.ilo.org/public/english/dialogue/actrav/new/291102.htm>, accessed 22 March 2004).

(9) *Mission Statement of the International Association for the Study of Forced Migration (IASFM)*. Oxford, IASFM, 1994. (<http://www.uni-bamberg.de/~ba6ef3/iasfm/mission.htm>, accessed 16 March 2004).



©IOM/Chauzy 1995

4- WHY PEOPLE MIGRATE: “FORCED” AND “VOLUNTARY” MIGRANTS

People have been forced to abandon their homes to escape persecution, political violence and armed conflict throughout history.⁽¹⁰⁾ What is different today, however, is the nature and health impact of armed conflict. Warfare is less about confrontations between professional armies. Rather it is about grinding struggles between military and civilians in the same country or between hostile groups of armed civilians. Increasingly wars are low-intensity internal conflicts, and they are lasting longer.⁽¹¹⁾ They are fought from apartment windows and in the lanes of villages and suburbs, where distinctions between combatant and non-combatant quickly blur.⁽¹²⁾ As a result, civilian fatalities in wartime climbed from 5 per cent at the turn of the century, to 15 per cent during World War I, to 65 per cent by the end of World War II, to more than 90 per cent in the wars of the 1990s.⁽¹³⁾ Concomitantly, the global case-load of refugees from armed conflict worldwide has dramatically increased from 2.4 million in 1974 to over 27.4 million today.⁽¹⁴⁾ The number of internally displaced persons in war-ridden countries is estimated at 30 million.⁽¹⁵⁾

Growing poverty (both real and relative) is pushing people to move in search of work. Images of a better life in other parts of the world are being heralded through mass media that now reaches the most remote areas and communities. The widening disparities in

wealth between North and South and the growing need for young and relatively cheap labour in the North suggest this migration trend will continue. The economic, demographic, technological and labour changes taking place in many Northern countries require people to be able to move in much the same way as materials and goods are moved – freely and at short notice.⁽¹⁶⁾ Despite these pressing factors, labour migrants are not generally considered to fall within the category of forced migrants. There is growing debate, however, as to the extent to which the lack of fulfilment of economic, social and cultural rights also forces people to abandon their homes to seek possibilities of survival and sustenance elsewhere. In short, it is increasingly difficult to distinguish clearly between “forced” and “voluntary” migrants. ◆

(10) United Nations High Commissioner for Refugees. *The State of the World's Refugees: Fifty Years of Humanitarian Action*. Oxford, Oxford University Press, 2000, at 1.

(11) Machel G. *Impact of Armed Conflict in Children (Report of the Expert of the Secretary-General of the United Nations)*. New York, UNICEF, 1996 (<http://www.unicef.org/graca/patterns.htm>, accessed 23 March 2004).

(12) *Ibid.*

(13) *Ibid.*

(14) *Ibid.*

(15) *Ibid.*

(16) Carballo M, Divino JJ, Zeric D. *Analytic Review of Migration and Health and as it Affects European Community Countries*. Geneva, International Centre for Migration and Health, 1997, at 3.

Section 2: Health implications for those left behind



©IOM/Chauzy 2003

This section links the reasons that people migrate with the health and human rights implications of moving for the populations left behind. It focuses attention on the issue of migrating health professionals by highlighting relevant trends, financial implications and ongoing trade negotiations.

5- THE “BRAIN DRAIN”: EFFECTS OF MIGRATING HEALTH PROFESSIONALS

Governments have an obligation to ensure that functioning public health and health-care facilities, goods and services, as well as programmes, are available in sufficient quantity to the population.⁽¹⁷⁾ This includes trained medical and professional personnel receiving domestically competitive salaries.⁽¹⁸⁾ Policies on human resources that improve health systems’ performance are especially important in order to achieve the Millennium Development Goals⁽¹⁹⁾ and to minimize constraints that countries may have in addressing key health problems such as HIV, tuberculosis (TB) and malaria.⁽²⁰⁾

In many parts of the world, especially in developing countries with established traditions of education and professional training, the drain of professionals poses a serious problem.⁽²¹⁾ This is most pronounced in countries where the capacity for reinvestment in the education system is limited. For these countries, losing health-care professionals may produce serious

deficiencies in the services available to local communities and in the capacity of developing countries to move forward with their health development plans. To compensate for such losses, remaining professionals may adapt to deliver services outside their scope of practice.⁽²²⁾ The health professionals who stay behind also bear the burden of greater workloads, added stress, poor pay, sub-standard equipment, inadequate supervision and information and lack of career opportunities, all of which may undermine their motivation to continue to work in such settings.⁽²³⁾ (These conditions not only apply in the context of cross-border migration, but also in cases of internal migration.⁽²⁴⁾)

► TRENDS IN INTERNATIONAL MIGRATION:

The so-called “brain-drain” has existed for decades. Of doctors trained in Ghana in the 1980s, 60% emigrated overseas,⁽²⁵⁾ and this is by no means an unusual pattern in many parts of Africa and Asia. A 1998 survey of seven African countries revealed vacancy levels in the public health sector ranged between 7.6% (for doctors in Lesotho) to 72.9% (for specialists in Ghana).⁽²⁶⁾ Malawi reported a 52.9% vacancy level for nurses.⁽²⁷⁾ Such vacancy rates inevitably lead to inadequate coverage; if this trend continues, some of the population’s health needs will become increasingly difficult to meet.⁽²⁸⁾

(17) The right of everyone to the enjoyment of the highest attainable standard of physical and mental health (International Covenant on Economic, Social and Cultural Rights). General Comment No. 14 (2000), paragraph 12(a). General comments serve to clarify the nature and content of individual rights and States Parties’ obligations.

(18) *Ibid.*

(19) *United Nations Millennium Development Goals*. New York, United Nations, 2000 (<http://www.un.org/millenniumgoals/>, accessed 23 March 2004).

(20) Mercer H et al. *Human resources for health: developing policy options for change (Draft Discussion Paper)*. Geneva, World Health Organization, 2001 (WHO/EIP/OSD).

(21) Stilwell B et al. *Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges*. *Human Resources for Health*, 2003, 1:8.

(22) *Ibid.*, at 8.

(23) *Ibid.*, at 7.

(24) *Ibid.*, at 4.

(25) Stalker, P. *Emigration-Brain Drain*. In: *Stalker’s Guide to International Migration* (http://pstalker.com/migration/mg_emig_3.htm, accessed 23 March 2004).

(26) Dvilo DY. *Retention and Deployment of Health Workers and Professionals in Africa (presentation)*. Addis Ababa, Consultative Meeting on Improving Collaboration Between Health Professionals and Governments in Policy Formulation and Implementation of Health Sector Reform, 2002.

(27) *Ibid.*

(28) *Ibid.*

With 42 million people now living with HIV/AIDS, expanding access to ARV (antiretroviral) treatment for those who urgently need it is one of the most pressing challenges in international health. In response, the World Health Organization, in collaboration with the international community, is working to provide life-saving ARV treatment to three million people in developing countries by the end of 2005.⁽²⁹⁾

Concerns about the feasibility of providing ARV treatment to large numbers of people in resource-limited settings include the issues of the complexity of regimens and the scarcity of trained health-care providers to administer the drugs.⁽³⁰⁾ However, the experience of ARV programmes now underway in developing countries has shown how optimal use can be made of available human resources. For example, aspects of the care of and follow-up of people living with HIV/AIDS can be delegated to health-care workers and community members.⁽³¹⁾

Overall data on international migration are scarce, but a variety of statistical sources do provide some useful data about the migration of health workers (e.g. censuses/surveys, administrative registers, migration visas, working permit data and border statistics). The nature of these sources may, however, vary from one country to another. In many countries, there are significant information gaps and a considerable proportion of flows is undocumented, making it difficult to compare data between countries.⁽³²⁾ Consequently, international monitoring of migration is hampered by data quality and comparability issues.

What is available in terms of reliable data does confirm that richer countries are continuing to recruit staff from developing countries⁽³³⁾ and that migration of health professionals will continue as long as there are more competitive salaries elsewhere. It is increasingly being recognized that “recruiting” countries should assess the impact of their policies on the fulfilment of human rights in other countries.⁽³⁴⁾

Professionals currently constitute the largest proportion of economic migrants. They leave in search of better pay and working conditions, professional development and a better life for themselves and their children. Health workers are among the most sought-after professionals, and are often recruited immediately after graduation. Health worker migration can result in a serious loss of human capital from the countries of origin, impeding health sector development and reducing the capacity of countries to deliver health services.

When migrating health professionals are educated in their home country in nationally subsidized educational systems, developing countries are supporting the health systems of developed countries.

Policy options could include:

1. CREATIVE CONTRACTS

A hospital in an industrialized country is working to conclude a bilateral agreement with hospitals in a developing country to recruit nurses for a limited period of time. They will give five-year contracts but three of these years will be spent in the country of origin, not in the recruiting country.

There seems to be some future in creative contracting such as this. This allows the recruiting country to financially subsidize the health sector, particularly human resources, in the country of origin, as well as enables the health professional to work overseas.

Further transparency in migration intentions and regulations would facilitate this process. Finding out whether professionals intend to migrate, and then using contracting mechanisms which specify length of contract in both countries, paid for or at least subsidized by the richer developed country, have the potential to result in gains for all parties.

2. INVESTING IN EDUCATION

Country A wishes to recruit nurses from Country B. Instead of simple recruitment, A has set up a nurse training institute in B, financed by prospective Country A employers. This institute trains nurses according to the B requirements, and some of these nurses migrate to A, while others stay in country B.

Investing in another country's education system is unusual, but where there are labour imbalances this may make good sense and provide an opportunity to compensate the ‘sending’ country financially and strengthen infrastructure.

Barbara Stilwell, World Health Organization/Evidence and Information for Policy, 2003

(29) World Health Organization and UNAIDS unveil plan to get 3 million AIDS patients on treatment by 2005. Geneva, World Health Organization, 2003 (Press Release 1 December 2003; <http://www.who.int/mediacentre/releases/2003/pr189/en/>, accessed 25 March 2004).

(30) Grubb I, Perriens J, Schwartlander B. *A Public Health Approach to Antiretroviral Treatment: Overcoming Constraints*. Geneva, World Health Organization, 2002, at 3.

(31) *Ibid.*, 4.

(32) See reference under footnote 21, at 5.

(33) See reference under footnote 25.

(34) *Duties sans Frontières: Human rights and global social justice*. Geneva, International Council on Human Rights Policy, 2003, 46-53.

Clearly, more needs to be done to devise solutions that benefit all parties concerned.⁽³⁵⁾ Identifying and acting upon possible incentives for health professionals to remain in the country of origin constitutes one option.⁽³⁶⁾ Financial support to increase doctors' and nurses' salaries and provide them with necessary supplies and equipment could give a significant boost to health infrastructure in Africa.⁽³⁷⁾

► FINANCIAL IMPLICATIONS

Given the financial investment governments make in training professionals, the loss of new graduates constitutes a massive financial as well as human resource loss for the countries in question. There is good reason to believe this practice is serving to widen the gap between rich and poor countries.⁽³⁸⁾ Many argue that the portion of international migrant workers' earnings that is sent back from the country of employment to the country of origin (widely known as "remittances") serves a central role in the economies of the countries of origin.⁽³⁹⁾ However, the reality is that not all migrants send money back home.⁽⁴⁰⁾ Even when they do, their capacity to remit funds is often limited by the vagaries of irregular employment in their countries of adoption.

Remittances flows are the second-largest source, behind foreign direct investments (FDI), of external funding for developing countries. In 2001, workers' remittance receipts to developing countries stood at \$72.3 billion, much higher than total official flows and private FDI flows. For the last decade, workers' remittance receipts to developing countries have exceeded the total of global development aid.⁽⁴¹⁾

⁽³⁵⁾ An important aspect of a human rights approach is the political participation of the population groups concerned and affected by health-related decision-making at the community, national and international levels. This would mean that migrant communities should have a voice in government processes which are aimed at setting priorities, making decisions, planning, implementing and evaluating policies and strategies which will affect their health and development.

⁽³⁶⁾ Improved living and working conditions have been identified as constituting such incentives. See *The Role of Wages in Slowing the Migration of Health Care Professionals from Developing Countries*, Geneva, World Health Organization, (unpublished document, available on request from Evidence and Information for Policy Cluster, EIP, World Health Organization, 1211 Geneva, 27, Switzerland), at 14-5. However, the authors caution that this conclusion is only applicable in certain situations, and that there is not enough information to give the highest quality of analysis for this conclusion.

⁽³⁷⁾ Friedman, EA. *An Assessment of the Feasibility of WHO's Proposal to Treat 3 Million HIV/AIDS Patients by 2005: A Physicians for Human Rights White Paper*. Boston, Physicians for Human Rights and Partners in Health, 2002 (http://www.phrusa.org/campaigns/aids/who_doc.html, accessed 24 March 2004).

⁽³⁸⁾ When F. Labour's new idea - scrambled government? Tory night of the living dead. *The Guardian*, 6 September 2000.

