THE INTERNATIONAL ORGANIZATION FOR MIGRATION IS COMMITTED TO THE PRINCIPLE THAT HUMANE AND ORDERLY MIGRATION BENEFITS MIGRANTS AND SOCIETY IOM ASSISTS IN MEETING THE GROWING OPERATIONAL CHALLENGES OF MIGRATION MANAGEMENT HEALTH ADVANCES UNDERSTANDING OF MIGRATION ISSUES ENCOURAGES SOCIAL AND ECONOMIC DEVELOPMENT THROUGH MIGRATION UPHOLDS THE HUMAN DIGNITY AND WELL-BEING OF MIGRANTS

No. 6

INTERNATIONAL MIGRATION DIALOGUE ON MIGRATION AND MIGRATION: BRIDGING THE GAP

World Health Organization

IOM International Organization for Migration

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

INTERNATIONAL
DIALOGUE
ON MIGRATION

HEALTH AND MIGRATION: BRIDGING THE GAP

mprp

IOM - Migration Policy and Research Programme

This book is published by the Migration Policy and Research Programme (MPRP) of the International Organization for Migration. The purpose of MPRP is to contribute to an enhanced understanding of migration and to strengthen the capacity of governments to manage migration more effectively and cooperatively.

Opinions expressed in the chapters of this book by named contributors are those expressed by the contributors and do not necessarily reflect the views of IOM.

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HEALTH AND MIGRATION: BRIDGING THE GAP

International Organization for Migration

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As the leading international organization dealing with migration and related issues, IOM acts with its partners in the international community to assist in meeting the growing operational challenges of migration management, advance understanding of migration issues, encourage social and economic development through migration, and uphold the human dignity and well-being of migrants.

Pursuant to Art. 1.1(e) of the IOM Constitution, the purposes and functions of the organization are to provide a forum for states as well as international and other organizations for the exchange of views and experiences, and the promotion of cooperation and coordination of efforts on international migration issues, including studies on such issues in order to develop practical solutions.

The International Dialogue on Migration was launched at the IOM Council in November 2001 to provide a forum for IOM's 105 Member States and Observer States and organizations to identify and discuss key issues and challenges in the field of international migration, with a view to enhancing understanding of and cooperation in migration. This seminar was one of the international workshops held within the framework of the International Dialogue on Migration.

World Health Organization

The World Health Organization is the United Nations specialized agency for health matters. Established on 7 April 1948, WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The mission of the External Relations and Governing Bodies (EGB) Cluster is to build and reinforce partnerships and alliances for health. Strong alliances are essential to the development of a more dynamic and influential organization. Key partners are Member States, international and regional organizations, civil society, the private sector and the media.

The work of the EGB Cluster focuses on:

- Establishing and nurturing partnerships and promoting liaison and cooperation with outside bodies to highlight the critical role of health in development;
- Identifying and facilitating the mobilization of critically needed financial resources. This includes renewed efforts in the public sector and more intensive, creative collaboration with the private sector;
- Supporting the effective working of the Executive Board and the Health Assembly, and providing high quality translation services;
- Promoting coherence and cohesiveness in the work of the Organization across Geneva Clusters, Regional Offices and Country Offices, particularly in the area of technical cooperation with Member States.

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) endeavours to make people healthier and safer domestically and abroad. As the leading federal agency protecting the health and safety of persons living in the United States and citizens travelling abroad, the CDC works with partners in the United States and the international community in general to put science into action through reliable information to enhance health decisions; developing and advocating sound public health policy; implementing prevention and preparedness strategies; promoting healthy behaviour; fostering safe and healthful environments, and providing leadership and training.

Recognizing that political borders are no boundaries for public health issues, CDC works with international partners, such as the World Health Organization (WHO) and the International Organization for Migration (IOM) to address global migration and the public health implications of mobile populations. Within CDC, the National Center for Infectious Diseases, Division of Global Migration and Quarantine, takes the agency lead in promoting the health of mobile populations.

The mission of the Division of Global Migration and Quarantine (DGMQ) is to decrease morbidity and mortality from infectious disease among mobile populations, including immigrants, refugees, migrant workers and international travellers, and to prevent importation and interstate spread of communicable diseases. Three branches are involved in accomplishing this objective: Quarantine and Border Health Services, Geographic Medicine and Health Promotion, and Immigrant, Refugee and Migrant Health. These branches oversee and implement a variety of activities and interventions that affect migrant health in the United States and abroad. Highlights of these efforts include monitoring the content and quality of medical examinations performed overseas and domestically for U.S.-bound migrants; recommendation of effective prevention and intervention strategies to prevent the entry of disease into the United States; liaison and coordination efforts addressing migrant health within the United States; response to refugee health emergencies; provision of technical assistance in clinical and intervention management, and the development and maintenance of surveillance systems for infectious disease and epidemiologic investigations among immigrant, refugee and migrant populations.

Foreword

IOM

The International Organization for Migration (IOM) launched the International Dialogue on Migration in 2001 to foster better understanding and cooperation concerning migration matters between governments, international and non-governmental organizations. As part of this process of identifying key issues and challenges concerning migration, IOM organizes specialized workshops to enable experts and officials to focus upon particular areas of increasing relevance.

The Seminar on Health and Migration was initiated in recognition of the need to assess the public health implications of increasingly mobile populations, and to integrate health policies into migration management strategies. This seminar was held in Geneva from 9 to 11 June 2004 with the co-sponsorship of the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC). It brought together health and migration officials from around the globe to exchange views on migration health policy concerns, perspectives and experiences.

This publication details the broad range of issues discussed during the seminar. Panels of experts encouraged debate on topics such as the use of pre-departure health screenings, the need to

address the mental health of migrants, healthcare access for migrants in an irregular status, and the migration of healthcare workers. The records of the discussions contained in the following chapters set out the main challenges and areas for policy reform, such as the need for programme support, local capacity building, information-sharing and communication of best practices.

There was broad agreement on the need for a global approach to public health management, the creation of comprehensive policies capable of servicing all migrant populations, and partnerships in migration health. Overall, this seminar has demonstrated the need to change the mindset on migration health from one of exclusion to one of inclusion.

This was the first time experts on health and migration had been brought together to identify common principles and agendas for action. I hope that this report will cultivate further awareness of this important policy area, and promote future collaboration at national, regional and international levels.

Brunson McKinley
Director General
International Organization for Migration (IOM)

Foreword

WHO

In a globalized and exceedingly mobile world, with around 1 billion people travelling or moving across borders every year, the risk of the spread of infectious diseases concerns all countries and populations.

The re-emergence of TB, the scourge of HIV / AIDS and SARS and potentially more dangerous outbreaks of human influenza bear witness to the global vulnerability caused by the increased mobility of people. It is the poor and the underserved among them who are the most vulnerable.

The response, as pointed out so clearly in this report, is the maintenance and strengthening of a global surveillance system and a robust global response mechanism. Health in a globalized world environment is not only a human right in itself; it makes also economic sense as a global public good.

Almost 40 million people have been infected by the HIV / AIDS virus, of whom close to half are women, a figure that has risen in every region of the world. Every five seconds another person is being infected with HIV. Migrant populations are among the most vulnerable groups. They often lack access to treatment and

care, and their needs merit attention. Inclusiveness and access to healthcare, rather than screening, is the best approach.

The migration of health workers from developing to developed countries is a key concern of WHO Member States. This report presents a global overview of the migration of health workers and evidence for effective policy options to manage migration, including codes of practice on ethical recruitment strategies, mutually beneficial trade agreements, the facilitation of return migration and improved planning and management of the health workforce in developed and developing countries. WHO is working side by side with IOM to find the most appropriate means to mitigate the negative health effects of migration.

Dr. Kazem Behbehani
Assistant Director-General
External Relations and Governing Bodies
World Health Organization

Foreword

CDC

In 2001, the International Organization for Migration (IOM) initiated a global discussion on the topic of promoting the health of underserved migrant populations. This discussion was intended to inform and promote cooperation between governments, nongovernmental organizations and international organizations in their effort to address the health needs of these populations. One of the objectives of this international dialogue was to identify cross-cutting key issues and common challenges. To accomplish this objective, IOM held a series of workshops to bring partners together to discuss these issues.

The fourth workshop in the series, entitled "The Seminar on Health and Migration" was held in Geneva, Switzerland, from 9 to 11 June 2004. This workshop, co-sponsored by the Centers for Disease Control and Prevention (CDC) and the World Health Organization was the first of its kind to bring together both health and migration expertise from around the world to explore the interrelations between migration and health. The workshop opened on the subject of "Health and Migration Challenges", followed by "Migration and Health Policy" and concluded with "The Way Forward". During the three-day workshop, participants reached a consensus recognizing the imperative to better address the public health implications of migratory

populations, to initiate the integration of public health policy into migration management strategies and to identify common courses for action. Overall, the sessions called for a shift from an "exclusive" to an "inclusive" model for migration health, considering the physical, mental and social well-being of migrants as of vital importance in the migration process.

Summaries of the discussion, dialogue and debates at the Seminar on Health and Migration are presented in this report. A number of topics were considered, including national migration policies and enhanced programmes, the mental health of immigrants, the migration of healthcare workers, healthcare for undocumented migrants, policy reform and investing in migration health. The discussions in the following chapters set forth many of the key issues on migration health and the major barriers towards achieving a well managed migration policy.

This workshop represents the first effort of its kind and sets the stage for many more to come. CDC encourages the efforts of experts and stakeholders to identify common principles and agenda items for public health action. They are also committed to disseminating what we learn to the public to inform, cultivate awareness, and promote partnerships and collaboration. This report will prove useful in translating this commitment into action and fostering interest in migration health.

Sincerely,

Martin S. Cetron, M.D.
Director, Division of Global Migration and Quarantine
Centers for Disease Control and Prevention

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SESSION II: PUBLIC HEALTH AND MIGRATION

A. Population Mobility and Public Health

B. Managing Global Public Health: Partnerships and Developing Bridging Public Health Programmes

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
BSE	Bovine Spongiform Encephalopathy
CDC	Centers for Disease Control and Prevention
CIC	Citizenship and Immigration Canada
GDP	Gross Domestic Product
GNP	Gross National Product
HIV	Human Immunodeficiency Virus
ID	Identification
IHR	International Health Regulations
IOM	The International Organization for Migration
IR	International Recruitment
NGO	Non-governmental Organization
PHEIC	Public Health Emergencies of International Concern
SARS	Severe Acute Respiratory Syndrome
TB	Tuberculosis
U.K.	The United Kingdom
UN	The United Nations
USA	The United States of America
U.S.	The United States
USD	United States Dollar
VFR	Visiting Friends and Relatives
WHA	World Health Assembly
WHO	World Health Organization

EXECUTIVE SUMMARY

Migration is a fact of modern life, and migrants play an essential role in today's global economy. As migration flows around the world increase, the health of mobile populations and the societies with which they are affiliated is becoming a major public concern. Yet, to date there has only been limited recognition of the interdependence between the two in either the migration or the public health policy domains. As migrants connect health environments, migrant health has become a critical element of migration policy and needs to be integrated into migration management strategies, for the benefit of individuals and societies alike.

The International Organization for Migration (IOM) organized a Seminar on Health and Migration in Geneva from 9 to 11 June 2004, as an inter-session workshop of the IOM Council International Dialogue on Migration, with the co-sponsorship of the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC). This Seminar brought together health and migration officials to exchange views on health and migration policy concerns, with particular focus on the public health implications of increasingly mobile populations. It provided a forum for policy makers, practitioners and other stakeholders from governments, intergovernmental agencies and non-governmental organizations to exchange perspectives and experiences and to engage in informal dialogue.

The Seminar focused on the public health implications of increasingly mobile populations. In addition to exploring general migration health challenges, participants took a closer look at specific subpopulations, including irregular and returning migrants, migrants in conflict situations, migrants with HIV/AIDS, and the ever growing ranks of migrating healthcare workers. By drawing out the issues associated with each, the range and complexity of health concerns in the migration context became clear.

The Seminar highlighted the need to change the ways we think about health and migration, specifically a change in the mindset from exclusion to inclusion. The physical, mental and social well-being of the migrant is vital at each stage of the migration process, from the decision to move, the journey itself, reception in the new community, and possibly eventual return. One of the most important aspects of a well managed migration health policy is the need to promote understanding within mixed communities. Successful integration into the host society requires a comprehensive interpretation of migration health going beyond infectious disease control to include chronic non-infectious conditions, mental health concerns, and understanding the human rights dimensions of health issues. This implies the creation of health policies that include all members of the community, regardless of citizenship or legal migration status.

Why is this so important? Migrants in a state of well-being would be more receptive to education and employment, and more inclined to contribute to their host societies. Migrants not perceived to be a health threat to their host communities would be less exposed to discrimination and xenophobia, and more likely to be included as equal participants. With this in mind, speakers and participants at the Seminar highlighted the following key issues, concerns and challenges involved in constructing comprehensive migration policies, and proposed a number of avenues to address these.

- **First**, the Seminar recognized the **close link between migration and health** and acknowledged the mounting need for a **global approach to public health management**. In particular,

it examined relations between population mobility and public health in the context of existing national and international migration and health policies.

- **Second**, the Seminar explored the prospects of taking an **inclusive approach** towards creating **comprehensive policies**, understanding health, and servicing all migrant populations.

- **Third**, the Seminar established the need for **partnerships** in various areas of migration management including programme support and border control of communicable diseases. A separate session evaluated the complex issues associated with the migration of healthcare workers, including the impact on development and diseases burden, and proposed policy options to alleviate the situation.

