

1st Research Exchange Workshop on
**Social Determinants
of Migrants' Health**
Across Asia and Europe

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PROCEEDINGS



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CONTENTS

PUBLIC TALK

Health and Migration: Perspectives from Asia and Europe 2

WORKSHOP

Day One

Session 1: Overview of Migration and Health in Asia and Europe 7

Session 2: State of Health of Asian Migrants in Europe 14

Day Two

Session 3: Multi-stakeholder Responses to Migrant Health Issues and Main Challenges..... 19

Session 4: Recommendations for Asia-Europe Cooperation on Migration and Health 27

CONCEPT PAPER 32

PROGRAMME DETAILS 33

PARTICIPANTS 36

ORGANISERS 38

PARTNERS 39

PUBLIC TALK

(7 March 2012)

Health and Migration: Perspectives from Asia and Europe

The public talk on “Health and Migration: Perspectives from Asia and Europe” was opened by **Ambassador Juan José Herrera de la Muela**, Director General of Casa Asia / ASEF Governor for Spain, **Mr Hidehiro Tsubaki**, Consul-General of the Consulate-General of Japan in Barcelona and **Mr Xavier Bosch**, Director General for Immigration of the Autonomous Government of Catalonia. **Mr Rafael Bueno**, Director of the Department of Politics and Society at Casa Asia, chaired the session.



The first speaker of this event was **Dr Jaime F. Calderon**, Regional migration health adviser for Asia and the Pacific at the International Organization for Migration (IOM). He introduced the topic by providing an overview of the migration dynamics and trends in Asia, including a brief profile of Asian migrants in Europe. He stated that the number of migrants had more than doubled over the last twenty-five years and, contrary to past trends, more and more countries were becoming sending, receiving or transit countries. The majority of migration flows take place internally or within a certain region: most migrants remain within the borders of their own country (740 million), and about 40% of an estimated 214 million international migrants move to a neighbouring country. The share of people migrating from so-called developing countries to developed countries is about 37% while approximately 60% of migrants move between developing or between developed countries. People move to improve their lives and that of their families, to join relatives, in pursuit of work or study opportunities, or in search of safety. As Dr Calderon pointed out, if international migrants were considered as a single population they would currently represent the fifth largest country by population size in the world.

In Europe, a significant proportion of migrants are of Asian origin. According to Eurostat data on migrants from the Colombo Process countries (CPC), 30% of these CPC

nationals residing in Europe are from China, followed by India and the Philippines. The main drivers of migration from CPC to the EU are labour migration and family reunification.

Over the past three decades, international mobility has become an increasingly important feature of the Asian landscape. Labour migration from the eleven Colombo Process countries has grown considerably since 2005 and of the top ten emigration countries, five are from Colombo Process member countries: India, China, Bangladesh, Pakistan and the Philippines. The primary destinations of temporary labour migrants are Gulf Co-operation Council Countries. However, flows to other Asian countries such as Malaysia, Singapore, Hong Kong, Taiwan, and Korea are also significant. Dr Calderon recognised that despite increasing regulation of the recruitment process, border control and repatriation, irregular migration in Asia remains intractable. Irregular migrants are crossing porous borders (Bangladesh, India, Thailand and Myanmar), or overstay their visa (Japan and the Republic of Korea).

The number of female migrants has surpassed that of their male counterparts in some sectors, due to the increase in demand for gender-neutral or gender-specified roles in service industries. Women currently make up about half of the world's migrant population (up to 70% or 80% in some countries). In terms of economic impact, Dr Calderon noted that according to the World Bank, remittances worldwide had more than doubled over the last five years (from US\$ 84 billion in 2005 to US\$ 173 billion in 2010).

The second part of Dr Calderon's presentation focused on the social determinants of migrants' health. He deplored that when talking about migration and health, myths and prejudices still prevail, such as the perception that migrants are carriers of diseases or that they are a burden for health systems in destination countries. The reasons for migration are largely to be sought in uneven distribution of resources, wealth and opportunities. As migrants move to “greener pastures”, they carry with them their health conditions, beliefs, health-seeking behaviours, knowledge, etc. In that sense, Dr Calderon explained, migration brings together populations of largely different epidemiological profiles and health background bridging the disparities between their systems. Contrary to the above-mentioned prejudice against migrants as carriers of diseases, the majority of migrants – at least when they enter the migration process – are young and comparatively healthier than populations in receiving

countries. This is often referred to as the “healthy migrant effect”. As Dr Calderon elucidated, it is the conditions encountered by migrants during their migration process, which may expose them to various risks and make them vulnerable to ill health.

Dr Calderon confuted the myth that migrants impose a significant burden on health systems by highlighting the numerous existing barriers to accessing health services for migrants. Contrary to public perception, migrants tend to underutilise health services for an array of reasons, which in turn are at the core of their vulnerability. Furthermore, due to a lack of inclusion in insurance schemes, migrants often pay for health services out of their own pockets. As services are expensive, migrants tend to forego basic primary care or delay seeking health care, and thus face preventable morbidity and mortality or make conditions more complicated. Besides the increased risk of permanent disability or death for the migrants, this also has public health consequences and ultimately leads to higher costs both for migrants as well as the health system. Dr Calderon stressed that migrants make critical contributions to countries in shortage of skills and manpower; this fact should be borne in mind and respected when discussing costs and benefits of extending health services to migrants. For instance, migrants help to maintain social services and contribute to productivity and economic growth. Finally, the relevance of remittances sent back to countries of origins should also be taken into account as these are often spent to improve livelihoods, health and education of families left behind.

Dr Calderon then turned to the importance of social determinants of migrants' health, referring to the definition given by the Commission on Social Determinants of Health (2008): social determinants of health are recognised as the conditions in which people are born, grow up, live, work and age. These conditions are shaped by political, social and economic forces. There are various layers of factors that determine the health and well-being of a person. The first layer is composed of biological factors, such as age, sex and constitutional make-up. The second layer is characterised by lifestyle, social and community networks. In addition, a person's health is strongly influenced by socio-economic, cultural and environmental conditions, which in turn shape living and working conditions. All these factors have implications for the health of an individual, and the migration process can entail particularly harsh conditions with severe health impacts. Thus, Dr Calderon argued, migration or displacement can be regarded as an additional layer of factors determining the health and well-being of people on the move.

The conditions surrounding the migration process frequently expose migrants to health risks and negative health outcomes. These conditions include experiences

and situations in the country of origin, during the migration journey, in the place of destination and in some cases, the country of origin after the return. The political, economic and social environment in the country of origin already influences migrants' well-being prior to leaving. The journey in itself may affect the health of migrants, especially if taking place through irregular routes. The ability to travel through legally regulated channels has a strong impact on the health outcome of the migration process. In the destination country, migrants often face numerous difficulties influencing their health status; these range from access to housing, jobs, healthcare and other social services to cultural and/or language barriers and social exclusion.

Depending on experiences, exposures and living conditions in the country of destination, the state of health of returning migrants may in fact be poorer upon return than before they left. Sometimes migrants return for health reasons, or due to a terminal illness. However, if they return with a chronic condition they may be unable to receive necessary care because services are not available or not affordable to them.

In the final part of his talk, Dr Calderon presented current commitments and initiatives, which address migration-related health challenges in Asia. He stated that more than ever before, a concerted effort to bring about policy and subsequently, programme and system change, could be witnessed. He illustrated this with the example of the 61st World Health Assembly (WHA) of 2008 which accepted a resolution on migrant health laying out concrete and overlapping action points for the World Health Organization (WHO) as well as its Member States. More precisely, the resolution urges the WHO Secretariat as well as WHO Member States to develop migrant-sensitive health policies and practices. It stipulates that WHO is to promote migrant health in collaboration with other relevant organisations and encourages inter-regional and international co-operation. To facilitate the reporting process, the action points of the resolution are grouped into four major inter-linked themes. These are: monitoring migrant health, policy-legal frameworks on migrant health, migrant-sensitive health systems and partnerships, and networks and multi-country frameworks.

On the issue of partnerships, networks and multi-country frameworks, Dr Calderon pointed out that important platforms had already been put into place to facilitate the integration of health in the agenda of migration management. These include the Regional Dialogue and Programme on Facilitating Managed and Legal Migration between Asia and the European Union, the Asia Pacific Preparatory Meeting for the Global Forum on Migration and Development, and the Ministerial Consultation of Labour Migrant Sending Countries.

Concerning policy and legal frameworks, he acknowledged that multi-level and multi-sectoral dialogues and consultations have in various cases helped to achieve consensus amongst governments and are thus useful instruments to support national initiatives addressing social determinants of migrants' health. To illustrate this argument, he referred to the Association of Southeast Asian Nations (ASEAN) Declaration on the Protection and Promotion of the Rights of Migrant Workers, the Joint Recommendation from the Regional Dialogue on the Health Challenges of Asian Labour Migrants, the Bangkok Statement on Migration and Development, the Dhaka Declaration of Colombo Process Countries and the Joint Recommendation of the 4th ASEAN Forum on Migrant Labour. He explained that all of these recommendations promote the health and social protection of migrants, including their access to health services.