⁽³⁹⁾ See reference under footnote 21, at 8. See also: Outward Bound. *The Economist*, 28 September - 4 October 2002, at 29-32.

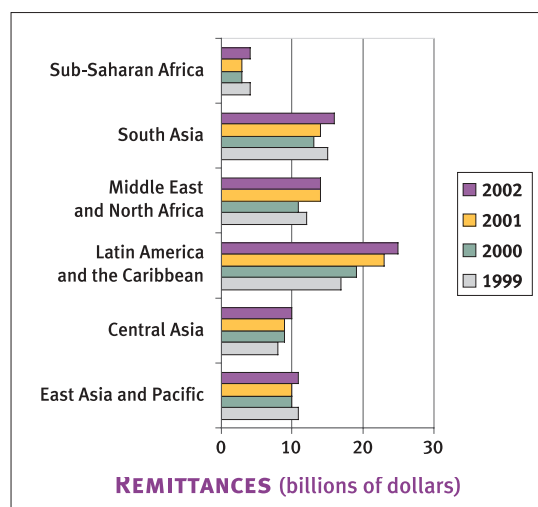
⁽⁴⁰⁾ According to Manuel Carballo, Director of International Centre for Migration and Health (ICMH), Geneva.

⁽⁴¹⁾ See reference under footnote 21, at 8.

⁽⁴²⁾ *Ibid.*, 9.

⁽⁴³⁾ *Ibid.*, 9. See also Evidence for Information and Policy, Health Services Provision, Draft Briefing Note, 16 December 2002 (unpublished document, available on request from Evidence and Information for Policy Cluster, EIP, World Health Organization, 1211 Geneva, 27, Switzerland), at 6.

CHART 2: REMITTANCES RECEIVED BY DEVELOPING COUNTRIES, BY REGION 1999-2002 (\$ BILLIONS)



Source: World Bank 2003⁽⁴²⁾

In addition, in the context of migrating health professionals, there is no evidence that remittances sent by emigrants necessarily contribute to investments in health in their countries of origin, particularly since remittances are not directly reinvested in human capital. Thus, even when the economic capacity of a country is strengthened over the long term, the short-term loss of health professionals can impact negatively on coverage of and access to services in developing countries.⁽⁴³⁾



©IOM/Allyanak 1995

► TRADE REGULATIONS

The issue of migrating health professionals is particularly topical as there are currently negotiations within the framework of the General Agreement on Trade in Services (GATS), the legal framework through which World Trade Organization (WTO) members progressively liberalize trade in services, including health-related services.⁽⁴⁴⁾ It is hoped that the negotiations, which began in 2000, will produce expansion of trade in health services, but also an opportunity to attract foreign direct investment and make it responsive to national health priorities.⁽⁴⁵⁾ However, there are risks associated with liberalization, as not all countries are poised to transform the potential gains into health benefits for the majority of people.

In some cases, trade in health services has aggravated existing problems of ensuring fair financing of, as well as equitable access to, health services. For example, poor countries that expend resources on the treatment of foreign patients may divert resources that could meet domestic supply needs. Moreover, the needs of remote regions and disadvantaged populations tend to be neglected as for-profit private, foreign-invested hospitals target more profitable markets.⁽⁴⁶⁾

A human rights approach requires governments to assess the potential impact of any trade agreement on the enjoyment of human rights, paying particular attention to the most vulnerable and marginalized population groups.⁽⁴⁷⁾ In the context of the human right to health, for example, this would mean assessing the impact of the trade agreement concerned on the availability, affordability, accessibility, quality and cultural acceptability of health facilities, goods

and services, paying particular attention to the most vulnerable population groups.⁽⁴⁸⁾ It would need to be demonstrated that the agreement would potentially promote or enhance the enjoyment of the right to health.

Under GATS, countries have the flexibility to manage trade in services in ways that respect, protect and fulfil the right to health by adopting regulatory strategies and enforcement mechanisms. The obligation of the State to protect human rights, for example, means that governments are responsible for ensuring that non-state actors, such as private companies, act in conformity with human rights law within their jurisdiction. In other words, governments are obliged to ensure that third parties conform with human rights standards by adopting legislation, policies and other measures to assure adequate access to health care, quality information, etc., and to provide an accessible means of redress if individuals are denied access to these goods and services.⁽⁴⁹⁾ ◆

Trade liberalization could contribute to enhancing quality and efficiency of supplies and/or increasing foreign exchange earnings if appropriate regulatory health frameworks exist. For example, hospitals financed by foreign investors can provide certain services not previously available. New hospitals can also offer attractive employment alternatives for health professionals who might otherwise leave the country. The revenue generated through the treatment of foreign patients may be used, for instance, to upgrade facilities that benefit the resident population as well.⁽⁵⁰⁾

WHO/WTO, WTO Agreements and Public Health, at pp.112-3.

(44) Though GATS entered into force in 1995, “so far the liberalizing effects have remained limited as most WTO Members have made relatively few commitments that go beyond existing levels of access”. WHO/WTO, *WTO Agreements and Public Health: A joint study by the WHO and the WTO Secretariat*. Geneva, World Health Organization and World Trade Organization, 2002, at 47. Within the GATS framework, trade in health services means “the provision of specialized and general health personnel, nursing services, hospital services, ambulance services and physiotherapeutic and paramedical services provided by medical and dental laboratories”. Definitions and Debates for Health and Trade Policy Makers: A Glossary of 103 Health and Globalization Terms. (unpublished document, available on request from Globalization, Trade and Health (GTH/ETH/SDE), World Health Organization, 1211 Geneva, 27, Switzerland).

(45) WHO/WTO, *WTO Agreements and Public Health: A joint study by the WHO and the WTO Secretariat*. Geneva, World Health Organization and World Trade Organization, 2002, at 19.

(46) *Ibid.*, 112-113.

(47) Hunt, P Report of the United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Geneva, Economic and Social Council, Commission on Human Rights, E/CN.4/2003/58 paragraphs 82-85.

(48) See reference under footnote 17, paragraph 12.

(49) Nygren-Krug H. *25 Questions and Answers on Health and Human Rights*. Geneva, World Health Organization, 2002. (Health and Human Rights Series No. 1), at 15.

(50) See reference under footnote 45, at 112-113.

Section 3:

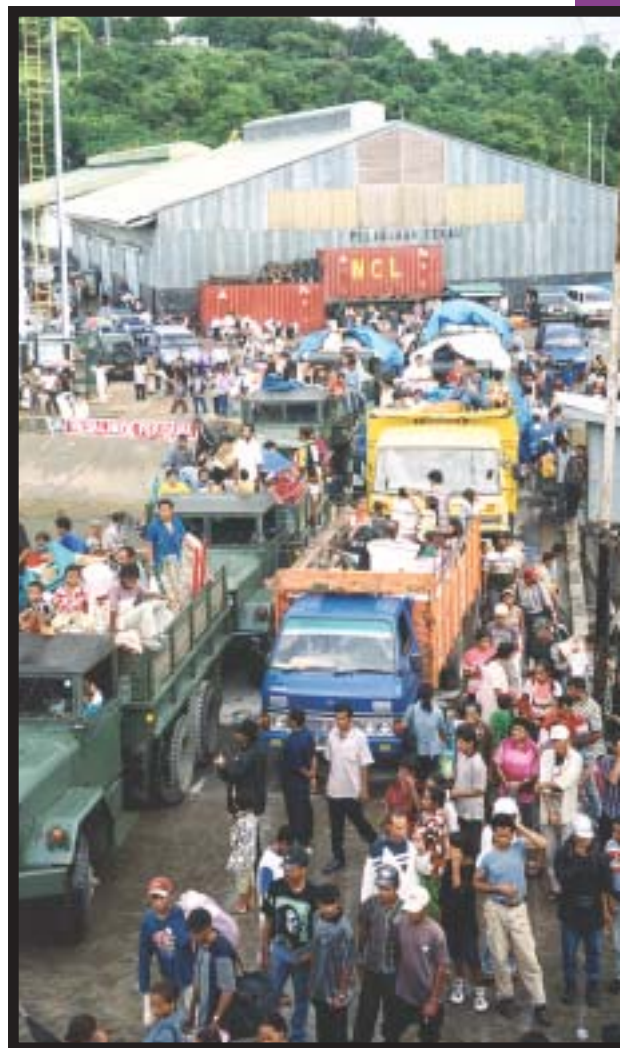
Health implications for those on the move

This section considers the health implications for those on the move both in the context of public health as well as in relation to the health of the individual. It considers the various ways in which migration is managed, such as detaining and screening at the border.

6- FORCED MIGRATION AND THE HEALTH IMPLICATIONS

► DEVELOPMENT DISPLACEES

A human rights approach requires that any development project be assessed in terms of its impact upon human rights, including the right to health.⁽⁵¹⁾ Despite the fact that policies and projects implemented to supposedly enhance 'development' generate the largest global cause of displacement, this often takes place with negligible recognition, support or assistance from outside the affected population.⁽⁵²⁾



©IOM/Lowenstein-Lom 2000

10 million people a year, on average, are displaced by dam projects alone.⁽⁵³⁾ Disproportionately affected are indigenous and ethnic minorities and the urban or rural poor.⁽⁵⁴⁾

China is currently constructing the 182 metre high Three Gorges Dam across the Yangtze river, which is expected to alter the health and welfare of millions of people by 2009. The lake will displace at least 1.3 million people and will directly impinge on 20 million others along its length. The population living near the future reservoir is crowded, poor and unhealthy. Health services, water supplies and sanitation are inadequate and there is a high incidence of rheumatic fever, hepatitis B, pneumonia, measles and diarrhoea. Other health risks include a possible resurgence of endemic infections: malaria, paragonimus, epidemic hantaanvirus haemorrhagic fever with renal syndrome, Japanese B Encephalitis and leptospirosis. Keshan disease, a commonly fatal cardiomyopathy of young women and children linked to low selenium soils, enterovirus infection, mouldy grain and the diets in endemic areas, may appear among the people ousted. Fluorosis from use of unchecked fluorine-containing coal and ground water is also a threat. A large workforce has assembled and the active nightlife increases the risk of HIV transmission, a risk that is further increased by the prevalence of gonorrhoea, which is the third most infectious disease in China. The most serious threat is that schistosomiasis could become established in the reservoir area. This parasitic disease persists along the Yangtze despite a 40 year control programme, with endemic areas only 40 km below the dam as well as 500 km above Chongqing. Epidemics of schistosomiasis, malaria and other parasitic infections have occurred around many reservoirs created by dams elsewhere. Yet no programme has been set up to combat the threats of the Three Gorges dam to public health.

“Public Health and Public Choice: dammed off at China’s Three Gorges?” Adrian Sleight & Sukhan Jackson, *The Lancet* 351 (9114): 1449-1450, 16 May 1998.

(51) See reference under footnote 47, at paragraphs 82-85.

(52) Loughna, S. *What is Forced Migration?* Oxford, Forced Migration Online (<http://www.forcedmigration.org/whatisfm.htm>, accessed 23 March 2004).

(53) *Ibid.*

(54) *Ibid.*



©IOM/Alyanak 1995

► INTERNALLY DISPLACED PERSONS AND REFUGEES:

In conflict situations, displacement of populations often means that health personnel are also displaced, causing disruption of health services and interrupting vital access to care.⁽⁵⁵⁾ Consequently, diseases that had previously been controlled may re-emerge as epidemics. For example, in Angola, trypanosomiasis, which had decreased from 2,500 to 3 cases between 1949 and 1974, re-emerged with one in three Angolans being at risk.⁽⁵⁶⁾

Civilians, especially mothers and children, are increasingly acknowledged to bear the brunt of the impact of modern conflicts, whether they are injured, displaced, traumatized or killed.⁽⁵⁷⁾ Men may be the combatants, but women, children and the elderly endure a torturous existence, and not enough is being done to protect them from war-related violence, exploitation and abuse.

Women and girls face extraordinary health risks in refugee camps, where they are often the victims of sexual assault, even by guards. Among a surveyed group of Burundian refugees in Tanzania, 25% of women in Kanembwa camp had been exposed to sexual violence.⁽⁵⁸⁾

► ASYLUM SEEKERS:

Refugees and asylum seekers arriving in countries of asylum have often experienced severe shock and trauma. Many are likely to be suffering from post-traumatic stress disorders (PTSDs), anxiety and the loss of family members. In many cases they may also have suffered torture and other abuses, including sexual abuse. Both short- and long-term psychosocial disability can be anticipated in displaced populations, and their capacity to adapt easily and actively to host countries may be limited.⁽⁵⁹⁾

The British Medical Association has criticised the hardening attitude to asylum seekers in Britain.⁽⁶⁰⁾ Faced with the problems of the risk to public health if entrants do not receive adequate health screening, it laments the lack of time for doctors to build up trust with survivors of trauma and torture, the lack of support for treatment of the high incidence of mental health problems and the fact that the current system means that vulnerable people arrive for treatment without warning, planning or language support. Primary care doctors are struggling to cope with people who claim to have suffered torture, rape or severe physical and psychological trauma.⁽⁶¹⁾

► SMUGGLED MIGRANTS

The introduction of more severe entry restrictions for migrants in general has given rise to an increase in the number of people trying to enter countries unofficially. Large numbers of migrants die each year whilst being smuggled by land or sea, with such tragic cases as the drowning of 356 people on an overcrowded boat that sank off the coast of Indonesia in 2001⁽⁶²⁾ and the suffocation of Chinese migrants in the back of a truck in the British port of Dover in 2000.⁽⁶³⁾

► VICTIMS OF TRAFFICKING

Traffickers use coercive tactics, including deception, fraud, intimidation, isolation, the threat and use of physical force and debt bondage to control their victims. Some of the negative health impacts endured by victims of trafficking, the vast majority of whom are women and children, include greater vulnerability to ill-health and lesser ability to implement healthy choices; exposure to health hazards and infectious diseases, particularly for those who experience poor living conditions;

(55) *Health and Social Status of Internally Displaced People in Bosnia and Herzegovina*. Geneva, International Centre on Migration and Health, 1996, at 7.