In addition, the Seminar explored a range of related challenges, including access to and quality of healthcare, public health and human rights protection of migrants in an irregular situation (including trafficked persons), as well as health issues in the cultural, economic, integration, security and development aspects of migration. Overall, the Seminar highlighted the fact that health is an integral part of effective migration management. It underlined the need for a commitment to partnerships and concluded that managing migration health is feasible through international cooperation, political will and appropriate migration health policy responses.

Relationship between Health and Migration: The Need for a Global Public Health Approach

As more people travel more quickly to more destinations, individuals link the health environments of their home, transit and host countries. Thus, global communities are being created, sharing health risks and potential benefits. Merging health

environments reflect the socio-economic and cultural background and disease prevalence of communities of origin, transit, destination and return. The re-emergence of tuberculosis (TB) in developed parts of the world, the rapid spread of the Human Immunodeficiency Virus (HIV) and Severe Acute Respiratory Syndrome (SARS) are just a few examples of the relationship between population mobility and health.

The main response to the public health risks posed by migration has been the medical screening of prospective migrants deemed to pose the highest risk. This practice is intended to contain the spread of infectious disease and identify those who may prove to be a heavy burden on publicly funded health services. However, the advantages of medical screening may be questioned in regard of a number of aspects:

- **Effectiveness** – Medical screening cannot and does not detect diseases during their incubation period. Effective screening is often frustrated by the attempts of migrants to conceal outward symptoms of infection through self-medication and temporary treatment. Less than one quarter of migrants to the US who are carriers of TB are identified at border points.

- **Ethics** – Screenings may result in the stigmatization of migrants in both source and host communities.

- **Applicability** – though screening is suited to addressing public health concerns of controlled, demand-determined, regular migration of developed nations, it is not suited to address risks associated with short-term travel, irregular and internal migration.

- **Dual Perspective** – a migration health policy needs to address the migrant both as a potential threat to the health of the host community, as well as an individual vulnerable to disease, with a need for care and a right to health.

Regulations sanctioning refusal of entry to those who are infected or ill are not an effective means of containing the global spread of infectious diseases. For instance, such regulations will not address public health threats generated by short-term travel, irregular migration, the circular mobility of labour migrants or the return of visiting family and friends. On the contrary, while medical screenings can encourage public support of migration, they may also create a false sense of security, leading to decreased public health surveillance and a narrow focus on the health problems of migrant populations.

Health screening could be a useful means of facilitating migrant integration into the host society through identifying the health needs of the migrant and introducing them to the healthcare system. However, in order to be effective, the screening would need to include assessments of non-infectious conditions, chronic illness, mental health and mental trauma.

Aside from the risk to the host country posed by communicable diseases, the health needs of migrants themselves should be considered. Migrants often have greater difficulty maintaining their health and well-being for a number of reasons. They are disproportionately affected by disease and other illnesses, whether acquired in source and transit countries on the journey or as a result of the socio-economic conditions of their stay in the host country. In addition, linguistic, cultural and legal barriers may limit migrants' access to health services available in the country. Migrants are frequently uninformed as to how much treatment is available, or how to request it. A comprehensive migration health policy needs to move beyond merely the control of disease, and work towards reducing the broader vulnerability of this population through access to healthcare.

Furthermore, contemporary migration links public health to security concerns, since international mobility may act as the agent of the intentional as well as unintentional spread of disease. A new formulation of the International Health Regulations (IHR) is under review and will address global health and security concerns; if adopted, it will come into force in January 2006. The

proposed framework will not only provide a vital international context for appraising global health threats, but could also act as the launch pad for improved national surveillance.

Overall, the best approach to the unavoidable and increasingly important domain of migrant health is the progressive development of a global public health system that would bridge communities of origin, transit, destination and return, a strong global disease surveillance mechanism, accessible healthcare systems within and across borders, and a rapid response mechanism to contain infectious disease outbreaks. Such a global approach would improve understanding of non-infectious health concerns and address underlying causes of diseases, ill health and inequality.

Managing Migration Health: From Exclusion Towards Inclusion

Inclusive Policies and Strategies

Today, most nations face challenges when developing migration policies that aim to integrate the health needs of both host communities and migrant populations. On the one hand, host communities want to protect themselves against the threat of disease that may be introduced as a result of people coming in; or they may want to reduce the increased demand and economic burden placed by newcomers on publicly funded health and welfare programmes. On the other hand, migrants may have health and welfare priorities that are associated with their basic human rights, including the right to health,[1] to a safe and dignified haven from persecution and access to available health and welfare services. Therefore, managing migration health requires a balance between a country's sovereign responsibilities to safeguard their constituents' rights and priorities to protect the sustainability of publicly funded health and welfare services, as well as to fulfil their international obligations such as the protection of vulnerable populations, such as asylum seekers.

The Seminar made it clear that only a global and inclusive approach, addressing the health needs of both the host and migrant communities, can lead to improved health for individuals and communities alike. Policies and practices of inclusion have a better chance of improving or maintaining the well-being of both local and migrant populations. In addition, such policies facilitate the integration of migrants into host communities by encouraging their economic and social contributions. Furthermore, exclusion from admissibility based on health raises issues of ethics and discrimination, and can contribute to the stigmatization of migrants.

How can we successfully achieve inclusive policies and management strategies?

Incorporating health into comprehensive migration policies entails more than making health services accessible and providing services and treatments. More research is needed to better understand the intricate connections between health and the multiple facets of contemporary migration in order to develop effective migration health policies and management strategies. It also requires enhanced public awareness and training on important integration issues affecting migrant communities, such as language barriers, cultural differences and migratory experiences, in order to competently address the factors influencing the health profiles of migrants. Finally, raising awareness of migration health issues within the host community, and involving the community in the provision of health services to migrants, can minimize local bias against migrant populations and bridge cultural gaps between the providers and recipients of such healthcare. Maintaining public support for migrants is a critical element of administering healthcare and other services.

Health as an Inclusive Concept

Health is "a state of physical, mental and social well-being and not merely the absence of disease or infirmity".[2] Migration health addresses the well-being not only of the individual migrant, but also of the communities, by building the necessary bridges between origin, transit, destination and return countries

and regions. The comprehensive interpretation of migration health goes beyond infectious disease control to the inclusion of chronic non-infectious conditions, mental health concerns, and an understanding of health and human rights issues.

Mental well-being is fundamentally interconnected with physical and social functioning and health outcomes.[3] Attending to the mental well-being of migrants is an important tool in facilitating their integration[4] into host communities, as people in a state of well-being will be more receptive to education and employment. In post-conflict or post-emergency situations, mental health functioning is an important element for the future stability of communities and society at large, as well as for facilitating peaceful reconstruction. The development of a nationwide mental health programme in Cambodia, as part of post-conflict rehabilitation, is a successful example of this. Mental health services should therefore be an integrated component of public health programmes.

Inclusion of Migrants in an Irregular Situation

Managing the health of migrants in an irregular situation, such as smuggled and trafficked persons, poses one of the greatest dilemmas for many governments. Although many acknowledge that providing access to health and welfare services to migrants in an irregular situation also means protecting their constituencies, others believe that supplying health services to migrants in an irregular situation may be perceived as implicitly recognizing and condoning irregular migration. Existing solutions to this policy problem include the provision of emergency healthcare alone, or access to health services only after a certain timeframe. Paradoxically, nations that do grant access to health and welfare services to migrants in an irregular situation have noticed that these migrants do not access them due to fear of arrest and deportation. In addition, a lack of culturally sensitive care contributes to the migrants' reluctance to access available services.

Voluntary return is a fast expanding means of managing irregular migration. However, the process of return may place added strain on the returning migrant, as well as the country of

origin, when the returnee has a health condition requiring care not available or affordable there. Currently, health policies and management practices are not in place to respond to the health concerns of the returnees. Innovative proposals, such as joint "source-destination responsibility models" and "equitable burden-sharing options", may offer solutions and stimulate a debate on national responsibilities.

Partnerships and Co-responsibilities

The Seminar underlined the importance of a global commitment to partnerships in the management and practices of migration health. Partnerships need to be built or strengthened between governments, as well as between organizations and communities, at national, regional and international levels. The recent SARS outbreak, and the international reaction that quickly followed, demonstrated how international cooperation can significantly reduce the spread of disease and protect public health globally. On the other hand, mismanagement of mobility and of public health can carry many implications that go beyond public health and in fact impact on the global economy, world trade and political relationships.

The following areas for developing or strengthening partnerships were prioritized:

Programme Support and Local Capacity Building

International and intersectoral sharing of best practices in the development, design, implementation and evaluation of programmes can increase the effectiveness and sustainability of health programmes. Programmes should be integrated into national structures, i.e. requested and accepted by local governments and integrated into national health plans. Initial programme development and final implementation should take advantage of the sharing of best practices and evaluation studies. Such comprehensive cooperation empowers communities to offer sustainable solutions.

Control of Communicable Diseases, Particularly Emerging Diseases

Communicable diseases do not respect boundaries. Thus, cooperation and coordination at a global level are needed in the prevention, early detection and rapid response for such diseases. Partnerships should be forged between migration authorities and health authorities and health providers in the form of information sharing and communication of best practices in order to control the spread of communicable diseases. Ultimately it is hoped that this endeavour will form the basis for a global public health system capable of the comprehensive monitoring of emerging infectious diseases.

Management of Migration of Healthcare Workers

The migration of healthcare workers is increasingly a challenge in the management of healthcare systems, particularly for developing countries that face public health crises, such as HIV / AIDS. In 2002, over 13,000 nurses and 4,000 physicians emigrated to the United Kingdom alone,[5] and migration flows will continue to increase due to the liberalization of trade and the forces of globalization. Partnerships can better manage the fluctuations in healthcare demands and available resources of individual nations. Examples of cooperative solutions in the management of healthcare workers include the use of bilateral agreements, such as that concluded between the United Kingdom and South Africa. These agreements can offer short-term exchange programmes whereby healthcare providers have the opportunity to be trained and work abroad for several years, capacity-building programmes to train health service providers who will later be deployed in countries experiencing shortages in medical staff, and the development of incentives to encourage qualified nationals to return home for short periods of time in order to utilize and transfer medical skills and knowledge.

Awareness Raising of Key Migration Health Issues

The Seminar on Migration and Health was the first arena for migration and health specialists to exchange views on the links between the two areas under discussion. Now, these links need

to be promoted both internally and externally to raise awareness among governments, intergovernmental organizations and non-governmental organizations, as well as the general public. Through such awareness raising, health issues can be integrated into the various aspects of the migration process through partnerships and cooperation at national, regional and international levels, to create comprehensive and inclusive migration policies.

Conclusions

Acknowledging that this is a time of real opportunity in migration health, this dialogue was dedicated to creating an understanding of health as an integral component of migration, and no longer considering migration and health as two isolated domains. Thus the Seminar proposed two action points that can be implemented immediately:

- A commitment to **promote and advocate the integration of health issues** in the various aspects of migration we are called upon to deal with.
- A commitment to **form partnerships and share responsibilities** between governments as well as between organizations at the community, national, regional and international levels.

The importance of creating a platform for dialogue from which strategic policy solutions and cooperative management can be forged cannot be overstated. The Seminar on Health and Migration in Geneva was the first initiative to create such a platform. Similar initiatives have begun on a regional level with the recent Health and Migration Seminar in Guatemala. Other follow-up events will be key to further disseminating the identified principles and action points and adjusting to regional realities. Through strengthening these networks, we are working towards the development of a global public health system that will bridge communities of origin, transit, destination and return.

REPORT OF THE MEETING[6]

This report provides a detailed résumé of the four main issues raised at the seminar.

First, it recognizes the close link between migration and health and acknowledges the mounting need for a global approach to public health management. In particular, it examined the relations between population mobility and public health in the context of existing national and international migration and health policies.

Second, it explores the prospects of taking an inclusive approach towards creating comprehensive policies, understanding health and servicing all migrant populations.

Third, it establishes the need for partnerships in various areas of migration management, including programme support, and border control of communicable diseases. Complex issues associated with the migration of healthcare workers are also presented.

Finally, the seminar discussed the way forward and working towards healthier migrants and healthier societies.

Objectives and Structure of the Meeting

Brunson McKinley, Director General, International Organization for Migration (IOM)

Mr. Orvill Adams, then Director, Human Resources for Health, World Health Organization (WHO)

Dr. Susan Maloney, Acting Chief, Immigrant, Refugee and Migrant Health Branch, Division of Global Migration and Quarantine, Centers for Disease Control (CDC)

The main objective of the seminar was to explore the significant links and interdependences connecting health and migration. This occurred in a non-negotiating setting, through experts' analysis and national experiences punctuated by dialogue and debate, all of which enriched and sustained the conversation by its diversity of perspective and depth of knowledge. The conference also aimed at framing four of the most prominent health and migration issues, focusing on the health objectives of migrants, source countries, destination countries, and emerging global public health concerns.

The structure of the meeting reflected these objectives, with sessions covering:

- *Health and Migration Challenges*: the characteristics of contemporary migration and modern-day epidemiology and the areas in which these two fields intersect.

- *Population Mobility and Public Health*: migration and movement as conduits of disease and policy options for detection, containment, and prevention.

- *Managing Global Public Health*: lessons and experiences from the field in tackling some of the diverse issues posed by the health and migration nexus.

- *Investing in Migration Health*: defining national responsibilities towards irregular migrants and refugees and developing international health regulations that are responsive to emerging threats.

- *Migration of Healthcare Workers:* evaluating "brain drain", channelling diaspora resources, forging international recruitment commitments, and retaining personnel in view of global shortages of healthcare workers.
- *What is Foreseen for the Future*: exploring collaborative policies that are sensitive to the health objectives of source countries, receiving countries, and migrants.

