



Migration: A Social Determinant of the Health of Migrants

International Organization for Migration (IOM)

Background Paper

In the framework of the
“Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health
and Health Inequalities” project
Co-funded by the European Commission DG Health and Consumers’ Health Programme
2006 and the Portuguese High Commissariat for Health

Dr Anita A. Davies
Ms Anna Basten
Ms Chiara Frattini

IOM Migration Health Department
Geneva, Switzerland



IOM • OIM

This document was produced with the financial contribution of the European Commission. Opinions expressed in this paper do not necessarily reflect the views of the European Commission.

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental body, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

International Organization for Migration
Regional Liaison and Co-ordination Office to the European Union
40 Rue Montoyerstraat
1000 Brussels
Belgium
Tel.: +32 (0) 2 282 45 60
Fax: +32 (0) 2 230 07 63
Email: MRFBussels@iom.int
Internet: <http://www.belgium.iom.int>
ISBN 978 92 9068 355 1
© [2006] International Organization for Migration (IOM)

All rights reserved. No part of this paper may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of IOM.

Table of content

Executive summary	3
Introduction	4
Key concepts	5
Social Determinants of Health	5
Migration	5
Migration Health	6
The migration process and health outcomes	7
Health hazards during the migration journey	7
Migrant health hazards in selected European destination countries	9
Access to health and social services	11
Change of life style and influences on migrants' health	12
Approaches to realizing migrants' health	14
Institutional framework: migrants' health from a human rights perspective	14
Migrants' health as an empowerment issue	16
Medical pluralism – enhancing cultural appropriateness of health systems?	17
Conclusion	19
Note about the authors	21
References	22

Executive Summary

This paper examines the relationship between migration and health from a human-rights and social equity based perspective. It discusses how migration can itself be seen as a determinant of migrants' health.

Migrants are affected by social inequalities and are likely to go through several experiences during the migration process which put their physical, mental and social well-being at risk. Migrants often face poverty and social exclusion, which has negative influences on health, especially in countries of destination and transit. Migrants' health is also to a large extent determined by the availability, accessibility, acceptability and quality of services in the host environment.

This paper thus considers issues around migrants' right to health, access to socially, culturally and language appropriate health and social care, and legal status. Social determinants of health are often recognized to be associated with living and working conditions, physical and social environment, education, gender, as well as degrees of social cohesion and integration. Migrants face specific difficulties with respect to their right to health. These health care services may be inadequately covered by state health systems and unaffordable health insurances; cultural barriers; difficulties accessing information on health services and health-related issues. These are strong challenges for undocumented migrants in particular. Undocumented migrants are often denied access to public health services or are reluctant to use services that are available to them for fear of being deported. Even those migrants with legal entitlements to health care may face various obstacles to utilizing these services.

In addition, the migration journey itself can pose significant health risks, particularly for migrants in an irregular situation.

At present, European health policies insufficiently address the health needs of migrants. This paper raises the issue that it is a good public health practice to promote access to services for all migrants irrespective of individuals' legal status in a country for the common good of all of society. The ability to lead a life according to one's values is considered as a part of a healthy environment and a healthy life. Well managed migrant health benefits all. Healthy migrants become productive members of the community. Therefore, the paper promotes a broad perspective which regards migrant health as a human rights and an empowerment issue.

Introduction

Migration is a fact of today's globalised world and increasingly a necessary component of economic and social development everywhere. Migration in Europe involves a diverse group of people, including migrants in regular and irregular situations, trafficked persons, asylum seekers, refugees and displaced persons and returnees. As migration is increasingly becoming a part of European life, the health implications of migration and the health of migrants need to be recognised as an important issue in health policy making.

Migrants go through several experiences which ultimately affect their health particularly in settings where they face a combination of legal, social, cultural, economic, behavioral and communications barriers during the migration process. Social inequities which exist in every society and between different societies mean that the freedom to lead flourishing lives and enjoy good health is unequally distributed amongst different population groups. Migrants frequently find themselves amongst those most negatively affected by these imbalances.

Individual biological, physical, behavioral, and social factors, interventions and access to social and health services determine the health of an individual. Migrants are likely to experience specific challenges in relation to health due to the nature of being a migrant. Social determinants of migrants' health relate to factors that influence the migration process, reasons for migrating, and the mode of travel, length of stay and the migrants' language skills, race, legal status. These determinants of migrants' health are complex and inter-related. Migrants can come from different backgrounds and situations, and once they migrate their status often changes dramatically. Different categories of migrants may have very different experiences. Determinants of migrants' health are shaped by their experiences and situations in the countries of origin, transit and destination. Migration itself adds a particular dimension to social determinants of health, given that being a migrant can make persons more vulnerable to negative influences to their health. Many of the factors that drive migration also contribute towards the health inequalities between countries and within countries. Being a migrant puts the individual in further social disadvantage when compared with individuals in the host community in the same social strata. In addition to being particularly vulnerable to certain health risks as a migrant, migrants often experience certain challenges and barriers to accessing health and social services, especially if they are undocumented. This in itself is a social determinant to the health of migrants.

This paper will thus consider migrants' health and the determinants of migrants' health from a human rights and social equity based perspective. This paper will discuss how migration is in itself a determinant of health. Migrant status and the process of migrating can have significant impacts on migrants' health.

After introducing the key concepts, the paper will examine the risks and challenges to health that migrants face during the migration process, including the migration journey and the situation in the country of destination. The following section considers approaches to realizing migrants' right to health by looking at it in a human rights framework and as a development issue. Finally the paper argues for multi-stakeholder and multi-sectoral cooperation to address social determinants of migrants' health and ensure migrant friendly services.

Key Concepts

Social Determinants of Health

Social determinants of health are recognized as the conditions in which people are born, grow up, live, work and age (Commission on Social Determinants of Health 2008). These conditions are shaped by political, social and economic forces. There are various layers of determinants influencing a person's health (see Figure 1). These are biological factors such as age and sex, life style factors, social and community influences, living and working conditions and general socio-economic, cultural and environmental conditions. All these factors have particular implications for migrants, and vice versa, migration can exacerbate the impact of these factors. Migration can therefore be regarded as an additional layer to the previous ones.