(56) *Health Impact of Large Post-Conflict Migratory Movements – the Experience of Mozambique. Report of Maputo Conference, 20-22 March 1996*. Geneva, International Organization of Migration, 1996, at 11.

(57) *State of the World's Mothers*. Washington, DC, Save the Children, 2003 (http://www.savethechildren.org/mothers/report_2003/index.asp, accessed 23 March 2004), at 1.

(58) Carballo, M. *Migrants, Displaced People and Violent Behaviour: a growing public health challenge*. Geneva, International Centre on Migration and Health, 1999.

(59) "Instead of providing rehabilitation and a supportive environment for individuals fleeing oppression, governments have gone to elaborate and costly lengths to reproduce the environment of threat and fear from which these people have fled." Silove D, Steele Z, Mollica RF. Detention of asylum seekers: assault on health, human rights, and social development. *Lancet* 2001, 357:1436-37.

(60) *Asylum seekers & their health*. London, British Medical Association, 2003 (<http://www.bma.org.uk/a.p.nsf/Content/asylumseekershealth>, accessed 23 March 2004).

(61) Doctors and Asylum Seekers. In: British Medical Association, eds. *The Medical Profession and Human Rights: A Handbook for a Changing Agenda*. London, Zed Books, 2001:382-412.

(62) Rodríguez Pizarro, G., Report of the Special Rapporteur on the human rights of migrants. Geneva, Economic and Social Council, Commission on Human Rights, E/CN.4/2002/94, 2002, paragraph 32.

(63) *United Nations Convention Against Transnational Organized Crime: The Protocol against the Smuggling of Migrants*. Vienna, United Nations Office on Drugs and Crime, 2000 (<http://www.unodc.org/palermo/smugg.htm>, accessed 24 March 2004).



©IOM/Foca 2003

physical violence or conditions of labour servitude; impacts on reproductive and sexual health, including sexually transmitted infections, unwanted pregnancies, unsafe abortions, infertility and HIV/AIDS; and emotional and mental health implications.⁽⁶⁴⁾

7- DETAINING MIGRANTS AND THE HEALTH CHALLENGES THIS POSES

Governments typically treat arriving migrants more as a problem than as an asset. To deal with influxes, many host governments have set up migrant detention centres for the processing, screening and administration of migrants before allowing them to settle in the host country, if at all.

At the time of the economic crisis of the late 1990s in South Korea, there were 90,000 undocumented migrants in the country. Thousands were ordered to leave the country or pay a fine, although many were unemployed and unable to pay. Detained migrants were often kept in inhuman, cramped conditions before being deported.

Amnesty International Index, ASA 25/02/99
Amnesty International, February, 1999.

Due to the inability and/or unwillingness of host countries to invest significantly in the health and sanitation of detention centres and refugee camps, many of these camps are overcrowded and lend themselves to communicable disease transmission. Refugees fleeing war, and other categories of migrants such as victims of trafficking, may experience post-traumatic stress that can lead to heightened aggression, exacerbated by the conditions in these centres and by the way they are treated. Whether and how this treatment affects

the people concerned in long-term ways is not clear but “ideological commitment” among affected children, when combined with PTSD, can result in violent tendencies later on in life and may be a cause of violence in and against host societies.⁽⁶⁵⁾



©IOM/Barriga 1999

Detention has also been found to negatively impact the availability and accessibility of health care, as well as the right to privacy. For example, it has been reported that, at times, consultations occur in the presence of guards, access to medical care has to be negotiated through staff other than the contracted periods, and appointments are cancelled if official escorts are unavailable.⁽⁶⁶⁾

In many Western countries that recognize the need for some minimum detention while identification and health screening is undertaken, the trend is now towards community release.⁽⁶⁷⁾ Indeed, a three-tiered system from closed detention to open and finally community release or a combination of models is probably called for everywhere. It may in fact be cheaper and certainly more humane to allow new arrivals to live with relatives or friends, with reporting requirements and/or bail/surety, reducing the need for public accommodation.⁽⁶⁸⁾

FROM PERSECUTION TO PRISON: THE HEALTH CONSEQUENCES OF DETENTION FOR ASYLUM SEEKERS

A recent survey by Physicians for Human Rights involving asylum seekers in detention throughout the United States suggests that detention is a significant stressor for asylum seekers, resulting in worsening of psychological symptoms. Asylum seekers in detention do not appear to be receiving adequate mental health services. Furthermore, this study raises concerns about the manner in which asylum seekers are treated both at the time of arrival in the country and whilst in detention.⁽⁶⁹⁾

(64) Phinney A. *Trafficking of Women and Children for Sexual Exploitation in the Americas*. Washington, DC, Women, Health and Development, Pan American Health Organization, 2001, at 4-6.

(65) See reference under footnote 58, at 12-13.

(66) Loff B. Detention of Asylum Seekers in Australia. *Lancet*, 2002, 359:792.

(67) Sweden, for example, detains arrivals to verify identity, but most detainees are released within a very short time, particularly if they have relatives or friends living in Sweden. In Sweden, a child can be detained for a maximum of six days. *Refugee Fact Sheet: Question and Answer*. Sydney, Amnesty International Australia, 2001 (http://www.amnesty.org.au/whats_happening/refugees/resources/fact_sheets/General_Questions, accessed 24 March 2004).

(68) *Alternatives to detention*. Glebe, The Refugee Council of Australia (http://www.refugeecouncil.org.au/html/current_issues/alternative51.html, accessed 24 March 2004).

(69) *From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers*. Boston and New York City, Physicians for Human Rights (PHR) and the Bellevue/NYU Program for Survivors of Torture, 2002.

8- SCREENING OF MIGRANTS AT THE BORDER



©IOM/Chauzy 1999

International law recognizes the right to leave one's country.⁽⁷⁰⁾ However, there is no corresponding obligation on another State to permit entry to its territory. Consequently, visas to leave a territory have been eliminated in almost all countries, but entry visas for nationals of certain countries are regularly introduced.

Traditionally, immigration issues have been considered to fall within the scope of national sovereignty. Governments in many countries are currently taking a restrictive approach to immigration. Today's migration is thus occurring against a backdrop of increasing discrimination and xenophobic hostility towards migrants and national policies that make entry, social integration and welfare difficult. The terrorist attacks of 11 September 2001 followed by the reinforcement of national security responses have served to harden these attitudes and to give fuel to the arguments of proponents of restrictive migration policies.⁽⁷¹⁾

Discrimination on the basis of health status is increasingly recognized as part of international human rights law.⁽⁷²⁾ It is less explicitly referred to in international human rights treaties compared to, for example, sex, race or religion. However, it is widely acknowledged to be included in the concept of "other status" and is accordingly one of the prohibited grounds of discrimination.

Profiling migrants according to their health status is common practice. Some governments use screening as a way of obtaining information necessary for referral of migrants for health care; however, others tend to use it to block entry. Official temporary workers, for example, are screened for common diseases at the time of entry into Switzerland and before work contracts are issued, but in the case of most easily treatable infections, including TB, treatment is offered by the State.⁽⁷³⁾ According to the US Department of State, approximately 60 countries require foreigners to be tested for HIV prior to entry for long-term visitors, i.e. students and workers.⁽⁷⁴⁾ From the available evidence, it is clear that there is no role for HIV testing among screening procedures for entry, as available epidemiological data on HIV transmission and natural history show that allowing HIV

infected migrants into a country does not create additional risk to the local population.⁽⁷⁵⁾ As far back as 1994, a WHO report demonstrated the ineffectiveness and counter-productiveness of travel restrictions for the following three reasons:⁽⁷⁶⁾ (1) HIV is already present in every country in the world; (2) it is impossible to close borders effectively and permanently; and (3) to the degree that people fear the application of restrictions, they may enter or remain illegally, and in such clandestine

status are not likely to utilize preventive interventions. The WHO document went on to note that there were two divergent views on the relationship between economic issues and travel restrictions for persons with HIV/AIDS. One view firmly proposed that such screening procedures were not justifiable on economic grounds. The other proposed that if there were justifiable economic grounds for such screening procedures, HIV/AIDS should not be singled out among other comparable health conditions.⁽⁷⁷⁾

In the case of highly infectious diseases such as SARS,⁽⁷⁸⁾ which pose an immediate threat to the health of the general public, screening at departure may provide an important avenue to protect public health. Recognizing the impossible task of sealing off national borders or effectively curbing immigration, and in light of the fact that carriers of disease may be unaware of their infectiousness, public health surveillance of persons suspected of being infectious and their contacts may provide the most effective strategy.⁽⁷⁹⁾ In practice, this may mean opening and expanding legal and regular (im)migration, making health screening for highly infectious diseases possible and applying isolation and quarantine measures appropriately in accordance with the Siracusa principles.⁽⁸⁰⁾ ◆

Limitations on the exercise of certain human rights can only be justified under certain conditions established under international human rights law. These conditions, which are referred to as the Siracusa principles, include the following:

1. The restriction is provided for and carried out in accordance with the law;
2. The restriction is in the interest of a legitimate objective of general interest;
3. The restriction is strictly necessary in a democratic society to achieve the objective;
4. There are no less intrusive and restrictive means available to reach the same goal;
5. The restriction is not imposed arbitrarily, i.e. in an unreasonable or otherwise discriminatory manner; and
6. The restriction is time-limited and subject to review.

(70) Universal Declaration of Human Rights (10 December 1948) (hereinafter UDHR), Article 13(2).

(71) *The Aftermath of September 11 – The Tightening of Immigration Policies*. Valencia, Statement by Human Rights Watch on the occasion of the Euro-Mediterranean Civil Forum, 13 April 2002 (<http://www.hrw.org/press/2002/04/valenciaspeecho413.htm>, accessed 14 April 2004).

(72) This has been reaffirmed in General Comment 14 and in resolutions of the UN Commission on Human Rights. See Resolutions 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).

(73) Braunschweig S, Carballo M. *Health and Human Rights of Migrants*. Geneva, International Centre on Migration and Health, 2001.

(74) *Human Immunodeficiency Virus (HIV) Testing Requirements for Entry into Foreign Countries*. Washington, DC, United States Department of State, March 2003 (<http://travel.state.gov/HIVtestingreqs.html>, accessed 23 March 2004).

(75) Matteelli A, El-Hamad I. *Asylum Seekers and Clandestine Populations*. In: Haour-Knipe M, Rector R, eds. *Crossing Borders: Migration, Ethnicity and AIDS*. Bristol, Taylor & Francis, 1996: 184-185.

(76) WHO Global Programme on AIDS. *Report of the Preparatory Meeting for a Consultation on Long Term Travel Restrictions and HIV/AIDS*. Geneva, World Health Organization, 1994, at 6.

(77) *Ibid.*, 7.

(78) Severe Acute Respiratory Syndrome.

(79) Spiro P. The legal challenges SARS poses. *CNN FindLaw*, 29 April 2003

(<http://edition.cnn.com/2003/LAW/04/29/findlaw.analysis.spiro.sars/>, accessed 23 March 2004).

(80) United Nations, Economic and Social Council, U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities, *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, Annex, UN Doc E/CN.4/1985/4 (1985)*.

Section 4:

Health and human rights of migrants in the host country



©IOM/Alyanak 1995

This section considers some of the health and human rights issues faced by migrants once in the host country. It focuses particular attention on the most vulnerable categories of migrants and highlights some of the key challenges to promoting and protecting their human right to health.

The degree of vulnerability in which migrants find themselves depends on a wide variety of factors, ranging from their legal status to their overall environment. What follows are some key elements, directly or indirectly related to the enjoyment of individual human rights, that can influence the health and well-being of migrants.