- *Where Can We Go from Here*: forging a common vision and viewing health as an issue that cuts across all facets of migration.

SESSION I: HEALTH AND MIGRATION CHALLENGES

What is contemporary migration? Why should health be considered in the context of migration? What are the key challenges from a global perspective? What is at stake from both a health and migration perspective? Why should we care?

Migration Perspective

Ms. Diane Vincent, Associate Deputy Minister of Citizenship and Immigration Canada (CIC), Canada

As the ongoing process of international globalization continues to influence both national and international events and activities, it is neither surprising nor unexpected that the relationships between health and migration are the subject of increased interest. A better understanding of these relationships will facilitate individual and multinational responses to future health and migration challenges. Some of the issues and factors related to health and the international migration of individuals and populations have been the subject of attention in traditional immigration receiving nations for many years. In fact, attempts to manage the international spread of infectious diseases through immigration health practices represent some of the oldest organized public health measures worldwide.

However, both the nature of migration and the global importance of public health have evolved dramatically during the past three decades. Today, in addition to being a major focus of public interest, the study and understanding of the health of migrants and mobile populations is becoming once again an important area of activity for healthcare providers, health policy analysts, immigration officials, social scientists, governments and international agencies. It is now time to consider more modern, forward-looking and collaborative approaches to meeting the health challenges associated with migration and population mobility.

The Health of Migrants and of Mobile Populations

An important area of activity for:

- Healthcare providers
- Health policy analysts
- Immigration officials
- Social scientists
- Governments and international agencies

The experience and understanding gleaned from traditional immigration health programmes can provide knowledge and insight in this regard. What we have learned is that, as the world becomes an increasingly more mobile place – 700,000,000 international journeys take place yearly and this number is growing – existing health and disease disparities can have a significant impact on migrants in both origin and receiving nations. Public, national and international strategies to manage regional disease disparities and isolated outbreaks of global importance require a good understanding and appreciation of the dynamics and nature of modern migration movements. Nations such as Canada, Australia and the US with their long-standing immigration health programmes, use this knowledge and capacity to help meet the challenges of situations such as the recent SARS episode.

The outcomes and best practices that result from dynamic and effective immigration health programmes have proved both useful and important in managing migration-related public health challenges. Proper screening and referral programmes, for example, continue to allow large immigration programmes from areas of the world where important infectious diseases are common to nations where these diseases are less prevalent without significant risk. Canada, for example, continues to have one of the world's lowest national rates of tuberculosis, despite large migratory inflows from areas of the world where the disease is prevalent. This does not mean that migrants and mobile populations are not at higher epidemiological risk, or that specific and directed attention at migration-related tuberculosis is not required. It does demonstrate, however, that these risks can be managed while sustaining a dynamic immigration programme and managing public health risks.

We understand that migration is both a fundamental and expanding global issue. At the same time, events of national and international health relevance are also evolving. These two factors will continue to generate areas of interest for policy makers and senior decision makers. As the processes and challenges created by the interface of migration and health are increasingly global and interrelated, the solutions and responses will, in consequence, need to be so also. The challenge before us is to begin to address through forward-looking and integrated global policy development frameworks the health issues related to population mobility. Just as we examine migration through the lens of human capital and labour markets, international safety and security, the global health consequences of migration should be likewise foremost in our minds.

Health Perspective

Dr. David Heymann, Representative of the Director General for Polio Eradication, WHO

Public health threats arise in migrant populations when diseases are communicable and infected persons move or migrate.

Cataloguing infectious diseases into three prime categories facilitates more accurate disease portrayals and clearer response-oriented discussion:

- **High mortality infectious diseases** are endemic throughout populations, like malaria, HIV/AIDS, diarrhoea, Acute Respiratory Infections (ARI), measles, and TB; except for measles, they cannot, at present, be prevented by vaccination but they can be prevented by interventions such as condoms (AIDS), and bednets (malaria);[7] they can also be treated, and a great challenge is to ensure access to medicines that can cure or prolong life for those who are infected.

High-mortality Infectious Diseases

Current situation

- Vaccines: vaccine development is a long-term investment with slow progress and high risk.
- Antibiotic failing: antimicrobial development has slowed down while resistance threatens to shorten new product life.
- Distribution of diseases: throughout populations/highly endemic.

Requiring:

- Sustained increased access to drugs and other goods through partnership.
- Realignment of 90/10 research gap through targeted research programmes.

- **Disability-causing infectious diseases** are often endemic in pockets of poverty. Many can be eliminated as public health problems (leprosy, lymphatic filariasis, onchocerciasis), while others can be eradicated (Guinea worm, poliomyelitis); like the high mortality infectious diseases, they have the potential to be reintroduced across borders.

Disability-causing Infectious Diseases

Current situation

- Endemic in pockets of poverty in developing countries.
- Drugs remain effective and resistance has not developed (yet).
- Vaccines prevent infection and exist for some.

Requiring:

- Increased access to drugs and other goods through partnerships with industry, development banks, bilateral donors and NGOs.

- **Emerging and re-emerging infectious diseases** are infectious disease threats that, like Bovine Spongiform Encephalopathy (BSE), severe acute respiratory syndrome (SARS), or avian influenza, have breached the animal-human barrier. They require continuous surveillance and, in the event of an outbreak, an immediate and coordinated national and international response, supported by international regulations and a global partnership for control.

Emerging/Re-emerging Infectious Diseases

Current situation

- Occur on every continent/health worker at great risk.
- Emerge from nature, usually animals.
- Spread worldwide in humans, insects, livestock and food/goods.
- Cause mortality/morbidity and cost to economies.

Requiring:

- Strong national surveillance and control.
- Coordinated global surveillance and response.
- International regulations.

Infectious diseases result in 14 million deaths each year. Over 80 per cent of these is due to six high mortality infectious diseases described earlier. Infectious diseases exact a severe human and economic toll, and negatively affect productivity, healthy work-time, household income and economic development.

The world has the goods needed to control, eliminate or eradicate infectious diseases. Antimicrobial medicines in conjunction with preventive education, distribution of protective devices such as contraceptives or bed-netting, can result in successful disease containment in developing countries, provided there is government commitment to make these goods available to populations in need. This approach, which relies on multi-sectoral coordination, has dramatically reduced mortality, disability and negative economic impacts from infectious diseases. Tuberculosis and malaria, for example, have been well controlled in countries such as Peru and Viet Nam, respectively, where governments have ensured access to medicines and preventive measures.

Refusing entry to those who are diagnosed as having an illness in migrant populations to prevent the spread and/or outbreaks of infectious diseases is not an effective means of containment. Many infectious diseases have incubation periods ranging from days to months and years that allow infected persons to travel while infected asymptomatically, thus escaping detection. If they remain undetected when they become ill, they can spread infectious diseases and cause outbreaks. The best means of preventing disease outbreaks among migrant populations is, therefore, good surveillance and disease detection with rapid and appropriate containment measures to prevent their spread. The same is true for the much larger category of people who travel internationally.

Regulations requiring refusal of entry to those who are ill may in fact result in a false sense of security and lead to reduced surveillance and attention to the health problems of migrant populations, and also to unintentional or deliberate discrimination.

Factors Contributing to Communicable Diseases among Displaced Persons

- Unstable or no government.
- Poverty: most complex emergency countries have a per capita GNP<400USD.
- Diseases already present in population and host country or region.
- Collapse of health services and disease control programmes.
- Multiple agencies providing healthcare, often poorly coordinated.
- Ongoing conflicts reduce access to goods and existing services.
- Health workers not prepared.
- Supply and logistic difficulties.

Infectious diseases do not respect borders and no country or population group is safe from the spread of infectious diseases in a globalized and highly mobile world environment. The best investment, therefore, is in good public health services: strong disease surveillance, robust and accessible healthcare systems, and rapid response mechanisms to contain infectious disease outbreaks.

Bridging Health and Migration

Dr. Danielle Grondin, Director, Migration Health, IOM

Migration

The movement of a person or group of persons from one geographical unit to another across an administrative or political border, wishing to settle definitely or temporarily in a place other than the place of origin.

Why is it important to consider health in the context of migration? **Migration** is a persistent facet of our modern world, bringing new challenges due to its magnitude and the complexity of migratory patterns: about 3 per cent of the world population are migrants, with women accounting for slightly more than 50 per cent.[8] Migratory patterns are diverse and complex (South to North, East to West, rural to urban, poor to rich, unsafe to safe, regular to irregular), changing form a unidirectional to multidirectional, including circular movements. Contemporary migration is a worldwide phenomenon that is changing the structure of family units, communities and societies. It will not stop and will continue as long as economic imbalance and conflicts exist. We still do not have a sound understanding of the complexity nor the diversity of the various patterns, and there are still mismatches between policies and the reality of these migratory patterns. **Health** is far more than just the absence of disease, rather it is a "state of physical, mental, and social well-being",[9] thus requiring the expansion of the traditional scope of migrant health that focuses of infectious disease control, to encompass care and management of non-infectious and chronic diseases, mental health conditions, and social maladjustments.

Migration Health

(…) addresses the state of physical, mental and social well-being of migrants and mobile populations.

What is migration in the context of health? Mobility patterns define the conditions of the journey and their impact on health. The legal status of migrants in receiving societies often determines access to health and social services. Mobility patterns (regular vs. irregular) and legal status often determine the degree of vulnerability of migrants in a society. Migrants are a particularly vulnerable population in terms of health issues and other reasons. Linguistic, cultural and religious differences or barriers combine to make the provision and receipt of migrant healthcare difficult.

They are disproportionately afflicted with disease, and often the incidence of disease is considerably higher than for locals in the host country or their counterparts in their country of origin.[10] They may have been exposed to new diseases in transit or in the host country. Often marginalized, they are seldom aware of their rights or how to request treatment from local government agencies, non- or intergovernmental organizations.

Why Bridge the Gap between Migration and Health?

- Migrants have a right to health.
- It benefits communities and society at large.
- It facilitates integration.
- It helps to stabilize societies, and foster peace and security.
- It facilitates development.

Why should we be concerned with bridging health and migration? Migrants have a right to health. Health concerns cut across all the varied and complex migration issues. Migration health focuses on well-being of migrants and communities at source, transit, destination and return countries and regions. Additionally, it addresses the specific public health issues of communities and the health of individual migrants through policy, advocacy, research and development, to work towards improving migrants' access to healthcare and thereby reduce their general vulnerability. The importance of integration, (i.e. autonomous participation and contribution to host societies) in respect of a successful migration outcome therefore calls for a comprehensive interpretation of "migrant health" beyond the control of infectious diseases towards the inclusion of chronic conditions, mental health concerns, cultural beliefs and understanding of health, and human rights issues.

How Can We Effectively Bridge Health and Migration Concerns?

By harmonizing policy and the needs of migrants and communities:

- Develop policy research to get the facts right and adapt the policies accordingly;
- Comprehensive policies;
- Evidence-based advocacy.

Capacity building:

- Training.

Cooperation and partnership:

- Among source, transit, destination and return countries/ regions.

Developing policies of prevention and care strategies aiming at:

- Inclusion instead of exclusion;
- Reducing vulnerability;
- Facilitating access to healthcare.

Discussion from Session I: Health and Migration Challenges

The debate centred on the use and administration of health screenings for prospective migrants. The effectiveness of health screenings was questioned because they neither can nor do detect diseases during the incubation period. As such, they can provide a false sense of security based on lower detection rates during the incubation period.

Health screenings also raised issues in connection with ethics and discrimination. They may result in the stigmatization of migrants in both source and host communities. Several participants challenged the practice of excluding applicants with specific inadmissible conditions, allowing countries to claim a low national incidence for certain infections. National prevalence rates are very misleading as they often mask a much higher disease incidence in immigration communities. Screening,

therefore, cannot be said to have effectively deflected or managed disease among the population it seeks to regulate.

While suited to controlling the demand-determined, regular migration of developed nations, the effectiveness of health screening was questioned regarding public health threats generated by travel, irregular and internal migration involving developing nations. Thus, nations with high rates of irregular migration stressed the need for an integrated policy approach and for more resources to address the healthcare needs of these migrant populations.

There are two aspects to the management of migration and health issues, viz. migrants as a potential health threat to receiving countries, and migrants as individuals vulnerable to disease and who need care. Thus, migrants can be vectors of illnesses, possibly endangering the host country. Therefore, countries need to protect themselves from potential infection. However, migrants are also "foreigners" who are excluded from the local social system and many relevant services, and are themselves potentially at risk. Their right to health needs to be served as well.

SESSION II: PUBLIC HEALTH AND MIGRATION

A. Population Mobility and Public Health

What is being done to address the impact of population mobility on public health? Why do we care? What lessons can we learn? What needs to be done?

Globalization of Communicable Diseases

Dr. Brian Gushulak, Director General, Medical Services Branch, Citizenship and Immigration Canada (CIC), Canada

A look at the modern, increasingly globalized international landscape reveals many levels of disparity. While often considered in the traditional medical model of differences in disease prevalence, these disparities are limited to infectious disease epidemiology and extend to acute inter-country economic and epidemiological inequalities, chronic and infectious diseases endemic in certain regions of the world only, and relatively poor healthcare capacity in migration source countries. These areas of disparity are then connected by an increasingly complex web of global movements in a world where traditional frontiers are losing their importance as sole points of entry. Clearly, migration in this context has health effects that vary with the situation of

the migrant. They may be positive, negative or neutral and influence programme and policy decisions, with the negative outcomes often generating the most attention. To combat these consequences, our policies and attitudes must reflect current realities; older and outdated national approaches simply are no longer valid.