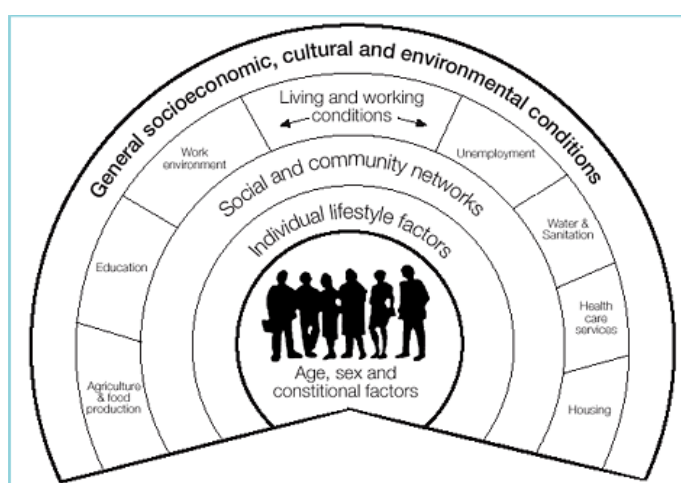


Fig. 1: Social Determinants of Health¹

Migration

Migration is a process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes (International Organization for Migration 2004). Migration can be long-term or short-term, internal or international.

It is estimated that between five and ten million people world wide cross an international border to take up residence in a different country each year. In 2005, 191 million individuals, this representing about three percent of the world population, were international migrants (International Organization for Migration 2005). Migration takes place for different reasons. In some cases people are forced to move from their communities as a result of political instability, conflict, environmental degradation and natural disasters. At the end of 2005 the United Nations High Commissioner for Refugees listed 20.8 million refugees, asylum seekers, internally displaced, and 'others of concern'.

¹ Source: http://lothianhealthandlife.scot.nhs.uk/lhls2002/images/report1/fig1_7.gif

Only forty percent of global migration covers movements from the global South (developing countries) to the global North (industrialized countries). South-South migration accounts for the other sixty percent (International Organization for Migration 2005). In addition to international migration, significant population mobility also takes place within countries, most commonly from rural to urban areas, but also from poorer rural areas to more prosperous ones. Internal and external migrations are often interconnected. Migration often starts with an internal move, from rural to urban areas, from where migrants may continue to another country and to another continent.

Migration Health

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization 1948). Migration health thus addresses the state of physical, mental and social well-being of migrants and mobile populations

However, the structural inequalities experienced by migrants have a significant impact on overall health and well-being. Migration health thus goes beyond the traditional management of diseases among mobile populations and is intrinsically linked with the broader social determinants of health and unequal distribution of such determinants.

There are different categories of migrants, including students, economic migrants, asylum seekers, irregular or undocumented persons, and displaced persons (Mladovski 2007). These groups face different health challenges and have different levels of access to health and social services. This interacts with social and economic inequalities. Lower socio-economic position and irregular status increase and exacerbate those challenges. Certain categories of migrants with legal documents and in a more comfortable socio-economic position may experience particular challenges and limits to accessing services due to language and cultural differences as well as institutional and structural obstacles.

The Migration Process and Health Outcomes

Migration processes can positively or negatively impact health outcomes just as health status can affect migration outcomes. Migration is in and of itself not a risk to health. Conditions surrounding the migration process can increase the vulnerability to ill health. This is particularly true for those who migrate involuntarily, fleeing natural or man made disasters and human rights violations; and those who find themselves in an irregular situation, such as those who migrate through clandestine means or fall into the hands of traffickers and end up in exploitative situations. Many migrant workers who lack proper immigration papers form a large and vulnerable population group. Migrant workers, in particular the undocumented workers are often involved in dangerous and degrading jobs, exposing them to occupational hazards, but have no health insurance. It is contrary to notions of social justice that these migrant groups which are at high risk of abuse, exploitation and discrimination, have the least access to health and social services (Clapham & Robinson 2009).

Health risk factors are often linked to the legal status of migrants, determining the level of access to health and social services. Further contributors include poverty, stigma, discrimination, housing, education, occupational health, social exclusion, gender, differences in language and culture, separation from family and socio-cultural norms.

Health hazards during the migration journey

The multifaceted dynamics of the migration processes pose major challenges for public health. Different categories of migrants can have different health challenges. The mode of travel and legal status of the migrant, are two factors that can determine a migrant's health status at various stages of the migration cycle. The migration process has three main phases: the pre-departure phase from the point of origin, the transit phase, and the phase of arrival and stay in the destination country. One should not forget that there can also be a return phase to the country of origin. This return phase can be repeated and is referred to as circular migration.

Migrants make various experiences influencing their health during all stages of this migration process. The physical and socio-economic environment at the migrants' place of origin (the pre-migration phase) determine many of the pre-conditions with which people migrate. Sometimes migrants may not have had access to adequate care in their countries of origin, as a result of which certain conditions which are easily treated in high-income countries may be more advanced in migrants and less effectively treated in destination countries.

The migratory journey itself (the movement phase) can affect the health of migrants in a negative way, especially if migrants are in an irregular situation, or migrate as refugees and displaced persons.

The ability or disability to migrate through legally regulated channels determines the impact the journey is likely to have on the migrants' health. Migrants who are able to use legal channels for migration have much better access to safe travel and health care during the journey. On the contrary, those who migrate without legal documents tend to undergo long and dangerous journeys. Travel conditions often include long days hidden in a truck or cramped in a small space on a boat or under moving trains (Van Liemt 2004). Many migrants from Africa attempt to enter the European Union by sea via the Canary Islands or the Italian

coast. Boats which are used to cross the Atlantic or the Mediterranean are often inappropriate for the purpose and create health and life threatening situations (Smith 2007). Migrants who survive these life threatening situations often suffer from long term physical and mental health conditions. Irregular migrants who fall ill during the transit journey or at the final destination often do not have access to health services. This can have detrimental effects on their health both in the short term and in the long term if diseases remain undetected and/or untreated (World Health Organization 2007).