According to Dr Calderon, it is crucial to support regional commitments and invest in programmatic responses to promote safe and legal migration. By way of an example for such a regional programme he described the co-operation between IOM and the EU to produce information, education and communication (IEC) materials for Asian migrants going to targeted European countries. Similarly, IEC materials promoting the skills of migrants from India, Sri Lanka and Bangladesh are made available in the EU. Dr Calderon also mentioned the work of non-governmental organisations such as SHISUK (Sikkha Sashta Unnayon Karzakram: Education, Health and Development Programme) and OKUP (Ovibashi Karmi Unnayan Program) in Bangladesh, and CARAM Cambodia (Co-ordination of Action Research on Aids and Mobility). These organisations provide essential information on rights, health and HIV to migrants in pre-departure training, and offer referral to services upon return.

He also referred to a programme in Thailand, where IOM works in close co-operation with the Ministry of Public Health to build capacity of the public health sector and improve migrants' access to health services, regardless of their immigration status. The programme that started in 2002 has since then established a network of migrant community health workers, introduced the concept of migrant-friendly or migrant-sensitive health services, promoted multi-sectoral collaboration, initiated the development of a border policy, supported research, and advocated for health financing schemes to support delivery of equitable health services to migrants. In Thailand, the Government facilitates regularisation of undocumented migrant workers through yearly registration processes that include health assessments and registration of migrants (and their family members) to the national health insurance scheme.

Furthermore, Dr Calderon recalled that a wide variety of programmes and interventions, which take into consideration particular needs of migrants, have been developed and implemented to improve migrants' access to health services. Building capacities in the public health system of source, transit and destination countries does not only focus on the control of communicable diseases, but also on how to assist and provide care for victims of human trafficking, exploitation and abuse. These experiences have led IOM to understand that migration health issues need to be integrated into the training and education of actors involved in service provision. This includes educational curricula of health service providers, trainers, policy makers, social scientists and health planners.

In response to social and health vulnerabilities, Dr Calderon also acknowledged efforts to empower migrants through knowledge-building. He described the case of ACHIEVE in the Philippines which provides pre-departure training to seafarers with the participation of former migrants as educators. It also works with the Department of Foreign Affairs to provide sensitivity trainings to Foreign Service personnel, preparing them for assistance of HIV-positive migrants on-site.

To conclude his presentation, Dr Calderon highlighted several challenges in monitoring migrants' health, namely the varying quality and availability of information, the dynamic nature of modern migration, and the health impact of migration that extends beyond the first generation of migrants. He explained that while investments have been made in research and advocacy, more efforts are needed to clarify and standardise definitions and indicators to allow for the collection of comparable national datasets. In addition, he argued for better monitoring of under-represented communities and migrant populations, as well as an improved economic analysis of current migration health interventions.

He acknowledged recent progress in mainstreaming health and social protection of migrants through dialogues and consultative processes involving health, immigration, labour and economic sectors. Investments in strengthening the delivery of services, capacity-building and empowerment of stakeholders in the migration management process have also been made. However, Dr Calderon argued that it remained necessary to work towards the development of national policies providing equal access to health and social services for migrants, regardless of their status. This is in the spirit of a rights-based approach to public health aimed at achieving health equity.

Finally, considering that while it is important to capitalise on what has been achieved, Dr Calderon also urged to continue strengthening inter-regional collaboration through building sustainable networks for the exchange of knowledge, skills and capacity. Moreover, frameworks

to ensure social and health protection throughout the migration process should be established, and the exchange of best practices at policy and field levels increased.

The second speaker of the public talk, **Dr Piroška Östlin**, Programme manager of the vulnerability and health programme at the World Health Organization-Regional Office for Europe (WHO-EURO), provided a European perspective on health and migration. She began by highlighting current challenges and opportunities in relation to understanding and addressing migrants' health in Europe. Dr Östlin emphasised that among the seventy-five million migrants in the WHO European region (886 million people) it was important to be aware of the great diversity of migrants as this term includes international migrants, internal migrants, migrants in an irregular situation, international labour migrants, stateless persons, trafficked persons, refugees, asylum seekers, etc.

She continued by pointing out that many migrants are usually employed in 3D (dirty, dangerous, and degrading) jobs, and migrants in irregular situations are deprived of most privileges afforded to nationals. She noted that children of migrant parents are one of the groups most at risk of poverty in the EU. In terms of health, Dr Östlin explained that in 2010, only five of the twenty-seven EU countries offered undocumented migrants access to health services beyond emergency care.



At the same time, she underlined that most countries economically depend on migrants. Over the period of 2000 to 2005, migration accounted for an estimated 21% of the average growth in gross domestic product (GDP) in the EU-15. She further explained that migrants help to counterbalance the ageing populations in Europe as net migration amounted to almost 85% of the EU's total population growth (2005).

Dr Östlin went on to talk about social determinants of migrants' health and argued that in order to advance

the health situation of migrants, it was crucial to follow the recommendations set out in the report "Closing the Gap in a Generation: Health equity through action on the social determinants of health"¹ published by the WHO Commission on Social Determinants of Health in 2008. The report recommends to improve daily living conditions, tackle the inequitable distribution of power, money and resources, and to measure and understand the problem as well as assess the impact of actions. She explained that conditions surrounding the migration process could increase vulnerability to ill health and pose barriers to accessing health and social services. Therefore, the causes of exclusionary processes across sectors should be addressed in order to bring about positive change in the health of migrants and ethnic minority populations.

Finally, after naming existing WHA resolutions related to migration and health, she presented the recently developed WHO European Region Health 2020 strategy. This is a value-based action-oriented policy framework, adaptable to different realities in the countries of the WHO European Region. Besides addressing ministries of health, the strategy also aims to engage ministers and policy-makers across government and stakeholders throughout society who can contribute to health and well-being. The Health 2020 strategy promotes a WHO European Region in which all people are able to achieve their full health potential and well-being, and in which countries, individually and jointly, work towards reducing inequities in health within the Region and beyond. Guided by the values and principles of Health 2020, the new WHO programme on Vulnerability and Health managed by Dr Östlin intends to raise awareness, promote political commitment and action related to changing the conditions that make people vulnerable to ill health. In particular, the programme aims at addressing the needs and expectations of vulnerable groups including migrants, Roma and other ethnic minorities.

Dr Östlin also mentioned that WHO supports Member States in implementing policies and programmes for the health of vulnerable groups, as well as in providing evidence and resources. Moreover, WHO promotes inter-country activities to strengthen the capacity of Member States and other stakeholders to better meet the health needs of vulnerable groups, advances cross-programme integration of perspectives on vulnerability and responsive actions, and builds stronger partnerships with other UN agencies, EC and NGOs on that issue.

To conclude her presentation, Dr Östlin emphasised that migrants were important resources for Europe, contributing to economic development and counterbalancing an ageing population, but that there are

¹ CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.
http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

substantial inequalities and barriers for them to access social and health services in destination countries. She further stressed that strengthening health systems and intensifying the focus on the social determinants of migrants' health requires a cross-government approach. Finally, she pointed out that the WHO European Policy for Health is an important framework, which allocates priority to protecting and promoting migrants' health as part of efforts to reduce general health inequities.

In her concluding remark, **Ms Sol Iglesias**, ASEF Director of the Intellectual Exchange Department, emphasised that migration and health are in fact common challenges for Asia and Europe. It is for this reason that ASEF, through its multi-disciplinary and multi-sectoral approach, aims to promote the inclusion of migrants' health in global and regional health strategies.

WORKSHOP

(8-9 March 2012)

Day One

Session 1: Overview of Migration and Health in Asia and Europe

Part 1

Chaired by **Dr Manuel Carballo**, Executive director of the International Centre for Migration, Health and Development (ICMHD), the first session introduced the issue of migration and health and dealt with migration trends in Asia and Europe, as well as their implications for the management of infectious diseases.



The first speaker, **Prof David Ingleby**, Emeritus Professor of Intercultural Psychology, Utrecht University, who has been involved in many Europe-wide collaborative projects on migrant health and has recently acted as Consultant to the Council of Europe and as adviser to the WHO Regional Office for Europe, opened this session with a presentation on the “Paradigm shifts in the discourse on migration and health”.

Prof Ingleby began by challenging the common notion that international migration has massively grown over the past decades as a result of new and easier ways to move. Suggesting that the growth of international migration followed the same dynamics as the overall growth of the world population, he argued that the growing number of international migrants could be explained by the increase of the world population as a whole and therefore may not be due solely to more and better opportunities for mobility of people. Furthermore, considering the growth rate of migrants as a percentage of the world population (30% over the last fifty years or 0.6% a year), he concluded that the increase in

individual mobility is lower than might be expected. If then, developments in transportation technologies have generally facilitated mobility, the reason why numbers of migrants have not grown more radically may be sought in whatever awaits migrants at the end of their journey. In many countries, migration policies have become more restrictive and therefore people may effectively be prevented from migrating through legal and regulated channels. Conversely, this situation induces migrants to seek irregular migration routes, which have in fact increased proportionally to the restrictiveness of migration policies.