New factors have shifted many of the parameters:

- Resurgence in the interest in public health and infectious diseases – SARS/pandemic influenza/smallpox;
- Significant interest in migration as a global process – not just the traditional immigration receiving nation;
- The process of globalization and the globalization of public health risks.

Disparity coupled with the increased ease of movement for all types of persons requires health officials to adapt to new categories of carriers, and to different channels of dissemination. For instance, disease surveillance officers should be aware that malaria is most likely to be imported not by migrants, but by a new category of individuals – those **v**isiting **f**riends and **r**elatives (VFR).

Combating emerging and re-emerging infectious diseases requires the widening of our disease-surveillance radar; the emphasis should no longer be on monitoring for a single specific disease or a basket of older diseases, but on surveying the entire field, in the hope of identifying emerging threats and looking beyond the "danger of the week".

- Globalization of disease is a part of our world.
- It is a process and should be managed as a process.
- Effective and cost-efficient solutions will be easier through collaborative efforts.
- Individual disease-based practices are unlikely to be effective unless they are part of a broader strategy.

An individual's migration history ought to be made available in the context of his/her health record. The migration paths pursued shed light on migrants' potential exposure to disease, cultural or religious conceptions of healthcare, mental health state, and experiences such as rape, loss, and similar conditions. Included as a lateral component of a migrant's health record, such information could facilitate better care before, during, and after migration. It may be hoped that physicians and other caregivers could then tailor their prognoses and services to an individual's recorded migration history.

Chronic infections and the presence of non-infectious diseases that are recurring and difficult to resolve, are likely to assume increasing importance as a migration-related health concern. Though not communicable, chronic conditions are often complex, costly and difficult to manage in cross-cultural settings. When present in significant numbers of migrants, they may place operational, logistical and fiscal strains on the host country's healthcare system, impede migrants' societal integration, and limit their potential economic contribution.

The Case of SARS: Lessons Learnt

Associate Professor Suok Kai Chew, Deputy Director of Medical Services, Epidemiology and Disease Control, Ministry of Health, Singapore

When dealing with emerging infectious diseases, early intervention can make a difference and avert most of the damage caused by the infective agent. Singapore's experience in dealing with SARS appeared to have confirmed this. Five SARS super-spreaders were responsible for the majority of the cases reported in Singapore. The transmission model of early cases indicated that accelerated identification and isolation could dramatically reduce disease transmission to secondary cases. Effective disease surveillance systems and disease transmission models are useful tools to understand the nature of the emerging diseases so that governments and agencies are able to put in place appropriate intervention measures to control and prevent the spread of the disease.

The prevention and control strategy to deal with the SARS outbreak in Singapore are divided into three essential categories: hospitals, communities, and trans-border regions. Partitioning the strategy into different areas, while maintaining a global perspective, was useful as it effectively addressed the varied needs in different risk areas.

A Three-pronged Strategy

- Prevention and control in hospitals;
- Prevention and control in the community;
- Prevention of trans-border spread.

Transparency, foreign and domestic, was vital to the Singapore Government's retention of public confidence throughout the crisis, and to restoring of economic confidence during and after the epidemic nationally and regionally. International and intersectoral sharing of best practices, and public information dissemination through the Internet and other media also contributed to Singapore's ability to remain transparent and on top of the situation.

Discussion from Session II-A: Population Mobility and Public Health

The discussion tended to question migrant health screenings as an effective means of sustaining low disease levels, addressing threats to public health, minimizing long-term costs and identifying migrants' health conditions in order to provide them with care.

Proponents of health screenings felt that screening identified some infections and could serve as a starting point for future health services for incoming migrants; thus, the first contact

between the migrant and the host country's health system. This type of screening, advertised as a means of facilitating migrant integration, ought then to assess non-infectious conditions in migrants as well, such as chronic illnesses, mental health, or mental trauma.

Others pointed out that screenings miss most cases of infection. Border checks in Taiwan detected only one SARS patient for every 1,000 people; among migrants into the U.S. less than one-quarter of TB cases is identified at border points. Protracted disease incubation periods along with measures taken by migrants to avoid detection (e.g. temporary treatment and self-medicating to conceal outward symptoms of infection) often make border checks ineffective.

Certain governments fear that ill migrants might become a strain on their national health systems. It was argued that supporting calculations misrepresented the issue by showing only one side of the equation, namely what migrants take from host governments. Migrants also increasingly contribute in a macroeconomic sense to national production and therefore income and the domestic multiplier effects, as well as taxable income to the state. Their contribution to national taxation may neutralize the public cost incurred by providing migrants with healthcare. When estimating the expense of new migrants to a country, one must also consider the potential economic, social and societal dividends migrants generate. When the costs and benefits of migration are considered from this broader perspective, the net result of investing in migrant health ought to be positive, with gains for both migrants and host countries.

Health screenings are considered useful in bolstering public support for migration. However, it is unclear whether screenings generate general support for migration through a placebo-like effect, i.e. by publicizing the country's health screening programme and thereby diminishing host country fears about receiving unhealthy migrants, or because the screenings actually detect and address ill applicants, thus generating a truly healthier migrant pool.

It was acknowledged by almost all concerned, that preserving public support is a vital, perhaps the most vital element in any sustainable migration policy. Without it, participants felt that migration programmes could simply cease to exist.

B. Managing Global Public Health: Partnerships and Developing Bridging Public Health Programmes

What are the benefits of including migrants in national and trans-national health schemes? Will this help the integration process? What public health issues confront particular groups of vulnerable people, such as trafficking victims?

Investing in Mental Health in Post-conflict Rehabilitation

Professor Ka Sunbaunat, Deputy Dean, Ministry of Health, Cambodia

The speaker detailed the mechanisms used in Cambodia to create a nationwide mental health programme, overcome patient and health-provider bias, disseminate a new service, and serve a national need. The programme pooled local and international resources, then trained, retained and distributed its new Cambodian mental health professionals throughout 12 provinces and the capital, creating a sustainable, integrated solution.

Priority Areas

- Organizational reform/ institutional development (national programme for mental health).
- Mental health human resource development (specialist, basic and primary mental health care training).
- Mental health service provision (basic and primary mental healthcare).
- Behavioural change (change attitude of mental health providers, consumers and their communities).
- Research (epidemiological study of mental illnesses).

The initiative established and developed innovative mental health services through accepted traditional venues, such as schools and primary practice offices. By using established infrastructures, the programme was able to launch the services inexpensively and in a manner directly accessible to the consumer. Advertising these through well-regarded media also conferred legitimacy to the care offered, a necessary condition for the programme's success.

Continued data collection on its care services, patient profile and distribution has allowed the programme to remain responsive to its current clients, 70 per cent of whom are women, while simultaneously identifying and reaching out to other, still under-served populations. This type of timely and relevant data collection, geared to the needs of its user, allows the programme to evaluate its current performance; assess general needs and conditions; guide corrective action or validate and promote the present approach; shape future goals and better allocate human, financial, technological, entrepreneurial and property resources.

Health as a Tool for Integration

Dr. Francisco Cubillo, Deputy Minister, Ministry of Health, Costa Rica

Migrants often experience conditions that increase their vulnerability. This overall "at risk" status can be exacerbated by disparities in health, socio-economic and education levels as can often be observed in many migrants. As individuals who have recently moved, migrants also lose family ties and safety networks and may experience mental or emotional vulnerability and low self-esteem.

The health status of migrants in Costa Rica is not on a par with that of the local population. Migrants represent fewer than 8 per cent of the population, yet account for 20 per cent of the health budget, and are still underserved.[11] Costa Rica has not yet isolated the specific factors driving this health status disparity, but it might be the result of a slightly higher initial prevalence of disease, compounded by unequal treatment and living conditions

that sustain and favour the transmission of disease. The determination of factors promoting higher prevalence rates of disease in migrants would make the better targeting of care possible.

Migrants are disadvantaged relative to the native population.

They often have a low socio-economic status with no access to either healthcare or social services.

They suffer from mental and emotional vulnerability and low self-esteem.

Provision of health services can serve to facilitate the integration of migrants into the local population.

National surveys have shown migrants to be at a disadvantage relative to the native population regarding employment, education and health. These circumstances are not formally separable into causes, e.g. deficient education and health, initial prejudice, and effects, e.g. poor wages, inferior healthcare provision and sustained discrimination. Rather, the various factors seem to mutually reinforce one another. For instance, if a bias against migrants, initially conditioned by unhealthy migrants, translates into health provider neglect, then that bias is responsible for both causing and perpetuating poor migrant health. Given the interdependence of the problems, it is hoped that efforts to improve one facet of the issue, e.g. poor healthcare, will work towards improving the conditions of migrants in other areas as well.

Costa Rican initiatives to address these issues include bilateral cooperation to immunize all children under five, and awareness programmes for the local population.

U.S./Mexico Tuberculosis (TB) Border Health Card: Bilateral TB Referral and Treatment Initiative

Dr. Stephen Waterman, Medical Epidemiologist, Divisions of Global Migration and Quarantine and Tuberculosis Elimination, CDC, USA

The U.S. and Mexico have cultivated a sense of shared responsibility and interest in migrant health. Joint efforts combating TB recognize the need for host and source country collaboration and have enjoyed high levels of political commitment from both sides of the border.

Goals of the US-Mexican Bilateral TB Referral and Case-management Project

- Ensure continuity of care and completion of therapy.
- Reduce TB incidence and prevent drug resistance.
- Coordinate referral of patients between health systems.
- Provide model for disease management.

The U.S. and Mexico created a Bilateral Tuberculosis Management and Referral Program with the aim of reducing TB incidence and preventing drug resistance through the completion of therapy, even across their border. In designing its Health Card, a focal point of the effort, the programme took into account a variety of patient concerns, so that, in its final form, the card is written in English and Spanish, and never mentions TB or the patient's name. Owing to concerns of stigmatization, the card instead records a unique ID number, lists a toll-free phone number serviceable in both countries and manned by trained personnel, contains each patient's individual record of treatment, most recent TB dose, and specific drug regimen, in a portable card format.

The programme is open to regular and irregular migrants.

The initiative is engaged in collecting and recording data on the composition, distribution, movement and follow-through of its participants. Such data will help to quantify the programme's impact and sustainability later on, as well as document its record as a potential bilateral model for controlling disease.

Public Health and Trafficking: When Migration Runs Amok

Dr. Daniel Verman, Director, Department for Programs and Coordination, the National Agency for Family Protection, Ministry of Labour, Social Solidarity and Family, Romania

Mr. Arin Pasescu, Principal Inspector, Ministry of Administration and Interior, Romania

Trafficked persons, or persons moved from one place to another for the purpose of exploitation, are a specific subset of migrants with unique concerns.[12] It is estimated that there are around 4 million people trafficked worldwide, with half a million originating from countries in eastern and central Europe.

Trafficked persons are at high risk of contracting infectious diseases; they are subject to mental illnesses, substance abuse and violence, all compounded by lack of financial resources to seek appropriate medical treatment. In that respect, trafficking has emerged as a significant global problem that warrants appropriate public health attention.

An additional concern in encompassing the problem of trafficking stems from inadequate data on the health problems of trafficked persons. This calls for increased cooperation between countries concerned by trafficking, and the consequent confidential sharing of medical information.

In its effort to combat trafficking, Romania signed the UN Convention against Trafficking in Human Beings, the Palermo Protocol, and endorsed the Brussels and Budapest Declarations. Romania has undertaken to implement the necessary policies, laws and programmes to prevent and mitigate the effects of trafficking in human beings.

The Romanian Government has adopted a national strategy to combat trafficking by establishing an inter-ministerial group responsible for public health interventions and medical assistance programmes for victims of trafficking in Romania. The programmes will provide for improved access to quality health services for victims of trafficking, sensitization and training of

health professionals to the needs of trafficked women, and culturally appropriate awareness raising campaigns.

Health Problems in the Context of Trafficking

- Mental trauma
- Physical trauma
- Communicable disease
- Violence, including sexual abuse

Discussion from Session II-B: Managing Global Public Health; Partnerships and Developing Bridging Public Health Programmes

Participants praised the initiatives undertaken by various government representatives, but emphasized the need for much more work to be done. Many specified continued collaboration between governments, and between organizations and governments, as the most effective means for meeting the health needs of migrants.

Discussion centred on the dilemmas posed by providing for the medical needs of irregular migrants, long a sticking point for many governments. Most governments acknowledge that in providing medical care to illegal migrants, they are also protecting their own citizens. However, some nations view supplying health services to irregular migrants as implicitly recognizing and condoning their presence. They often find it difficult to divorce their policing and regulatory functions from the humanitarian aspects of healthcare delivery. Governments tend to be most reluctant to provide routine or non-emergency medical care;[13] they are seldom in the position to grant amnesty to irregular migrants simply because migrants' are in a medical care context. To do so would be to create a haven from immigration enforcement that some feared could be quickly abused. Providing

full health coverage to irregular or illegal migrants would also offer a blanket-service that could be easily exploited; non-residents might travel to the area solely for the purpose of seeking free health treatment.

Countries that in fact granted health services to irregular migrants while maintaining their illegal status, have often found it difficult to convince migrants that it was safe for them to seek care, without fear of deportation, arrest, etc.[14] One participant felt that there was a unique role for non-governmental organizations to provide the necessary services because, in these instances, they are the only party migrants feel they can trust, especially regarding internal migrants who were displaced by conflict.

Others viewed the sensitivity of healthcare providers to the cultural and religious backgrounds of migrants as vital to increasing their receptiveness to treatment. One participant labelled cultural sensitivity as a necessary new component of any health system. Others were deeply impressed by the Cambodian success of de-stigmatizing and integrating mental healthcare.