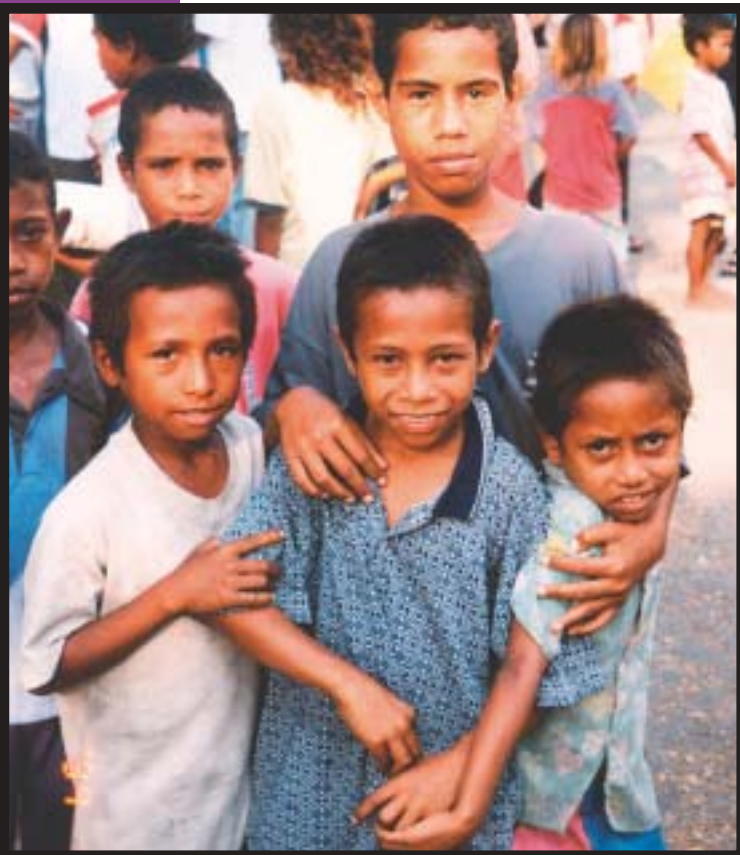
“The willingness of rich countries to welcome migrants, and the way that they treat them, will be a measure of their commitment to human equality and human dignity. Their preparedness to adjust to the changes that migration brings will be an indicator of their readiness to accept the obligations as well as the opportunities of globalization, and of their conception of global citizenship. And their attitude to the issue will also be a test of their awareness of the lessons, and obligations, of history.”⁽⁸¹⁾

► ACCESSIBILITY IN RELATION TO LEGAL STATUS

One of the most important determining factors of whether migrants face barriers to accessing health services is the question of their legal status in the country. It is therefore appropriate to begin this analysis by exploring the health and human rights issues pertaining to undocumented or “irregular” migrants.

Laws and policies which prevent migrants from accessing social services, including health care, based on immigration status rest upon and convey the idea that irregular migrants themselves are primarily responsible for their precarious situation, that it would be expensive for taxpayers to afford them health services and that excluding them from social benefits would serve to deter future irregular migrants. Allowing irregular migrants access to health services is therefore often considered charity or ‘generosity’ on behalf of the State. According to human rights law, however, governments have legal obligations in relation to the health of every person within their jurisdiction.

(81) Secretary-General Kofi Annan’s Emma Lazarus Lecture on international flows of humanity, 21 November 2003. New York, NY, United Nations, 2003. (Press Release SG/SM/9027; <http://www.un.org/News/Press/docs/2003/sgsm9027.doc.htm>, accessed 23 March 2004).



©IOM/Lowenstein-Lom 2000

An HIV-positive migrant, D, successfully challenged his deportation from Great Britain to St. Kitts, a Caribbean Island-State, by arguing that his removal would expose him to inhuman and degrading treatment in breach of Article 3 of the European Convention on Human Rights. On appeal, the European Court of Human Rights held in D's favour, stating that Article 3 was violated as D's removal to St. Kitts would result in the abrupt withdrawal of life-prolonging medical treatment, owing to that country's inability to provide adequate anti-retroviral treatment. While noting that the circumstances were exceptional in this case, the Court stated that the protections against inhuman or degrading treatment contained in Article 3 are absolute and must be enforced regardless of the nature of the potential deportee's conduct.

(*D v. United Kingdom* (1997) 24 ECHR 423)

Although human rights apply to everyone within a state's territory, differential treatment on grounds of nationality is in certain circumstances permissible.⁽⁸²⁾ However, under the Convention Against Racial Discrimination, as between non-nationals governments may not favour some nationalities over others.⁽⁸³⁾

The hiring of migrants in an irregular situation may be encouraged by restrictive state policies not obligating employers to provide health coverage to such migrants, as the labour force then becomes cheaper than recruiting nationals requiring health insurance.

Both human rights law and public health imperatives would, however, require that irregular migrants be afforded at least a minimum level of public health protection. Nevertheless, there are only two international treaties that expressly recognize health rights of irregular migrants: the Convention on Migrant Workers (1990) and the Rural Workers' Organizations Convention (1975). It should also be noted that in interpreting the right to health, the Committee on Economic, Social and Cultural Rights stated that States have an obligation to respect the right to health "by refraining from denying or limiting equal access - on economic, physical and cultural grounds - for all persons, including... asylum seekers and illegal immigrants, to preventive, curative and palliative health services".⁽⁸⁴⁾

The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families of 1990 confers on all migrant workers and members of their families, regular and irregular migrants alike, the right to emergency medical care. However, it fails to provide that irregular migrants should benefit from disease prevention measures such as early diagnosis and medical follow-up.



©WHO/Virot

(82) *Nottebohm* (Liechtenstein v. Guatemala) (1951-1955) ICJ Rep. 4, p.23.

(83) International Convention on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965, entry into force 4 January 1969) (hereinafter ICERD). Article 1(1) declares: "Racial discrimination" shall mean any distinction, exclusion, restriction or preference based on race, colour, descent or national or ethnic origin...". Stating further that the provision "shall not apply to distinction, exclusion, restriction or preference between citizens and non-citizens" (Article 1(2)), it nevertheless requires the States to ensure that "legal provisions... do not discriminate against any particular nationality" (Article 1(3)).

(84) See reference under footnote 17, paragraph 34.

There are strong commonalities in the objectives pursued by governments in the field of irregular migration. Their political and legal responses, however, may differ greatly. The experiences of France and England exemplify this, demonstrating different approaches to the question of social rights for irregular migrants with significant implications for public health and human rights:

Beginning with the passage of the Loi of 1893, France has more than a century-long tradition of guaranteeing free access to health care to underserved communities, regardless of their legal status or nationality. In 1999, the French legislature passed the *Couverture Maladie Universelle* (CMU) which aimed to provide equal access to health care to all economically deprived people. The CMU conditions access to health care on stable and regular residence, thereby excluding irregular migrants from its benefits coverage. Irregular migrants' access to free consultations, treatments and prescriptions was nonetheless maintained through the *Aide Médicale de l'Etat* (AME). A change in the law in 2002, however, requires the beneficiaries of the AME to contribute toward the expense of their treatment, which some fear will dissuade irregular migrants from seeking medical help, thereby exacerbating their vulnerability. Faced with strong criticism, the government has for the time being suspended the implementation of the AME reform. Despite this acknowledgement of the government's responsibility to provide health care to irregular migrants, many obstacles prevent their access in practice: poor publicity and low awareness in the migrant community; fear of deportation; complex procedures; and heavy demand placed on hospital resources.

England has taken a different approach by not explicitly addressing irregular migrants' right to health care in its legislation. Eligibility for England's National Health Service (NHS) is predicated on whether a person is "ordinarily resident" in the United Kingdom. As "overseas visitors", irregular migrants must in principle bear the costs of hospital services and are entitled to limited treatment under the NHS. Moreover, in respect of non-emergency treatment, general practitioners have discretion when deciding whether they will provide treatment through the NHS or on a private payment basis. Most irregular migrants cannot afford to pay as a private client might otherwise be able to do.

The French and English experiences with irregular migration vary widely in their political and legal manifestations. However, irregular migrants' access to health care is inadequate in each system. While French law stigmatizes irregular migrants by permitting access only through a complex, targeted scheme, English law makes access to health care uncertain by remaining silent on the issue.

Sylvie Da Lomba, Fundamental social rights for irregular migrants: a case study of irregular migrants' right to health care in France and England, University of Leicester, U.K., paper delivered to conference titled Irregular Migration And Human Rights Conference, 29 June 2003.

National health-care plans often discriminate against temporary migrants (most fall under this category for a time) and especially undocumented ones by making only emergency care available for non-citizens.⁽⁸⁵⁾ This forces migrants to wait until they feel their condition is sufficiently hazardous to justify going to emergency clinics. Minor problems that could have been treated at the early stages may become more serious and therefore more expensive to treat. Instead, most undocumented migrants initially try to solve the problems on their own by self-medication or by referring to other non-professionals within their community.⁽⁸⁶⁾ The strain on emergency care services and the consequent inefficient use of health services has not dissuaded policymakers from maintaining such policies.

Migrant workers often fall outside of state-sponsored health programs, and frequently are unable to afford private insurance. Consequently, migrant workers, even in very rich countries, generally live in poor health conditions and are largely uninsured and frequently uninformed about the programs that do cover them. In a survey of migrant farmworkers in California, the majority of whom were young married Mexican men of low educational attainment, the group evidenced high rates of asthma, stroke, heart disease and diabetes. Almost 20% of these men were at high risk for elevated cholesterol, high blood pressure or obesity, and many were severely anaemic. Approximately 30% had never been to a doctor, over half had never seen a dentist, 75% had no health insurance and a mere 7% were covered by government sponsored low-income insurance programs. Additionally, while 20% had experienced work-related injuries that should have led to workers' compensation, only 30% of all workers even knew about such programs.⁽⁸⁷⁾

(85) Verbruggen N, ed. *Health Care for Undocumented Migrants: Germany, Belgium, the Netherlands, United Kingdom*. Brussels, Platform for International Cooperation in Undocumented Migrants (PICUM), 2001.

(86) *Ibid.*, 37.

(87) Hanson P. Migrant Farmers "Suffering in Silence": California Groups Look at Problems and Solutions. *The Hispanic Outlook on Higher Education: Ethnic Newswatch*, 2002, 12(17):28.

Another factor which may deter irregular migrants from seeking care and treatment altogether is the fear that health providers may have links to immigration authorities. When this is the case, it can have a chilling effect on irregular migrants trying to access health-care services. Such links may also compromise the commitment of health professionals to respect the right to privacy of those seeking care. Professional confidentiality should be promoted and protected by the law, and support should be provided to health professionals in upholding this principle in the context of working with undocumented migrants. In practice, health professionals often are reluctant to disclose medical details yet are prepared to reveal the name of someone they are treating. It is vital, therefore, to clarify that doctor/patient confidentiality is a broad principle.⁽⁸⁸⁾

From a human rights perspective, governments should be fostering the independence of the health profession. Its allegiance should first and foremost be to uphold health as a human right. Educating health workers on human rights in relation to irregular migrants could be a useful way forward to address some of the problems in the health sector. 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 enforcement of immigration law.

With the onset of globalization and the consequent increase in international migration, "...there is growing acknowledgement and understanding that 'what goes around, comes around'. The 'Global Village' is much more than a global market – in a global village there is one global public health. Tuberculosis (TB) provides an effective example of the importance of providing health care to migrants. In Australia, Hong Kong (China), Malaysia and Singapore, the numbers of tuberculosis cases have not decreased for several years because of the incidence of tuberculosis among new immigrants".

UNAIDS/IOM, *Migrants' Right to Health (2001) 18*.

In the case of infectious diseases, in some countries legislation has been implemented in favour of universal access to care and treatment. For example, the new law for contagious diseases in Germany requires that some infectious diseases, such as tuberculosis, be diagnosed and treated anonymously and free of charge at public health offices.⁽⁸⁹⁾ However, in relation to other health problems such as mental health, where the benefit to the general public is not directly obvious, services are rarely available for irregular migrants.⁽⁹⁰⁾

"Public health initiatives by intent and design are universal, and the protection of the public health requires access by the entire community. Restrictions on access to services placed on immigrants would seriously limit the effectiveness of outreach, case finding, and prevention and treatment programs related to infectious diseases."⁽⁹¹⁾

The problem of access to services is not limited to migrants in an irregular situation. Even regular migrants may be excluded from public services and benefits where such services are restricted to citizens and permanent residents. For example, regular immigrants who have entered the United States since the passage of the Personal Responsibility and Work Opportunity Act of 1996 are eligible for Medicaid only after five years of continuous residence.⁽⁹²⁾

The European Parliament is considering extending provisions under the terms of which a national of a third country who is legally resident in a Member State and who would like to work in another Member State will be able to benefit from a transfer of rights acquired under a social security scheme. This would finally close a gap in the law, and represents a further necessary and important step to ensuring equal treatment for third country nationals residing in a Member State.⁽⁹³⁾

(88) See reference under footnote 85, at 90.

(89) *Ibid.*, 38.

(90) *Ibid.*, 43.

(91) Committee on Community Health Services, Health Care for Children of Immigrant Families. *Pediatrics*, 1997, 100(1):153-156.

(92) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). The Act was amended in 2002, yet the five-year ban remained in force. See: *Temporary Assistance for Needy Families: Program Instruction*. Washington, DC, United States Department of Health & Human Services, Administration for Children and Families, Office of Family Assistance, 2003 (<http://www.acf.dhhs.gov/programs/ofa/pi2003-3.htm>, accessed 16 March 2004).