Pertaining to the growing concern about migrants' health, Prof Ingleby dedicated the second part of his presentation to changes in the way people think about migration and health or the *paradigm shifts* in the discourse on migration and health. According to him, the first paradigm of migrant health is the perception of a migrant as a source of infection and consequently as a threat to public health. This reasoning, which has often been criticised for disrespecting human rights, continues to be used by governments wishing to restrict immigration. However, while the concern about imported diseases may be reasonable, Prof Ingleby argued, this should not serve as a justification for restrictive migration policies. On the contrary, policies need to incorporate a human rights approach.

The second paradigm highlighted in Prof Ingleby's presentation was migrant health as a wider public health issue. Public health itself has changed significantly over the last hundred years. Whereas in the past governments used to be concerned mainly with the control of infectious diseases, the focus has shifted towards health problems linked to non-communicable diseases (NCDs). This relates to migrant health in two ways: one, migrants may be in poor health due to social determinants and particular health risks to which they are frequently exposed. Second, migrants are often in a difficult situation concerning access to health services and quality of services available to them.

Addressing the first aspect of migrants' health, Prof Ingleby explained that whereas in the past migrants' health was generally attributed to characteristics such as genetic factors or cultural differences, more recently, living conditions and social status have also been taken into consideration. This is most notably the case since the

² Sir Michael Marmot is professor of Epidemiology and Public Health at University College London and was Chair of the WHO Commission on Social Determinants of Health from 2005 to 2008.

significance of social determinants of health has become recognised in public health agendas due to the work of Sir Michael Marmot². While Prof Ingleby considered this change as a positive development, he noted however that research in this area has generally overlooked the subject of migration, thus neglecting the issue of migrant health even though it is intrinsically bound up with social determinants of health. He emphasised the importance of maintaining efforts to keep this issue on the agenda.

Concerning the second aspect of access to and quality of healthcare, Prof Ingleby stressed that it was central to ensure that migrants are allowed to use the health system, that there are no financial or legal barriers to accessing services and that these services are adapted to their needs. In this respect, Prof Ingleby suggested that there was still a lot of work to be done.

The third paradigm mentioned in the presentation was the global approach to migrant health which goes beyond the national focus on migrants in one's own country. In this context, Prof Ingleby called for a joined approach, which would involve discussions about migrants' health in different countries as well as exchanges of ideas and good practices. This could take place between receiving and sending countries in order to develop practical initiatives benefitting the health of migrants. Moreover, Prof Ingleby argued for a less strict conceptual divide between internal and international migration. In China alone, there are estimated to be over 100 million internal migrants - half of the estimated number of international migrants. Persons moving within large countries such as China, Russia or India are likely to face drastic transitions and challenges similar to those faced by international migrants. In light of this fact, Prof Ingleby commended to pay closer attention to the health of such "floating populations" in large countries.

Regarding this third paradigm, Prof Ingleby introduced two concepts considered central to the study of migrants' health in a global perspective: the first concept is that of a *demographic transition*. This refers to the transition from high birth and death rates to low birth and death rates as a country develops from a pre-industrial to an industrialised economic system. The second concept, the *epidemiological transition*, describes a phase of development characterised by a sudden and stark increase in population growth rates brought about by medical innovation in disease or sickness therapy and treatment. This is followed by a re-levelling of population growth from subsequent declines in fertility rates. According to Prof Ingleby, demographic transition is central to explaining migration flows, and epidemiological

transition can illuminate how the illness profile of the host and migrant population is likely to change.

Finally, in the last part of his presentation, Prof Ingleby focused on the issue of promoting research and policy-making on migrant health. He stated that migrants are victims of a "rights deficit" as most of them are not citizens of the country of residence and suffer varying degrees of social exclusion. As a general rule, he observed that countries with high migrants populations show more "migrant-friendly" policies than countries with fewer migrants. For instance, if 20% of a country's population are migrants, the level of rights conferred to migrants is high (as is the case in Switzerland). However, Prof Ingleby criticised the practice of some countries interested in the benefit of cheap migrant labour without the obligation to allow them equal rights, to turn a blind eye to irregular migration. In these cases, undocumented migrants provide cheap labour without any social, health or legal protection. Irregular migrants possess no form of protection and are forced to fend for themselves.

In his conclusion, Prof Ingleby listed the international organisations which have supported migrant health, including the UN, WHO and IOM, and shared documents he considered as very informative on migrant health: the WHO Global Consultation on Migrant Health entitled "Health of migrants - The Way Forward"³ and the WHO-EURO policy briefing on "How health systems can address health inequities linked to migration and ethnicity"⁴.

Dr Carballo thanked Prof Ingleby for the insightful overview of the paradigm shifts regarding migrant health, from a historical, epidemiological, political and social perspective. He then opened the floor to discussions by asking what form of international regulation that respects human rights could be applied in a world of growing movement and a potentially rapid spread of infectious diseases, and what might be the implications of such an approach.

Discussion

Commenting on a chart that had been shown during a presentation, illustrating the evolution of international migration as a percentage of the world population from 1965 to 2005, a participant from Singapore suggested that it might be interesting to observe if the financial crisis and the swing to the right in many of the recent elections in the EU have had an impact on migrant flows and social services over the years. Prof Ingleby responded by saying that in general, policies today were much more

³ Health of migrants: the way forward - report of a global consultation, Madrid, Spain, 3-5 March 2010. http://www.who.int/hac/events/consultation_report_health_migrants_colour_web.pdf

⁴ How health systems can address health inequities linked to migration and ethnicity. Copenhagen, WHO Regional Office for Europe, 2010. http://www.euro.who.int/__data/assets/pdf_file/0005/127526/e94497.pdf

inequitable not only for migrants but also for poorer parts of the population who are paying for the mistakes of the bankers. But still, he deliberated that it was difficult to predict the results of these developments, which might have positive or negative impacts.

Reacting to the perception that migrants were a source of infection and a threat for host societies, a participant from the Philippines reminded the audience that in many countries migrants are required to pass a medical exam before being allowed to enter labour migration schemes, adding that these types of practices reinforced the idea that only persons in good health migrate, a situation also known as the “healthy migrant effect”.

A participant working for IOM argued that when talking about epidemiological transition it was important to bear in mind that a lot of middle income countries in Asia such as India, have to face what is called a double burden where infectious diseases have not declined and non-communicable diseases are increasing. This fact needed to be taken into account by receiving and sending countries when dealing with migrant health issues. She also mentioned that based on the experience of IOM in engaging both the receiving countries and the sending countries, it is believed that it is very important for such exams or pre-migration screening of potential labour migrants to balance a public health and human rights approach on the one hand, and the requirements in terms of border control on the other hand. But she felt that there is still a lot to be done to guarantee this balance in the migration policies of many countries.

Talking about the common perception that migrants could pose a threat to the health of the host population, a participant from the Philippines suggested that the public in receiving societies should be made aware of the often very healthy life styles of migrants (e.g. low prevalence of smoking and alcohol drinking, traditionally healthy diets) which in fact reduce the risk of NCDs.

Dr Carballo closed the first part of this session by inviting the researchers and officials participating in this workshop to think about the arrival and post-arrival dynamics and factors that influence the health of the migrants.

Part 2

The second part of this first session started with a presentation on the “Trends and challenges of migration in Asia” delivered by **Mr Mohammad Harun-or-Rashid**, Regional coordinator of CARAM Asia (Coordination of Action Research on AIDS and Mobility- Asia), an International non-governmental organisation founded in 1997 with a special consultative status at the Economic and Social Council (ECOSOC) of the United Nations. Mr Harun-or-Rashid began by explaining that CARAM Asia, which focused on evidence-based research, was working

on three key thematic areas: migrant workers' rights; migration, health and HIV; and migration, development and globalisation. He stated that migration was not a new phenomenon but that today the issue of international migration has to take into account three strong dynamics, namely the interests of different groups, states' sovereignty, and the universality of human rights.



Talking about the specific interests of different stakeholders, Mr Harun-or-Rashid deplored that in receiving countries, migrants were often portrayed negatively by politicians and the media with the consequence that a negative perception of migration increased in the general host population. He also regretted that migrants were tolerated in these countries mainly because they were needed for the economy, but they were not afforded any social or legal protection. The sending countries on the other hand, sent their citizens to work abroad in order to sustain their economy through the remittances but did not challenge the receiving countries to respect the rights of the migrants, especially in relation to health.

He concluded that the interest of both parties, sending and receiving countries, was first and foremost economic growth and stated that despite the existence of international instruments to protect the human rights of migrant workers (e.g. programmes and conventions run by the International Labour Organization (ILO) and IOM), very often countries did not follow and implement these instruments.

In terms of states' sovereignty, he pointed out that states focused mainly on national security; in relation to migration, governments prioritised the protection of the country against the (perceived) risk of diseases imported by migrants.

Moreover, Mr Harun-or-Rashid pointed to the two different types of migration – voluntary and forced migration – and explained that it was becoming more and more difficult to distinguish the two as for many migrants migration had become a way to survive rather than a free choice.

