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OIM Organisation Internationale pour les Migrations
OIM Organización Internacional para las Migraciones

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RAPPORT DU SEMINAIRE

"SANTE ET MIGRATION"

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RESUME ANALYTIQUE

Introduction

1. Les migrations appartiennent à notre quotidien et les migrants jouent un rôle essentiel dans l'économie mondiale actuelle. A mesure que les flux migratoires prennent plus d'ampleur à l'échelle planétaire, la santé des populations mobiles et des sociétés qui sont à leur contact apparaît comme un problème public majeur. A ce jour, cependant, on ne constate qu'une prise de conscience limitée de l'interdépendance entre le phénomène migratoire et la politique de santé publique. Sachant que les migrants sont, sur le plan sanitaire, des éléments de contact entre les communautés dont ils sont originaires, les pays de transit et de destination et les communautés dans lesquelles ils sont appelés à retourner, la santé dans le contexte migratoire est devenue un aspect critique de toute politique migratoire, et il importe qu'elle soit intégrée dans les stratégies de gestion des migrations, dans l'intérêt à la fois des individus et des sociétés.

2. L'Organisation internationale pour les migrations (OIM) a organisé un séminaire sur le thème "Santé et Migration" à Genève, du 9 au 11 juin 2004, à titre d'atelier intersessions du Dialogue international sur la migration dans le cadre du Conseil de l'OIM, avec le coparrainage de l'Organisation mondiale de la Santé (OMS) et des Centres de contrôle et de prévention des maladies (CDC). Ce séminaire a permis la rencontre de fonctionnaires des deux milieux – santé et migration - ainsi que de décideurs, de praticiens et d'autres parties prenantes appartenant à des administrations gouvernementales et à des organisations intergouvernementales ou non gouvernementales, l'accent étant mis sur les implications, en termes de santé publique, de la mobilité croissante des populations.

Relations entre santé et migration: la nécessité d'une approche globale de santé publique

3. A une époque où les voyageurs se déplacent plus rapidement que jamais et vers des destinations toujours plus nombreuses, une sorte de fusion s'opère au niveau sanitaire, reflétant les conditions socio-économiques et culturelles, ainsi que la prévalence des maladies au sein des communautés d'origine, de transit, de destination et de retour. La réémergence de la tuberculose dans certaines régions développées de la planète, la propagation rapide du virus de l'immunodéficience humaine (VIH) et le syndrome respiratoire aigu sévère (SRAS) sont quelques exemples parmi d'autres des liens unissant la santé et la mobilité des populations.

4. La principale réponse aux risques que posent les migrations pour la santé publique a été le contrôle médical des migrants censés être les plus exposés. Cette pratique vise à contenir la propagation des maladies infectieuses. Les avantages de cette action de dépistage peuvent cependant être mis en doute sur un certain nombre de points :

- **Efficacité** – Les actions de dépistage ne permettent pas de déceler les maladies dans leur stade d'incubation. Moins d'un quart des migrants porteurs de la tuberculose sont dépistés à leur arrivée aux postes frontières des Etats-Unis.

- **Ethique** – Les actions de dépistage risquent de se traduire par une stigmatisation des migrants, tant dans les communautés d'origine que dans les communautés d'accueil.

- **Applicabilité** – Si les dépistages répondent bien aux préoccupations de santé publique des pays développés en termes de migrations contrôlées, régulières et répondant à une demande de main-d'œuvre, ils ne sont pas conçus pour prendre en compte les risques liés aux déplacements de courte durée ni aux migrations internes ou irrégulières, et peuvent de ce fait créer un faux sentiment de sécurité.

- **Double perspective** – Une politique sanitaire de la migration doit considérer le migrant tout à la fois comme un vecteur de risque pour la santé de la communauté d'accueil et comme une personne en situation de vulnérabilité face à la maladie, en attente de soins et pouvant se prévaloir du droit à la santé.

5. Les dépistages médicaux peuvent apparaître comme un moyen utile de faciliter l'intégration des immigrés dans la société d'accueil, moyennant l'identification de leurs besoins sanitaires et leur incorporation dans le système de soins de santé. Cependant, de tels dépistages, pour être efficaces, doivent comprendre une évaluation des conditions non infectieuses, des maladies chroniques, de la santé mentale et des traumatismes psychiques.

6. Pour différentes raisons, les migrants ont souvent de la peine à préserver leur état de santé et à se maintenir dans les conditions qui favorisent le bien-être. Ils subissent dans une mesure disproportionnée les maladies et autres pathologies, qu'ils en aient été victimes dans les pays d'origine ou de transit durant leur migration ou qu'elles résultent des conditions socio-économiques de leur séjour dans le pays d'accueil. D'autre part, les obstacles linguistiques, culturels et juridiques peuvent restreindre leur accès aux services sanitaires existants. Ils sont fréquemment mal informés des types de traitement qui peuvent leur être proposés ou de la manière dont ils peuvent en faire la demande. Une politique globale de la santé dans le contexte migratoire doit aller au-delà du simple dépistage des maladies et œuvrer pour une moins grande vulnérabilité des populations immigrées sous la forme d'un accès facilité aux soins de santé.

7. Dans l'ensemble, la meilleure approche de cette problématique d'importance grandissante que représente la santé des migrants est la mise au point d'un système mondial de santé publique capable d'établir une passerelle entre les communautés d'origine, de transit, de destination et de retour, de mettre en place un solide mécanisme de surveillance des maladies à l'échelle mondiale, d'assurer l'accès aux structures sanitaires à l'intérieur et au-delà des frontières, et d'offrir un mécanisme de réponse rapide permettant de contenir les épidémies. Une telle approche globale devrait en outre prendre en considération les causes sous-jacentes des maladies, des problèmes de santé et de l'inégalité.

Gérer la problématique de la santé dans le contexte migratoire: Comment passer de l'exclusion à l'intégration

Politiques et stratégies d'intégration

8. A l'heure actuelle, la plupart des nations se heurtent à des difficultés lorsqu'elles tentent de mettre sur pied des politiques migratoires visant à intégrer tout à la fois les besoins sanitaires des communautés d'accueil et des populations immigrées. D'une part, les communautés d'accueil veulent se protéger contre la menace des maladies, lesquelles peuvent être apportées de

l'extérieur, ou elles peuvent vouloir réduire la demande accrue et le poids économique que font peser les nouveaux venus sur les programmes de santé publique et de sécurité sociale tributaires des finances publiques. D'autre part, les migrants peuvent avoir des priorités en termes de santé publique et de sécurité sociale qui soient liées à leurs droits humains fondamentaux, notamment le droit à la santé[1] et l'accès aux services existants de santé publique et de sécurité sociale. C'est pourquoi la gestion de la santé dans le contexte migratoire requiert des gouvernements qu'ils trouvent le point d'équilibre entre leurs responsabilités souveraines vis-à-vis de leurs électeurs, des services de santé et de sécurité sociale tributaires des finances publiques, mais aussi au regard de leurs obligations internationales concernant la protection des populations vulnérables.