(93) Committee on Employment and Social Affairs. Report on the proposal for a Council regulation on extending the provisions of Regulation (EEC) No 1408/71 to nationals of third countries who are not already covered by these provisions solely on the ground of their nationality (COM(2002) 59 CE C5-0084/2002 CE 2002/0039(CNS)). Brussels, European Parliament A5-0369/2002 (<http://www.december18.net/instrumentsregionEU/Oomen-Ruijten.pdf>, accessed 25 March 2004).

► ACCESSIBILITY IN RELATION TO AFFORDABILITY

The realization of the right to health requires that “health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all.”⁽⁹⁴⁾ Unequal recognition and protection under the law are major impediments to equal and affordable access to health services.⁽⁹⁵⁾

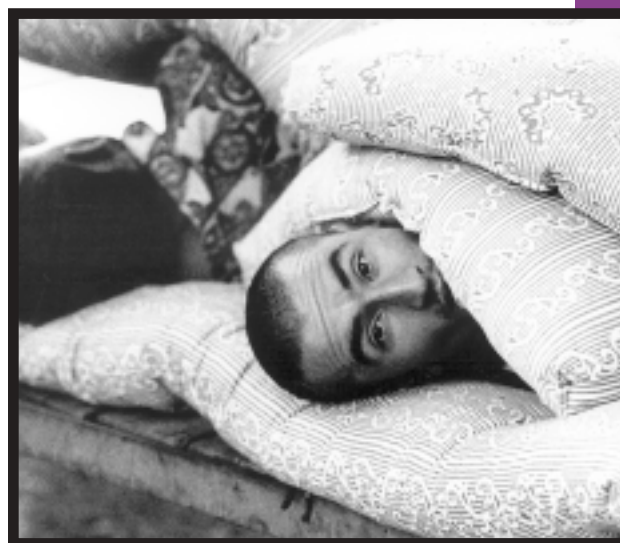
Migrant workers often suffer on account of inability to obtain health insurance. In addition to unsafe working and living conditions, migrants frequently resist seeking medical treatment because of associated costs, inability to miss work, inability to find childcare and problems of transportation. Many are unfamiliar with the local health-care systems, and may have linguistic or cultural difficulties communicating their problems.

Although the United States government has instituted a number of programmes to offer medical insurance to children regardless of their or their parents’ immigration status, many parents do not take advantage of these because their transience makes it difficult to collect such benefit, because they are concerned about their immigration status or because of problems physically accessing health care.⁽⁹⁶⁾

Encouragingly, there are positive initiatives occurring among some large transnational corporations to ensure affordable and accessible health care for migrant workers and their families. Some of these companies have understood the threat to productivity posed by poor health, especially HIV/AIDS and tuberculosis. In parts of southern Africa, for example, AIDS-related illness and death has reduced the workforce by 20%.⁽⁹⁷⁾ Thus many corporations are collaborating with each other and with governments and civil society to tackle diseases such as HIV/AIDS.⁽⁹⁸⁾ The southern African mining industry, which depends almost entirely on migrant workforces, has taken a lead in this field.

AngloGold is a large international gold mining company with the majority of its workforce in South Africa. In an effort to address the rising number of cases of tuberculosis (TB) amongst their South Africa employees, AngloGold has initiated a TB programme “to reduce the increasing disease and cost burden associated with TB, enabling the company to remain globally competitive for the benefit of employees, their families, shareholders and South Africa”.⁽⁹⁹⁾ A mainstay of its policy is ensuring employee coverage and thus “employees have free access to mining health facilities; one registered spouse and the children from that relationship are eligible for free TB detection and treatment”.⁽¹⁰⁰⁾

Global Health Initiative: Private Sector Intervention Case Example: AngloGold TB Programme



©IOM/Alyanak 1995

► STIGMA AND DISCRIMINATION

Overt or implicit discrimination violates one of the fundamental principles of human rights law and often lies at the root of poor health status. The right to health obliges 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”.⁽¹⁰¹⁾ In the context of health, these grounds are “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status”.⁽¹⁰²⁾

⁽⁹⁴⁾ See reference under footnote 17, at paragraph 12(b).

⁽⁹⁵⁾ *Racial and Economic Exclusion Policy Implications*. Geneva, International Council of Human Rights Policy, 2001 at 6-9.

⁽⁹⁶⁾ Guasasco C, Heuer LJ, Lausch C. *Providing Health Care and Education to Migrant Farmworkers in Nurse-Managed Centers*. *Nursing Education Perspectives*, 2002, 23(4):166-171.

⁽⁹⁷⁾ *Issue Brief: HIV/AIDS in the Workplace - Business Importance*. San Francisco, Business for Social Responsibility, 2003 (<http://www.bsr.org/BSRResources/IssueBriefDetail.cfm?DocumentID=49032>, accessed 25 March 2004).

⁽⁹⁸⁾ *Global Health Initiative (GHI)*. Geneva, World Economic Forum, 2003 (<http://www.weforum.org/site/homepublic.nsf/Content/Global+Health+Initiative>, accessed 25 March 2004).

⁽⁹⁹⁾ *Global Health Initiative Private Sector Intervention Case Example: Detecting active tuberculosis (TB) cases, with 88% of cases being cured or completing treatment, for less than US\$85 per employee per year*. Geneva, World Economic Forum, 2002 (http://www.weforum.org/pdf/Initiatives/GHI_TB_CaseStudy_AngloGold.pdf, accessed 25 March 2004).

⁽¹⁰⁰⁾ *Ibid.*

⁽¹⁰¹⁾ See reference under footnote 17, at paragraph 12(b).

⁽¹⁰²⁾ See reference under footnote 17, at paragraph 18.

In 1998 the United Arab Emirates screened their entire population and repatriated all migrant workers who tested positive for HIV/AIDS.⁽¹⁰³⁾ Practices such as the one in the UAE can easily discourage migrant populations from attending health facilities for fear of deportation⁽¹⁰⁴⁾ and may in fact be counter-productive to the public health objectives of screening. In some cases they may also raise concerns about the right to privacy and from a public health perspective have shown not to be particularly effective at protecting the public's health.

Failure to enforce the law in favour of equality because of stigma or discrimination constitutes an important obstacle to equal treatment. Governmental responsibility for nondiscrimination includes ensuring equal protection and opportunity under the law, as well as de facto enjoyment of rights such as the right to public health, medical care, social security and social sources.⁽¹⁰⁵⁾

Stigma refers to attitudes that certain groups are inferior in one or many ways based merely on their membership in a group. For example, where dominant groups tolerate with equanimity the systematic marginalization of other groups, and justify their disadvantage suggesting the group itself is at least partly at fault and fails to deserve equal treatment, they stigmatize the group. Stigma contrasts from discrimination in that the former is about perceptions rather than practice. However, the two are inherently linked as stigma permits or promotes discriminatory consequences. There is also evidence that where discrimination is effectively curbed, stigmatization is likely to be less, or to be less overt.⁽¹⁰⁶⁾

Though they are among the categories most in need of social protection, even as nationals of the country concerned, Romani communities in Eastern Europe (often referred to as "travellers" as they tend to migrate within and between countries) continue to be unable in practice to access health and other social services.⁽¹⁰⁷⁾ Rectifying the situation is difficult because the Romani communities have tended to respond to discrimination by internalizing the expectations of the wider society. When a group becomes self-isolating, it becomes politically invisible and therefore vulnerable.⁽¹⁰⁸⁾

► DISCRIMINATION ON THE BASIS OF SEX AND GENDER ROLES

Due to their double marginalization as women and as migrants, women migrant workers may easily find themselves in situations in which they are vulnerable to violence and abuse, both at home and at work.⁽¹⁰⁹⁾



©IOM/Motus 1997

The UN Special Rapporteur on the Human Rights of Migrants has highlighted the problems faced by female migrant workers, particularly domestic workers, including "withholding of wages, acts of physical and sexual violence, under-nourishment and the seizure of passports".⁽¹¹⁰⁾ IOM reports that a high number of Ethiopian women die while working in Arab states as temporary workers, and that women returning home often arrive evidencing "broken limbs and back, acid burns and other physical abuse".⁽¹¹¹⁾

(103) See reference under footnote 73, at 10.

(104) *Ibid.*

(105) *World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance: Health and Freedom from Discrimination*. Geneva, World Health Organization, 2001 (WHO/SDE/HDE/01.2).

(106) See reference under footnote 95, at 5-8.

(107) *Ibid.*, 8.

(108) "It may also fail to adapt to changes in the wider society and this can increase its economic vulnerability. Accustomed traditionally to living rather separately, dependent economically on trading with local communities, Roma in Romania, Hungary, Bulgaria and the Czech Republic were severely disrupted during the Communist period by policies that required them to live in permanent housing and work in factories. After the fall of communism, most Roma lost or left their factory employment but found their old markets were no longer viable." *Ibid.*, 16.

(109) Rodriguez Pizarro G. Report of the Special Rapporteur on the human rights of migrants. Geneva, Economic and Social Council, Commission on Human Rights, E/CN.4/2000/82, paragraph 56.

(110) *Ibid.*, paragraph 63.

(111) Ethiopia: Interviews with victims of trafficking. *IOM News*, Geneva, International Organization for Migration, June 2001.

The Ministry of Labour of the Hashemite Kingdom of Jordan endorsed a Special Working Contract for non-Jordanian domestic workers. The contract is the first of its kind in Jordan, and is expected to become a model for other countries in the Arab region. It augments coordination between the sending countries and Jordan, as a receiving country to increasing numbers of migrant workers from Asia; guarantees migrant workers' rights to life insurance, medical care, rest days, repatriation upon expiration of the contract; and reiterates migrant women's right to be treated in compliance with international human rights standards. This initiative was prompted by the increase in numbers of migrants employed as domestic workers in the Arab region. The lack of legal protections for these workers increased the violations committed against them and minimized the support these workers could get in the host countries.⁽¹¹²⁾

⁽¹¹²⁾ *Special Working Contract for Non-Jordanian Domestic Workers: An Opportunity to Enhance Protection for a Particularly Vulnerable Group of Women Workers*, 21 January 2003. Amman, United Nations Development Fund for Women / Arab States Regional Office (Press Release; http://www.unifem.org/jo/press_releases.htm, accessed 25 March 2004).

⁽¹¹³⁾ International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966 entry into force 3 January 1976), Article 7. (hereinafter ICESCR).



©ILO/Classet 1997

▶ THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS⁽¹¹³⁾

There is a high risk that migrants, especially low-skilled migrants or migrants in an irregular situation, will be placed in high-risk, low-paid jobs with poor supervision. They typically accept positions that local workers refuse, which are frequently oriented towards mining, construction, heavy manufacturing and agricultural tasks that can expose them to a range of occupational health risks, including toxic

⁽¹¹⁴⁾ Carballo M, Siem H. Migration, Migration Policy, and AIDS. In: Haour-Knipe M, Rector R, eds. *Crossing Borders: Migration, Ethnicity and AIDS*. Bristol, Taylor&Francis, 1996, at 35-36. See also under footnote 16, at 55.

⁽¹¹⁵⁾ Bollini P, Siem H. No Real Progress Towards Equity: Health of Migrants and Ethnic Minorities on the Eve of the Year 2000. *Social Sciences and Medicine*, 1995, 41(6):819-828.

⁽¹¹⁶⁾ ICESCR, Article 11.

⁽¹¹⁷⁾ ICESCR, Article 11.

⁽¹¹⁸⁾ *Factsheet: Occupational Risks from Pesticides*. Toronto, World Wildlife Fund Canada, 2000 (<http://www.wwf.ca/satellite/prp/factsheets/occupational-risks.html>, accessed 25 March 2004).

⁽¹¹⁹⁾ See reference under footnote 16, at 59.

agents, long hours and little if any protection in terms of clothing and other equipment. Linguistic obstacles, poor communication, lack of familiarity with modern machinery and different attitudes to safety are all factors that increase the work-related health risks.⁽¹¹⁴⁾ In general, occupational accident rates are about twice as high for immigrant workers as native workers in Europe,⁽¹¹⁵⁾ and there is no reason to believe the situation is not similar in other parts of the world.

Employers often consider migrants to be too temporary to commit resources to training, and communication problems often reduce this possibility even further. Migrant workers, and in particular undocumented migrant workers, often accept these dangerous working conditions for fear of bringing attention to themselves and losing their jobs or being deported. Lack of familiarity with the country, the culture and the language also means that migrant workers are typically unaware of their rights.