Talking about the link between migration and globalisation, Mr Harun-or-Rashid identified several factors leading to large-scale migration: these include economic and political globalisation, and intolerable living conditions (poverty, unemployment, economic and political instability, deterioration of the environment created by the adoption of neo-liberal policies, and the increased use of remittances for development) Often these factors would result in short term contractual migration. This form of migration frequently disrespected migrants' right to health and well-being, despite certain conditions set out in the Colombo Process, a consultative process on the management of overseas employment and contractual labour for Asian countries of origin.

Mr Harun-or-Rashid saw the explanation for this trend in the fact that receiving and sending countries generally placed their focus on remittances and development. However, quoting the results of a research study commissioned by CARAM-Asia on development and remittances, he showed that the remittances sent by migrant workers do not benefit the country of origin in the long term. On the contrary, low-paid jobs in the destination country filled by migrant workers support destination economies. To illustrate that the development of a country could not rest on remittances, Mr Harun-or-Rashid used the example of the Philippines, which receives substantial sums in remittances and nonetheless remains a developing country with a weak health system. He underlined that development is only achievable through sustainable national policies focusing on the domestic development of infrastructure, education, healthcare system, agriculture, industries, etc.

Mr Harun-or-Rashid went on to highlight that strong competition was taking place amongst sending countries encouraging their citizens to migrate. When the conditions in receiving countries become too strict in the eyes of sending countries, they re-orient their citizens to other receiving countries with less restrictive conditions. Within this competition, according to CARAM-Asia's experience, the contractual labourers are very often not aware of the laws in destination countries and of their rights. In addition, most of them do not have health protection or insurance, and are forced to return to their country of origin when they are seriously sick or injured.

Concerning migration trends in Asia, Mr Harun-or-Rashid elaborated that there were three kinds of countries: labour sending countries (e.g. Bangladesh, Cambodia, China); labour sending and receiving countries (e.g. India, Malaysia, Pakistan) and labour receiving countries (e.g. Brunei Darussalam, Japan, South Korea). He explained that destinations of the labour migrants were changing with the evolution of the political and economic situation of countries and regions. As an illustration, a decade ago the majority of migrant workers went to Middle Eastern countries due to the boom in oil prices, but after the

decline in oil prices and Gulf wars the migration flows shifted to Southeast Asian countries (notably Thailand, Malaysia, Singapore).

Continuing his presentation, Mr Harun-or-Rashid deliberated that health as a tangible indicator of migrants' well-being could be used as a lens to analyse migration today. He pointed out that health had not yet gained much attention in the current migration policy debates. At the same time, focusing on migrants' health rights may dispel common misconceptions about migrants as vectors of diseases. He underlined several factors jeopardising the health of migrants, such as adverse living conditions (e.g. overcrowded housing, poorly ventilated space), poor working conditions (e.g. low pay, physically demanding work, unsafe work places), and psycho-social conditions (e.g. limited access to information and healthcare services, no community or family support, single entry policy). He regretted that in many Asian receiving countries, few sustainable initiatives were implemented effectively to improve these difficult conditions and to protect migrants' health. He further mentioned existing contradictions between certain laws and national policies within a given country, and explained that these divergences were very often unfavourable to migrants. For instance in some countries, migrants have access to treatment and healthcare services like other citizens but are deported if tested HIV positive.

In terms of access to health care and treatment, Mr Harun-or-Rashid confirmed that migrants faced various barriers such as financial constraints as well as the lack of official documents, which represent significant obstacles to accessing health care. The financial burden may even be further exacerbated by policies such as Malaysia's double fee policy, whereby foreign citizens are charged twice as much for the same treatment as local citizens. In addition to these barriers, he noted the existence of cultural obstacles such as the culture of silence and conservative attitudes towards sexual and reproductive health, which can have disastrous consequences, particularly for women but also for men. Moreover, Mr Harun-or-Rashid named certain structural barriers such as the lack of a health component in pre-departure briefing programmes, and the absence of information on health insurance matters for migrants who are not aware that they are entitled to insurance. Equally problematic are exclusionary laws for migrants in destination countries as well as the privatisation of healthcare systems, resulting in a shift in health care provision from public to profit-centred private services.

Focusing on the current cyclical short-term recruitment system of migrants, Mr Harun-or-Rashid argued that in general migrants were treated as commodities with sending countries considering them as "export products" as the name of some national migration policies – "labour export policy" – revealed. Furthermore, he

pointed out that numerous actors such as recruitment agencies and health screeners took advantage of the situation to earn money off migrants, especially if their activities (recruitment, training, health exams) remained unmonitored by governments. On that point, he summarised that in many cases, migration had become a money-making venture for health screeners and recruiters and a very costly decision for migrants.

Concluding his presentation, Mr Harun-or-Rashid urged governments not to use health as a border control tool to restrict entry and in the name of CARAM-Asia, made some recommendations to Asian authorities. These included the removal of HIV status as a barrier to receive a travel visa and residency permit, the abandonment of mandatory health testing systems and immediate deportation, and the recognition of domestic work as "work", as well as one paid day off a week for domestic workers.

The second speaker, **Dr Ursula Karl-Trummer**, Executive director of the Center for Health and Migration, Vienna, and senior researcher at the Vienna University of Economics and Business spoke on "The main social determinants of health of migrant populations in Europe". She started her presentation by recalling the WHO definition of social determinants of health as "the conditions in which people are born, grow, live, work and age, including the health system" and underlined that these circumstances "are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices". As a multi-dimensional concept, she said that social determinants of health are increasingly being recognised as relevant and are taken into account in research as well as in international and European resolutions dealing with health. When discussing social determinants of health, the terms "inequalities" and "inequities" are often used interchangeably; however, Dr Karl-Trummer highlighted the distinction between the two terms by explaining that when inequalities become unfair they become inequities.

In the second part of her presentation, she focused on the "gradient debate" which, according to her, is very much concentrated on socio-economic health determinants (e.g. income, education, occupation). Recent studies provide very strong evidence that income and education are closely correlated to health and mortality. While she recognised that this debate was very interesting and that migrants may be seen as groups of special vulnerability concerning their socio-economic status, she questioned whether socio-economic status was sufficient to explain differences regarding health of various migrant populations and underlined that research on socio-economic determinants of health seldom includes data on ethnic or migrant background. From this she concluded that it remains unclear whether healthcare

systems need to develop specific programmes for migrants.

The third part of her presentation was dedicated to answering three main questions:

- *Are migrants in the EU Member States particularly affected by socio-economic disadvantages?*



According to her recent research in Austria, Belgium, Greece, Ireland, Italy, Spain, Sweden and the United Kingdom (UK), the response to this question is positive. In all countries except the UK, third country nationals (i.e. migrants from outside the EU) are less frequently found in higher income classes compared to non-migrants. In Austria and Belgium, third-country nationals are more frequently found in the lowest, and less frequently in the highest educational level classes compared to non-migrants. Finally, in Ireland and the UK, a high share of third country nationals falls into the category of highest education levels (over 60% and over 40% respectively), but the distribution among income classes is comparable to that among non-migrants which means that higher educated migrants have lower salaries than expected for their level of education.

- *Does migration status constitute an independent determinant of health, besides its possible influences on socio-economic status?*

To answer this question, Dr Karl-Trummer proposed a regression analysis, which showed that in all eight countries under study, education and income have a significant influence on self-rated health. This result clearly illustrates that there is a social gradient in health. Furthermore, in six of the eight countries (Austria, Belgium, Spain, Greece, Sweden and the UK) migrant status has a significant negative influence on health status controlled for socio-economic variables.

Dr Karl-Trummer suggested that there are three main factors indicating that migration status is in fact an independent determinant of health. The first important factor is the limitation of access to health care for

migrants, and most dramatically for undocumented migrants. The *Nowhereland* project⁵ supported by the European Commission analyses access to healthcare for undocumented migrants in the EU. This research reveals that twenty EU Member States deny access to their health systems to undocumented migrants. In these countries, the only gate to healthcare is emergency care, which in the end, however, is extremely costly. As Dr Karl-Trummer pointed out, it would be much more effective and less expensive for the health system to allow for preventive treatment rather than postpone treatment to the point where emergency care becomes necessary. Today, only five EU Member States (France, The Netherlands, Portugal, Spain and Switzerland) offer migrants full access to their healthcare services.

The second factor supporting the argument of migration status as an independent determinant of health is the fact that even those services available to migrants are often inappropriate. Dr Karl-Trummer noted that even the most highly developed healthcare systems in Europe failed to provide high quality care to the migrant population. Quoting evidence from quantitative and qualitative research, she showed that migrant status and ethno-cultural diversity increase the risk of treatment errors and that patients with language barriers carry a significantly higher risk for serious medical incidents to occur during hospitalisation. According to Dr Karl-Trummer, reasons for the occurrence of such incidents can be sought in inappropriate responses to patients' needs, communication difficulties and misunderstandings. These may be due to various factors such as insurance status, language difficulties, different perceptions and expectations, as well as stereotyping. In this context, studies indicate the emergence of a so-called "happy migrant effect" describing low levels of complaints from patients with a migrant background. Dr Karl-Trummer suggested that explanations for this phenomenon may be a feeling of extreme powerlessness in combination with the inability to communicate in the local language, low expectations of healthcare due to bad experiences in the country of origin, as well as politeness and a social desirability bias, i.e. the tendency to answer in a manner that is thought to be viewed favourably by health providers.