Moreover, often these journeys are unsuccessful. Many returning migrants may continue to have limited access to health care, or may opt not to utilize available services, be stigmatized or discriminated against. Yet, despite the physical, social and mental health hazards, migrants often repeat the journey multiple times.

Migrants' Health Hazards in European Destination Countries

There is no coordinated European approach to integrating migrants' needs (particularly of non-EU migrants) into national health and welfare systems. The approaches of the different countries to integrating migrants' health depend on various factors, including the particular patterns of migration and migrants entering the country, as well as the type of welfare state and legal system. Policies addressing migrants' health needs are more developed in some countries than in others. However, even where such policies exist, it is not always clear how well they are implemented in practice and whether all the relevant actors, including health and non-health providers and administrators are well informed about legal provisions. This for instance is a problem which has been identified in Italy where health coverage is provided by law to all migrants, including those who lack legal documents. Yet, NGOs criticize that implementation of the law differs significantly between regions and within regional health centres and hospitals. In agricultural areas access to health services for migrants tends to be very limited. Moreover, the level of information amongst health and other key service providers may also vary. In some cases it has been found that local health administrators have asked migrants for documentation even though this is not required by law (Platform for International Cooperation on Undocumented Migrants 2007).

In general, the Platform for International Cooperation on Undocumented Migrants (PICUM) finds that access to health care is not guaranteed for undocumented migrants in Europe. In some countries care and treatment, including in emergencies, may only be provided on a payment basis, unaffordable to most undocumented migrants. PICUM claims that there is a general tendency in the EU to restrict access to health care for undocumented migrants, linking access to health services with immigration control. In Germany for instance, medical practitioners were until recently legally required to notify the authorities of any undocumented migrant seeking assistance. This law has been reviewed by the Government and the provision of treatment to undocumented migrants has been de-penalized. However, undocumented migrants still have no access to the formal health system. Under the German health care system individuals are insured through their employment or through another family member who is employed. This presupposes legal employment and residence status and thus excludes undocumented migrants (Platform for International Cooperation on Undocumented Migrants 2007).

Most migrants arrive in the host country in relatively good health. This has been attributed to the fact that the young and healthy are more likely to migrate and to survive a difficult journey (Vissandjee et al. 2004). Over a period of time this "healthy migrant effect" appears to decline (Wiking et al. 2004). It has been speculated that this decline in migrants' health can be related to low socio-economic status, in which the migrants often find themselves in the host country. The link between health and poverty is fairly obvious, and there is also a connection between health and inequality in the case of migrants. This is observed among migrants in European countries where basic material needs tend to be available to the host community but where migrants are often times particularly affected by social inequalities. These inequalities can have specific impacts on migrants' health. For instance, higher mortality rates are found in persons of lower social strata than persons of higher strata. Marmot explains this phenomenon by adopting a broad approach to the concepts of poverty and wealth, which goes beyond the material needs for food, water, shelter. His definition encompasses the human need for autonomy, empowerment and freedom to lead a life one values (Marmot 2006). If these human needs are met a person will be able to enjoy a life of good health. On the contrary, the more a person is deprived of these human needs, the more

detrimental the effects on their health. Migrants often do not have the autonomy, empowerment and freedom to lead their life based on their social and cultural norms. Lacking control over various factors influencing health, migrants' opportunities to make healthy choices in life may already be limited.

The Commission on Social Determinants of Health illustrated the complexity of inequalities related to various factors including gender, age and ethnic identity (Commission on Social Determinants of Health 2008). To the extent that migrants often find themselves in the lower social strata they are also especially affected by poor housing conditions. Recent data from the WHO Regional Office for Europe illustrates that households of the lower income groups suffer much more frequently from dampness and mold than households with higher incomes. Similarly, crowding (where less than one room is available per person) was found to be common in households that reported being under strong economic pressure. Being associated with noise disturbance, low indoor air quality, a higher frequency of household accidents, and lack of privacy, crowding can have significant negative effects on physical and mental health (Braubach & Savelsberg 2009).

In addition, migrants are vulnerable to discrimination, stigmatization and xenophobia. These factors interact with social inequalities and can both result in and be a result of social exclusion which has also been recognized as a social determinant of health (Wilkinson & Marmot 2003).

Migrants often work in environments that can expose them to risk factors for both communicable and non communicable diseases. Unskilled migrant workers tend to have a higher risk of work-related injuries and long-term occupational related illnesses. Migrants without legal documents in particular are vulnerable to exploitation, seeing themselves forced to accept bad working conditions as they fear deportation if they claim better conditions. Migrants' wages tend to be lower than those of their national counterparts and employers rarely provide health insurance. In instances where migrant farm workers are illegible for health services, they are often not accessed because, workers are often paid by the hour or by piece work and therefore are reluctant to seek health care during working hours since missing work means a decline in income. As a result, workers may only seek help from medical services when injuries or illnesses become unbearable (Arcury & Quandt 2007).

Mobility is often associated with certain risks to HIV and sexually transmitted infections. Separation from their families and from familiar social norms, feelings of loneliness, poverty, exploitative working conditions, including sexual abuse all increase the risk of HIV infection as workers have been found to be more likely to engage in unsafe behaviours. At the same time, these same factors may cause mental illnesses such as depression and anxiety (Kandula et al. 2004). However, mental ill-health may sometimes be misunderstood due to cultural differences, understanding of etiology of disease and fear of stigma if mental health services are used. Migrants themselves may thus simply not perceive themselves as being in need of psychological assistance. A study involving Chinese diaspora in Great Britain showed that the idea of "mental illness" amongst the Chinese study participants was mostly equated with "psychosis". The perception and understanding of mental health was altogether very different from the Western understanding of the concept. As a result, Chinese migrants in Britain were found to be rather unlikely to seek help for mental health problems from the British national health system (Green et al. 2006).