SESSION III: MIGRATION AND HEALTH POLICIES

A. Investing in Migration Health

What regulations exist at the international and national level to address cross-border health? What are their objectives and how effective are they in addressing global public health? What are the policy options to improve and provide access to health and social services? What about deportation or voluntary return?

The International Health Regulations: Updates and Perspectives

Mr. William Cocksedge, International Health Regulations, Communicable Disease, WHO

More than ever before, public health and security are now global concerns. International movement serves to conduct people and goods, but it may also act as the agent of the un/intentional spread of disease.

International Health Regulations (IHR) are a necessary and vital component of any health and health-related security scheme; however, the present IHR are woefully outdated. Largely a leftover from 1969, IHR currently require international reporting

for only three diseases: cholera, plague and yellow fever, none of which would classify today as an imminent global emergency. Nor do they encourage information sharing or collaboration and they provide little flexibility in handling Public Health Emergencies of International Concern (PHEIC).

IHR Principle

The best way to prevent the international spread of diseases is to detect public threats early, with effective response actions when the problem is small.

This requires:

- Early detection of unusual disease events by effective national disease surveillance.
- International coordination as a necessary part of effective response to public health emergencies of international concern.

There is, however, a new formulation of the International Health Regulations (IHR), which effectively addresses global health and security concerns.[15] Aimed at containing known risks, responding to the unexpected, and improving preparedness, the revised IHR would, if adopted, come into force in January 2006. These IHR would standardize the protocol for the surveillance, reporting, and management of Public Health Emergencies of International Concern (PHEIC). In order to identify PHEIC, the regulations call for the establishment of National Focal Points, or at least two officials per county responsible to their respective government and the WHO for the collection, pooling and verification of information from internal and external sources, on potential health threats. Once a concern is submitted, an independent panel of experts assesses it and appropriate procedures are implemented, as necessary. This framework provides not only a vital international context for appraising global health threats, but could act as the launching point for stepped-up national surveillance as well.

The international health regulations are designed to ensure "maximum security against the international spread of disease

with a minimum interference with world traffic". Significantly, the regulations encourage sufficient capacity at national points of entry[16] and view borders as a valuable arena for the detection and containment of disease. Governmental discretion is upheld in the implementation of border health screenings as well,[17] so long as all activities respect the "rights persons may have under applicable international agreements which provide for, or protect, the rights of persons."[18]

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

Dr. Susan Maloney, Acting Chief, Immigrant, Refugee and Migrant Health Branch, Division of Global Migration and Quarantine, CDC

A dynamic relationship and interdependence exist between migration and health, and between the needs of the numerous populations involved in the migration process. Host and receiving nations must balance their own needs with those of migrant populations. In the past, these categories of needs have often, and unnecessarily, been pitted against one another. Historically, this has led to migration health policies that have focused selectively on protecting receiving nations from disease importation and costly post-migration utilization of healthcare resources through the use of quarantine and regulatory exclusion. This approach has led at times to discriminatory, inadequate and ineffective migration health programmes. Despite these policies, receiving nations remained at risk of disease importation. For migrant populations, these policies led to restricted movement, poorer health status, lack of access to necessary healthcare, ethical or confidentiality problems, and stigma and alienation in host and resettlement communities.

Major changes and improvements have been achieved in our approach to migration and health issues in the past century; yet, even today, global migration health policies contain vestiges of this exclusionary paradigm. Focusing primarily on regulatory exclusion is harmful to both migrants and receiving countries. Exclusionary statutes, particularly those enforced through identification of specific inadmissible conditions, may

inadvertently encourage migrants to conceal or temporarily treat their disease, resulting in increased migrant mortality and multi-drug-resistant diseases. Concentration on exclusion may sometimes leave host nations unprepared to deal with the health needs of those migrants whom they actually admit, raises ethical or discriminatory issues for those conducting health examinations, and can result in migrant stigma or alienation in both host and resettlement communities. Exclusionary policies, by virtue of their emphasis on the screening of individuals, also prove impractical for large or expedited caseloads and are insensitive to the changing dynamics within global health climes.

Inverting host nations' policies and perceptions regarding migration, so that statutes are inclusive and migration is viewed as an asset to be cultivated, is beneficial to migrant and host country alike. Both parties may reap the rewards of successful migration; migrants stand to gain employment, security, certain necessary services, and a new locale, while host nations profit from migrants' as diverse, economically productive, generative members of societies and communities. However, health is a necessary prerequisite for the full realization of these benefits.

Integrating Health and Migration – Achieving a Balance	
Benefits	
Receiving Population	Migrant Population
▪ Improved disease protection ▪ Better resource utilization ▪ Infrastructure support ▪ Improved health and productivity	▪ Timely and safe movement ▪ Targeted health intervention ▪ Reduced morbidity and mortality ▪ Better health care access – reduced stigma

Investing in migrants' health early on can deflect larger costs later. Realization of this has led to the U.S. Enhanced Refugee Health Program, which starts to address healthcare needs of U.S.-destined refugees while they are still overseas. The programme first ensures quality staffing and infrastructure in the field, evaluating, training and lending resources to support the capacity currently in place, where necessary.

Extending health services in the country of origin or transit allows patients to be served by health facilitators who are closer geographically and often culturally to the patients' circumstances and health needs. By providing quality healthcare prior to resettlement, the U.S. hopes to forge a positive relationship with the refugees and host and resettlement communities. Overseas intervention also decreases refugee health utilization once in the U.S., reduces treatment costs and avoids overburdening the domestic health system.

Local health interventions have included a relevant immunization regime and augmented tuberculosis, HIV / AIDS, malaria and intestinal parasite screenings, treatment and referrals. As part of the Enhanced Health Program for Liberian refugees in Côte d'Ivoire, staff were able to identify *Onong n'yong* fever, an emerging infectious disease in West Africa, prevent its importation, prevent importation of malaria, rubella and varicella, and create and transmit refugee health records to the United States for post-migratory care.

Health and Irregular Migration

Mr. Paris Aristotle, Victorian Foundation for Survivors of Torture, Melbourne, Australia

Refugees and asylum seekers often leave behind physically and emotionally distressing situations in their source nations or camps. The conditions of their respective histories generate a core array of social and psychological experiences, which take observable form in traumatic reactions.

Trauma is a condition that can radiate through all facets of life, seriously impairing a person's ability to function. The Victorian Foundation for Survivors of Terror surveyed its clients for the presence of deleterious psychological conditions and persisting medical or social needs, 18 years after resettlement.

The average prevalence rate for any one of 34 different tested conditions – from sustained employment problems to depression or disturbed sleep – was 51 per cent. Without delving into the particulars, the exaggerated time frame for which a majority of

the refugees continued to feel the impact of their trauma, manifested in a mean of 17 different ways per individual, seems at least superficially suggestive of the far-reaching, recurring effects of trauma.

Psychological Trauma

Many refugees and asylum seekers experienced psychological trauma in their source nations or camps.

The impact of such trauma can manifest itself in many different ways.

Health services provided for this group of migrants should address these issues.

There are the means of addressing refugee and asylum seekers' trauma, and to the best of our ability, we need to do just that. Inaction has serious negative consequences, exacted in human suffering and maladjustment. Governments and other involved parties ought to sincerely investigate the nature and extent of their obligations to refugees, and assess whether the environment and tenor of their current services are in accordance with their obligations.

As the developed world increasingly invests heavily in allowing people to move, policies encourage the opposite. Return migration – preventing people from moving permanently – is widely advocated by the same countries and individuals that are busy making the world smaller and facilitating high volume and more accessible means of movement. In the field of movement and the stance of return, there appears to be some dissonance between what our investments do and what our policies say.

Health and Return Migration

Dr. Eva Louis Fuller, Director, Cooperation in Health Policy Analyses, Ministry of Health, Jamaica

Many of the considerations introduced concerned migrants' health issues raised in the context of return. The migration of asylum seekers and the risk of the spread of disease to the host country were also briefly considered.

Return Migration

Return migration is the movement of a person returning to the country of origin or habitual residence, after spending at least one year in another country. This return may be voluntary, or imposed by an expulsion order.

Return migration includes voluntary repatriation.

To some extent the poor health status of migrants is an outgrowth of divergent national conceptions and policies regarding how and when governments become responsible to these individuals.[19] Thus, the intersection of migration and health cuts to the core of a larger and still unexplored discussion on the mechanisms that obligate states to provide personalized health services.

International legislation mandates the right to health for all individuals,[20] presumably achievable only through the provision of a certain minimum level of healthcare. Thus, in principle, all nations agree that everyone has a right to basic health services. There is disagreement over the application rather than the validity of this precept, as nations employ different protocols to determine which parties are responsible for providing person-specific care.

Many health-related migration misunderstandings are the result of migrants linking two nations that endorse divergent models of how and when countries are responsible for the health and safety of individuals. This can result in unequal burden-sharing among the countries concerned, in migrants, particularly irregular migrants, simply falling through the cracks in the divergent systems because they are not eligible to receive health service from either nation, and in individuals exploiting policy differences in the countries concerned for their own benefit and to the country's detriment.

There are **three different legislative responsibility models** currently in use **to determine a country's healthcare obligations toward migrants**.

The host nation: based on the territorial responsibility model, where states are responsible towards all individuals, legal or irregular, within their national boundaries.

This view finds expression in Costa Rica, where, according to Dr. Cubillo, everyone within the country's borders receives free medical care. In Jamaica, free medical care and other social services are also available, but the question arises as to the level to be provided for immigrants and returnees relative to the level of care available to nationals.

The source nation: based on a contractual obligation, where citizenship is the exclusive determinant for healthcare responsibility; e.g. non-emergency national healthcare is provided only for citizens.

Where a relationship between the migrant and the country is established: this occurs when either a sending or receiving country benefits from, or harms the individual.

The speaker advanced this type of joint source-destination responsibility model as the most equitable burden-sharing option, proposing that its more nuanced categories would better manage those emigrants who, for instance, left their country of origin as infants, adopted criminal or pathological behaviour in the host country and were deported to the source country, or who spent all their productive years in the country of destination, and return home with high medical costs in their old age.

Widespread pension and / or social security provisions of host countries that restrict receipt of payment to those living within their national borders, further complicate inter-country health coverage issues. They may also place an undue burden on developing nations, which often reabsorb their emigrated citizens once they retire. Developing countries, which may not have benefited from the worker's productivity, are forced to fund these older returnees' health bills which often means a net capital loss for the source nation per emigrated individual.

Discussion from Session III-A: Health and Migration Challenges

Participants invoked the need to assist vulnerable migrant groups. Their needs are real, one participant urged, and responsibility for migrant care is a joint world concern. All types of migrants are vulnerable, though one participant, citing the Berlin Charter,[21] voiced particular concern for returnees, internally displaced persons, refugees, asylum seekers, irregular migrants and trafficked persons.

Another participant felt that policy and discussion emphasizing the utility or no of health screenings for incoming migrants had unduly averted the discussion's focus from the health needs of already settled migrants. Often marginalized and living in poor sanitary conditions, the health needs of resident migrants need to be addressed by governments and all types of organizations.

It is important to address the question of national responsibility and avoid double penalization of migrants and source countries. Returning migrants may also bring back diseases. For instance, in the 1960s, the return migration of single workers from Europe is linked to the increase in the prevalence of certain diseases upon their return to their countries of origin.

Efforts should shift from a migration-health paradigm of exclusion to one of inclusion. The fact that only a small percentage of migrants have the possibility to access medical care underlines the need for a new healthcare system consistent with current demographics and the WHO goals for universal health. Programmes should include multiple language health providers, public information on disease prevention, as well as therapy and mental health services to asylum seekers and other migrants. Health should be viewed as a necessary prerequisite for the integration of migrants.

Migration and health issues must be dealt with in terms of co-responsibility rather than exclusive responsibility. One should emphasize the complementary aspects of most migration-health

responsibilities. For instance, IOM works with the WHO, and many present at this conference believe in the need for co-responsibility for these important global issues.

B. Migration of Healthcare Workers

What are the issues related to the migration of healthcare workers? What are the country experiences in managing the migration of healthcare workers? What are the different policy options available to countries to deal with workforce mobility?

Global Overview of Migration of Healthcare Workers

Mr. Orvill Adams, Director, Department of Human Resources for Health, WHO

The factors that drive general migration have encouraged and sustained the movement of healthcare workers from developing countries. This can be easily observed in national immigration schemes with, for instance, over 13,000 nurses and over 4,000 physicians emigrating to the U.K. in 2002 alone.[22] As education programmes converge and the job market for highly skilled labour expands to cover the entire globe, such labour migration is likely to continue.

Overall migration flows are increasing and likely to do so in the future.

Trade agreements are removing barriers to labour flows between countries.

Gap between standards of education is narrowing.

There is a global labour market for certain categories of health workers.

Developing countries tend to take a negative view of the drain of their health professionals; as an opportunity lost, where the government invested time and money to train individuals who subsequently emigrated. It is also often construed as undermining the national capacity to care for the local population; first, by attracting a large percentage of its skilled personnel and, second,

by leaving those who remain severely understaffed so that morale drags and work appears insurmountable. On the positive side, remittances do mitigate some of the financial drain experienced, though they are not necessarily channelled specifically back into the healthcare system.

By underestimating the value of community health workers, the current data relating to the need for healthcare professionals could be overstating the need of developing countries. Often not accounted for in health surveys, these caregivers serve certain local populations, and an analysis of the shortage of health workers that does not take their presence into account, risks being skewed.

Developing countries interested in managing their shortage of skilled health workers may work on facilitating return migration, pooling the resources of the diasporas, and training personnel oriented exclusively to local needs – though instituting a deliberately incomplete curriculum could backfire by impeding workers' ability to efficiently serve their own country as well. Collaborative intercountry schemes could include the drafting and adoption of bilateral agreements as well as advocate the creation and adoption of binding ethical recruitment guidelines to reduce or prohibit emigration from severely underserved countries.