Finally, the third factor in support of the argument that migrant status constitutes an independent social determinant of health can be seen in conflicting cultural images and demands. This was shown in a recent study on childbearing and post-natal experiences of Chinese-speaking and Japanese mothers in Austria, which revealed that conflicting beliefs and habits cause confusion⁶. Different health images and values from two

cultures can cause tension, for instance in relation to the question of appropriate diet for breast-feeding mothers.

Concluding her presentation, Dr Karl-Trummer made three recommendations: First, to develop models to explain causal pathways from migrant status to (ill) health; second, to work on better evidence on the interplay of various social determinants of health, (socio-economic status, mechanisms of inclusion/exclusion); and third, to improve public health systems and organisations by incorporating diversity management and "migrant-friendly" services.

Discussion

Reminding the audience that 8 March was World Women's Day, a participant from Indonesia proposed to look at the issue of violence against women, especially migrant women, leading to health problems (reproductive health problems, mental problems, even suicide) and to place this issue at the centre of the discussion on migrant health.

Dr Karl-Trummer followed this comment by adding that the situation of Turkish women in Austria is in many cases significantly worse than for women from other countries. She also emphasised that in recent research on violence against women, one of the main challenges was to define "domestic violence" as there were various approaches to viewing the issue.

Mr Harun-or-Rashid added that violence against women was a main concern for CARAM-Asia given that every day the NGO is informed of twenty cases of violence against women migrants in the Middle East and Asia. Congratulating the efforts of UN Women to put this issue high on the agenda of the international community, he also advised all actors in this field to work together at regional and inter-regional levels to support these efforts, and encouraged NGOs to report more on known cases.

A participant working for IOM underlined the importance of cultural competencies and the need for interpretation to face language barriers. She provided the example of the Dutch Government, which has developed useful policies in this area and decided to subsidise interpretation in healthcare services for migrants.

Commenting on both presentations, a participant from the Netherlands agreed that migrants face a systematic lack of rights and power and are generally treated as a "product". He recalled that if all migrants were to form a country it would be the fifth largest in the world but without any political representation at the international

⁵ <http://www.nowhereland.info/>

⁶ Seidler, Yuki. "Asian Migrants' Maternal Health in Vienna, Austria." MSc thesis, the University of London, London School of Hygiene and Tropical Medicine, 2011.

level. He argued that international organisations such as IOM were supposed to take migrants under their wings, but then asked what would happen if this fifth largest country were to occupy a seat at the UN. He invited the participants to think about how to give more political power to migrants.

Another participant from the Netherlands made a comment on the representation of migrants in the EU and argued that regarding the outcomes of recent research on this issue, things were moving very slowly despite the tremendous advocacy work of NGOs like CARAM-Asia. Then he asked how we should take this forward as things were not moving at the political level.

Mr Harun-or-Rashid agreed to the previous comment and added that so far there was no real political will to give more power to migrants. Furthermore, he affirmed that there were still too many differences between diplomatic discourses used by politicians when they address the issue of migration in international forums, and the real involvement of officials to deal with urgent problems faced by migrants. CARAM-Asia wants to co-operate with other NGOs to confront these double standards and to propose solutions based on case studies. He added that CARAM-Asia was asking sending and receiving countries to stop the competition on migration; however, he said that many countries did not recognise this competition and the problems that it generates, and therefore remained unable to find solutions.

A representative from IOM agreed that a lot of discussion took place on the consequences of this competition and the need for “migrant-friendly” national policies. Yet, thus far there had only been very few concrete results and discourses had not yet been efficiently translated into practice. He considered that bringing people together for discussions was crucial and referred to the success of initiating the Colombo Process. He suggested that international organisations, governments and civil society organisations needed to get together in a particular venue to achieve concrete results.

A representative from Platform for International Cooperation on Undocumented Migrants (PICUM), an NGO working with undocumented migrants, agreed that migrant status is an important determinant of migrants' health. She added that there is very little awareness concerning migration status and its impact regarding violence. She reported that PICUM looks at the issue not so much in narrow terms of domestic violence or workplace violence, but rather analyses the relationship between the perpetrator and the migrant (most often women). They have found that insecure migration status favours a power relationship that can facilitate violence. This situation not only concerns migrants in an irregular situation but also migrant women who have a resident

permit that is tied to their husband or their employer. This power relationship is potentially very dangerous for migrant women. For some women it means that they have no control over their health and their body if they depend on their husband's consent to them seeking medical care. In addition, victims of violence frequently avoid reporting their experiences for fear of being deported. PICUM's representative affirmed that in this context, the well-known slogan “violence reported, victim deported” is in the mind of many migrants. However, she highlighted that in few countries like France and Spain, legislation allows migrant victims of violence to express their situation through social assistance services.

A participant from Thailand argued that while there are international instruments for the protection of migrants, a major challenge remains in that many states still have to ratify them. She questioned the efficiency of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families as lacking “teeth” and proposed to use other international instruments, which are widely ratified to better protect migrants.

WHO's representative reminded the audience that her organisation had invested a lot of work on domestic violence and female migrants' health. A comprehensive resource package is available for states wishing to address these issues. She also said that it would be beneficial if some Member States piloted some of the tools to see how they worked and then adapted them to their specific situations.

Finally, answering a question from the audience about the role of regional organisations in migration, particularly in Southeast Asia, Mr Harun-or-Rashid explained that through initiatives such as the Joint United Nations Initiative on Mobility and HIV/AIDS in Southeast Asia (JUNIMA)⁷, ASEAN member countries were involved in migrants' health.

Dr Carballo closed the first session of the workshop by thanking the speakers and participants for illustrating the complexity of migration issues and stated that in order to move ahead, a human face needed to be put on migration and its consequences. The international community possessed many useful international instruments to protect migrants' health, but these instruments were not effectively used because of a lack of understanding of the phenomenon as well as a lack of political will. Dr Carballo urged states to ratify international instruments and to educate both public and administration to better understand the situation of migrants and also consider migrants' families left behind. Finally, he emphasised that the EU needed to change its approach to migration, as it could not function nationally or regionally without accepting migrants.

⁷ <http://www.junima.org/>

Session 2: State of Health of Asian Migrants in Europe

Part 1

Chaired by **Dr Poonam Dhavan**, Public health specialist at the International Organization for Migration (IOM), the second session of the workshop dealt with the state of health of Asian migrants in Europe. It focused on patterns of infectious diseases in Asian migrant populations in the EU, the determinants that affect Asian migrants' health in the receiving countries in Europe and the concomitant health outcomes of Asian migrants in Europe.

Dr Trinidad Osteria, President of the Yuchengco Centre of De La Salle University in Manila, and **Dr Daniela Carrillo**, Researcher, Health and Welfare Sector, Fondazione ISMU in Milan, Italy, started this session by sharing the outcomes of an ASEF-commissioned research study on the health dimension of Southeast Asian migration to Europe. The research was conducted together with **Dr Anna Vittoria Sarli**, Researcher from Fondazione ISMU, and focused mainly on two large migrant groups, the Chinese and the Filipinos, in Madrid and Milan.

Dr Osteria introduced the topic by explaining that over the past decades, declining fertility rates, which led to a shrinking workforce and consequently a reduction of productivity in Europe, fuelled migration to the region. At the same time, a rising proportion of elderly persons, coupled with the increasing difficulty for families to care for the elderly due to shrinking household sizes, challenged solvency of pension and social insurance schemes. In this context, she stated that Europe regarded immigration as a solution to its imminent problems because it could provide an opportunity for governments to rise to the challenges of the demographic developments and balance population ageing, to foster economic growth by providing the labour force requirements for industrialising economies and to enhance socio-cultural enrichment in the region.

According to IOM, China is the largest of all Asian sending countries: in 2009, 30.1% of Asian migrants in Europe came from China, followed by 12.7% of migrants from India and 11.4% from the Philippines. The majority of migrants from Asia to Europe live in three countries – Italy, Germany and Spain – which together attract around 80% of the total. Moreover, the great majority of these migrants (80%) are of working age (15-64 years old). In terms of gender distribution, the numbers of men and women are almost equal. However, a closer look by country of origin reveals higher shares of female migrants amongst those coming from Thailand, Indonesia and the Philippines. In Spain and Italy, the numbers of Filipino and Chinese

migrants have gradually increased since 2000. In 2009, 151,540 Chinese and 31,000 Filipinos lived in Spain and 170,260 Chinese and 113,680 Filipinos were registered as living in Italy.

Dr Osteria then elaborated on some major issues in the study of migration and health conducted in Madrid and Manila from September 2011 to January 2012. She said that policy-makers in Europe generally recognised the importance of data and research in the field of migration and health in order to develop evidence-based policies and programmes. She also found that many data sources and published articles were available, although they had not been consolidated and systematically analysed for meaningful policy and programme inputs.