A study conducted in the US equally noted that mental health services are underused by

migrants. The authors of the study also suggest that this is due to the stigma which is attached to mental illnesses in many cultures. Another argument may be that mental distress may in some cultures be articulated through physical complaints. Western medicine may misdiagnose these cases. Medical practice being based on Western screening tools and understandings of illness and disease, practitioners may be unable to respond adequately (Kandula et al. 2004).

Many women migrants also face the risk of sexual abuse and exploitation which can have a negative impact on their mental state of health. Women domestic workers are especially vulnerable to sexual exploitation and abuse, including violence, due to the invisible nature of their work, and may suffer from physical and mental health problems as a result. Moreover, female domestic workers and trafficked persons who have experienced sexual abuse are frequently confronted with major obstacles related to their right to reproductive health (sexually transmitted diseases, including infection with HIV/AIDS, unwanted pregnancies, unsafe abortions) (Duckett 2001).

Migrants' access to health and social services

It has already been noted that access to health and social services for migrants is strongly determined by their legal status, with undocumented migrants having the least access to services. Legal status is thus a precondition for the ability to receive adequate care. In addition to this the availability, accessibility, acceptability and quality of services depend on various other influences, including social, cultural, structural, linguistic, gender, financial and geographical factors. As has been indicated above, different beliefs and knowledge about health and ill health can deter migrants from using national health services. Moreover, health literacy in the sense of awareness of entitlements to care and availability of services may pose a barrier to the use of services. This is true for all migrants regardless of their socio-economic or legal status. The very nature of mobility can make it difficult to identify available health care service providers. Seasonal and temporary workers may prefer to delay care until they return to their places of origin. Migrants' working hours and the distance of their workplaces may not allow them to get care during the times when public health services are open. Thus mobility makes follow-up treatment and long-term care as in the case of tuberculosis (TB) directly observed treatment (DOTS) difficult. As a result of travelling and lacking access to care, migrants may be unable to complete their treatment, which in the case of tuberculosis may lead them to develop multidrug-resistant TB. Similar risks exist in the cases of HIV and malaria.

Completion of immunization of migrant worker children and antenatal care for their wives is often difficult to complete as some of the care started in their country of origin and is not continued in the new host country (Arcury & Quandt 2007).

Language is frequently cited as a major obstacle to the use of health and social care services for migrants. The lack of language skills can be a great barrier to understanding bureaucratic procedures and the functioning of the health system. Migrants often move with their culture and traditional norms which often differ from the host community. This is a particular challenge for women migrants who adhere to traditional norms and have limited contacts outside their communities.

Migrants may be reluctant to seek medical help because of various communication problems.

Unfortunately, most health facilities may not have available medical translators familiar with a wide range of cultural and traditional norms that potentially bridge this challenge. Thus, communication problems can be caused by language differences which may prevent the migrants from understanding the bureaucracies of the health systems and from expressing their needs. This may be exacerbated by a second level of communication barrier, due to different perceptions and understandings of illness, disease and responses to them. As a result, some migrants may prefer to seek help from traditional healers.

For women migrants getting health care may in some cases be even more difficult than for men. Cultural norms may prevent women from accepting care from male practitioners. Migrant-friendly services need to be able to respond to the particular needs of women migrants and other groups.

Cultural and ethnic reproductive and sexual health practices and norms of behaviour among certain migrant groups, such as female genital mutilation and the use of contraception, may challenge or conflict with those in the host community. Recognition and management of reproductive and sexual health issues requires cultural competence in health care providers. Such cultural competence, however, may not be part of current medical education programmes in Europe.

Migrants should be provided with information on the health services that are available for their use. Often migrants are not included in the development of migrant services or asked for feedback on the services. Thus, many services are not used because they are not culturally acceptable to the migrants. Studies in Switzerland and Italy have shown that the migrants' lack of awareness of health care and preventive services has been a main reason why these services are underutilized by migrants. Wolff et al. find that undocumented migrant women significantly under-use preventive reproductive health measures such as Pap tests and breast examinations. Sixty one percent of the undocumented migrant women included in the study were unaware of emergency contraception and seventy-five percent of their pregnancies were unintended. Moreover, undocumented pregnant women were found to be at an eleven-fold higher risk for delayed pre-natal care compared to the legally residing pregnant women included in the study. The undocumented women were also more often exposed to violence during their pregnancy. The study identified a need for culturally and linguistically appropriate education on contraception, family planning and cancer screening (Wolff et al. 2008).

WHO Europe has also stated that recently arrived migrants, refugees and asylum seekers tend to have less access to care and sometimes hide their pregnancies from the authorities, including the health services (World Health Organization Europe 2007).

A recent study conducted among ethnic minority women in Finland revealed that women of African and Somali origin had high perinatal mortality rates compared to women of Finnish origin. Moreover, women from East Europe, the Middle East, North Africa and Somalia were found to have a significant risk of low birth weight for newborns (Malin & Gissler 2009).

Cultural and/ or religious barriers or a lack of information about the availability of vaccinations for children may sometimes prevent children of migrant background from participating in routine vaccination services (Barnett et al. 2009).

Change of life style and influences on migrants' health

Various studies have considered the effect of acculturation as a specific factor influencing migrants' health (Jasso et al. 2004; Marmot 2006; Oppedal et al. 2004; Wiking et al. 2004). Depending on the cultures of countries of origin and destination, acculturation can have positive and negative effects on health. In some cases migrants may come from cultures with more protective health practices than are common (or perceived to be common) in the country of destination. As a result of adopting health practices of the destination country, their health may deteriorate. Rural to urban migration as well as migration to different countries and cultural contexts may lead to changes in life style, notably adopting more Western dietary habits and activity patterns. This can lead to an increased risk of obesity, diabetes and cardio vascular disease (Ebrahim & Smeeth 2005).

Studies have found that diabetes is rather rare in communities in developing countries where a traditional life style has been preserved. Research conducted in France found that to the extent that the traditional health diet is preserved, migrants from the Mediterranean on average remain healthier and have lower mortality rates than the local-born population (Darmon & Khlal 2001).