9. Les politiques et les pratiques d'intégration offrent de meilleures perspectives pour ce qui est d'améliorer ou de maintenir le bien-être des populations autochtones et immigrées, indépendamment de leur statut au plan légal ou de la citoyenneté. Par ailleurs, de telles politiques facilitent l'intégration des migrants dans les communautés d'accueil en encourageant leur participation économique et sociale. De plus, une politique d'exclusion basée sur des considérations de santé, outre qu'elle est source de discrimination, pose des problèmes d'éthique et peut contribuer à la stigmatisation des migrants.

10. Davantage de recherches devront être menées pour mieux comprendre les liens entre la santé et les migrations contemporaines, afin de mettre au point des politiques et des stratégies efficaces. Par ailleurs, une prise de conscience accrue dans le grand public s'impose, en même temps qu'une sensibilisation aux vrais problèmes d'intégration que sont le barrage de la langue, les différences culturelles et le vécu de l'expérience migratoire, si l'on veut accorder l'attention requise aux facteurs qui influent sur le profil sanitaire des migrants. Enfin, le fait de faire participer la communauté à la fourniture de services de soins de santé en faveur des migrants peut atténuer sensiblement les préjudices dont les populations immigrées sont victimes au plan local et combler le fossé culturel entre les prestataires et les bénéficiaires des soins de santé. Le maintien d'une politique publique de soutien aux migrants et les efforts déployés pour favoriser la compréhension mutuelle au sein des communautés hétérogènes constituent un aspect critique de la gestion des services de soins de santé, entre autres.

La santé en tant que concept intégral

11. La santé est définie comme "un état de complet bien-être physique, mental et social et ne consiste pas seulement en une absence de maladie ou d'infirmité".[2] La santé dans un contexte de migration concerne le bien-être non seulement des migrants eux-mêmes, mais aussi des communautés avec lesquelles ils sont en contact et porte également sur les pathologies chroniques non infectieuses, les problèmes de santé mentale et la compréhension des questions relatives à la santé publique et aux droits de l'homme.

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[1] L'article 25 de la Déclaration universelle des droits de l'homme stipule ceci: "Toute personne a droit à un niveau de vie suffisant pour assurer sa santé, son bien-être et ceux de sa famille, notamment pour l'alimentation, l'habillement, le logement, les soins médicaux ainsi que pour les services sociaux nécessaires."

[2] Voir à ce propos le préambule de la Constitution de l'Organisation mondiale de la Santé, http://www.who.int/about/definition/fr/

12. Le bien-être mental est fondamentalement lié au bien-être physique et social et à l'état de la santé publique.[3] Le fait de se soucier du bien-être mental des migrants a pour résultat de faciliter leur intégration[4] dans les communautés d'accueil, en ce sens que les personnes qui ont un sentiment de bien-être sont plus réceptives à l'éducation et à l'emploi. En conséquence, la santé mentale doit faire partie intégrante des programmes de santé publique. Dans les situations d'après-conflit ou d'après-crise, l'état de santé mentale constitue un élément important de la stabilité future des communautés et de la société au sens large, en même temps qu'un facteur incitatif pour la reconstruction dans un climat pacifique.

L'inclusion des immigrés en situation irrégulière

13. La gestion de la santé des immigrés en situation irrégulière, dont font notamment partie les personnes ayant fait l'objet d'un trafic ou introduites de façon clandestine, pose à de nombreux gouvernements l'un de leurs plus grands dilemmes. Si beaucoup ont le sentiment que le fait de rendre les services de soins de santé et de sécurité sociale accessibles aux immigrés en situation irrégulière sert également les intérêts des électeurs, d'autres en revanche considèrent que le fait de laisser les migrants en situation irrégulière bénéficier des services de soins de santé revient implicitement à légitimer la migration irrégulière. Les solutions proposées pour résoudre ce dilemme sont la fourniture des soins de santé uniquement en cas d'urgence ou l'accès aux services de soins de santé après un temps d'attente défini. Les nations qui permettent aux immigrés en situation irrégulière de bénéficier des soins de santé et des services de sécurité sociale ont constaté que, dans certains cas, les immigrés n'y ont pas recours par crainte d'être arrêtés et expulsés ou de ne pas être traités d'une façon prenant en compte leurs particularités culturelles.

14. Les retours volontaires sont un moyen de gérer la migration irrégulière auquel les gouvernements ont de plus en plus souvent recours. Toutefois, ce processus peut conduire à aggraver encore la pression que subit non seulement le migrant ayant opté pour le retour, mais aussi le pays d'origine, dès lors que les rapatriés présentent des états de santé exigeant des soins qu'ils ne peuvent pas leur être donnés sur place ou que le pays ne peut pas se permettre. A l'heure actuelle, il n'existe pas de politiques sanitaires ni de pratiques de gestion permettant de répondre aux préoccupations des rapatriés dans le domaine de la santé. Des propositions innovantes, par exemple sous la forme de "modèles de responsabilité partagée entre les pays d'origine et de destination" ou "d'options de partage équitable du fardeau" peuvent apporter une solution sur ce plan et stimuler un débat sur les responsabilités nationales.

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[3] L'Organisation mondiale de la Santé estime que 12 pour cent des frais mondiaux de soins de santé sont imputables aux désordres mentaux et autres troubles de comportement, alors que les budgets de la plupart des pays dans le domaine de la santé mentale n'atteignent même pas 1 pour cent des dépenses nationales. Quarante pour cent des pays n'ont aucune politique de santé mentale et 30 pour cent n'ont pas de programme de santé mentale. OMS: Rapport sur la santé dans le monde 2001: La Santé mentale: Nouvelle conception, nouveaux espoirs. Genève, Organisation mondiale de la Santé, 2001.