Echoing the discussion of the first workshop session, she pointed out that policy interest in migrants' health often stemmed from the presumption that migrants come from countries with high rates of infectious diseases, which they would potentially transmit to the host population.

Simultaneously, she also explained that European policy-makers were beginning to recognise that predisposing factors to illnesses are related to living and housing conditions, lifestyle and dietary changes in the country of destination as well as attitudes towards medical care. She underlined that health status and health outcomes are influenced by factors such as the duration of stay in the host country, changes in social and economic situation, access to and acceptability of health services, degree of integration in mainstream society, and cultural practices at the preventive and curative levels.

Dr Osteria then presented the research study conducted with Dr Sarli and Dr Carrillo, which aimed at formulating meaningful recommendations for the incorporation of Asian (Filipino and Chinese) migrants' health concerns in public health policies and programmes in Italy and Spain. Particular objectives were 1) to identify the barriers and facilitating factors to access to and utilisation of health services by migrants, 2) to determine the prospects of co-operation between Southeast Asia and Europe for the planning and implementation of programmes on



migrants' health in Europe, and 3) to address emerging health problems in both regions. In order to reach these objectives, the research analysed Asian migrants' morbidity patterns, predisposing factors, health-seeking behaviour, health services utilisation and attitudes towards health services, including healthcare providers. The study also assessed decentralised health policies and their implementation to examine whether and to which extent the expressed health needs of migrants were addressed. In addition, the perspectives of healthcare providers on the current health programmes were considered and the barriers to delivery of services were addressed.

Dr Osteria went on to present some central results: data on leading causes of morbidity in China and the Philippines showed that NCDs were the most prevalent causes of death.

Reviewing current European policies on migrant health revealed three central problems: first, there is a general lack of adequate regional and national level data disaggregated by sex, which provides reliable information on illness patterns and health service utilisation including clinic consultations as well as levels of satisfaction with received services. Moreover, current healthcare systems are unable to provide services that respond to specific needs of migrants. This is mostly due to a cultural divide, language problems and heavy workloads of healthcare providers among others. Finally, the research exposed inadequate implementation, monitoring and evaluation of initiatives related to a lack of standardised mechanisms for retrieval, appropriate indicators, and reporting systems.

Subsequently, Dr Osteria went into detail on the specific findings of the research project.

First, concerning migrants' health in Spain, she described the following patterns:

- Many of the industries in which migrants are employed present significant occupational health hazards, including exposure to chemicals, physical exertion from manual labour, heavy lifting, and mental health problems due to isolation and loneliness.
- Ischemic heart problems and cerebrovascular diseases show higher prevalence rates amongst migrants than amongst the average population.
- Incidences of hypertension, obesity, diabetes, smoking, and alcoholism are increasing among migrants.
- Cancer incidence rates may not be higher than those of native populations but the illness tends to be detected at a later stage among migrants.

- Higher numbers of work-related problems and injuries (musculoskeletal disorders, chronic respiratory infections) are also reported among migrant workers.
- Communication problems exacerbate migrants' health risks (e.g. inability to read safety warnings, misunderstanding of safety instructions, and lack of awareness of occupational risks).
- Common mental health disorders found in migrants are depression and anxiety, which affect their functioning and are not reported since these may jeopardise their work prospects.

Secondly, referring to the argument about migrants as carriers of infectious diseases, she highlighted that this concern had been raised in many regional dialogues while, in reality, the risk of transmission of illnesses from migrants to receiving countries seemed rather insignificant. She explained that 22% of newly discovered cases of tuberculosis (TB) in 2008 involved migrants, mostly from Asia or Africa. If latent tuberculosis infection rates of 52% to 72% and active infection rates of 7.8% have been reported among migrants, most cases are reactivated in the first five years after arrival. She thus emphasised that early treatment is necessary, yet often delayed because many migrants tend to hide their condition and do not seek medical attention until the illness reaches a very severe state.

Then, Dr Osteria went on to discuss the different factors affecting health service utilisation by migrants. These include health beliefs and health-seeking behaviour, lack of knowledge of the health system, fear of discrimination, employment constraints (difficulties in taking time off work to visit doctors, impact on incomes etc.), socio-cultural issues (such as differences in mind-sets between providers and patients, tendency to seek remedies from traditional systems), and communication problems.

Regarding this last point, Dr Osteria underlined that the use of cultural mediators was very controversial and warned that a mediator who had lived in Europe for a long time might have difficulties understanding certain dialects or regional and cultural specificities. As a consequence a mediator could in fact render the interaction between patient and provider even more complicated, particularly if adding or filtering information through his/her own interpretation. Dr Osteria thus proposed to closely evaluate these services and emphasised that one of the most efficient solutions might be to better integrate migrants within the host society; *inter alia* supporting them in learning the local language and thus enabling them to communicate with doctors and nurses by themselves. She acknowledged the usefulness of translating brochures and posters distributed to migrants, but also stressed that information

material needed to be understandable; in general, she said, the impact of information materials in terms of comprehensibility and behaviour modification had not been assessed.

The next part of the presentation was dedicated to the specific research findings on Chinese and Filipino migrants in Spain. Concerning the experiences of Chinese migrants she highlighted the following issues:

- Illnesses encountered in 2011 included respiratory tract infections, fever, diabetes, diarrhoea, kidney problems, pneumonia, and hypertension.
- The Spanish healthcare system provided appropriate treatment for the respective illnesses. Most patients used Chinese treatments (herbal medicine, acupuncture, healers, etc.) before approaching a health service delivery point in the city. They take Chinese medicine, which was easily available or had been brought back from home visits to China.
- Patients were able to explain causes and manifestations of their illnesses.
- Regarding government health services, main problems Chinese migrants encountered were: long waiting time, bureaucracy, including tedious paperwork in getting a health card, and language (communication) barriers.
- However, they did not see problems in terms of technical competence of providers, adequacy of facilities and availability/affordability of Western drugs.

Research findings related to Filipino migrants' health in Spain included the following points:

- Illnesses encountered in the previous year by the Filipinos included cough, colds and flu, diarrhoea/gastroenteritis, respiratory infections such as pneumonia and tuberculosis, chronic respiratory diseases such as emphysema, arthritis, diabetes and cardiovascular, and circulatory problems (high cholesterol, hypertension, stroke).
- Filipino migrants use health centres but the frequency of visits is relatively low. The clear tendency is for them to visit the service delivery point when an illness becomes serious or when home or self-management does not relieve the symptoms. Little time is devoted to illness prevention.
- Although consultation is free and medicines are relatively inexpensive, long waiting time reduces

their income (as they often work in positions which are paid by the hour).

- Language difficulties play a central role as Filipino migrants underlined difficulty in communication with the provider regarding clinical history, symptoms and management.
- Migrants also mentioned feelings of being discriminated against by providers, who were perceived to have a negative attitude toward Asian migrants.
- It was felt that health providers lacked knowledge of the migrants' background, which would lead to misunderstanding patients' health situation and problems.
- Regarding certain health problems, migrants had particular understandings concerning diagnosis and management, and when presented with a different diagnosis, doubted the competence of providers.
- Poor interpersonal relations between providers and clients led migrants to conclude that providers are serious and unfriendly.

Concluding her presentation on research findings in Spain, Dr Osteria gave the floor to Dr Carrillo for a presentation of her research on Chinese and Filipino migrants in Italy, particularly in Milan.

Dr Carrillo began by underlining that some of her findings were very similar to the ones found in Spain. After introducing health policies for foreigners in Italy, which allow EU and non-EU nationals registered with the National Health Service (SSN) the same health care and equal treatment as Italian citizens, she presented the quantitative and qualitative research she conducted with Dr Sarli in Milan from September 2011 to January 2012.

Regarding the quantitative findings, Dr Carrillo explained that:

- From October 2010 to October 2011, 55% of the Chinese migrants and 58% of the Filipino migrants interviewed used Italian health services. More precisely, 10.2% and 21.1% of Chinese and Filipino migrants respectively went to see a general practitioner (GP) while around 82% and 71% of them never or rarely went to see a GP.
- In terms of illness management, 35.7% and 47.1% of the Chinese and Filipino migrants interviewed used pharmaceuticals only, while 16.1% and 8.2% used both pharmaceutical and traditional family medicine and products.

- Main sources of health-related information for Chinese migrants were friends/social networks, alternative health care and the Internet. For Filipino migrants friends/social networks, the Internet and public/government health services represented the most important sources of information. These findings indicate that health prevention brochures and pamphlets will probably not be an efficient way to reach these populations in Milan.

Dr Carrillo's qualitative research revealed that:

- Health workers consider communication with Chinese migrants very challenging, as the latter feel that direct questions are intrusive, require concrete answers and control their emotions in front of the health provider.
- Health providers see Filipinos as well integrated in the network of health services and as possessing a good knowledge of the healthcare system in Italy, while some Filipino migrants question the competencies of health providers.
- Main barriers that Chinese and Filipino migrants have to face are language barriers, which according to Dr Carrillo reveal the crucial role of linguistic-cultural mediators, and the bureaucratic procedure as well as poor knowledge of the apparatus (especially in the case of Chinese migrants).