Using Bilateral Arrangements to Manage Migration of Healthcare Workers: The Cases of South Africa and the United Kingdom

Ms. Daisy Mafubelu, Health Attaché, Permanent Mission of South Africa to the UN, Switzerland

Surveys show that both push and pull factors are behind the emigration of South African healthcare professionals. Push factors such as a sense among workers of geo-political and economic uncertainty in South Africa and perceived and real job-related concerns, including poor working conditions, lack of professional growth opportunities, poor salaries, overworking and understaffing caused indirectly and directly by HIV / AIDS, with some personnel dying from the disease and others, if not sick

themselves, called on to care for infected family or friends, contribute to the general push factors and desire to emigrate.

Among the external pull factors leading workers going abroad are aggressive recruitment strategies, tax exemptions, study opportunities along with the health professionals' own desire for career development and personal and familial advancement:

International Migration of Healthcare Workers	
Push Factors	Pull Factors
Economic ▪ Perceived levels of salaries ▪ Exchange rates ▪ Perceived crime rate ▪ Perceived economic security ▪ Uncertainty about future	Economic ▪ Possibility to improve financial status ▪ Aggressive recruitment ▪ Tax exemptions ▪ Ability to settle debts ▪ Possibility of constituting a nest-egg
Political ▪ Perceived crime rate ▪ Perceived economic security ▪ Uncertainty about future	Social ▪ Personal security and stability ▪ Better educational opportunities for children
Job Related ▪ Conditions of service ▪ Overworking ▪ Understaffing ▪ Lack of opportunities for professional growth and development ▪ Environment not conductive to productivity	Career Opportunities ▪ Professional career development ▪ Study opportunities

South Africa has employed a broad range of strategies to retain its healthcare workers and is concurrently researching, monitoring and evaluating the success of such programmes. The strategies include:

- Improving salaries and conditions of service
- Rural staffing plan
- Incentives to work in rural areas
- Migration and retention strategy
- Strategy to manage scarce skills
- Contract-based overseas training
- Opportunity risk study
- Training of middle-level workers
- Exchange programmes in the SADC region and beyond
- Strategies to attract returning emigrants
- Co-sponsor WHA resolution on international migration
- Commonwealth Code of Practice for the International Recruitment of Health workers
- Intergovernmental agreements to manage recruitment.

South Africa and the United Kingdom have recently concluded a resolution on the international migration of health personnel. Predicated on the principles outlined in the World Health Assembly,[23] the memorandum is designed to institute two-way time-limited exchange placements; share information, advice and expertise, and cooperate on health education and workforce issues. It will also be used to cover areas of staffing shortages, such as rural regions in South Africa, or comparable positions in the U.K.

Using Bilateral Arrangements to Manage Migration of Healthcare Workers: The Cases of the U.K. and South Africa

Mr. Rob Webster, Director of Workforce Capacity, Department of Health, England

International recruitment (IR) is appropriate, if conducted ethically. To that end, England was the first developed country

to devise a Code of Practice for ethical recruitment that prohibits the NHS from recruiting from specific developing countries, and protects those workers who do emigrate under U.K. law. Moreover, international service is often a unique, positive opportunity for individuals and nations to develop and cultivate skills, experience and training.

Difficulties in retaining health workers are not exclusively a problem in the developing world. Instead, it is symptomatic of a global shortage of healthcare professionals, where world demand has outstripped world supply. The ramifications of this shortage are felt in the developing world, but are also evident in developed nations such as the U.K., with large numbers of professionals migrating to countries such as the U.S. and Australia. Working towards retaining professionals has become a constant struggle.

In the U.K., successful skill retention programmes have been based on improving "soft" incentives as well as "hard" salary levels. Improving career expectations and options, valuing professional status, and benefits such as on-the-job childcare and flexible working hours have made a significant difference, whereas single strategies based on pay and contractual obligations have not.

International recruitment can be a positive force for individuals and for the developing world. Any negative effects of IR are the result of current context, or the global shortage of healthcare workers. Although inter- and intra-national efforts may help in managing healthcare worker emigration, they do not address the root problem of global shortage.

These themes are clearly part of the World Health Assembly Resolution 57.19: "International migration of health personnel: a challenge for health systems in developing countries". The UK is in a good position in relation to the resolution. Progress still needs to be made, but the UK, through its Memorandum of Understanding with South Africa, for example, can help to demonstrate good practice in this area.

WHA 57.19 Sets the Context

Strategies to mitigate adverse effect of migration (in Member States).

Strategies that could enhance effective retention of health personnel (in Member States).

Set up government-to-government agreements.

Establish mechanisms to mitigate the adverse effects on developing countries, in particular, HR development.

Using the Diaspora to Strengthen Health Workforce Capacity

Professor Ken Sagoe, Director of Human Resources Department, Ministry of Health, Ghana

Emigration and poor initial capacity has left Ghana with an acute shortage of health professionals. This, in turn, overloads the personnel that remain, decreases staff morale, creates poorly manned or unmanned facilities, and generates overall poor service, culminating in the public's loss of confidence in the healthcare system.

Ineffective healthcare in a country rife with disease has seriously impeded the ability to create sustainable development options. As always, a minimum health level is a prerequisite for full productive potential to be actualized.

Joint Ghana-IOM surveys suggest that the international landscape is ripe for the mobilization of the following groups:

- **The Diaspora**: When questioned, the Ghanaian diaspora was sympathetic toward the state,[24] and most physicians expressed willingness to help improve what they view as Ghana's poorly resourced health system. Complementary efforts by the state to harness this potential would link the diaspora with NGOs to support local communities to create twinned facilities staffed by the diaspora; further cultivate remittances and other individual donor efforts, and devise a governmental website/database to update and inventory Ghanaian professionals abroad.

- **The International Legal Community**: Global and media interest have made pertinent many of the issues surrounding the migration of highly skilled individuals, while development of regional and international codes of practice for ethical recruiting have established viable, binding prototypes that may serve as a springboard for future efforts.

- **Other Concerned Stakeholders in Developed Nations**: Initial studies indicate the "intense interest" and "goodwill" of all stakeholders to contribute to healthcare development in Ghana.[25] With continued Ghana-Netherlands partnership, this ought to translate into the inter-country transfer of medical knowledge, short-term internships for Ghanaians, and a maintenance centre for Ghanaian medical equipment.

MIDA Ghana – Netherlands Healthcare Project I

Project objectives:

- To transfer knowledge, skills and experiences through short-term assignments and projects.
- To facilitate short practical internships for Ghanaian Medical residents and specialists in the Netherlands.
- To develop a centre for the maintenance medical equipment in Ghana.

Project supported by the Ghanaians and the Dutch governments, and Ghanaians and West Africans living in The Netherlands.

MIDA-Ghana – Netherlands Healthcare Project II

- Indicates strong interest and goodwill by all stakeholders to cooperate with IOM to contribute to healthcare development in Ghana.
- Advises the use of existing functional network of professional or national associations.
- Ghanaian Government must facilitate the process of reintegration of the diaspora.

MIDA Ghana – Netherlands Healthcare Project III

- Mobilizes the diaspora in the Netherlands, North America, the UK and Germany.
- Currently funded by the Dutch Ministry of Foreign Affairs. More funding is required.

Exporting Health Workers to Overseas Markets

Professor Binod Khadria, Professor of Economics and Chairperson, Zakir Husain Centre for Educational Studies, School of Social Sciences, Jawaharlal Nehru University, India

Before passing judgement on the value of a phenomenon, one must seriously analyse its effects. For instance, the emigration of healthcare workers, regarded as painful brain drain by many, has the potential to act as a positive, restorative force. When a source country's gains from the out-migration of its highly skilled workers surpass its losses, then the phenomenon could be said to constitute a net positive effect.

Positive Effects of Emigration for a Source Country:

- Money – in the form of remittances, bank transfers, or portfolio investments.
- Machinery – through technology transfer and know-how.
- Manpower – through the return, exchange or visit of emigrant skilled workers.

The necessary condition of a worldwide presence of one's nationals could therefore be supplemented by a sufficient condition for that nation's successful, win-win globalization. However, for the migration of skilled workers to constitute a net positive effect, it must recover the losses incurred through the migration of human capital. These losses include: (a) the skills or technology embodied in the emigrant, and (b) the associated investment in education.

Employing the above mechanisms, the speaker pointed out some approximate calculations of these effects of the emigration of Indian knowledge workers on the source nation.[26] He determined that an international presence of Indian professionals had not meaningfully recuperated the nation's loss of skills and investment, nor increased the *average productivity* of the domestic workforce remaining in India.

In India, lately money is primarily sent home by the unskilled and semi-skilled workers, and not by the majority of those high-skill workers whose families have joined them abroad. Moreover, remittances tend to be used not for development but mainly for consumption, financing of dowries or home construction. Also, wherever it had begun to be directed into educational investment, most of it resulted in a reverse flow of remittances to the developed destination countries in the form of overseas student fees.

Similarly, technology transfer by Indian expatriates has not been well managed, and most of the technology returned to the source country had been relatively old and outdated. Likewise, the return of manpower or the restoration of national expertise was not substantial, and most returnees decided to work in multinational corporations located in India. On the whole, the out-migration of Indian skilled workers – whether professionals or students – i.e. the fully formed or the semi-finished human capital, respectively,[27] cannot be said to have satisfied the sufficient condition of deriving significant gains for the source country, though it might have satisfied the necessary condition of their global geo-economic presence, for the phenomenon to be called a successful win-win globalization.

Return to the source country – whether through temporary or circulatory migration – when involuntary, can turn entire family units into nomadic units, which do not fully belong in either locale. As such, it is potentially best categorized as forced migration.

Return migration also undermines many of the long-term, positive results that make expensive migrant healthcare a worthwhile investment for host countries. However, it is beneficial for receiving countries in that it acts as a safety valve to empty immigrant communities to reduce racial tensions, if necessary, and provides labour replacement at low cost, at the same time correcting the ageing profile of the population with younger immigrant workers on the one hand, and acquiring the latest vintages of knowledge and technology embodied in the younger generations, on the other.

Discussion from Session III-B: Migration of Healthcare Workers

Participants felt the emigration of healthcare workers to be a negative phenomenon that needed to be redressed through national and international collaboration. Many stated that the emigration of a significant number of a country's healthcare workers could lead to the potentially serious domestic shortage of health personnel. This shortage further exacerbated servicing problems for remaining healthcare workers and difficulties in maintaining the delivery of national health services. These shortfalls, occurring in a priority development sector such as health, reduce national output through the emigration of productive, developed human capital and through the weakened health capacity available to the resident population, impeding the ability to work to full potential. External input is also discouraged since neglected or unhealthy workers are less capable of attracting foreign direct investment into the country. Emigration of the highly trained, most productive members of society also erodes national income tax collection that, in turn, could make the financing and training of more healthcare workers difficult.

Some delegates proposed compensation schemes, where developing countries would be reimbursed for their education and training expenses, or awarded "transfer fees", upon emigration of their health professionals. However, the practical implications of such proposals was questioned during the discussions. There are multiple beneficiaries of the continued mobility of health professionals, including the individual, family members, the developed host nation, the developing source nation, the recruitment agency, hospital, and those served. Among this tangled web of stakeholders, it would be extremely difficult to isolate and obligate a party responsible to reimburse the developing nation's training costs. There are also divergent interests at play, which are not readily reconcilable. Often, an individual interest in the well-being of self and family can be at odds with the society's interest to benefit from its trainees. Furthermore, developed and developing countries also have conflicting concerns. Compensation plans also presume that

nations would be willing to repay debts of human capital that they may not agree that they owe. Even if agreed to in theory, national bans on the migration of specific immigrant categories still pose difficulties in implementation; in Canada, for example, despite setting the 1989 entrance rate for foreign doctors at zero, a significant number of doctors were able to immigrate into the country through family reunification, new marriages, or as refugees.

Panellists and participants also stressed the mechanisms through which a country's international human presence could be turned to its own advantage. A skilled diaspora may be used to promote networks for national trade, tourism and investment, while its temporary return may confer needed services or development and encourage the local community.[28] It may also be harnessed as a source of donor capital or private remittances in the form of currency, technology or household goods. Workers' remittances should not be underestimated; they represent a relatively stable, substantial monetary inflow to developing countries, second in size only to foreign direct investment.[29] Though primarily private and family funds, remittances may be used both for welfare and growth promotion in developing countries.

The migration of highly skilled workers, including healthcare professionals, has the potential to be a positive force for both individuals and world communities.[30] Although international and national efforts may help deliver healthcare workers and services more evenly worldwide, these efforts still do not address the root cause of understaffing, viz. global shortages. If a sufficient number of individuals per annum were trained and prepared to work as healthcare personnel, then, although mobility and differentially desirable postings would persist, the current crisis and its associated problems would dissolve.

Some participants observed that a truly sustainable solution to the uneven emigration of healthcare workers must address the issue as expressing a global shortage of healthcare professionals. In order to correct the disparity and the resulting acute need, we must pick up the difficult task of training and motivating enough healthcare workers to care for the world's growing population.

SESSION IV: THE WAY FORWARD

A. What is Foreseen for the Future?

What progress might be feasible? Can we work towards healthier migrants and healthier societies?

HIV/AIDS and Population Mobility – Where to Go from Here?

Dr. Telku Belay, Head of Advocacy, Mobilization and Coordination Department HIV / AIDS Prevention and Control Office, Ethiopia

Since its outbreak, the HIV / AIDS epidemic has spread within and across national borders. There are now 42 million people infected with HIV, and 27.9 million more have already died. These numbers should serve as a reminder of the need for vigilant containment efforts in the early stages of any outbreak, and particularly in the context of the mobility of people.