[4] L'intégration suppose qu'une personne est membre à part entière d'une société, et jouit de tous les droits, privilèges et responsabilités qui sont ceux des autochtones, et qu'elle participe et contribue ainsi à la vie de cette société.

Partenariats et co-responsabilités

15. Le séminaire a souligné l'importance d'un engagement mondial portant sur l'instauration de partenariats et l'exercice conjoint de responsabilités concernant la gestion et les pratiques sanitaires dans le contexte migratoire. Il faut nouer des partenariats ou renforcer ceux qui existent entre les gouvernements, mais aussi entre les organisations et les communautés, tant au niveau national que régional et international. L'épidémie récente de SRAS et la réaction internationale qu'elle a rapidement suscitée ont montré ce que peut faire la coopération internationale pour réduire sensiblement la propagation d'une maladie et protéger la santé publique à l'échelle mondiale. A l'inverse, une mauvaise gestion de la mobilité et de la santé publique peut avoir toutes sortes de conséquences qui dépassent le simple cadre de la santé publique et se répercutent sur l'économie mondiale, le commerce mondial et les relations politiques internationales.

16. Les domaines ci-après ont été désignés comme prioritaires dans la perspective d'un développement ou d'un renforcement des partenariats:

- ***Appui aux programmes et renforcement du potentiel local***
  Un échange international et intersectoriel des meilleures pratiques en matière d'élaboration, de conception, de mise en œuvre et d'évaluation de programmes peut se traduire par un gain d'efficacité et de durabilité des programmes sanitaires. Il serait souhaitable que ces programmes s'inscrivent dans des structures nationales, autrement dit qu'ils soient sollicités et acceptés par les gouvernements locaux et intégrés dans les plans sanitaires nationaux.

- ***Lutte contre les maladies contagieuses, notamment les maladies nouvelles***
  Une coordination s'impose entre les autorités des domaines migratoire et sanitaire et les prestataires de soins de santé dans une optique de prévention, de détection précoce et de réponse rapide aux maladies contagieuses. A terme, il faut espérer qu'une telle entreprise constituera le fondement d'un système mondial de santé publique en mesure de surveiller à l'échelle planétaire les maladies infectieuses émergentes.

- ***Migration des professionnels de la santé***
  La migration des professionnels de la santé pose un défi croissant au niveau de la gestion des systèmes de soins de santé, particulièrement dans les pays en développement confrontés à des crises sanitaires telles que le VIH/SIDA. En raison de la libéralisation du commerce et des forces à l'œuvre sur la scène de la mondialisation, ces flux migratoires sont appelés à s'amplifier encore. En instaurant des partenariats, il est possible de mieux gérer les fluctuations dont font l'objet la demande de soins de santé et les ressources disponibles des pays considérés individuellement. Les accords bilatéraux constituent un instrument utile, en ce sens qu'ils permettent des programmes d'échange à court terme, des programmes de renforcement de potentiel à l'intention des prestataires de soins de santé, et la mise au point de systèmes incitatifs susceptibles d'encourager les nationaux qualifiés à retourner dans leur pays afin de faire profiter ces derniers de leurs compétences et de leurs connaissances dans le domaine médical.

- ***Sensibilisation aux problèmes essentiels que pose la santé dans le contexte migratoire***
  Il faut insister sur les liens entre la sphère migratoire et la sphère sanitaire afin de susciter une prise de conscience au sein des gouvernements, des organisations intergouvernementales et des organisations non gouvernementales, de même que dans le grand public.

Conclusions

17. Partant du constat selon lequel une réelle opportunité s'offre aujourd'hui pour mener une action sur le plan de la santé dans le contexte migratoire, ce dialogue a été voué à susciter une prise de conscience de la problématique sanitaire en tant qu'élément à part entière du fait migratoire, et donc à faire en sorte que la problématique migratoire et la problématique sanitaire cessent d'être considérées comme deux domaines distincts. C'est sur cette base que le séminaire a proposé deux mesures à mettre en œuvre sans attendre:

- L'engagement **à promouvoir l'intégration des questions sanitaires** dans les différents aspects du fait migratoire où nous sommes appelés à intervenir, et à plaider pour cette intégration.

- L'engagement à **nouer des partenariats et à partager les responsabilités** entre les gouvernements, mais aussi entre les organisations, aux niveaux communautaire, national, régional et international.

18. On ne pourra jamais trop souligner l'importance d'une plate-forme de dialogue à partir de laquelle on puisse élaborer des solutions politiques stratégiques et une politique de gestion concertée. Le séminaire Santé et Migration qui s'est tenu à Genève a été la première initiative dans la voie de la création d'une telle plate-forme. Des initiatives similaires ont été entreprises au niveau régional, avec le séminaire Santé et Migration qui s'est tenu au Guatemala. Avec le renforcement de ces réseaux, nous oeuvrons à la mise en place d'un système mondial de santé publique capable de combler l'écart entre les communautés d'origine, de transit, de destination et de retour.

HEALTH AND MIGRATION SEMINAR

REPORT OF THE MEETING

All speakers participated in their personal capacity. The views expressed are thus not necessarily those of their governments.

9 JUNE: HEALTH AND MIGRATION CHALLENGES

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, Center for Disease Control (CDC)

1. The main objective of the seminar was to explore the significant links and interdependencies 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, centering around the health objectives of migrants, source countries, destination countries, and emerging global public health concerns.

2. 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 conductors 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 nexus of health and migration.
- *Investing in Migration Health*: defining national responsibilities toward ir/regular migrants and refugees and developing international health regulations, which are responsive to emerging threats.
- *Migration of Health Care Workers:* evaluating "brain drain", channelling diaspora resources, forging international recruitment commitments, and retaining personnel in light of global shortages of health care workers.
- *What is Foreseen for the Future*: exploring collaborative policies 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 which cross cuts 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 are at stake from both health and migration perspectives? Why should we care?

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

3. 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. 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 on the planet.

4. 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 health care providers, health policy analysts, immigration officials, social scientists, government 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.

5. The experience and understanding gleaned from traditional immigration health programs 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 good understanding and appreciation of the dynamics and nature of modern migration. Nations such as Canada, Australia and the US with long-standing immigration health programs use this knowledge and capacity to help in meeting the challenges of situations such as the recent SARS episode.

6. The outcomes and best practices that result from dynamic and effective immigration health programs have proved both useful and important in managing migration-related public health challenges. Proper screening and referral programs, for example, continue to allow for large immigration programs 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 program and managing public health risks.