▶ THE RIGHTS TO ADEQUATE FOOD⁽¹¹⁶⁾ AND HOUSING⁽¹¹⁷⁾

Within any population there are sub-populations at higher risk. There are an estimated 13,000 migrant farm workers in Canada, of which 10,000 are in Ontario. Most Ontario workers come from Jamaica and Mexico and spend seven months of the year engaged in picking fruit and other agricultural labour. Pesticide-induced injuries are visible in field workers, with labourers suffering from swollen eyes and mouth sores. Like other farm workers, migrant workers are not covered by many kinds of worker protection, with the exception of workers' compensation.⁽¹¹⁸⁾

Access to safe and adequate food and nutrition is closely linked to the economic capacity of people, and, in the case of migrants, presents a number of complex and interrelated challenges. In addition to the dramatic changes migrants are often required to make to their dietary habits in cross-border movements, the economic nature of migration means that migrants may have little to spend on food; even where this is not the case, the culture clash involved in adapting to new ingredients and habits can be serious.⁽¹¹⁹⁾

Housing is an indicator of the quality of life people enjoy, and in the case of migrants, especially undocumented migrants, housing is typically problematic. Not only do most migrants arrive with little money but in many cases their official status is temporary and does not allow them to “invest” in good quality housing, even if they had the money to do so. Social barriers often reinforce this further by allocating only selected areas of towns and cities to migrants.

The frequency with which new migrants are forced to concentrate in poor areas of towns and cities and in substandard housing where overcrowding and inadequate sanitation are the norm has been highlighted by numerous studies.⁽¹²⁰⁾ In post-industrial settings such as the Netherlands, Austria, France, Italy and Germany this has become a source of potential morbidity, including childhood accidents, for migrants of all ages.⁽¹²¹⁾

► THE RIGHT TO FAMILY LIFE

“Let us remember from the start that migrants are not merely units of labour. They are human beings. They have human emotions, human families, and above all, human rights - human rights which must be at the very heart of debates and policies on migration. Among those rights is the right to family unity - and in fact families reuniting form by far the largest stream of immigration into North America and Europe.”⁽¹²²⁾

Studies of migrant workers in various parts of Africa report a combination of poor housing, hazardous working conditions and serious social disruption. They refer to chronic alcohol abuse and patterns of sexual behaviour that are conducive to the rapid spread of sexually transmitted infections including HIV/AIDS⁽¹²³⁾ largely due to separations from wives and girlfriends.⁽¹²⁴⁾ One study in South Africa has found that migrant workers and their partners are about twice as likely to be infected with HIV as non-migrant couples.⁽¹²⁵⁾

In response to the negative health outcomes that result from isolating migrant workers, and in recognition of the right to family life, many corporations are altering their policies to allow for families to be together in an effort to enhance employee productivity.

At the Kahama Mining Corporation Limited (KMCL) in Tanzania, a wholly-owned subsidiary of Barrick Gold Corporation, initiatives have been introduced to deal with issues of HIV/AIDS in the workplace. Recognizing the importance of family presence for migrant workers, “workplace prevention programmes focus on supporting affordable local housing for miners and their families”. At KMCL, this involves the “development of a home ownership scheme for mine employees to allow them to live close to the workplace. One of the aims of this programme is to decrease at-risk sexual behaviour resulting from the separation from families”.

World Economic Forum, Global Health Initiative: Private Sector Intervention Case Example: Developing a sustainable HIV/AIDS programme for employees through deep community involvement⁽¹²⁶⁾

(120) Ibid., 33.
 (121) See reference under footnote 73, at 8.
 (122) See reference under footnote 81.
 (123) Girdler-Brown B. Eastern and Southern Africa. *International Migration*, 1998, 36:513-551.
 (124) Schooks M. All That Glitters: How HIV Caught Fire In South Africa - Part One: Sex and the Migrant Workers. *The Village Voice*, April 28-May 4, 1999.
 (125) Ibid., citing Lurie M. Migration and AIDS in southern Africa: Challenging common assumptions. *A&M News*, Oct 2002, 4: 11-12 (<http://www.aidsmobility.org/lurie.html>, accessed 23 March 2004).



© Who/Virt

(126) Global Health Initiative Private Sector Intervention Case Example: Developing a sustainable HIV/AIDS programme for employees through deep community involvement. Geneva, World Economic Forum, 2002 (http://www.weforum.org/pdf/Initiatives/GHI_HIV_CaseStudy_BarrickGold.pdf, accessed 25 March 2004).



©IOM/Lowenstein-Lom 1999

► PHYSICAL ACCESSIBILITY OF HEALTH SERVICES

The right to health requires health facilities, goods and services to be “within safe physical reach for all sections of the population, especially vulnerable or marginalized groups”.⁽¹²⁷⁾ However, location, distance and timing of opening hours of health services may pose problems for migrants. For a variety of reasons, migrant workers may be less able to request time off to seek health care during the day. Indeed, in many countries, they need to take two or more jobs to survive economically and are thus unable even to access care in the evenings.⁽¹²⁸⁾ In addition they often live and work in areas of towns and cities or agricultural areas where services tend not to be physically located.

(127) See reference under footnote 17 at paragraph 12(b).

(128) See reference under footnote 73, at 11.

(129) Anglo American plc Workplace Program. New York, Global Business Coalition on HIV/AIDS, 2002 (http://www.businessfightsaids.org/wpp_popup.asp?CompanyID=48, accessed 25 March 2004).

(130) See reference under footnote 17, paragraph 12(c).

(131) Carballo M, Siem H. Migration, Migration Policy, and AIDS. In: Haour-Knipe M, Rector R, eds. *Crossing Borders: Migration, Ethnicity and AIDS*. Bristol, Taylor & Francis, 1996, at 44.

(132) See reference under footnote 73, at 10.

(133) See reference under footnote 131, at 36.

(134) See reference under footnote 85, at 41.

Increasingly, many transnational corporations have developed their own health services or facilities for employees and their dependents. Anglo American Corporation is a mining corporation with operations and developments in Africa, Europe, South and North America and Australia and a considerable migrant workforce. During the 1990’s, Anglo American developed a comprehensive HIV/AIDS programme for its employees addressing both prevention and treatment; components include condom distribution, treatment of STDs and voluntary counseling and testing; research in many companies shows that this approach has been successful in raising levels of AIDS awareness; increasing demand for condoms; and lowering of STD incidence. In August 2002, Anglo American announced plans to provide ARV therapy to its employees with HIV/AIDS.

Global Business Coalition on HIV/AIDS: Anglo American plc Workplace Program⁽¹²⁹⁾

► CULTURALLY SENSITIVE AND GOOD QUALITY HEALTH SERVICES

A crucial element of the right to health is that all health facilities, goods and services must be culturally appropriate.⁽¹³⁰⁾ However, culturally appropriate health-care services are usually limited, and require resources and a mentality of support for, and cooperation with, migrants. In fact, few steps are taken to explicitly tailor services to the needs of migrants⁽¹³¹⁾ and in many situations this leads to wrong diagnoses, inappropriate treatment and poor compliance on the part of patients.⁽¹³²⁾

“The culture shock that often accompanies initial contact with a new sociocultural system can be psychologically complex and involve far more than simple negation of access to local health and social services. Social integration and then acculturation is a complicated process involving linguistic, social, cultural and conceptual transference processes that can denude migrants of everything they have previously been used to and which may have provided the basis for their identity.”^{99 (133)}

Quality of services is also an important factor to consider in the context of how migrants are treated when accessing health care. There have been reports of health professionals admitting lower standards of care and treatment in cases where insurance status could not be clarified in advance, for example by treating a fracture with a plaster dressing rather than fixing the fractured bone surgically.⁽¹³⁴⁾

► THE RIGHT TO SEEK, RECEIVE AND IMPART INFORMATION⁽¹³⁵⁾

Accessibility of health information includes the right to seek, receive and impart information and ideas concerning health issues.⁽¹³⁶⁾ Even when domestic legislative provisions guarantee access to services, lack of awareness among migrants impedes their ability to access care.

Many migrants simply cannot communicate with health providers in a meaningful way. Only in a few countries are interpreters routinely used in health-care facilities; for example, in Sweden adverse pregnancy outcomes in immigrant groups have proved to be as culturally influenced as they are biologically determined.⁽¹⁴²⁾ As a result, the chances of misdiagnosis and inappropriate treatment have been and continue to be high. Nowhere is this more evident than in the field of mental health, where communication between the patient and the health-care provider is of fundamental importance.

To conclude, it is important to sensitize and enlist the cooperation of public health authorities to ensure the enjoyment of the rights to health information and education for migrants both in the context of health-care services as well as in the broader context of health promotion efforts. ◆



©WHO/Virot

In fact, lack of information about what is available or about health matters in general is one of the reasons migrants most often give for not using health services effectively and for not taking action themselves to prevent illness.⁽¹³⁷⁾ 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 in women belonging to the ethnic majorities in the same countries.⁽¹³⁸⁾ Abortion rates are higher and levels of use of modern contraceptives are generally lower.⁽¹³⁹⁾ The differences are related to lower levels of information about relevant services and entitlements, for example, with respect to antenatal care or access to contraceptives.⁽¹⁴⁰⁾ Overall, it has been reported that in Europe, migrants are systematically ill-informed; they come from different backgrounds, have linguistic barriers and many of them have poor educational backgrounds.⁽¹⁴¹⁾

⁽¹³⁵⁾ International Covenant on Civil and Political Rights (Adopted 16 December 1966, entry into force 23 March 1976). (Hereinafter ICCPR).

⁽¹³⁶⁾ See reference under footnote 17, paragraph 12(b).

⁽¹³⁷⁾ See reference under footnote 73, at 11.

⁽¹³⁸⁾ Ackerhans M and 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.

⁽¹³⁹⁾ *Ibid.*

⁽¹⁴⁰⁾ *Ibid.*

⁽¹⁴¹⁾ *Ibid.*

⁽¹⁴²⁾ *Ibid.*

Conclusion



©IOM/Lowenstein-Lom 1999

“...the answer must lie in managing migration - rationally, creatively, compassionately and cooperatively. This is the only approach that can ensure that the interests of both migrant and host communities will be looked after and their rights upheld.”⁽¹⁴³⁾

People living in different societies around the world are increasingly interdependent. We often refer to the world as a “global village”. In such terms, it can be visualized as a single community currently displaying inequities comparable to those which characterized industrializing countries (such as England or France) in the 19th century, when similarly profound disparities existed between rich and poor.⁽¹⁴⁴⁾

Over time, governments came to realize, or were pressured to realize, that extreme social and economic inequalities are unsustainable. Change was generated in favour of recognizing their responsibilities towards people in terms of ensuring access to education, sanitation and access to health services. Unless and until there is a similar awakening of responsibilities of rich governments towards poor populations in the South, disparities will continue to widen. The world will remain unstable and the mounting evidence that migration is rising should come as no surprise.

Current surveys indicate that there is little uniformity in migration management, even among regional groupings such as the European Union. There is also a lack of data, which makes it impossible to present a coherent picture of the interlinkages between migration, health and human rights. We have thus only been able to make preliminary observations about the degree to which migrants are subject to discriminatory practices, how they make use of health services and how they participate in the economy, including by providing health services.

“Just as reducing the constraints on trade in goods made the world richer in the second half of the 20th century, so reducing the constraints on the movement of people could be a powerfully enriching force in the first half of the 21st.”⁽¹⁴⁵⁾

The potential economic benefits to the world of liberalizing migration are said to dwarf those of removing trade barriers.⁽¹⁴⁶⁾ This is particularly true where populations are ageing and economies need boosting from mobile labour which can respond where skills are in short supply; for example, where hospitals want to hire foreign doctors and nurses. Although vital to make voters understand that they can gain from being more open to immigration, economic arguments must be coupled with human rights imperatives. Human rights law, mechanisms and approaches require migration policies that safeguard human dignity and ensure humane and just approaches. As countries are grappling with how to handle increased migration, therefore, it is important that the human rights framework is considered as an important pillar for policy-making. Coupled with another important pillar - the collection of sound statistics - successful strategies can be developed.

We are far from the required paradigm shift towards treating migrants as “global citizens” and “rights-holders” regardless of where they are coming from and where they are going. Such a paradigm shift will take time, dialogue, accurate information, good will and, above all, political will. This report represents only a small step in this direction. ◆

⁽¹⁴³⁾ See reference under footnote 81.

⁽¹⁴⁴⁾ See reference under footnote 144, at 1.

⁽¹⁴⁵⁾ A better way. *The Economist*, 2 November 2002:15.

⁽¹⁴⁶⁾ A modest contribution. *The Economist*, 2 November 2002:11.



©IOM/DeCesare 2002

Annex I: Main Categories of Migrants

Asylum seekers are people who have fled to another country where they have applied for state protection by claiming refugee status, but have not received a final decision on their application. The most recent UNHCR information estimated that there were almost 1,015,000 asylum seekers worldwide.⁽¹⁴⁷⁾

Development displacees⁽¹⁴⁸⁾ are people who are compelled to move as a result of policies and projects implemented to supposedly enhance 'development', such as the building of dams and roads; urban clearance initiatives; mining and deforestation; and the introduction of conservation parks/ reserves and biosphere projects. It has been estimated that during the 1990s some 90 to 100 million people around the world were displaced as a result of infrastructural development projects.

Internally displaced persons (IDPs), like refugees, are forcibly displaced by circumstances of war, civil conflict and political persecution. However, unlike refugees, they do not cross international borders but rather remain in the territory of the state of their nationality and, technically, under the jurisdiction of the government of that State. According to UN Guiding

Principles on Internal Displacement, IDPs are "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border".⁽¹⁴⁹⁾ Although it has been estimated that there are 20 to 25 million IDPs worldwide,⁽¹⁵⁰⁾ the lack of registration and national authorities' reluctance to admit to the problem means that this number may be a gross underestimation.