Summarising the findings, Dr Carrillo described some common traits between Chinese and Filipino migrants in Milan: these include mistrust of services, the habit to return to the country of origin for treatments, a taboo on reproductive health and sexually transmitted diseases, often leading to illegal abortion practices, and impairment of mental health due to exhausting living conditions.

Overall, Dr Carrillo's findings indicate that the use of healthcare services is neither coherent nor systematic, help is rarely sought from the family doctor, most migrants face language barriers, and finally, bureaucratic complications pose a significant obstacle to accessing health services.

Based on these conclusions, Dr Carrillo recommended developing outreach actions in the communities to spread information on the health system and other specific issues, strengthening sex education among migrants, and employing linguistic-cultural mediators in health services. Finally, she invited the audience to read the full report of the joint project, which is to be published in late 2012 or early 2013.

Discussion

A participant from the Netherlands underlined that all the presented findings conformed to findings in other groups of migrants in Europe and thanked the researchers for giving more concrete evidence on some important issues related to migrants' health.

A participant from Singapore emphasised the importance for studies to take into account the push factors inducing migrants to leave their countries, in order to complete the picture of migration trends.

A participant from Switzerland who had worked for WHO raised two issues: first, referring to the preference of migrants to defer visits to Western doctors and bring back medicines and treatments from their country of origin, he explained that this practice was not related to a particular social or economic background. For, he recalled that amongst WHO staff there was an informal medical system whereby Indian physicians treated their colleagues of Indian origin because they did not trust the Swiss system. The second issue raised by this participant was the growth of telemedicine programmes. Such a programme exists in Geneva: irregular migrants from Peru and Bolivia send their health enquiries through electronic channels to Peruvian or Bolivian health professionals who consider the information and return diagnosis, prescriptions and traditional medicine.

Finally, a participant from Austria commented on the utilisation of a cultural mediator for consultation with migrants unable to speak the language of the health provider. She referred to empirical research indicating two elements of conflict that should be taken into account before using a mediator: first, the complex relationship and effective interaction between the providers, the mediator and the patient; second, the possible embarrassment for the patient caused by having to talk to someone from the same community about sensitive issues such as drug or alcohol consumption.

Part 2

After the break, Dr Poonam Dhavan, introduced **Dr Elvira Méndez**, specialist in preventive medicine and public health general director of the Health and Family Association (Spain). In her presentation on "Contraception and abortion patterns in Pakistani migrant women in Barcelona", she highlighted the results of a descriptive study on a population of 190 female Pakistani users of the programmes "Care for mothers at risk" and "Mothers between two cultures", run by the Health and Family Association between 2008 and 2011.

Similarly to the overall Pakistani population in Barcelona, the share of Pakistani women had increased significantly from 1,698 in 2008 to 3,542 in 2011. Dr Méndez

proposed a socio-demographic profile of Pakistani women users of the programmes. She explained that many of these women lived in the neighbourhood of Ciutat Vella and had their roots in the Punjab region (Gujrat and Gujranwala). They were in reproductive age (19-45 years), with the 25-31 year-olds being the most frequent age group. 89% were married and 83% were housewives. More than half of the study group did not understand Spanish (58%). In relation to fecundity and reproductive health profiles, she noted that 57.8% of the women had more than two children. 68.4% of the women did not use contraceptives and 23.5% of couples used the male condom as a contraceptive method to space births. Dr Méndez also found that 94% of the women had had a pregnancy of less than twelve weeks of gestation and that 30.9% had had abortions.

Finally, stating that intrauterine device (IUD) is recognised by WHO as the best contraceptive method for the prevention of repeated abortions, Dr Méndez revealed that 35.6% of Pakistani women had accepted IUD counselling and 18.1% made use of the method.



The second part of Dr Méndez's presentation focused on Pakistani women as subset of the entire group who participated in the Health and Family Association's programmes "Care for mothers at risk" and "Mothers between two cultures". She presented data that compared Pakistani women with the entire group in terms of socio-demographic profile (percentages of being in a marriage relationship, illiteracy, education level up to primary school, etc.), and reproductive health profile (percentages of having more than two children, not using contraception method, having previous abortions, etc.). With regard to fecundity and reproductive health, Pakistani women were seen to have more children and make less use of contraceptive methods than the rest of the women participating in the programmes. In addition, the study showed that more Pakistani women had a pregnancy of less than twelve weeks of gestation than the rest of the women but fewer Pakistani women had had a previous abortion. In terms of IUD counselling acceptance and implementation, the level was shown to be lower

but very close to that of the women going to the centre created by the association.

Ending her presentation, Dr Méndez concluded that:

- Educational levels and employment status of Pakistani women users were lower than those of the cohort of vulnerable women.
- Pakistani women showed a pattern of medium-high fecundity and a clear preference for more children than the group of vulnerable women.
- Their use of contraceptive methods is aimed at the spacing of births and couples often choose male-controlled methods (male condom).
- The women use abortion as a control strategy of fertility in marriage if a new child is seen as too much of a burden at a particular time.
- Pakistani women use long-term contraceptive methods, even after an abortion, at a rate similar to total of vulnerable women.
- They make lesser use of services available for contraceptive advice than do vulnerable women.
- Reproductive health seeking behaviour of Pakistani women is strongly influenced by the cultural standards of their community and to a lesser extent by the legal accessibility to health services.
- In Spain, documented migrants have full rights and legal access to public health services, however, the lack of Spanish language skills represents a barrier to developing more autonomous and healthy behaviours.

At the end of the presentation, the chairperson of the session, Dr Poonam Dhavan, thanked Dr Méndez for her very insightful and informative presentation, as well as all the speakers and participants of this second session.

Day Two

Session 3: Multi-stakeholder Responses to Migrant Health Issues and Main Challenges

Part 1

Chaired by **Dr Maruja M. B. Asis**, Director of research and publications, Scalabrini Migration Centre, Philippines, the third session dealt with the role of the governmental, inter-governmental and non-governmental actors involved in the area of migration and migrant health. Current policies at different levels addressing migrant health issues in Asia and Europe were also examined.

The first speaker of this session was **Dr Poonam Dhavan**, Public health specialist at IOM who delivered a presentation on “Multi-stakeholder response in migration health”. The first part of her presentation focused on migrant health and social epidemiology. She introduced the topic by explaining that structural, policy, environmental and individual factors interact in causing illnesses and health risks around migration and mobility. The health status of migrants influences the type of mobility (voluntary or forced, legal or irregular). The risk of illnesses can also be unevenly distributed across different migrant groups. In designing effective response strategies, she emphasised that inequalities in health and access to quality care for migrant groups cannot be addressed by health systems alone, as social determinants of health cut across various sectors.

Dr Dhavan presented some key questions when analysing the health–migration nexus: Are migrants more vulnerable to particular diseases than nationals? Does in- and out-migration affect the demand for health services in the country (increase or decrease)? Do migrants and their dependents have less (or better) access to healthcare while abroad compared to access back home? Do female migrants find it more difficult or easier than male migrants to access health services, particularly keeping in mind their need for sexual and reproductive health services? Do migrant households that stay behind have access to health services/health insurance? Do returning migrants have access to health/social services in their own countries? Are social security benefits portable?

To illustrate how social epidemiology helps to better understand migrants' health status, Dr Dhavan shared the findings of a research study she conducted with colleagues from IOM for the Asia Europe Journal (Volume 8, Number 4, April 2011). The research looked at the unique features of some non-communicable disease (NCD) burdens and risk factors in South Asian populations in Europe and how this might have an

influence on the design of response strategies. Results showed that South Asian migrants in Europe are more at risk of NCDs than their counterparts in the countries of origin and than the European host populations. Dr Dhavan underlined that the risk of NCDs depended on multiple factors such as profile and background of migrants, their legal and socio-economic status and lifestyle in the receiving country as well as their access to health services. In this context, she argued that challenges exist for migrants and health service providers, due to low awareness levels among migrants, as well as legal, financial, linguistic and cultural barriers.

In relation to response strategies of multiple stakeholders, Dr Dhavan emphasised that migration is a process and therefore several important factors have to be addressed in response to migrant health. These include pre-departure factors, travel health factors, host community factors and return factors. She provided an overview of key stakeholders that IOM emphasised in its work on migration and health. Specifically these are ministries of labour, immigration, health, foreign affairs, justice, recruitment agencies, facilities for health screening, migrant families, and transport operators/traffickers in the sending countries; and ministries of labour/immigration/ health/ foreign affairs/justice, employers, border officials, health and social services (private/public), local communities, and migrant associations in the receiving countries.

Within this context, she stated that the intervention of IOM is based on several basic principles and public health approaches such as avoiding disparities in health status and access, ensuring migrants' health rights, reducing mortality and morbidity and minimising the negative impact of the migration process.