7. We understand that migration is both a fundamental and expanding issue on the global scene. 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.

8. As the processes and challenges created by the interface of migration and health are increasingly global and interrelated, the solutions and responses will, by conclusion need to be the same. 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 also be foremost in our minds.

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

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

10. 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, diarrhea, Acute Respiratory Infections (ARI), measles, and TB; except for measles they cannot, at present, be prevented by vaccination but can be prevented by interventions such as condoms (AIDS), and bed-nets (malaria)[1]; 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.
- *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.
- *Emerging and remerging infectious diseases* are infectious disease threats that, like Bovine Spongiform Encephalopathy (BSE), severe acute respiratory syndrome (SARS), or avian influenza, have breeched 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.

11. Infectious diseases result in 14 million deaths each year. Over 80% of this mortality 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.

12. The world has the goods needed to control, eliminate or eradicate infectious diseases. Antimicrobial medicines in conjunction with preventative 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, reliant upon multi-sectoral coordination, has dramatically reduced mortality, disability and negative economic impact from infectious diseases. Tuberculosis and malaria, for example, have been well controlled in countries such as Peru and Vietnam respectively, where governments have ensured access to medicines and preventive measures.

13. Refusing entry of those who are diagnosed with illness in migrant populations in order to prevent the spread of infectious diseases and /or infectious disease outbreaks is not an effective means of containing the spread of infectious disease. 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.

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

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

Bridging Health and Migration
Dr. Danielle Grondin – Director, Migration Health, IOM

16. 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% of the world population are migrants, women accounting for slightly more that 50% of them.[1] 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 a multidirectional including circular movement. Contemporary migration is a worldwide phenomenon that is changing the faces 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 good understanding of the complexity and the diversity of these various patterns, and there are still mismatch between policies and the reality of these migratory patterns. **Health** is far more than just the absence of disease, but is a "state of physical, mental, and social well-being",[2] thus requiring expanding 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 misfits.

17. 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 defines access to health and social services. Mobility patterns (regular vs. irregular) and legal status often define the level of vulnerability of migrants in a society. Migrants are a particularly vulnerable population for health issues and for other reasons. Linguistic, cultural, and religious estrangement or barriers conspire to make provision and receipt of migrant health care difficult.
They are disproportionately afflicted with disease, often with considerably higher incidence than locals in the host country and their counterparts in the source country[2,]. They may have been exposed to new diseases in transit or in their host country. Often marginalized, they are seldom aware of their rights or how to request treatment from local governments, non- or inter-governmental organizations

18. WHY should we be concerned in bridging health and migration? Migrants have a right to health. Health is a crosscutting issue of all varied and complex migration issues. Migration health focuses on wellbeing of migrants and communities at source, transit, destination and return countries and regions. Additionally, it addresses the specific public health issues (of communities) as well as the health of individual migrants through policy, advocacy, research, and development, to work toward improving migrants' access to health care, thereby reducing their general vulnerability. The importance of integration, (i.e., autonomous participation and contribution to host societies) with respect to a successful migration outcome, has therefore called for a comprehensive interpretation of 'migrant health' beyond infectious disease control, towards inclusion of chronic conditions, mental health concerns, cultural beliefs and understanding of health, and human rights issues.

19. How can we effectively bridge health and migration? By:

- harmonizing policy to the needs of the migrants & communities
  * develop policy research, so to get the facts right and adapt the policies accordingly
  * policy comprehensiveness
  * evidence – based advocacy
- building capacity via training
- establishing co-operation & partnership between source, transit, destination & return countries/regions
- developing policies of prevention & care strategies aiming at
  * inclusion rather than exclusion
  * reducing vulnerability
  * facilitating access to health care

Discussion from Session I: Health and Migration Challenges

20. Debate centered on the use and administration of health screenings for prospective migrants. The effectiveness of health screenings was questioned because they cannot and do not detect diseases during their incubation period. As such, they can provide a false sense of security via lower rates of detection due to a disease's incubation period.

21. Health screenings also raised issues of 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. Country-wide prevalence rates are deeply misleading; they often mask much higher disease incidence in immigration communities. Screening, therefore, cannot be said to have effectively deflected or managed disease among the population that it regulates.

22. The applicability of health screening was also questioned as being particularly suited to controlling the demand-determined, regular migration of developed nations but not addressing public health threats generated from travel, irregular, and internal migration of developing nations. Thus, nations with high rates of irregular migration stressed the need for an integrated policy approach and for more resources in addressing the health care needs of these migrant populations.

23. The management of migration and health issues has two aspects: migrants as a potential threat to receiving countries and migrants as individuals vulnerable to disease who need care. Migrants may act as vectors of illness, 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 potentially threatened. Their right to health needs to be served as well.

Session II: PUBLIC HEALTH & 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

24. Evaluation of 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 inequality, chronic and infectious diseases endemic in only certain regions of the world, and relatively poor health care capacity in migration source countries. These realms of disparity are then connected by an increasingly complex web of global movements, within a world where traditional frontiers are losing their importance as sole points of entry. Clearly, migration from this context has outcomes for health that vary with the situation of the migrant. These outcomes may be positive, negative or neutral and the outcome influences program and policy decisions with negative outcomes often generating the most attention. In order to combat these consequences, our policies and attitudes must reflect these current realities; older national approaches simply are no longer valid.

25. Disparity coupled with increasing ease of movement for all types of persons requires health officials to adapt to new categories of carriers and to different channels of conduction. For instance, disease surveillance officers should know that malaria is most likely to be imported not by migrants, but by a new category of individuals, or those Visiting Friends and Relatives (VFR).

26. Combating emerging and reemerging infectious diseases requires widening 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 hopes of identifying emerging threats and looking beyond the danger of the week.

27. An individual's migration history ought to be made available in the context of his/her health record. Migrants' paths of movement shed light on their potential exposure to disease, cultural or religious conceptions of health care, mental health state, and experiences--such as rape, loss, etc. All of this information, made a lateral component of one's health record, could facilitate better care before, during, and after migration. One hopes that then physicians and other caregivers could tailor their prognoses and services to the particulars deduced from an individual's migration history.

28. Chronic infections and non-infectious diseases, which are recurring and difficult to resolve, will likely 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 health care system, impede migrants' societal integration, and limit their potential economic contribution.

The Case of SARS: Lessons Learnt

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

29. 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.

30. 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.

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

Discussion from Session IIA: Public Health and Migration

32. The dialogue tended to question migrant health screenings as 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.

33. Proponents of health screenings felt that screening identifies 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.