By contrast, some Arab, Asian Indian, Chinese, and U.S. Hispanic communities that have undergone processes of westernization and urbanization are at higher risk. Amongst these communities, the prevalence of diabetes ranged from fourteen to twenty percent (Hossain et al. 2007).

Comparing the health of children from ethnic minority communities in Germany with German-born children, Will et al. found that children from ethnic minorities in Germany are more frequently overweight or obese than German-born children. The patterns of obesity and overweight are further influenced by socio-economic class as well as the duration of stay after immigration (Will et al. 2005).

In addition to dietary changes and low exercise, financial constraints, employment problems and the lack of a network of social support can also significantly affect migrant's health. The links between stress and ill-health are well known. Studies have found that Chinese living in Great Britain are affected by a more severe lack of social support than the general population. They also frequently reported worries about harassment (Green et al. 2006).

Acculturation can also have both positive and negative effects on migrants' mental health as Oppedal et al. found in their study on immigrant youth in Norway. While stating that acculturation to a different cultural setting supports a healthy development and mental state of young migrants, some of the adolescents were found to be particularly vulnerable to self-perceived discrimination and an ethnic identity crisis, especially if they lacked social support from their family and/or close social contacts (Oppedal et al. 2004).

Approaches to Realizing Migrants' Health

The institutional framework: migrants' health from a human rights perspective

An adequate approach to addressing migrants' health and well-being needs to be set in a human rights framework. Migrants, as all human beings, are entitled to basic human rights. This includes the right to health. Many measures can be taken to ensure the enjoyment of the right to health for all. For example, the right to health should be formally recognized in national laws, and the practical obstacles to its enjoyment by all migrants should be eliminated.

Migrant health has been addressed in a number of international and European forums, notably the conference on Health and Migration in the EU: Better Health for All in an Inclusive Society, which was convened in Lisbon in September 2007 through the Portuguese EU Presidency. Recommendations emphasized the need for coherent immigration policies that incorporate the health dimension at both the EU and Member State level. In November 2007, in Bratislava, European health ministers signed the Bratislava Declaration on Health, Human Rights and Migration.

The World Health Assembly Resolution 61.17 which was endorsed by the Sixty-first World Health Assembly in May 2008 urges Member States and WHO to promote the inclusion of migrants' health in regional health strategies; to develop and support assessments and studies and share best practices; to strengthen service providers' and health professionals' capacity to respond to migrant needs; to engage in bilateral and multilateral cooperation; and to establish a technical network to further research and enhance the capacity to cooperate.

A framework for considering migrants' right to health in a human rights perspective exists; however, it needs to be turned into a reality for migrants.

The World Health Organization's Constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights to every human being without discrimination of race, religion, political belief, economic or social condition" (World Health Organization 1948). The broadest formulation of the right to health is contained in art.12 of the International Covenant on Economic, Social and Cultural Rights, which defines it as: "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (International Covenant on Economic, Social and Cultural Rights 1966). As all human rights, the right to health is inter-related with other civil and political rights and economic, social and cultural rights (Potts 2008).

The right to health is recognized by international and regional instruments as well as national legislation. The central international instrument recognizing the right to health is considered to be the abovementioned International Covenant on Economic, Social and Cultural Rights (Potts 2008; OHCHR-WHO 2008). The Committee on Economic, Social and Cultural Rights, which monitors the implementation of the Covenant, has provided an authoritative interpretation of art.12, and has clarified the components and characteristics of the right to health in its General Comment No.14 of 2000. Several other international instruments that protect human rights recognize or refer to elements of the right to health. Among these instruments, the International Convention on the Protection of the Rights of All Migrant Workers and members of their Families explicitly identifies the right to health for migrants in

regular and irregular status (art.28, 43 (e) and 45 8c) (International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families 1990). It provides for the right to equal treatment and access to social and health services for regular migrant workers and members of their families and nationals, and it acknowledges the right to emergency medical treatment for all migrant workers and members of their families regardless of their legal status in the country. It has been widely criticized, though, that the convention fails to guarantee access to preventive medical treatment: early diagnosis and medical follow-up and palliative health services are some examples (Pace 2007; Pace 2009). On the EU level, human rights instruments recognizing the right to health include the European Social Charter (art.11 and 13) and the European Convention for the Promotion of Human Rights and Fundamental Freedoms and its protocols.

According to the interpretation given by the Committee on Economic, Social and Cultural Rights, the right to health does not only encompass the right to health care, but also the right to the underlying determinants of health. In addition, the right to health contains freedoms, such as the right to make decisions about one's health or the right to be free from discrimination and from non-consensual medical treatment; and it contains entitlements, such as the right to a system of health protection, the right to participation in health-related decision making at the national and community levels, the right to maternal, child and reproductive health (Pace 2009; Potts 2008; OHCHR-WHO 2008). Four inter-related essential components have been identified concerning the right to health: availability, accessibility, acceptability and quality. Availability is related to the physical presence of health facilities and implies that there is a sufficient quantity of health facilities, goods and services within the country. Accessibility has to be granted in its four dimensions: non discrimination, physical accessibility, economic accessibility (affordability), and information accessibility. Acceptability means that health facilities, services and goods must be culturally appropriate and must also be respectful of medical ethics. Quality implies that health facilities are medically and scientifically appropriate and of good quality within the economical possibilities of the country (Potts 2008).

Migrants face specific difficulties in relation to the right to health. In some states there is no specific legislation on access to health care for undocumented migrants (PICUM 2007). In several countries, irregular migrants are granted "essential care" or "emergency health care" only (OHCHR-WHO 2008). Due to the absence of a uniform interpretation of these concepts there is a lack of clarity on migrants' entitlements and therefore to possible discriminatory practices. Moreover, it results in undocumented migrants seeking medical care only when they are severely ill (OHCHR-WHO 2008; Nygren-Krug 2003).