The need for early intervention should impel every one of us to immediate and concerted actions to control the spread of HIV infection; without that, the epidemic and the human cost for individuals, family and communities, as well as the economic costs will continue to escalate. Identifying populations that are more vulnerable to HIV infection is a way to reducing its spread through preventive education and offering more effective care tailored to groups' needs.

Migrants with different linguistic, cultural, economic, racial or religious orientations from their host communities may be in particularly vulnerable conditions, subject to discrimination, xenophobia, exploitation or harassment. Specifically, undocumented or irregular migrants, internally displaced persons as well as refugees, mobile workers stationed far from home, and migrants in a country of transit are at higher risk of HIV infection and related death.

Migration, Mobility and HIV/AIDS

Migrants and mobile people become more vulnerable to HIV/AIDS. By itself, being mobile is not a risk factor for HIV/AIDS. It is the situations encountered and behaviours possibly engaged in during the mobility or migration that increase vulnerability and risk. Migrant and mobile people may have little or no access to HIV information, prevention (condoms, STI management), health services.

The vulnerability of undocumented migrants is exacerbated by their illegal and clandestine condition. They often live on the margins of society, try to avoid contacts with authorities, have little or no legal access to prevention and healthcare services, and may be unaccustomed to contacting non-governmental organizations there to help them.

Possible Solutions to Manage Migrants' Health: Thailand's Perspective

Dr. Chat Kittipavara – Health Supervisor, Bureau of Inspection and Evaluation, Office of the Permanent Secretary, Ministry of Public Health, Thailand

Healthcare for irregular migrants is a politically charged and controversial issue. On the one hand, governments have an interest in protecting their own citizens from public health risks by insuring health coverage to everyone – including irregular migrants – inside their territorial limits. However, supplying even rudimentary care to irregular migrants is often construed as undermining legal migration channels and rewarding irregular movements.

The Royal Thai Government has implemented a massive irregular migrant registration programme aimed at the estimated 1 million undocumented migrant workers inside the Kingdom. Advertised in the migrants' three principal languages and promulgated through consenting employers, undocumented workers who register are granted the right to primary and reproductive healthcare, communicable disease control services, a health examination and a work permit, in the hope of thus taking care of migrants and reducing their exploitation as well as the risk of contagion. By supplying shareable information concerning a large segment of the population, it is likely that the programme will prove useful to other ministries as well.

Solving Migrant Health in Partnership

Thailand's Ministry of Public Health (MOPH) works in partnership with IOM and WHO to tackle migrant health issues:

- IOM-MOPH migrant health project since 2000.

Provision of primary healthcare, reproductive health and communicable disease control services for migrants and host communities.

- Thailand MOPH collaborates with WHO on a Border Health Programme. This includes:
  - Multi-agency collaboration,
  - Support to provincial health coordination meetings,
  - Capacity-building skills at the provincial health level,
  - Improved data collection in the border area,
  - Development and dissemination of a standardized multi-lingual maternal and child health record booklet for use in the boarder areas.

Population Mobility and Health Crises in Conflict Situations

Dr. Mohammad Al Sharan, Director, Department of Emergency Medical Services, Ministry of Health; Chairman, Patients Helping Fund, Kuwait

Individuals and entire communities in conflict situations are often sidelined and deprived of health services.

This can be particularly painful when the conflict itself exacerbates their need for care.

Kuwaiti experience has found that there are four principal means of delivering healthcare to individuals or communities in conflict situations. The method employed has marked effects – on donors, recipients and local populations. Thorough understanding of each possibility, informed by an appreciation of the dis / advantages of all four models, should help illuminate many of the recurring tensions that confront donors who deliver personnel-intensive humanitarian aid to populations from, or in, insecure or unsafe locales.

Four ways of delivering healthcare to individuals or communities in conflict situations:

- Providing ***health services in the underserved population's homeland*** is generally advantageous for the recipients, though difficult to execute and sometime risky for the suppliers. Local delivery tends to improve the general health system, supply new equipment, train local staff, create job opportunities, benefit more people, uphold family units and address a larger spectrum of health concerns, while avoiding costly transportation, immigration procedures, and unpleasant refugee status. However, supplying medical services in the country of conflict may be complicated by security and control issues, such as safety risks for the staff, difficulty of transporting and storing supplies, politically impeded distribution, and the theft or sale of medicines.

- Conversely, when ***healthcare is supplied in the country of refuge,*** both the primary advantages and disadvantages tend to accrue to the local population, i.e. the community not involved in the conflict. The local people may benefit from refugee

facilities; however, the increased caseload may strain their health system or capacity, or create friction between the two communities. Immigration difficulties may also prove an encumbrance in moving those in need.

- ***Services provided in the donor country*** are relatively easy to facilitate, allowing the safe, free provision of care within an already established system, without endangering donor personnel in the potentially volatile conflict region or necessitating substantial initial outlays for new infrastructure in the conflict-ridden nation. However, care in the donor country also severs patients from their families, a circumstance which can increase vulnerability at home and prove a source of aggravation for those being treated abroad.

- ***Third-country treatment*** often proves beneficial for the individuals receiving treatment, but is by no means a comprehensive solution. When feasible, its advantages include ease of access, availability of specialty care and increased patient comfort, inspired by close geographic, cultural and linguistic ties. However, under this type of arrangement, close monitoring by the sponsoring, donor nation may not be possible, and it is likely to work only for a limited number of specific cases.

Discussion from Session IV-A: What is Foreseen for the Future?

The discussion brought out many of the implications stemming from migrant stigmatization and underscored the need to maintain public support for migration.

Maintaining public support for migration is, in fact, one critical part of administering healthcare and other services to vulnerable migrant groups. One participant labelled this a “global concern”.

Local bias stigmatizes migrants and may be used as an excuse by host communities to supply inferior care (e.g. health services or education),[22] impede integration, segregate neighbourhoods, restrict migrants' career and educational mobility and ultimately act as a socially and economically indenturing force. National bias may also jeopardize existing migration schemes where constituent approval is needed for the implementation of migration programmes. Bias is also an active, self-perpetuating force, sustaining migrants' negative conditions and thus allowing for bias to continue.

The factors that tend to generate prejudice towards migrants include, but are not limited to, health issues. A host population's bias may stem from real and perceived fears that migrants constitute a threat to the health, safety, security or cultural integrity of the local community. Participants also worried that migrants may be a fiscal threat – overburdening social security and state-sponsored health insurance plans, receiving better health treatment than is available to the host community, and an economic threat – depressing minimum wages, increasing competition and unemployment rates.

Local concerns that sustain prejudice against migrants need to be competently and appropriately addressed; some require analytical data-based responses,[23] and others would be better served through informational or positive awareness campaigns.[24]

Participants recommended approaches to minimize local bias, using Dr. Al Sharan's third example, or providing medical care in the country of refuge, as a template.

Their suggestions included:

1. Permitting members of a local community to partake of health services provided in a local refugee camp.
2. Employing local community members to work in a refugee camp.
3. Recruiting locals to be involved in and to contribute their skills to a refugee aid effort.

Other areas of discussion depicted migration, or the globalization of the movement of people, as the corollary of the globalization of capital and markets. One participant emphasized the importance of bridging cultural gaps between the recipients and providers of healthcare. Another reminded the conference of the needs of irregular migrants, warning that ignoring their health concerns is simply not viable. Still others highlighted the rights of older migrants who migrate from the developed to the developing world, stressing their right to healthcare until the end of life, to die in dignity, and to own sufficient financial means.

B. Where Can We Go from Here?

Closing Remarks on the Theme "Benefits of Investing in Migration Health"

Dr. Danielle Grondin, Director, Migration Health, IOM

Migration and human mobility are a fact of modern life. We can't stop movement and don't want to as the movement of people is essential in today's more global economy. As people move, so they connect individual and environmental health factors from one country to another. Here too the issue is not to stop movement but to manage the health implications and opportunities.

Well-managed migration health, including public health, promotes understanding, cohesion and inclusion in mixed communities. It can be a tool to facilitate integration of migrants within communities, to stabilize societies, and to enhance development. At each stage of the migration process, from the decision to migrate, to the journey itself, through reception and integration in a new community and to return to the country of origin – the physical, mental and social well-being of individual migrants, their families and their communities need to be considered in policy making and practice. The promotion of healthy living conditions for everyone implies the establishment of public health policies and practices that would integrate all

members within communities, regardless of citizenship and the migration status.

Here, we are speaking of a paradigm shift – of a change in the way we think about health and mobility. Why so? Migrants in a state of well-being will be more receptive to education and employment, and be more inclined to contribute in the fabric of the host societies. Migrants not perceived to be a health threat to host societies would be less exposed to discrimination and xenophobia, and be more likely to be included as equal participants in communities. A well-managed approach to migration health presents opportunities for improving global health, including global public health, and understanding, for the benefit of all societies.

Action Points

Dr. Danielle Grondin, Director, Migration Health, IOM

This is a time of real opportunity in migration health and we must seize it. First, this seminar was dedicated to creating understanding, to no longer considering migration and health as two isolated domains, but health as an integral part of migration.

- One action point is for each of us, in our respective roles and responsibilities, to commit ourselves to promote and advocate the integration of health issues in the various aspects of migration we are called upon to deal with, such as students, business people, asylum seekers, refugees and returnees.

- Second is the need for a commitment to partnership and of related co-responsibilities, as illustrated by some of the topics discussed.

- Partnerships between governments – the opportunities provided for under bilateral agreements to manage the mobility of health workers, and to promote cooperation in the economic and, more

generally and importantly, in the areas of public health, social and development.

- Partnerships between organizations at the community, national, regional and international levels.

- For its part, IOM is committed to continue the catalytic role of highlighting the importance of comprehensive approaches to migration health, and to bring together the relevant stakeholders, as we have done here this week as a first step.

Dr. Orvil Adams, Director, Department of Human Resources for Health, WHO

Migration and health are multi-stakeholder issues that concern governments, non- and intergovernmental organizations, and UN agencies alike. Efforts like this forum, that draw on the diversity of resources, expertise and perspectives of the many players involved, deepen everyone's understanding and help to forge a common vision that may be drawn upon later, beyond the context of this discussion. Our collective vision seems to centre on the need to manage migration in a manner sensitive to the health objectives of source countries, receiving countries, and the migrants themselves. This goal must be advanced through rigorous research that directs, informs and impels our action.

Dr. Susan Maloney, Acting Chief, Immigrant, Refugee and Migrant Health Branch, Division of Global Migration, CDC

Migrants move across global frontiers, thus the discussion of health and migration is, of necessity, a global one. The issues we have identified and discussed at the conference highlight the essential need for host and receiving countries to collaborate, to address both national interests and global public health concerns. It is my hope that there will soon be a permanent forum for governments and agencies to discuss and negotiate their positions and concerns, and to work towards improving the integration and harmonization of migration and health policies.

Discussion from Session IV-B: Where Can We Go from Here?

Migration is, and will remain, a fact of life. This workshop represents an international dialogue on policy concerns. Though management of migration is mostly the prerogative of national governments, it is clear that we improve our understanding and awareness if we strive towards better and better coordinated cooperation. The IOM International Dialogue on Migration series, launched in 2001, is intended to bring together all stakeholders, identify areas for goal-oriented collaboration and cooperation. However, the ultimate aim is not a new binding legal framework.

Migration and health issues are a component for full integration into society. Migration can be a fundamentally positive experience. However, that is not possible without a serious investment of resources, planning, personnel and more. The cross-sectoral approach used here has highlighted many of the benefits of managed migration and investing in a migrant's health.

Cooperation must be continued. The seminar has underscored the need to systemize healthcare workers' preparation to handle migrants' health – i.e. the varying cultural, linguistic and religious profiles of migrants.

Almost everyone would agree that there are benefits to investing in migration health. The challenge is how to realize those benefits, and how to highlight them. This dual challenge involves the informing of public opinion through public education, and developing and underpinning understanding through research and analysis. In order to systematically approach research, one should consider the health objectives of: (a) the receiving and sending societies; (b) migrants in the receiving societies, and (c) those who remain in their original economies and countries.

Three main points taken from the seminar include the need to: (a) address economic globalization as it increases flows of labour migrants; (b) improve information and exchange between

countries, and (c) apply policies without neglecting the conditions of the local population.

Thus, there is a continual need to consider the social, cultural, and religious aspects of migrant healthcare.

Annex 1: Further Reading

International Organization for Migration

2003 *World Migration 2003*, Geneva.

2003 Position paper on psychosocial and mental well-being of migrants.

2002 Position paper on HIV / AIDS and migration.

IRCRCS

2002 *The Berlin Charter*, available from www.ifrc.org / meetings / regional / europe / berlino2.

United Nations

1948 *Universal Declaration of Human Rights*, Article 22, Article 25, available from www.UN / overview / rights.html

1993 *Return Migration Profiles, Impact and Absorption in Home Countries*, United Nations Economic and Social Commission for Western Asia.

2000 *United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime.*

UNAIDS

2001 *Migrants' Right to Health*, USAID, Geneva.

World Health Organization

1946 Preamble to the Constitution of the World Health Organization, as adopted by the International Health Conference, New York, 19-22 June, 1946; http://www.who.org/about/definition/en/.

2003 "International migration, health and human rights", *Health and Human Rights Publication Series*, Issue(4), December 2003.

2004 Intergovernmental working group on the revision of international health regulations, Working paper, 12 January 2004, available from http://www.who.int/csr/resources/publications/IGWH_IHR_WP12_03-en.pdf.