34. Others pointed out that screenings miss most infection cases. Border checks in Taiwan detected only one SARS patient for every 1000 people; less than one-quarter of U.S. migrants' TB 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 ineffectual.

35. Certain governments' fear that ill migrants might prove a strain on their national health systems. These calculations were argued as misrepresenting the issue by presenting only one side of the equation, namely what migrants take from host governments. Migrants give back as well, increasing, in a macroeconomic sense, national production, income, and domestic multiplier effects, while contributing, in a microeconomic sense, their productivity and taxable income to the state. This final benefit, through national taxation, may neutralize in a sector-specific manner the government's costs incurred by providing migrants with health care. When estimating the monetary costs of new migrants to a country, one must also consider the economic, social, and societal dividends that migrants contribute. When governments consider from this broader perspective the costs and benefits of migration, the net result of investing in migrant health ought to be positive, with gains for both migrants and host countries.

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

37. It was acknowledged, from almost all corners, that preserving public support is a vital, perhaps the most vital ingredient in any sustainable migration policy. Without it, participants felt that migration programs could simply cease to exist.

B. Managing Global Public Health: Partnerships and Developing Bridging Public Health Programs
What benefits are there for including migrants in national and trans-national health schemes? Will this help the integration process? What are the public health issues confronting particular vulnerable peoples, such as trafficking victims?

Investing in Mental Health in Post-conflict Rehabilitation
Professor Ka Sunbaunat – Deputy-Dean, Ministry of Health, Cambodia

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

39. The initiative established and developed innovative mental health services, through accepted traditional venues, such as schools and primary practice offices. By using established infrastructure, the program launched the services inexpensively, in a manner made directly accessible to the consumer. Advertising these through well-regarded media also conferred initial, immediate legitimacy to the care, a necessary condition for the program's success.

40. Continued data collection on its care services, patient makeup, and distribution has allowed the program to remain responsive to its current clients, 70% of whom are female, 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 program to evaluate its current performance; assess general needs and conditions; direct its 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

41. Migrants often experience conditions, which increase their vulnerability. This overall "at risk" status can be compounded by disparities in health, socio-economic and education levels, often 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.

42. The health status of migrants in Costa Rica is not on par with that of the local population. Migrants represent fewer than 8% of the population[3], yet account for 20% of the health budget and are still under-served. Costa Rica has not yet isolated the specific factors driving this health status disparity, but it might be due to slightly higher initial prevalence of disease compounded by unequal treatment and living conditions favourable to the sustainment and transmission of disease. Determining more specifically the factors that promote their higher-prevalence rates might allow better targeting of care.

43. National surveys have shown migrants to be at a disadvantage from native populations when it comes to employment, education and health. These circumstances are not formally separable into causes—say, deficient education and health, initial prejudice—and effects—poor wages, inferior health care provision, and sustained discrimination. Rather, the various factors seem to reinforce and feed off of 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 inter-dependence and connection of the problems, it is hoped that efforts to improve one facet

of the issue, say poor health care, will work toward improving migrants' conditions in other arenas as well.

44. Costa Rican initiatives to address these issues include bilateral cooperation to immunize all children under five and awareness program of 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

45. 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.

46. The U.S. and Mexico created a Bi-National Tuberculosis Management and Referral Program with the aims of reducing TB incidence and preventing drug resistance through completion of therapy, even across borders. In designing its Health Card, a focal point of the effort, the program took into account a variety of patient concerns, so that, in its final form, the card is written in English and Spanish, never mentions TB or the patient's name. Due 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.

47. The program is open to regular and irregular migrants.

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

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;
Arin Pasescu – Principal Inspector, Ministry of Administration and Interior, Romania

49. Trafficked persons, or persons moved from one place to another for the purpose of exploitation[3] are a specific subset of migrants with unique concerns. It is estimated that there are around four million people trafficked worldwide, with half a million originating from countries in Eastern and Central Europe.

50. Trafficked persons are at high risk of contracting infectious diseases; they are subject to mental illnesses, substance abuse and violence, all of which is 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.

51. 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.

52. 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

committed itself to implement policies, laws and programs to prevent and mitigate the effects of trafficking in human beings.

53. The Romanian Government National Strategy for combating trafficking is currently setting up an inter-ministerial group that will introduce public health interventions and medical assistance programs for victims of trafficking in Romania. The programs will include improved accessibility 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.

Discussion from Session IIB: Managing Global Public Health: Partnerships and Developing Bridging Public Health Programs

54. Participants praised the initiatives undertaken by various governmental presenters, but emphasized that there is still a lot of 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.

55. 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 the presence of these migrants. They often find it difficult to divorce their policing and regulatory functions from the humanitarian aspects of health care delivery. Governments tend to be most reluctant to provide routine or non-emergency medical care;[4] 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.

56. Those nations that actually have granted health services to irregular migrants, while maintaining their illegal status, often have difficulty convincing migrants that it is safe for them to seek care, without fear of deportation, arrest, etc.[5] One participant felt that there was a unique role for non-governmental organizations in providing necessary services, because in these instances, they are the only party that migrants can trust, especially for internal migrants displaced by conflict.

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

10 JUNE: MIGRATION & HEALTH POLICIES

Session III: MIGRATION & HEALTH POLICIES

A. Investing in Migration Health

What types of regulations exist at the international and national level to address cross-border health? What are their purposes, and how effective are they in addressing global public health? What are the options for policies to improve and provide access to health and social services? And what about deportation or voluntary return?

The International Health Regulations: Updates and Perspectives
Mr. William Cocksedge – International Health Regulations, Communicable Disease, WHO

58. Public health and security are now, more than ever, 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.

59. International Health Regulations (IHR) are a necessary, vital component of any health and health-related security schema; however, the present IHR are woefully outdated. Largely left over from 1969, IHR currently require international reporting for only three diseases—cholera, plague and yellow fever—none of which would classify as an imminent global emergency. They also do not encourage information sharing or collaboration and provide little flexibility in handling Public Health Emergencies of International Concern (PHEIC).

60. There is, however, a new formulation of the International Health Regulations (IHR) which effectively addresses global health and security concerns.[6] 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.