The ratification of international binding instruments recognizing the right to health determines obligations for states of both progressive and immediate realization. A health system that is accessible to all, that is effective, integrated and of good quality, should be created by the states within their resource availability. Amongst the obligation of immediate effect is the requirement that states prepare a national plan for health care and protection, and that the right to health is realized consistently with the principle of non-discrimination. Governments thus have a responsibility to ensure equal protection and opportunity under the law, and a de facto enjoyment of the right to health for migrants. The principle of non-discrimination is first and foremost a right on its own, and it also is a constitutive element of all rights including the right to health (Pace 2009).

The General Recommendation XXX on Discrimination Against Non Citizens of the

Committee on the Elimination of Racial Discrimination states that measures have to be adopted by state parties to “respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services”. The General Comment No.14 of the Committee on Economic, Social and Cultural Rights, also states that States must: “refrain from denying or limiting equal access to health care for all persons, including asylum seekers and illegal immigrants”. Furthermore, Comment No.14 clarifies that discrimination is forbidden regarding access to health care, underlying determinants of health and means and entitlements for their procurement, on the following grounds: “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status, sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health”. The prohibition of discrimination based on “other status” has given room to discussion and it is believed by some that “other status” can be broadly interpreted and that arguably covers the status of migrants (Fitzpatrick & Brotman 2002).

Migrants’ health as an empowerment issue

Social determinants of health are a development issue. Socio-economic, cultural, environmental, living and working conditions are at the basis of enabling physical, mental and social well-being. Health and development empowerment strategies can be used to reduce health inequalities as has been highlighted in a WHO Regional Office for Europe Health Evidence Network (HEN) report (Wallerstein 2006).

Not only are the concepts of health and empowerment interlinked, they are also basic principles for overall development. Both are development aims in themselves but also transcend and further other development goals. There are three directly health related Millennium Development Goals (MDGs): improving child health (Goal 4), maternal health (Goal 5) and combating HIV/AIDS and other diseases (Goal 6). However, all eight MDGs have a health dimension: Ending poverty and hunger improves health; and only healthy persons can pursue education. Empowering women and ensuring gender equality has a positive impact not only on the health of women but also on the health of their families since it is women who, in most parts of the world, carry the primary responsibility for caring tasks and for the well-being of the family. Environmental sustainability equally is important for a healthy environment in which sustainable access to clean water is guaranteed.

Migration transcends these development goals. Not only do migrants have a right to achieving the same health status as their hosting communities, there is also a need to improve health globally, particularly of vulnerable groups. Migrants play a role in this. In the age of globalization, migrant health is also a public health issue. This is not to say that migrants pose a threat to public health of host countries; on the contrary, migration can be beneficial to the migrants as well as to countries of origin and destination. In view of the scope, the speed and the nature of different forms of migration, research and policy making need to address disparities within and between different populations, in social and economic terms as well as in terms of epidemiological profiles, health seeking behaviours and performance of health systems in countries of origin, transit and destination. The benefits of including migrants in public health strategies have been seen in Thailand where the Ministry of Public Health, in partnership with IOM, has introduced the concept of migrant-friendliness in health service delivery with an overarching theme of “Healthy Migrants, Healthy Thailand”. This helps to

improve health literacy of migrants and access to basic public health services.²

Old and emerging diseases are challenges to public health. What is important to underline however, is that a systematic response to these challenges requires going beyond the boundaries of the health sector alone and be developed in a multi-sectoral approach for health. This will address the underlying social, economic, cultural, structural and environmental determinants of health that result in inequalities and vulnerability to diseases. Addressing the health needs of migrants bridges public health rights, and development issues, avoids stigma and long term health and social costs, protects global public health, facilitates integration and contributes to social and economic development.

Medical pluralism – enhancing cultural appropriateness of health systems?

European health systems are for the most part based on Western medical knowledge and practices. Health policies implicitly assume that migrants will adopt the health practices and beliefs of the host society.

To the extent that migration is recognized as a public health concern, policies exist to address migrants' health, for instance in the context of preventing communicable diseases.

Mladovski finds that European health policies tend to focus either on newly arrived migrants or on more established migrant communities (Mladovski 2009). A more comprehensive, rights- and equity-based approach is necessary. In the light of ageing populations, health systems also need to take into account culturally appropriate long-term care.

As has been seen, access to and usage of health services can be obstructed by differences in health beliefs and knowledge. The incorporation of different medical traditions in health systems may help to enhance the cultural appropriateness of health services. Migrants could benefit and contribute to such a pluralist medical system. It may safely be assumed that there is a demand for traditional cultural services within migrant communities (and possibly amongst the host community, too, as in the case of acupuncture); and at the same time, health professionals with a migrant background may be able to contribute a range of alternatives to biomedicine.

Examining the use of traditional Chinese medicine and treatment by Chinese diaspora in Great Britain, Green et al. find that many times Chinese migrants combine the two medical systems and use privately offered traditional Chinese medicine and treatment as well as the Western treatment offered by the National Health Service (NHS). Chinese understandings differ from Western medical knowledge. While the Western approach concentrates on anatomic parts as separate entities, the Chinese understanding of health, illness and body is a more holistic approach which focuses on the flow of energy in the body. In general, Western medicine was seen to be more efficient for immediate pain relief, whereas Chinese medicine was felt to be more appropriate for addressing the underlying causes of illness and curing chronic illnesses. Both forms of medicine were used by the participants of the study. This, the authors suggest, can also be considered as a way of preserving the Chinese identity while integrating into the new environment at the same time (Green et al. 2006).

Altogether the study indicates that the maintenance of traditional health beliefs is a strategy

² <http://esango.un.org/innovationfair/notes/iom.pdf>

to maximize access to medical resources, particularly when encountering access barriers to receiving health care in the formal system of the destination country otherwise.

Integrating different cultural approaches to health may thus offer access to care for some migrant communities. However, national health services also need to invest in overcoming the language barrier and training health service providers to ensure accessibility and acceptability of all services to migrants. In order to address obstacles and respond to different needs, health service providers need to be informed about the cultural background and particular barriers that different types of migrants in different situations may face. However, while cultural awareness and sensitivity is important there is a risk of stereotyping which needs to be avoided. One should be aware that not every member of a particular migrant community necessarily shares the cultural beliefs and practices that may be associated with this culture.