Migrant workers constitute a major category of migrants in general. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families has defined a migrant worker as "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",⁽¹⁵¹⁾ a definition similar to those enshrined in the relevant ILO Conventions.⁽¹⁵²⁾

According to UN and ILO estimates, out of the 175 million migrants worldwide, 120 million are migrant workers and their families.⁽¹⁵³⁾ Today, ILO estimates, there are roughly 20 million migrant workers, immigrants and members of their families across Africa, 18 million in North America, 12 million in Central and South America, 7 million in South and East Asia, 9 million in the Middle East and 30 million across all of Europe. Western Europe alone accounts for approximately 9 million economically active foreigners along with 13 million dependants.⁽¹⁵⁴⁾

A refugee is defined by the 1951 Convention Relating to the Status of Refugees as any person who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country".⁽¹⁵⁵⁾ The 1951 Convention relating to the Status of Refugees is the foundation for the international regime for the protection of refugees.⁽¹⁵⁶⁾ The 1967 Protocol removed geographical and temporal restrictions from the Convention.

(147) *Refugees by Numbers 2003*. Geneva, United Nations High Commissioner for Refugees, 2003, at 4 (<http://www.unhcr.org.uk/info/briefings/statistics/documents/numb2003.pdf>, accessed 23 March 2004).

(148) See reference under footnote 52.

(149) *Guiding Principles on Internal Displacement. Report of the Representative of the Secretary-General on Internally Displaced Persons*. Geneva, United Nations, 1998 (Extract from the document E/CN.4/1998/53/Add.2).

(150) See reference under footnote 147, at 1.

(151) International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (adopted 18 December 1990, entry into force 1 July 2003). (Hereinafter MWC).

(152) See annex 2.

(153) *ILO meeting calls for change in migration policies in Southern Africa*. Geneva, International Labour Organization, 2002. (Press Release; <http://www.ilo.org/public/english/dialogue/actrav/new/291102.htm>, accessed 23 March 2004).

(154) *Current dynamics of international labour migration: Globalisation and regional integration*. Geneva, International Labour Organization, 2002 (<http://www.ilo.org/public/english/protection/migrant/about/index.htm>, accessed 23 March 2004).

(155) Convention Relating to the Status of Refugees (adopted 28 July 1951, entry into force 22 April 1954).

(156) It consolidates previous international instruments relating to refugees and provides the most comprehensive codification of their human rights.

UNHCR estimates that at the beginning of 2002 there were approximately 10.4 million refugees worldwide.⁽¹⁵⁷⁾ However, the number of de facto as opposed to registered refugees is probably higher, as refugees frequently find themselves in similar situations to undocumented labour migrants where they choose not to be documented for fear of rejection or other reprisal. In countries with poorly defined borders and where families may be living on both sides of borders, refugees may be taken in by relatives and not even come to the attention of local authorities.

Temporary contract workers are the most common category of documented labour migrants. They are admitted to the host country for limited periods with the intention that they will return home when their contract expires. The majority are low-skilled and recruited to work in agriculture and construction, both of which are seasonal and in which market fluctuations can easily dictate changes in demand.

Trafficking in persons is a growing global problem with an estimated 700,000 to 4 million **victims of international trafficking** each year.⁽¹⁵⁸⁾ Trafficking in persons is defined by the Protocol against Trafficking as “the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, abduction, fraud, deception, abuse of power or a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation”.⁽¹⁵⁹⁾

Smuggled migrants are covered under the Protocol against the Smuggling of Migrants by Land, Sea and Air, which defines the phenomenon as “the procurement, in order to obtain, directly or indirectly, a financial or other benefit, for the illegal entry of a person into a State Party of which the person is not a national or a permanent resident”.⁽¹⁶⁰⁾



©IOM/Barriga 1999

Permanent immigrants are a major category of migrants, particularly for traditional countries of immigration. No common legal definition has been laid down in international law; national legislation and practice vary considerably in defining immigrant categories, qualifications and treatment. Nonetheless, until non-nationals admitted for purposes of immigration have achieved permanent resident or citizenship status, they also may be subject to disadvantages or limitations in access to health care and health rights in relation to nationals of those countries.

International labour migration is increasingly selective in terms of gender and age and many national immigration and ‘temporary’ labour migration policies legally proscribe **families accompanying temporary migrant workers**.⁽¹⁶¹⁾ Family reunification programmes have been initiated to allow migrant workers’ families to join them after a certain time. Family reunification constitutes a large proportion of all documented immigration into Western countries, accounting for over 70% of all immigrants admitted into the USA in 1998.⁽¹⁶²⁾

To complete this overview of international legal provisions and accepted definitions, **foreign students** should be mentioned. They move to benefit from academic programs and opportunities offered by countries and educational institutions. The United States continues to be the most popular destination, with almost 590,000 foreign students enrolled in US universities during the 2002-2003 academic year.⁽¹⁶³⁾ ◆

⁽¹⁵⁷⁾ See reference under footnote 147, at 4.

⁽¹⁵⁸⁾ *Trafficking in Persons: USAID's Response*. Washington, DC, USAID Office of Women in Development, 2001, at 1.

⁽¹⁵⁹⁾ Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (adopted 15 November 2000, entry into force 25 December 2003), Article 3(a).

⁽¹⁶⁰⁾ Protocol Against the Smuggling of Migrants by Land, Sea and Air, Supplementing the United Nations Convention Against Transnational Crime (adopted 15 November 2000, entry into force 28 January 2004), Article 3(a).

⁽¹⁶¹⁾ See reference under footnote 16, at 17.

⁽¹⁶²⁾ *World Migration Report 2000*. Geneva, International Institute on Migration, 2000, at 243.

⁽¹⁶³⁾ *The Economic Benefits of International Education to the United States: A Statistical Analysis*. Washington, DC, NAFSA: Association of International Educators, 2003. (<http://www.nafsa.org/content/PublicPolicy/DataonInternationalEducation/EISIntroB.pdf>, accessed 16 March 2004)



UN Photo #UN23783

Annex II: International Legal & Policy Instruments and Mechanisms Relevant to Health & Migration

INTERNATIONAL HUMAN RIGHTS INSTRUMENTS

The international human rights legal framework contains a number of core treaties which apply to all people, including migrants. The most fundamental human rights instrument is the **Universal Declaration of Human Rights** (UDHR, 1948), which to a large extent forms part of customary international law. Everyone is entitled to all the rights and freedoms contained in the UDHR, without distinction of any kind, including national origin.⁽¹⁶⁴⁾ The basic human rights provided for in this instrument, including the right to recognition before the law and the right

to a standard of living adequate for health and well-being,⁽¹⁶⁵⁾ are applicable to migrants, including those in an irregular situation.

Under the **International Convention on the Elimination of All Forms of Racial Discrimination** (ICERD, 1965), States parties have an obligation to guarantee the civil, political, economic, social and cultural rights of the whole population and not just of citizens.⁽¹⁶⁶⁾ However, the ICERD provides for the possibility of treatment differentiating between citizens and non-citizens, although between non-citizens, States may not discriminate against any particular nationality.⁽¹⁶⁷⁾

In 1966 the provisions of the UDHR were codified into binding law set out in two treaties - the **International Covenant on Economic, Social and Cultural Rights** (ICESCR) and the **International Covenant on Civil and Political Rights** (ICCPR). These two treaties, together with the UDHR, form what is known as the International Bill of Human Rights.

Article 12 of the ICESCR provides the most authoritative articulation of the right to health in international human rights law. The 148 States Parties to the ICESCR “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.⁽¹⁶⁸⁾ In addition, the ICESCR includes several other rights that are essential to the realization of this right, including the rights to food,⁽¹⁶⁹⁾ housing,⁽¹⁷⁰⁾ safe and healthy working conditions⁽¹⁷¹⁾ and education.⁽¹⁷²⁾ Although these rights should be exercised without discrimination of any kind as to, *inter alia*, national origin, the Covenant specifically permits developing countries to determine the extent to which they will guarantee the *economic* rights set forth in the Covenant to non-nationals.⁽¹⁷³⁾

It should be borne in mind that the principle of *progressive realization* of human rights⁽¹⁷⁴⁾ imposes an obligation on States to move as expeditiously and effectively as possible towards the realization of rights. This principle is therefore relevant to both poorer and wealthier countries, as it acknowledges the constraints due to the limits of available resources, but requires all countries to show constant progress in moving towards the full realization of rights.

The ICCPR also recognizes several rights which are integral to the realization of the right to health, such as the rights to information,⁽¹⁷⁵⁾ privacy,⁽¹⁷⁶⁾ freedom of movement⁽¹⁷⁷⁾ and security of person.⁽¹⁷⁸⁾ The ICCPR requires States to

(164) UDHR Article 2.
(165) UDHR Article 25.
(166) ICERD, Article 5. See also the statement made by CERD, which was established to monitor implementation of the Convention. UN Doc CERD/226/Add.9 paragraph 314.
(167) ICERD, Article 1.
(168) ICESCR, Article 12.
(169) ICESCR, Article 11.
(170) ICESCR, Article 11.
(171) ICESCR, Article 7.
(172) ICESCR, Article 13.
(173) ICESCR, Article 2 (3).
(174) ICESCR, Article 2.
(175) ICESCR, Article 19.
(176) ICESCR, Article 17.
(177) ICESCR, Article 22.
(178) ICESCR, Article 6.

guarantee the rights recognized in the Covenant to all individuals within their territory and subject to their jurisdiction, without distinction of any kind.⁽¹⁷⁹⁾ The Human Rights Committee, which is the body charged with overseeing the implementation of the ICCPR, has confirmed that “[i]n general, the rights set forth in the Covenant apply to everyone,...irrespective of his or her nationality...”.⁽¹⁸⁰⁾ The Covenant also contains a broad provision against discrimination based on national or social origin, birth and other social status,⁽¹⁸¹⁾ in addition to specific protection of the right to non-discrimination.⁽¹⁸²⁾

Building upon the International Bill of Rights, other international human rights treaties have focused either on specific groups or categories of populations, such as women and children, and most recently migrant workers, or on specific issues such as racial discrimination.

The **Convention on the Elimination of all Forms of Discrimination against Women (CEDAW, 1979)** applies to all women, citizens and non-citizens alike. The Convention includes provisions for States Parties to eliminate discrimination against women in the field of health care in order to ensure access to health-care services, including those related to family planning, and to ensure appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.⁽¹⁸³⁾

The **Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT, 1984)** applies to any individual who has been subject 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 subject to torture.⁽¹⁸⁴⁾

Several conventions delineating specific international standards for occupational health and safety have been elaborated under International Labor Organization (ILO) auspices, and widely ratified. These provide standards for 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. For instance, the **ILO Convention No.155 concerning Occupational Safety and Health (1981)**⁽¹⁸⁵⁾ prescribes the progressive application of comprehensive prevention measures 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 as well as 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 the **ILO Convention No. 167 concerning Safety and Health in Construction (1988)**.⁽¹⁸⁶⁾



©IOM/Chauzy 2003

The **Convention on the Rights of the Child (CRC, 1989)**, which has achieved almost universal ratification, includes the right of the child to the highest attainable standard of health.⁽¹⁸⁷⁾ Moreover, it provides a framework of protection that is 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”.⁽¹⁸⁸⁾

The implementation of the core human rights treaties is monitored by committees of independent experts known as treaty monitoring bodies. Each of the six major human rights treaties⁽¹⁸⁹⁾ has its own monitoring body which meets regularly to review State Party reports and to engage in a “constructive dialogue” with governments on how to live up to their human rights obligations. Under each of the core human rights treaties, United Nations human rights treaty monitoring bodies provide a mechanism for increasing governmental accountability for human rights.