61. 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,[7] 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,[8] so long as all activities respect the "rights persons may have under applicable international agreements which provide for, or protect, the rights of persons."[9]

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

62. A dynamic relationship and interdependence that exists 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. Historicallly, this has led to migration health policies, which have focused selectively on protecting receiving nations from disease importation and costly post-migration utilization of health care resources through the use of quarantine and regulatory exclusion. This approach has led at times to discriminatory, inadequate, and ineffective migration health programs. Despite these policies, receiving nations remained at risk for disease importation. For migrant populations, these policies led to restricted movement, poorer health status, lack of access to necessary health care, ethical or confidentiality problems, and stigma and alienation in host and resettlement communities.

63. 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 multidrug- resistant diseases. Concentration on exclusion may sometimes leave host nations unprepared to deal with the health needs of those migrants that 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.

64. 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 precondition, prior to full realization of these benefits.

65. 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 begins addressing health care needs of U.S. destined refugees while they are still overseas. The program first ensures quality staffing and infrastructure in the field evaluating, training, and lending resources to support the capacity currently in place, when necessary.

66. 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 health care 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.

67. Local health interventions have included a relevant immunization regimen and augmented tuberculosis, HIV/AIDS, malaria, and intestinal parasite screenings, treatment, and referrals. As part of the Enhanced Health Program for Liberian refugees in Cote 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

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

69. Trauma is a condition, which can radiate through all facets of life, seriously impairing one'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 post-resettlement. The average prevalence rate for any one of 34 different tested conditions — from sustained employment problems to depression or disturbed sleep — was 51%. 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.

70. There are 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 terms of human suffering and mal-adjustment. Governments and other involved parties ought to conduct honest introspection about the nature and extent of their obligations to refugees, and assess how adequately the environment and tenor of their current services live up to their obligations.

71. As the developed world increasingly invests heavily in allowing people to move, its 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, more accessible movement. In the field of movement and the stance of return, there appears to be a measure of 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

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

73. Migrants' poor health status is in large part an outgrowth of divergent national conceptions and policies regarding how and when states become responsible to these individuals.[10] Thus, the intersection of migration and health cuts to the core of a larger, largely unexplored discussion on the mechanisms that obligate states in the provision of personalized services.

74. International legislation dictates that all individuals have a right to health,[11] presumably achieved only through the provision of a certain minimum level of health care. Thus, in principle all nations agree that everyone has a right to basic health services. Disputes arise over the application rather than the validity, of this precept, as nations employ different protocols to determine which parties are responsible in supplying the person-specific care.

75. There are *three different legislative responsibility models* currently in use *to determine state's health care obligations toward migrants.*

- *The Host Nation*: supports an intra-territorial responsibility model, where states have a responsibility toward all individuals—legal or irregular—within their national boundaries.
    - This view finds its expression in Costa Rican policy where, according to Dr. Cubillo, everyone living within the country's borders receives free medical care. In Jamaica, free medical care and other social services are also provided, but the following question is being asked: at what level should these be provided for immigrants and returning residents, compared with the level of care available to nationals?
- *The Source Nation*: conceives of contractual based obligation, where citizenship is the exclusive determinant for health care responsibility.
    - E.g.: All models where non-emergency national health care is provided only for citizens.
- *The Nation that Entered into a Relationship with the Migrant*: occurs when the state, which may be sending or receiving, either benefits from the individual or causes detriment to him/her.
    - 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 source country as infants, learned criminal or pathological behaviours in the host country, but were deported back to the source

country, or contributed all of their productive years in the country of destination, but then return home with high medical costs in their old age.

76. Many health related migration misunderstandings are the result of migrants linking two nations that endorse divergent models of how and when countries accept responsibility for individuals. This can result in unequal inter-country burden sharing; in migrants, particularly irregular migrants, simply falling through the cracks because they are ineligible for service from either nation; and in individuals that exploit inter-country policy differences, to their own benefit and the nation's detriment.

77. Widespread pension and/or social security provisions of host countries, which restrict receipt of payment to those within national (source country) borders, exacerbate 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 return migrants' health bills, often generating a net loss of capital for the source nation, per emigrated individual.

Discussion from Session IIIA: Health and Migration Challenges

78. 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,[12] articulated particular concern for returnees, internally displaced persons, refugees, asylum seekers, irregular migrants, and trafficked persons.

79. Another participant felt that policy and discussion emphasis on the in/utility of health screenings for incoming migrants had unduly averted the discussion's focus from the health needs of already settled migrants. Often marginalized and subject to poor sanitary conditions, the health needs of resident migrants need to be addressed by governments and all types of organizations.

80. 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 disease prevalence within their countries of origin upon their return.

81. Efforts should shift from a migration-health paradigm of exclusion to one of inclusion. The fact that only a small percentage of migrants have a right to access medical care underlines the need to create a new health care system consistent with its current demographics and the WHO goals for universal health. Programs 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.

82. Migration and health issues must be dealt with in terms of co- rather than exclusive responsibility. One should emphasize the complementary aspect 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 world issues.

B. Migration of Health Care Workers

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

Global Overview of Migration of Health Care Workers
Mr. Orvill Adams – Director, Department of Human Resources for Health, WHO

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

84. Developing countries tend to view the drain of their health professionals negatively, as opportunity loss, where the government expended time and money training an individual that then emigrated. It is also often construed as undermining national ability to care for the local population, first, by luring away 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 health care system.

85. By underestimating the value of community health workers, the current data relating to the need for health care professionals could be overstating the need of developing countries. Often untabulated in health surveys, these care givers serve certain local populations, and any analysis of the health worker shortage that does not take into account their presence runs the risk of being skewed.

86. 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 in a manner oriented to exclusively local needs—though instituting a purposefully incomplete curriculum could backfire by impeding workers' ability to efficiently serve their own country as well. Collaborative inter-country schemes could include the drafting and adoption of bilateral agreements as well as advocacy for the creation and assumption of binding ethical recruitment guidelines that reduce or prohibit emigration from severely underserved countries.

Using bilateral arrangements to manage migration of Health Care Workers: The Case of South Africa and the United Kingdom
Daisy Mafubelu – Health Attaché, South African Permanent Mission to the UN, Switzerland

87. Surveys show that both push and pull factors are behind South African health care professionals immigration to other countries. Contributing to a general desire to emigrate are push factors such as workers' sense of geo-political and economic uncertainty in South Africa and perceived and real job related concerns including poor conditions of service, 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. Among the external pull factors leading workers abroad are aggressive recruitment strategies, tax exemptions, study opportunities, along with their own desire for career development, and personal and familial advantage.