2004 *International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries*, WHO, Geneva.

Annex 2: Useful Definitions

Useful Definitions

Various Practices and Types of Migration

Return migration – the movement of a person returning to his/her country of origin or habitual residence after spending at least one year in another country. This return may or may not be voluntary, or result from an expulsion order. *Return migration* includes voluntary repatriation.

Forced migration – the non-voluntary movement of a person wishing to escape from armed conflict or a situation of violence and/or the violation of his/her rights, or a natural or man-made disaster. This term applies to refugee movements, movements caused by trafficking and the compelled exchange of populations among states.

Irregular migration – the movement of a person to a new place of residence or transit using irregular or illegal means, as the case may be, without valid documents or carrying forged documents. This term also covers trafficking in migrants.

Orderly migration – the movement of a person from his /her usual place of residence to a new place of residence, in accordance with the applicable laws and regulations governing exit of the country of origin, and travel, transit and entry into the host country.

Smuggling of migrants – this term describes the procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a state of which he/she is not a national or a permanent resident. Illegal entry means the crossing of borders in violation of the requirements for legal entry into the receiving state.

Total migration/net migration – the sum of the entries or arrivals of immigrants, and of exits, or departures of emigrants, yields the total volume of migration, and is termed *total migration*, as distinct from *net migration*, or the migration balance, resulting from the balance between arrivals and departures. The net immigration balance, or positive migration balance, refers to arrivals exceeding departures, and net emigration, or negative migration balance, to departures exceeding arrivals.

Useful Definitions (cont.)

Trafficking in persons – this term refers to the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation includes, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.

Re-emigration – the movement of a person who, after returning to his/her country of departure for some years, leaves again for another stay abroad, or another destination.

Annex 3: Agenda

IOM International Organization for Migration
OIM Organisation Internationale pour les Migrations
OIM Organización Internacional para las Migraciones

IOM's International Dialogue on Migration
Co-sponsored by WHO and CDC

SEMINAR ON HEALTH AND MIGRATION

9-11 JUNE 2004, INTERNATIONAL CONFERENCE CENTRE, GENEVA

AGENDA 9TH JUNE 2004	
08:30-10:00	**Registration**
10:00-10:30	***Chair:*** *Dr. Danielle GRONDIN, Director, Migration Health, IOM.* **Opening remarks** *Mr. Brunson McKINLEY, Director General, International Organization for Migration (IOM).* **Welcome comments from the co-sponsors**: *Mr. Orvill ADAMS, Director, Department of Human Resources for Health, World Health Organization (WHO).* *Dr. Susan MALONEY, Acting Chief, Immigrant, Refugee and Migrant Health Branch, Division of Global Migration and Qurantine, Centers for Disease Control and Prevention (CDC), USA.*
10:30-13:00	**Session I: HEALTH AND MIGRATION CHALLENGES**
	What is contemporary migration? Why should health be considered in the context of migration? What are the key challenges from a global perspective? What is at stake from both a health and migration perspective? Why should we care? ***Commentator***: *Ms. Michele KLEIN SOLOMON, Deputy Director, Migration Policy and Research, IOM.* ***Topics and Speakers:*** **Migration perspective**, *Ms. Diane VINCENT, Associate Deputy Minister of Citizenship and Immigration Canada (CIC), Canada.* **Health perspective**, *Dr. David HEYMANN, Representative of the Director General for Polio Eradication, WHO.* **Bridging health and migration**, *Dr. Danielle GRONDIN, Director, Migration Health, IOM.* *Discussion*

15:00-18:00	Session II: PUBLIC HEALTH AND MIGRATION
15:00-16:20	***A. Population mobility and public health*** What is being done to address the impact of population mobility on public health? Why do we care? What lessons can we learn? What needs to be done? ***Commentator:*** *Dr. Louis LOUTAN, Médecin-adjoint responsable de l'unité, Unité de médecine des voyages et des migrations, Hôpitaux Universitaires de Genève (HUG), Switzerland.* ***Topics and Speakers:*** **Globalization of communicable diseases**, *Dr. Brian GUSHULAK, Director General, Medical Services Branch, CIC, Canada.* **The case of SARS: lessons learnt**, *Associate Professor Suok Kai CHEW, Deputy Director of Medical Services, Epidemiology and Disease Control, Ministry of Health, Singapore.* ***Discussion***
16:20-18:00	***B. Managing global public health …Partnerships and the development of public health bridging programmes.*** What benefits are there to include migrants in national and transnational health schemes? Will this help the integration process? What are the public health issues of particular vulnerable people, such as victims of trafficking. ***Commentator:*** *Professor Edvard HAUFF, University of Oslo, Norway.* ***Topics and Speakers:*** → In post-conflict situations. **Investing in mental health and post-conflict rehabilitation**, *Professor Ka SUNBAUNAT, Deputy-Dean, Ministry of Health, Cambodia.* → In situations of economic migration. **Health as a tool for integration**, *Dr. Francisco CUBILLO, Deputy Minister, Ministry of Health, Costa Rica.* **US/Mexico tuberculosis (TB) border health card: Bilateral TB referral and treatment initiative**, *Dr. Stephen WATERMAN, Medical Epidemiologist, Divisions of Global Migration and Quarantine and Tuberculosis Elimination, CDC, USA.* **Public health and trafficking: When migration goes amok**, *Dr. Daniel VERMAN, Director, Department for Programs and Coordination, The National Agency for Family Protection, Ministry of Labour, Social Solidarity and Family, Romania.* ***Discussion***
18:00	**End of day one.**

AGENDA 10TH JUNE 2004	
10:00-18:00	**Session III: MIGRATION AND HEALTH POLICIES**
10:00 - 13:00	***A. Investing in migration health*** What regulations exist at international and national level to address cross-borders health? What is their purpose and how effective are they in addressing global public health issues? What are the policy options to provide access to, and improve health and social services for, regular and irregular migrants? What about deportation or voluntary return? ***Commentator:*** *Mr. Josue Lucio ROBLES OLARTE, Specialist in Public Management, Ministry of Social Protection, Colombia.* ***Topics and Speakers:*** **International Health Regulations: updates and perspectives**, *Mr. William COCKSEDGE, International Health Regulations, Communicable Disease, WHO.* **National migration health policies: Shifting the paradigm from exclusion to inclusion**, *Dr. Susan MALONEY, Acting Chief, Immigrant, Refugee and Migrant Health Branch, Division of Global Migration, CDC, USA.* **Health and irregular migration**, *Mr. Paris ARISTOTLE, Victorian Foundation for Survivors of Torture, Melbourne, Australia.* **Health and return migration**, *Dr. Eva Lewis FULLER, Director, Cooperation in Health/Policy Analyses, Ministry of Health, Jamaica.* ***Discussion***
	13:00-15:00 LUNCH
15:00-18:00	***B. Migration of health care workers*** What are the issues related to the migration of healthcare workers? What are the country experiences in managing health staff migration? What are the different policy options available to countries in dealing with health staff mobility? ***Commentator:*** *Ms. Meera SETHI, Regional Advisor for Sub-Saharan Africa, IOM.* ***Topics and Speakers:*** **Global overview of migration of health care workers**, Mr. *Orvill ADAMS, Director, Department of Human Resources for Health, WHO.* **Using bilateral arrangements to manage migration of healthcare workers: The case of South Africa and the United Kingdom**, *Ms. Daisy MAFUBELU, Health Attaché, South African Permanent Mission to the UN, Switzerland and Mr. Rob WEBSTER, Director of Workforce Capacity, Department of Health, United Kingdom.* **Using the Diaspora to strengthen health workforce capacity**, *Prof. Ken SAGOE, Director of Human Resources Department, Ministry of Health, Ghana.* **Exporting health workers to overseas markets**, *Prof. Binod KHADRIA, Professor of Economics and Chairperson, Zakir Husain Centre for Educational Studies, School of Social Sciences, Jawaharlal Nehru University, India.* ***Discussion***
18:00	**End of day two**

AGENDA 11TH JUNE 2004	
10:00-13:00	**Session IV: THE WAY FORWARD**
10:00-12:00	***What is foreseen in the future?*** What progress might be feasible? Can we work towards healthier migrants and healthier societies? ***Commentator:*** *Ms. Helena NYGREN-KRUG, Health and Human Rights Adviser, Department of Ethics, Trade, Human Rights and Law, Sustainable Development and Healthy Environment, WHO.* ***Topics & Speakers:*** **Population mobility and health crises in conflict situations** *Dr. Mohammad AL SHARHAN, Director, Department of Emergency Medical Services, Ministry of Health, Kuwait.* **Possible solutions to manage migrants' health: Thailand's perspective**, *Dr. Chat KITTIPAVARA, Health Supervisor, Bureau of Inspection and Evaluation, Office of the Permanent Secretary, Ministry of Public Health, Thailand.* **HIV/AIDS and population mobility – Where to go from here** *Dr. Teklu BELAY, Head of Advocacy, Mobilization and Coordination Department HIV/AIDS Prevention and Control Office, Ethiopia.*
12:00-13:00	***Where can we go from here?*** **Closing remarks on the theme of " benefits of investing in migration health"** ***Commentator:*** *Ms. Michele KLEIN SOLOMON, Deputy Director, Migration Policy and Research, IOM.* ***Speakers:*** *Mr. Orvill ADAMS, Director, Department of Human Resources for Health, WHO.* *Dr. Susan MALONEY, Acting Chief, Immigrant, Re.fugee and Migrant Health Branch Division of Global Migration and Quarantine, CDC* ***ACTION POINTS*** *Dr. Danielle GRONDIN, Director, Migration Health, IOM.*
13:00 – 14:30	**End of meeting – Reception**

Annex 4: List of Participants/ Speakers

List of Participants/Speakers*

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Endnotes

1. Article 25 of the Universal Declaration of Human Rights states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services".
2. As stated in the Preamble to the Constitution of the World Health Organization, http://www.who.org/about/definition/en/.
3. The World Health Organization estimates that 12 per cent of the global burden of disease is due to mental health and behavioural disorders, but the mental health budgets of most countries constitutes less than 1 per cent of their national expenditures. Forty per cent of the countries have no mental health policy and 30 per cent no mental health programmes. WHO: *World Health Report*, 2001, Mental Health: New Understanding, New Hope, World Health Organization, Geneva, 2001.
4. Integration implies being a full member of society with all the rights, privileges and responsibilities of the native born, participating and contributing to that society.
5. General Medical Council 2002; Nursing and Midwifery Council 2002.
6. All speakers participated in their personal capacity. The views expressed are thus not necessarily those of their governments.
7. Of the six major high mortality infectious diseases, there is only an effective vaccine for measles. 90/10 rule should ensure that 90 per cent of the research is conducted in areas where there are knowledge gaps.

8. *World Migration 2003*, IOM, Geneva, 2003.

9. WHO (1946) definition for health as stated in the preamble of the WHO Constitution.

10. For instance, Burmese migrants in Thailand have a significantly higher incidence of HIV / AIDS than their counterparts in Myanmar or the local Thai population.

11. From Censo de Población (2000) Instituto Nacional de Estadística y Censos, Costa Rica 2000.

12. United Nations (2000). *The United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons*, UN General Assembly 2000.

13. *Introduction to Migration Management*, Section 2.7. IOM.

14 Anecdotal evidence from U.S. bi-national tuberculosis programme, which is open to irregular and legal migrants, demonstrates that it is primarily regular migrants who seek care. Likewise, in Germany, though the health system welcomes all migrants, irregular migrants very seldom request care.

15. World Health Organization Intergovernmental Working group on the revision of International Health Regulations, Working paper, 12 January 2004, http://www.who.int/csr/resources/publications/IGWG_IHR_WP12_03-en.pdf.

16. Working Paper, Part IV - Points of Entry, Article 13a.

17. Working Paper, Article 37.1.

18. Working Paper, Article 36.1.

19. This, coupled with definitional complications arising from disparity in health system performance worldwide, is responsible for many of the misunderstandings between countries regarding migrant healthcare.

20. Universal Declaration of Human Rights, Article 22: "Everyone, as a member of society, has the right to social security…" and Article 25: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family…". See also *World Migration 2003*, Ch. 5, pp. 85-86 for an overview of eight international legal instruments governing migrant and human rights to health.

21. **The Berlin Charter**, adopted by the International Red Cross and Red Crescent Societies at its European Regional Conference in 2002 committed the organization to: "work with those whom migration has put in special jeopardy".

22. General Medical Council, 2002; Nursing and Midwifery Council, 2002.

23. World Health Assembly (WHA) 57.19 on the International Migration of Health Personnel.

24. Those surveyed felt that: "The quality of life is better in Ghana than elsewhere."

25. Surveys conducted by MIDA-Ghana-Netherlands Healthcare Projects I, II, and III.

26. Specifically citing the example of his surveys on emigration of the IT specialists from the Bangalore region and the doctors and nurses from the Delhi hospitals.

27. Depending on the educational stage reached at the time of migration.

28. Migration for Development in Africa, or MIDA, programmes have experience in facilitating such exchanges, and through the use of information and communication technologies (ICT), it has been possible to implement similar e-learning, skill transfer programmes in a cost-effective manner. See MIDA: Mobilizing the African Diasporas for the Development of Africa, 2004.

29. *Global Development Finance 2003*, The World Bank, p. 158, Figure 7.1: "Workers' remittances and other inflows, 1998-2001".

30. Including both developed and developing countries. Specifically, developing countries may be served by the international presence of their nationals as a means of soliciting business contacts, along with those causes enumerated above. Negative effects of this migration are a result of the global shortage of healthcare workers, which, in practice, is unevenly felt across countries.

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