Conclusion

In conclusion, migrant populations may be particularly exposed to specific determinants of health. Migration itself can be a strong determinant of physical and mental health of migrants. More information and data is needed for human rights, evidence-based migration health policies and strategies.

It has been observed that migrants do not utilize health and social services optimally even when available. Migrants may exhibit low awareness of personal safety and health concerns, and may not practice basic preventive health measures. Services that promote health or prevent illness may not be accessible or acceptable because of linguistic or cultural barriers, as they may not recognize migrants as groups with different risks and needs. Social inequalities, poverty and social isolation may limit the use of health services, particularly for migrants in an irregular situation.

The health of migrants is a human rights and social equity issue. This becomes clear when adopting a broad definition of poverty and wealth, which encompasses the need for autonomy over the circumstances determining one's life and health. Migrants need to be empowered to be able to make healthy choices in life and lead a life according to their own values. In a rights-based framework which aims at achieving health equity and improving the health of migrants by addressing the broader determinants of health, services need to become more migrant friendly. This requires the exploration of different means to improve cultural awareness in service provision, including through the training of health and social service providers and medical pluralist approaches.

It is in the interest of both migrants and host communities' health that migrants are not left to fall between the cracks and that they have equitable access to health and social services.

The specific health challenges which migrants experience both throughout the migration process as well as in the country of destination illustrate why migration itself can be considered a social determinant of health. The management of migrants' health goes beyond the traditional management of diseases among mobile populations and is intrinsically linked with the broader social-determinants of health and unequal distribution of health and social services.

It is for this reason that multi-disciplinary and multi-sector stakeholders should work in partnership to avoid social exclusion and improve the health of all people including migrants. The Social Determinants of Health Framework looks to improve access to health, but it goes beyond health care to understand and combat the broader causes of ill health.

Especially in the case of migration, there is a need to develop and strengthen partnerships between various sectors to:

- Develop and implement integration and prevention strategies to decrease stigmatization, social exclusion, discrimination and marginalization of migrant populations. Also to offer language, cultural and gender sensitive services, and facilitate ethnic community participation in the delivery of health services and policy design.
- It is crucial to ensure that national policies and laws respect the rights of migrants and improve access to health promotion, prevention, care and treatment for all migrants regardless of their immigration status.

- Multi-sectoral partnerships are necessary to support research to assess and document the links between migration and social determinants of health; as well as to enhance national and international surveillance and information systems and ensure inclusion of disaggregated health data concerning migrant populations.

Note about the authors

Dr Anita Alero Davies

Anita A. Davies is a Public Health Physician with the Migration Health Department, International Organization for Migration (IOM) Geneva.

Dr Davies has 17+ years experience of clinical practice, policy deployment, teaching and research in public health. Dr Davies has worked at the national and district level, with NGOs and international organizations in Africa. She has also worked in public health in the British National Health Service (NHS).

Dr Davies is particularly interested in capacity development and public health issues relevant to vulnerable groups. Dr Davies is currently the focal point for migration health and development, emerging and re-emerging diseases in migrant communities.

Anna Basten

Anna Basten holds a Master of Arts in Global Political Economy from the University of Kassel, Germany and a BA in Social Sciences and French from the University of Manchester, UK.

Anna Basten has worked with refugees at the Caritas Home for Refugees in Salzburg (Austria) and was involved in community empowerment in Mauritania (GTZ).

In 2008 Anna Basten joined the International Organization for Migration (IOM) in Geneva, Switzerland. Her main focus areas are Migration Health and Development, including Migration of Human Resources for Health, as well as Migration and Gender.

Chiara Frattini

Chiara Frattini has graduated in Law at the Università Statale di Milano, Italy, and holds a Masters' in International Cooperation from the Istituto per gli Studi di Politica Internazionale of Milan, Italy. She has worked at development NGOs in Italy and Argentina and at the International Federation of Red Cross Red Crescent Societies in Geneva, Switzerland. She worked at the International Organization for Migration, Regional Office for Mexico and Central America. She is now working as Project Assistant with the Migration Health Department of the International Organization for Migration in Geneva, Switzerland.

References

- Arcury, T.A. & Quandt, S., 2007. Delivery of Health Services to Migrant and Seasonal Farmworkers. *Annual Review of Public Health*, 28, 345-363.
- Barnett, T. et al., 2009. *Migrant health: Background note to the ECDC report on migration and infectious diseases in the EU*, Stockholm: European Centre for Disease Prevention and Control. Available at: http://www.ecdc.europa.eu/en/files/pdf/Health_topics/0907_TER_Migrant_health_Background_note.pdf [Accessed August 14, 2009].
- Braubach, M. & Savelsberg, J., 2009. *Social inequalities and their influence on housing risk factors and health. A data report based on the WHO LARES database*, Copenhagen: WHO Regional Office for Europe. Available at: <http://www.euro.who.int/Document/E92729.pdf> [Accessed September 3, 2009].
- Clapham, A. & Robinson, M., 2009. *Realizing the Right to Health*, Zurich: rüffer & rub.
- Commission on Social Determinants of Health, 2008. *Closing the Gap in a Generation. Final Report. Executive Summary*, World Health Organization. Available at: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html [Accessed August 17, 2009].
- Darmon, N. & Khlat, M., 2001. An Overview of the Health Status of Migrants in France, in Relation to Their Dietary Practices. *Public Health Nutrition*, 4(02), 163-172.
- Duckett, M., 2001. *Migrants' Right to Health*, Geneva: UNAIDS. Available at: http://whqlibdoc.who.int/unaid/2001/UNAIDS_01.16E.pdf [Accessed September 16, 2009].
- Ebrahim, S. & Smeeth, L., 2005. Non-communicable diseases in low and middle income countries: a priority or a distraction? *International Journal of Epidemiology*, 34, 961-966.
- Fitzpatrick, J. & Brotman, S., 2002. *The Human Rights of Migrants*, Geneva. Available at: http://www.baliprocess.net/files/ConferenceDocumentation/The%20Human%20Rights%20of%20Migrants_%202002.pdf [Accessed September 16, 2009].
- Green, G. et al., 2006. "We are not completely Westernised": Dual medical systems and pathways to health care among Chinese migrant women in England. *Social Science & Medicine*, 62(6), 1498-1509.
- Hossain, P., Kavar, B. & El Nahas, M., 2007. Obesity and Diabetes in the Developing World -- A Growing Challenge. *N Engl J Med*, 356(3), 213-215.
- International Convention on the Protection of the Rights of All Migrant Workers and Members of

Their Families, 1990. Available at: <http://www2.ohchr.org/english/law/cmw.htm> [Accessed September 16, 2009].