88. South Africa has employed a broad range of strategies to retain its health care workers and is concurrently conducting research on the success of these programs. Among the initiatives deployed are efforts to manage professional health risks; train mid-level workers who might have a harder time emigrating; improve health care workers' remuneration, though Government of South Africa salaries still can not be internationally competitive; staff rural, underserved areas; create an exchange program with specific developed nations; disperse and reward personnel with scarce skills; attract returning emigrants; and educate trainees overseas in exchange for their services post-schooling.

89. South Africa and the United Kingdom have also recently concluded a resolution on the International Migration of Health Personnel. Predicated upon the principles outlined in the World Health Assembly,[14] the memorandum is designed to institute two-way time-limited exchange placements; share information, advice and expertise; and partner 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 Health Care Workers: The Case of UK and South Africa
Rob Webster – Director of Workforce Capacity, Department of Health, England

90. 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, which 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.

91. Difficulty retaining health workers is not exclusively a problem in the developing world. Instead, it is symptomatic of a global shortage of health care 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 toward retaining professionals has become a constant struggle.

92. In the U.K., successful skill retention programs 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 childcare on the job and flexible working hours have made a significant difference, whereas single strategies based on pay and contractual obligations have not.

93. 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 health care workers. Although inter- and intra-national efforts may help manage health care worker emigration, they do not address the root problem of global shortage.

94. 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.

Using the Diaspora to Strengthen Health Workforce Capacity
Ken Sagoe, Prof. - Director of Human Resources Department, Ministry of Health, Ghana

95. 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 health care system.

96. Ineffective health care 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.

97. 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,[15] 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 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.[16] 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.

Exporting health workers to overseas markets
Binod Khadria – Professor of Economics and Chairperson, Zakir Husain Centre for Educational Studies, School of Social Sciences, Jawaharlal Nehru University, India

98. Before passing judgment on the value of a phenomenon, one must seriously analyze its effects. For instance, the emigration of health care 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.

99. Positive effects of emigration could accrue to a source country as the return of: a) money – in the form of remittances, bank transfers, or portfolio investments; b) machinery – by technology transfer and know-how; or c) manpower – through the return, exchange, or visit of emigrant skilled workers. The necessary condition of worldwide presence of one's nationals could therefore be supplemented by a sufficient condition for that nation's successful, win-win globalization. However, in order for the migration of knowledge 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.

100. 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.[17] He determined that an

international Indian presence has not meaningfully recuperated the nation's loss of skill and investment, nor has it increased the *average productivity* of the domestic workforce remaining within India.

101. 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. Wherever it has started going into educational investment lately, most of it has resulted in a reverse flow of remittances to the developed destination countries in the form of overseas student fees. Similarly, technology transfer by the expatriate Indians has not been well managed, and most of the technology returned to the source country has been relatively old and outdated. Likewise again, return of manpower or restoration of national expertise was not substantial, and most returnees decided to work in the multinational corporations located within India. On the whole, the out-migration of Indian knowledge workers - whether professionals or students - i.e., the fully formed or the semi-finished human capital respectively[18] cannot be said to have led to fulfilling the sufficient condition of deriving significant gains for the source country, thought it might have satisfied the necessary condition of their global geo-economic presence, for the phenomenon to be called a successful win-win globalization.

102. 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 health care 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 labor replacement at low costs, at the same time correcting the aging structure of the population with younger immigrant workers on the one hand, and acquiring the latest vintages of knowledge and technology embodied in their younger generations on the other.

Discussion from Session IIIB: Migration of Healthcare Workers

103. Participants tended to consider the emigration of health care workers as a negative phenomenon that needs to be redressed through intra- and inter-national collaboration. Many explained that when a significant amount of a country's health care workers leave, it creates a domestic shortage of health personnel. This shortage further magnifies servicing problems for those health care workers who remain, with 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 residual population —impeding its ability to work to full potential. External input is also discouraged since ill-tended or unhealthy workers are deemed less attractive for foreign direct investment. Emigration of those highly trained, most productive members of society also erodes national income tax collection which can, in turn, make the financing and training of more health care workers difficult.

104. Some delegates proposed compensation schemes, wherein developing countries would be reimbursed for their educational training expenses or awarded "transfer fees", upon emigration of their health professionals.

105. However, the pragmatics of such proposals was questioned during discussion. There are multiple beneficiaries of the continued mobility of health professionals, including the individual, his/her family, the developed host nation, the developing source nation, the recruitment agency, hospital, and clientele served. Amongst this tangled web of stakeholders, it would be extremely difficult to isolate and obligate a responsible party that would then 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 is at odds with society developing full advantage 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.

106. Panelists 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.[19] 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 gross size only to foreign direct investment.[20] Though primarily private and family funds, remittances may be used both for welfare and growth promotion in developing countries.

107. The migration of highly skilled workers, including health care professionals, has the potential to be a positive force: for individuals and world communities.[21] Although inter- and intra-national efforts may help deliver health care workers and services more evenly worldwide, these efforts still do not address the root cause of understaffing - global shortage. If enough individuals per annum were trained and prepared to work as health care personnel, then, although mobility and differentially desirable postings would persist, the current crisis and its associated problems would dissolve.

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

11 JUNE: THE WAY FORWARD

Session IV: 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

109. Since its outbreak, the HIV/AIDS epidemic has spread across and within borders. There are now 42 million people infected with HIV and 27.9 million others 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 mobility of people.

110. 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 on individuals, family and communities, as well as economic costs will continue to escalate. Identifying populations more vulnerable to HIV infection is a way to reduce its spread, by doing preventative education and offering more effective care tailored to groups' needs.

111. Migrants with different linguistic, cultural, economic, racial or religious orientations than their host communities may be in particularly vulnerable conditions, subjected 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 for HIV infection and related death.

112. The vulnerability of undocumented migrants is exacerbated by their illegal and hidden status. They often live on the margins of societies, may try to avoid contacts with authorities, have little or no legal access to prevention and health care services, and may be unaccustomed to relating to 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 Permanent Secretary, Ministry of Public Health, Thailand

113. Health care for irregular migrants is a politically charged and controversial issue. On 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 movement.

114. The Royal Thai Government has implemented a massive irregular migrant registration program, aimed at the estimated one million undocumented migrant workers within the Kingdom. Advertised in the migrants' three prime languages and promulgated through consenting employers, undocumented workers that register are granted the right to primary and reproductive health care, communicable disease control services, a health examination, and a working permit, in hopes of taking care of migrants and reducing their exploitation as well as the risk of contagion. By supplying shareable information about a large segment of the population, the program will likely prove useful to other ministries within the government as well.