In May 2000, a **General Comment 14 on the right to the highest attainable standard of health** was adopted by the Committee on Economic, Social and Cultural Rights and set criteria for the full enjoyment of the right to health.⁽¹⁹⁰⁾ It stated that the right to health must be understood as a right to the enjoyment of a variety of

⁽¹⁷⁹⁾ ICESCR, Article 2.
⁽¹⁸⁰⁾ The position of aliens under the Covenant (International Covenant on Civil and Political Rights). General Comment No.15 (1986), paragraph 1.
⁽¹⁸¹⁾ Ibid.
⁽¹⁸²⁾ ICCPR, Article 26.
⁽¹⁸³⁾ Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entry into force 3 September 1981) (hereinafter CEDAW), Article 12.
⁽¹⁸⁴⁾ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984, entry into force 26 June 1987) (hereinafter CAT), Article 3.
⁽¹⁸⁵⁾ ILO Convention (No. 155) concerning Occupational Safety and Health and the Working Environment (adopted 22 June 1981, entry into force 11 Aug 1983).
⁽¹⁸⁶⁾ ILO Convention (No.167) concerning Safety and Health in Construction (adopted 20 June 1988, entry into force January 31 1995).
⁽¹⁸⁷⁾ Convention on the Rights of the Child (adopted 20 November 1989, entry into force 2 September 1990) (hereinafter CRC), Article 24.
⁽¹⁸⁸⁾ CRC, Article 2.
⁽¹⁸⁹⁾ CAT, ICERD, ICCPR, ICESCR, CEDAW, CRC.
⁽¹⁹⁰⁾ See reference under footnote 17.

facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health and emphasized that these must be made available, accessible, acceptable and of good quality.⁽¹⁹¹⁾

There are two extra-conventional mechanisms within the UN system that are particularly relevant to promoting and protecting the health and 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:

- (a) To gather, request, receive and exchange information from all relevant sources, including Governments, intergovernmental organizations and nongovernmental organizations, on the realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;
 - (b) To develop a regular dialogue and discuss possible areas of cooperation with all relevant actors;
 - (c) To report on the status of the realization of the right to health, and on developments relating to this right, including on laws, policies and good practices most beneficial to its enjoyment and obstacles encountered domestically and internationally to its implementation;
- and
- (d) To make recommendations on appropriate measures to promote and protect the realization of the right of everyone to health, with a view to supporting States' efforts to enhance public health.⁽¹⁹²⁾

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:

- (a) To request and receive information from all relevant sources, including migrants themselves, on violations of the human rights of migrants and their families;
- (b) To formulate appropriate recommendations to prevent and remedy violations of the human rights of migrants, wherever they may occur;
- (c) To promote the effective application of relevant international norms and standards on the issue;
- (d) To recommend actions and measures applicable at the national, regional and international levels to eliminate violations of the human rights of migrants;

and

- (e) To take into account a gender perspective when requesting and analysing information, as well as to give special attention to the occurrence of multiple discrimination and violence against migrant women.⁽¹⁹³⁾

INTERNATIONAL LEGAL NORMS SPECIFIC TO NON-NATIONALS

Under the **1951 Convention relating to the status of refugees**, refugees shall be accorded the same treatment as the nationals of the 142 States Parties with respect to social security, including in relation to maternity, sickness, disability and old age.



©WHO/Virot

Two specific instruments that provide for the protection of the basic labour and human rights of migrant workers, and promote inter-State cooperation on labour migration, have been elaborated by the ILO. The **ILO Convention No. 97 concerning Migration for Employment (Revised)**⁽¹⁹⁴⁾ 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**⁽¹⁹⁵⁾ obliges States parties to respect the basic human rights of all migrant workers – irrespective of their legal status.

(191) Ibid., paragraph 12.
 (192) Resolution 2002/31, Geneva, Economic and Social Council, Commission on Human Rights.
 (193) Resolution 1999/44, Geneva, Economic and Social Council, Commission on Human Rights.
 (194) ILO Convention (No.97) concerning Migration for Employment (adopted 1 July 1949, entry into force 22 January 1952). The Convention is accompanied by Recommendation (No.86) concerning Migration for Employment (adopted 1 July 1949).
 (195) ILO Convention (No. 143) concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers (adopted 24 June 1975, entry into force 9 December 1978).

The impetus for the United Nations to begin negotiations on the first multilateral treaty to fight organized crime – the **United Nations Convention Against Transnational Organized Crime** (2000)⁽¹⁹⁶⁾ – was the post-Cold War realization that many forms of transnational organized crime pose a serious threat to democracy. The Convention, which entered into force on 29 September 2003,⁽¹⁹⁷⁾ is supplemented by the **Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children**, which speaks of measures to provide for the physical, psychological and social recovery of victims of trafficking in persons.⁽¹⁹⁸⁾ It is also supplemented by the **Protocol against the Smuggling of Migrants by Land, Sea and Air**, which also contains protection and assistance measures to be afforded by states aimed at protecting the rights of these particularly vulnerable groups of migrants.⁽¹⁹⁹⁾ The two protocols have received the requisite 40 ratifications and will enter into force by early 2004.⁽²⁰⁰⁾

The **International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families** entered into force 1 July 2003. A main thrust of this Convention is that migrant workers are entitled to protection of their basic human rights regardless of their legal status. It recognizes in particular the right of *all* migrant workers and their families to emergency medical care,⁽²⁰¹⁾ and the right of *documented* migrant workers and their families to equality of treatment with nationals and to access to health services.⁽²⁰²⁾ It also provides for inter-State cooperation in protecting migrants, reducing irregular migration and exploitation of migrants and in assuring safe and dignified return.

Although there is no legally binding treaty which deals specifically with the treatment of IDPs, it is important to stress that they are as entitled to the protection of international law as all other citizens in their country. Furthermore, the UN General Assembly has acknowledged the **Guiding Principles on Internal Displacement**,⁽²⁰³⁾ which although not in themselves legally binding are based on existing human rights and humanitarian law, and constitute the international normative framework for the provision of protection and assistance to IDPs.

INTERNATIONAL CONFERENCES (POLICY COMMITMENTS TO ENSURING THE HUMAN RIGHTS OF MIGRANTS)

Global conferences have played a key role in guiding the work of the UN since its inception: these mobilize governments and NGOs to take action; establish international standards and guidelines for national policy; provide a forum where new proposals can be debated and consensus sought; and set in motion processes whereby governments make commitments and regularly report back. Several recent major UN conferences have specifically emphasized the linkages between migration and health.⁽²⁰⁴⁾ Although not part of the formal international human rights legal framework, these conferences generate declarations and programmes of action which represent global policy commitments on the part of nation-states.

The **Vienna Declaration and Programme of Action** (1993) attached “great importance... to the promotion and protection of the human rights of persons belonging to groups which have been rendered vulnerable, including migrant workers” and to the elimination of all forms of discrimination against them. It urged States to create conditions to foster greater harmony and tolerance between migrant workers and the rest of the society of the State in which they reside.⁽²⁰⁵⁾

The Programme of Action of the 1994 **International Conference on Population and Development** includes numerous references to migrants and health. For example, it urges governments to provide migrants and refugees with access to adequate health-care services. It also urges governments to ensure that internally displaced persons receive basic health-care services, including reproductive health services and family planning.⁽²⁰⁶⁾

The **Beijing Platform for Action** (1995)⁽²⁰⁷⁾ recognizes that women face barriers to full equality and advancement because of race, language, ethnicity, culture or other status. It also recognizes that additional barriers exist for displaced immigrant and migrant women, including women migrant workers. It urges governments to ensure the full realization of the human rights of all women migrants, including women migrant workers; to provide them protection against violence and exploitation; and to intro-

(196) United Nations Convention against Transnational Organized Crime (adopted 15 November 2000, entry into force 29 September 2003).

(197) *UN Convention Against Transnational Organized Crime to enter into force on 29 September*. Vienna, UN Information Service, 7 July 2003 (Press Release L/T/4373 - SOCCP/263; <http://www.un.org/News/Press/docs/2003/Lt4373.doc.htm>, accessed 23 March 2004).

(198) See reference under footnote 159, Article 46.

(199) See reference under footnote 160, Article 16.

(200) As of April 2004, the Protocol against the Smuggling of Migrants by Land, Sea and Air had 112 signatories and 46 Parties. The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children had 117 signatories and 52 Parties. *Signatories to the UN Convention against Transnational Crime and its Protocols*. Vienna, United Nations Office on Drugs and Crime, 2004 (http://www.unodc.org/unodc/en/crime_cicp_signatures.html, accessed 19 April 2004).

(201) MWC, Article 28.

(202) *Ibid.*, Articles 43 and 45.

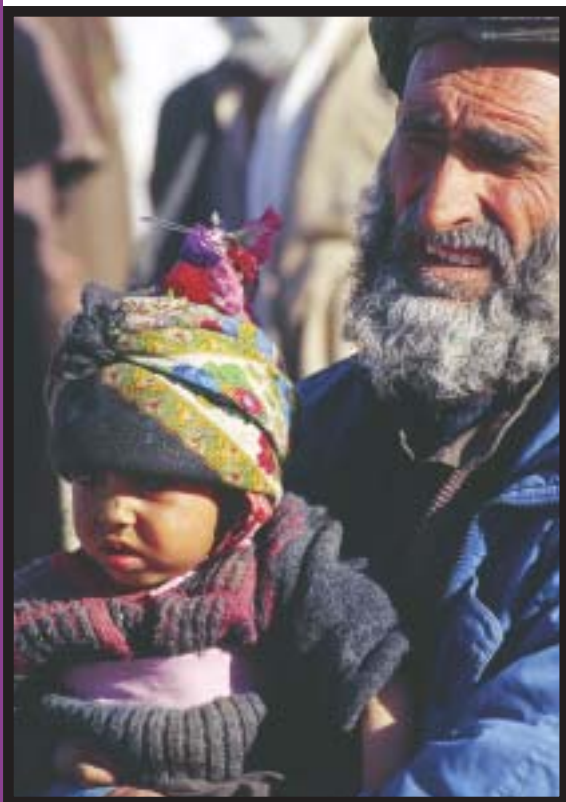
(203) See reference under footnote 149.

(204) *World Migration Report*. Geneva, International Organization for Migration, 2002, at 88.

(205) Vienna Declaration and Programme of Action of the World Conference on Human Rights, Vienna, 1993. United Nations document A/CONF.157/23, Part II, paragraphs 24, 33 and 34.

(206) Programme of Action of the United Nations International Conference on Population & Development, Cairo, 1994. United Nations document A/CONF.171/13, paragraph 9/22.

(207) Beijing Declaration and Platform for Action, Fourth World Conference on Women, Beijing, 1995. United Nations document A/CONF.177/20, paragraphs 58(k)-(l); 125(b)-(c).



©IOM/Chauzy 2003

duce measures for the empowerment of documented women migrants. It also urges the establishment of linguistically and culturally accessible services for migrant women and girls, including women migrant workers, who are victims of gender-based violence, as well as recognition of the vulnerability to violence and other forms of abuse of women migrant workers, whose legal status in the host country depends on employers who may exploit their situation.

The 1999 final document proposing key actions for the further implementation of the **Programme of Action of the Cairo Conference (ICPD+5)** urges governments in both countries of origin and countries of destination “to provide effective protection for migrants [and] provide basic health and social services, including sexual and reproductive health and family planning...”⁽²⁰⁸⁾ The same document calls for heightened support for refugee populations to safeguard their health and well-being.

The **Beijing +5 Outcome Document** (2000) reiterated key concepts from the 1995 Beijing Declaration and Platform for Action. The document also highlighted the health risks for women and girls arising from the effects of globalization on migratory flows of labour as a current challenge affecting the full implementation of the Beijing Declaration and Platform of Action.⁽²⁰⁹⁾

United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS, adopted in June 2001, urges the development and implementation of national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers by 2005. This should include the provision of information on health and social services.⁽²¹⁰⁾

The **World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance** in Durban, South Africa, in 2001, specifically urges “all States to prohibit discriminatory treatment based on race, colour, descent or nation or ethnic origin against foreigners and migrant workers, *inter alia*, where appropriate, concerning the granting of work visas and work permits, housing, health care and access to justice”.⁽²¹¹⁾ In addition, host countries of migrants were urged to “consider the provision of adequate social services, in particular in the areas of health...as a matter of priority, in cooperation with United Nations agencies, the regional organizations and international financial bodies”.⁽²¹²⁾

The International Plan of Action on Ageing adopted by the **Second United Nations World Assembly on Ageing in Madrid** in 2002 calls for the integration of older migrants into their new communities through “measures to assist older migrants to sustain economic and health security”.⁽²¹³⁾ ◆

(208) Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, New York, 1999. United Nations document G.A. RES/S-21/2, paragraph 24(a). See also reference under footnote 204, at 88.

(209) Report of the Ad Hoc Committee of the Whole of the twenty-third special session of the General Assembly, New York, 2000. United Nations document A/S-23/10/Rev.1.

(210) Resolution adopted by the General Assembly: Declaration of Commitment on HIV/AIDS, New York, 2001. United Nations document A/RES/S-26/2.

(211) Report of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, Durban, 2001. United Nations document A/CONF.189/12, 2/81.

(212) *Ibid.*, 2/30.

(213) International Plan of Action, Second United Nations World Assembly on Ageing, Madrid, 2002. United Nations document A/CONF-197/9, Annex 2.





“This timely report makes an important contribution to the growing debate on international migration policy. It examines the health of an increasingly vulnerable population from a human rights perspective. In so doing, it demonstrates the value of human rights as a policy tool. It also recognizes that a paradigm shift is needed ‘towards treating migrants as global citizens and rights holders’ .”

Mary Robinson
United Nations High Commissioner for Human Rights (1997-2002)

Health & Human Rights Publication Series Issue No.4

For more information, please contact:

Helena Nygren-Krug
Health and Human Rights Adviser
Department of Ethics, Trade, Human Rights & Law
Sustainable Development and Healthy
Environments Cluster
World Health Organization
20, Avenue Appia – 1211 Geneva 27 – Switzerland
Tel. (41) 22 7912523 – Fax: (41) 22 7914726
www.who.int/hhr

ISBN 92 4 156253 6



9 789241 562539