International Covenant on Economic, Social and Cultural Rights, 1966. Available at: <http://www2.ohchr.org/english/law/cescr.htm> [Accessed September 16, 2009].

International Organization for Migration, 2004. *Glossary on Migration*, Geneva: IOM.

International Organization for Migration, 2005. *World Migration*, Geneva: IOM.

Jasso, G. et al., 2004. *Immigrant Health--Selectivity and Acculturation*, EconWPA. Available at: <http://ideas.repec.org/p/wpa/wuwp/0412002.html> [Accessed June 11, 2009].

Kandula, N., Kersey, M. & Lurie, N., 2004. Assuring the Health of Immigrants: What the Leading Health Indicators Tell Us. *Annual Review of Public Health*, 25, 357-376.

Malin, M. & Gissler, M., 2009. Maternal care and birth outcomes among ethnic minority women in Finland. *BMC Public Health*, 9, 84.

Marmot, M., 2006. Health in an unequal world. *The Lancet*, 368(9552), 2081-2094.

Mladovski, P., 2009. A framework for analysing migrant health policies in Europe. *Health Policy*.

Mladovski, P., 2007. Migrant Health in the EU. *Eurohealth*, 13(1). Available at: http://www.euro.who.int/Document/Obs/Eurohealth13_1.pdf [Accessed September 2, 2009].

Nygren-Krug, H., 2003. *International Migration, Health & Human Rights*, World Health Organization.

Office of the United Nations High Commissioner for Human Rights (OHCHR); World Health Organization (WHO), 2008. *The Right to Health*, Fact Sheet No. 31, Office of the United Nations High Commissioner for Human Rights.

Oppedal, B., Roysamb, E. & Sam, D.L., 2004. The effect of acculturation and social support on change in mental health among young immigrants. *International Journal of Behavioral Development*, 28(6), 481-494.

Pace, P. (ed.), 2007, *Migration and the Right to Health: A Review of European Community law and Council of Europe Instruments*, International Organization for Migration.

Pace, P., 2009, *Migration and the Right to Health: A Review of International Law*, International Organization for Migration.

- Platform for International Cooperation on Undocumented Migrants, 2007. *REPORT Access to Health Care for Undocumented Migrants in Europe*, Brussels: PICUM. Available at: [http://www.picum.org/HOMEPAGE/Health%20care/REPORT%20Access%20to%20Health%20Care%20for%20Undocumented%20Migrants%20in%20Europe%20\(17\).pdf](http://www.picum.org/HOMEPAGE/Health%20care/REPORT%20Access%20to%20Health%20Care%20for%20Undocumented%20Migrants%20in%20Europe%20(17).pdf) [Accessed August 14, 2009].
- Potts, H., 2008. *Participation and the right to the highest attainable standard of health*, University of Essex. Available at: http://www2.essex.ac.uk/human_rights_centre/rth/docs/Participation.pdf [Accessed September 16, 2009].
- Smith, H., 2007. 50 migrants feared dead as boat capsizes. *The Guardian*. Available at: <http://www.guardian.co.uk/world/2007/dec/11/turkey.greece> [Accessed June 18, 2009].
- Van Liemt, G., 2004. *Human trafficking in Europe: an economic perspective*, Cornell University ILR School. Available at: <http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1008&context=forcedlabor> [Accessed June 18, 2009].
- Vissandjee, B. et al., 2004. Integrating ethnicity and Migration as Determinants of Canadian Women's Health. *BMC Women's Health*, 4.
- Wallerstein, N., 2006. *What is the evidence on effectiveness of empowerment to improve health? (Health Evidence Network Report)*, Copenhagen: WHO Regional Office for Europe. Available at: [Accessed June 11, 2009].
- Wiking, E., Johansson, S. & Sundquist, J., 2004. Ethnicity, acculturation, and self reported health. A population based study among immigrants from Poland, Turkey, and Iran in Sweden. *J Epidemiol Community Health*, 58(7), 574-582.
- Wilkinson, R. & Marmot, M., 2003. *Social Determinants of Health: The Solid Facts*, Copenhagen: WHO Regional Office for Europe. Available at: <http://www.euro.who.int/DOCUMENT/E81384.PDF> [Accessed September 2, 2009].
- Will, B., Zeeb, H. & Baune, B., 2005. Overweight and obesity at school entry among migrant and German children: a cross-sectional study. *BMC Public Health*, 5(1), 45.
- Wolff, H. et al., 2008. Undocumented migrants lack access to pregnancy care and prevention. *BMC Public Health*, 8. Available at: <http://ukpmc.ac.uk/articlerender.cgi?artid=1436004> [Accessed June 23, 2009].
- World Health Organization, 1948. *Constitution*, WHO.

World Health Organization, 2007. *Health of Migrants. Report by the Secretariat*, WHO. Available at: http://www.who.int/hac/techguidance/health_of_migrants/B122_11-en.pdf [Accessed June 15, 2009].

World Health Organization Europe, 2007. *Disparities in progress towards the Millennium Development Goals on reducing child and maternal mortality*, Available at: <http://www.euro.who.int/document/mediacentre/fs0807e.pdf> [Accessed August 14, 2009].