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

115. 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.

116. Kuwaiti experience has found that there are four prime means of delivering health care 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.

a) 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 transporting and storing supplies, politically impeded distribution, and the theft or sale of medicines.

b) Conversely, when *health care 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.
c) *Services provided in the donor country* are relatively easy to facilitate, allowing for 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.
d) *Third-country treatment* often proves beneficial for those individuals who receive 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. Also, 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: The Way Forward

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

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

119. Local bias stigmatize 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 schemas where constituent approval is needed for the implementation of migration programs. Bias is also an active, self-perpetuating force, sustaining migrants' negative conditions and thus allowing for bias to continue.

120. 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 a 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 nominal wages, increasing competition and unemployment rates.

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

122. 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, and 3) otherwise recruiting locals to be involved in and to contribute their skills to a refugee aid effort.

123. Other areas of discussion depicted migration, or the globalization of movement and people, as the corollary of the globalization of capital. One participant emphasized the importance of bridging cultural gaps between the recipients and providers of health care. 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 health care until the end of life, to die in dignity, and to own sufficient financial means.

Session IV: Where can we go from here?
Closing remarks on the theme "benefits of investing in migration health"

Dr. Danielle Grondin – Director, Migration Health, IOM

124. 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.

125. 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 wellbeing of individual migrants, their families, and their communities needs 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 migration legal status.

126. 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 wellbeing 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 participant 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.

127. ACTION POINTS:
- This is a time of real opportunity in migration health and we must seize the moment. First, this seminar was dedicated to creating understanding, to now no longer consider migration and health as two isolated domains, but health as an integrated part of migration.
- One action point is for each of us in our respective roles and responsibilities, to make a commitment to promote and advocate the integration of health issues in the various aspects of migration we are called to deal with, such as students, business people, asylum seekers and refugees, returnees etc.
- Second, is the need for a commitment to partnership and of related co-responsibilities, which was illustrated with some of the topics discussed:
    - Partnerships between governments -- the opportunities that bilateral agreements provide to manage not only the mobility of health workers but to promote cooperation in the economic sphere more generally and importantly in the public health, social, and development realms
    - Partnerships as well between organizations at the community, national, regional and international level

128. For its part, IOM commits to continuing the catalytic role of highlighting the importance of comprehensive approaches to migration health, and bringing 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

129. Migration and health are multi-stakeholder issues that concern governments, non- and inter-governmental 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

130. 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 concerns and positions, working towards a better future for health and migration.

Discussion from Session IV: Where can we go from here?

131. Migration is a fact of life and a continuing phenomenon. This workshop represents an international dialogue on policy concerns. Though management of migration is mostly the prerogative of national governments, it is understood we better our understanding and awareness if we work toward greater cooperation. The IOM International Dialogue on Migration series, launched in 2001, intends to bring together all the stakeholders, identifying areas for collaboration and cooperation. However, the purpose is not to invent a new binding legal framework.

132. 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, etc. The cross-sectoral approach used here has highlighted many of the benefits of managed migration and investing in a migrant's health.

133. Cooperation needs to be continued. The seminar has underscored the need to systemize health care workers' preparation to handle migrants' health – i.e., the varying cultural, linguistic, and religious issues held by migrants.

134. Most everyone would agree that there are benefits of investing in migration health. The question is how to derive those benefits, and the challenge will be how to highlight them. This dual-tiered challenge involves building public opinion, through public education, and strengthening 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.

135. 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, c) apply policies without neglecting conditions of a local population.

136. There is a continual need to consider the social, cultural, and religious aspects of migrant health care.

End Notes

[1] Of the six major high mortality infectious diseases, there is only an effective vaccine for measles.
[1] World Migration Report 2003, IOM, Geneva, 2003
[2] As stated in the Preamble to the Constitution of the WHO, http://www.who.org/about/definition/en/
[2,] For instance, Burmese migrants in Thailand have a significantly higher incidence of HIV/AIDS than their counterparts in Myanmar and than the local Thai population.
[3] Censo de Población 2000, Instituto Nacional de Estadística y Censos
[4] The United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons, 2000
[5] Introduction to Migration Management, Section 2.7, IOM
[6]Anecdotal evidence from the U.S. bi-national tuberculosis program, which is open to irregular and legal migrants, demonstrates that primarily regular migrants seek care. Likewise, in Germany, though the health system welcomes all migrants, irregular migrants very seldom request care.
[7] 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
[8]Working Paper, Part IV - Points of Entry, Article 13a
[9]Working Paper, Article 37.1
[10] Working Paper, Article 36.1
[11] This coupled with definitional complications arising from disparity in health system performance worldwide is responsible for many of the inter-country misunderstandings regarding migrant health care.
[12] 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, Chapter 5, pps 85-86 for an overview of eight international legal instruments governing migrant and human rights to health.
[13] The Berlin Charter, adopted by the International Red Cross and Red Crescent Societies at its European Regional Conference, 2002 committed the organization: "to work with those whom migration has put in special jeopardy".
[14] General Medical Council, 2002; Nursing and Midwifery Council, 2002.
[15] WHA 57.19 on the International Migration of Health Personnel
[16] Those surveyed felt that: "The quality of life is better in Ghana than elsewhere."
17 Surveys conducted by MIDA-Ghana-Netherlands Health Care Projects I, II, and III
18 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.
[19] Depending on the educational stage reached at the time of migration.
[20] Migration for Development in Africa or MIDA programs have experience facilitating such exchanges, and through use of Information and Communication Technologies (ICT), it has been able to implement similar e-learning, skill-transfer programs in a cost effective manner. See MIDA: Mobilizing the African Diasporas for the Development of Africa, 2004.
[21] Global Development Finance 2003, The World Bank, pg 158, Figure 7.1 "Workers' remittances and other inflows, 1998-2001"
[22] 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 health care workers, which, in practice, is unevenly felt between countries.
[23] For instance, Costa Rican surveys detected health care workers whose negative attitudes towards migrants—sometimes pejoratively labeling them "new citizens"—spilled over into neglectful or sub-standard health care.
[24] See the World Bank's Global Development Finance, 2003, Chapter Seven, pps 166-169 for a quantitative analysis of some of these concerns.
[25] See IOM's Online Project Compendium, project category Mass Information and Integration, for potential project ideas.