At the global level, Dr Dhavan stressed that one of the key achievements in the area of migration health was the World Health Assembly Resolution on the Health of Migrants (WHA 61.17) which calls upon WHO Member States “to ensure equitable access to health promotion and care for migrants” and also “to promote bilateral and multilateral co-operation on migrants' health among countries involved in the whole migration process”. The resolution and the Global Consultation on Migrant Health which took place in Madrid in 2010 recommend a focus on four main pillars: migrant health monitoring, policy and legal framework, migrant-sensitive health systems and partnership, and network and multi-country frameworks. In addition, crosscutting issues such as multi-sectoral action, public health (infectious diseases, health and social burden) and economic and financial aspects (remittances, resource cost for health system) should be taken into account.

Concerning the issue of migrant health monitoring, Dr Dhavan mentioned that IOM had recently launched guidelines for countries that wish to engage in such a

process. She stated that governments tend to focus on the areas of economic development, employment and labour markets, neglecting socially relevant issues including development, health and the environment.

In terms of policy and legal frameworks, according to Dr Dhavan, one of the key issues in migrant health is what sending and receiving countries are able to offer to the migrants by way of social protection: social security schemes, employer-based health insurance or tax-based schemes for healthcare. As an illustration, she noted that Sri Lanka and the Philippines have developed insurance schemes that allow overseas workers to continue to contribute and have a certain level of coverage either for themselves or the family left behind. In Europe, Spain and Portugal were mentioned as positive examples, as these countries take policy measures to enabling migrants to access services irrespective of their status. Dr Dhavan also referred to certain bilateral agreements, for instance between Morocco and Germany, allowing migrants and mobile populations portable healthcare coverage if they continue to contribute into the funds.

Dr Dhavan also mentioned that in Spain, all migrants and asylum-seekers who are registered with the authorities and possess individual health cards are entitled to health coverage. Italy presents a similar care: if registered with the national health service, migrants are granted equal rights as citizens. She concluded that these efforts recognise the important contributions migrants make to economies and societies.

As an example of multi-sectoral action, she highlighted the recent efforts of Sri Lanka to form an inter-sectoral national response to various migrant health issues. This effort involved the establishment of a national co-ordination framework for migration health development, which acts as a “hub” for administrative and technical co-ordination. Moreover, a national research project on migration health was launched to develop an evidence base for formulating migration health policy. Technical guidelines and protocols for health requirements for long-stay visa applicants and for the establishment of a Visa Health Unit for the Ministry of Health were also developed.

Finally, Dr Dhavan mentioned a health guide recently produced by the UK Health Protection Agency (HPA) as an example of efforts to create migrant-sensitive health systems. The health guide explains to different types of health professionals how they can better address the health needs of newly arrived migrant patients and how to effectively inform migrant populations of the functioning of the National Health Service (NHS). She added that the health guide also emphasised cultural competencies and understanding of migrant populations.

In the last part of her presentation, Dr Dhavan shared lessons learned from all these experiences and efforts. These include the following recommendations:

- Migration health policies should consistently be informed by research and evaluation, and research findings need to be translated into action.
- Migration indicators such as national and demographic health surveys, or indicator surveys on AIDS and the Millennium Development Goals (MDGs), should be integrated in health information systems.
- There is a need to look at the “triple A-Q” factors (Availability, Accessibility, Acceptability and Quality) to create more migrant-sensitive health systems. Language services, culturally informed healthcare delivery, culturally tailored health promotion and disease control, and migrant-friendly support staff are components needed to generate improvement in migrant-sensitive health systems.
- A ‘spaces of vulnerability’ approach should be taken to improve the health of migrants and communities along the migration continuum. Moreover, migrant groups need to be engaged in evidence generation and the translation of data into policies and programmes.
- It is of central importance to put migrants’ health high up on the agenda in regional mechanisms and strengthen bi-regional co-operation (such as the Asia Europe Meeting)
- Migration and health need to be linked on the global policy agenda.

Following up on the topic of regional response to migration and health, **Dr Isabel de la Mata**, Principal advisor for public health at the Directorate-General for Health and Consumers (DG SANCO) in the European Commission (EC) delivered a presentation on “EC involvement in addressing the issue of migrants and communicable diseases”.

She began by pointing out that very few issues in the area of migration are decided at the EU level. Most migration-related issues including health issues remain within the responsibility of the EU Member States. There is no single universal EU policy on migration and migration-related issues.

However, there are certain efforts at the European level to address the health of vulnerable populations. Dr de la Mata presented the programmatic action of the European Commission in this area. She thereby paid particular attention to communicable diseases since the

European Commission has been co-operating with ASEF in this area through the ASEF Public Health Network since 2009. She explained that DG SANCO places its main focus on vulnerable populations and health inequalities. The Commission's strategy to address health inequalities is set out in the "Commission Communication - Solidarity in Health: Reducing Health Inequalities in the EU"⁸, published on 20 October 2009. In addition, the EU has developed several major policy strategies and programmes relevant to reducing health inequalities as they are meant to be instruments for minimising economic and social disparities (Europe 2020 Strategy, EU sustainable development strategy, Public health and the Health programme). To reach this objective, the EU is working directly (through EU policy) and indirectly (through national authorities and stakeholders).

Dr de la Mata went on to present an overview of the fourteen social determinants actions dealing with communicable diseases and migration funded under the Public Health Programme 2003-2008 and the Health Programme 2008-2013. The action presented included programmes on "AIDS and mobility in Europe" (2007), on "Screening for Hepatitis B and C among migrants in the European Union, EU HEP SCREEN" (2010) and on "Empowering civil society and public health systems to fight tuberculosis epidemic among vulnerable groups, TUBIDU" (2010). Dr de la Mata emphasised that the results of these actions and the reports provided by the European Centre for Disease Prevention and Control (ECDC) on infectious diseases and migration have been closely analysed and translated into European policies or recommendations for Member States.

Table 1: Social determinants actions dealing with communicable diseases and migration funded under the Public Health Programme 2003-2008 and the Health Programme 2008-2013

Year	Action
2005	Monitoring the health status of migrants within Europe: development of indicators (MEHO) http://www.meho.eu.com/
2005	Network for communicable disease control in Southern Europe and Mediterranean countries (Episouth) http://www.episouth.org
2006	Increasing Public Health Safety for the External Borders of an Enlarged EU (PHBLM Project) http://www.iom.int/jahia/Jahia/increasing-public-health-safety-alongside-new-eastern-european-border-line/lang/en

2006	Health and migration in the EU: Better health for all in an inclusive society, Portuguese European Presidency conference http://register.consilium.europa.eu/pdf/en/07/st15/st15609.en07.pdf
2006	European Network for HIV/STI prevention and Health promotion among migrant sex workers (TAMPEP) http://www.tampep.eu
2007	AIDS & MOBILITY, AIDS & Mobility Europe 2007 – 2010 http://www.aidsmobility.org/
2008	EUROSUPPORT 6 (ES VI) : Developing a training and resource package for improving sexual and reproductive health of people living with HIV (PLWH) http://www.sensoa.be/eurosupport/euro-support.htm
2008	Correlation Network: European Network Social Inclusion and Health http://www.correlation-net.org/
2009	Improving Access to HIV/TB testing for marginalized groups (Imp.Ac.T.) http://www.projectimpact.eu/
2009	Highly active prevention: scale up HIV/ AIDS/STI prevention, diagnostic and therapy across sectors and borders in CEE and SEE (BORDERNetwork) http://www.bordernet.eu/BORDERNetwork_2010-2012/
2009	Addiction prevention within Roma and Sinti communities (SRAP) http://srap-project.eu/2011/07/04/684/
2009	Promote Vaccinations among Migrant Populations in Europe (PROMOVAX) http://www.promovax.eu/
2010	Empowering civil society and public health system to fight tuberculosis epidemic among vulnerable groups (TUBIDU)
2010	Screening for Hepatitis B and C among migrants in the European Union (EU HEPscreen) http://www.hepscreen.eu/

Note. Adapted from de la Mata, I. (March, 2012). *Actions funded by the Health Programme addressing Migrant and Communicable diseases.* Presentation given at the ASEF's Public Health Network 1st Research Exchange Workshop and Public Talk on Social Determinants of Migrants' Health across Asia and Europe, Barcelona, Spain. Available at: <http://www.asef.org/images/docs/Dr%20Isabel%20de%20la%20Mata-EC%20presentation.pdf>. Adapted with permission.

⁸ http://ec.europa.eu/health/social_determinants/policy/commission_communication/index_en.htm

Some of the central lessons drawn from the experience of these programmes include first, that infectious disease related age-standardised mortality rates were much higher in male migrants than in the native male population. Second, only 54% of countries offer measures for the immunisation of migrants and only 41% support specific measures for the immunisation of nomadic populations.

Naming it as one of the main challenges for Europe in the area of migration health, Dr de la Mata underlined the need to implement adequate, effective and specifically targeted services, effective health promotion, outreach strategies and prevention campaigns addressing communicable diseases, counselling and treatment. She further emphasised the necessity to support equal opportunities, access to health care and free health promotion and prevention for all migrants and ethnic minorities. Moreover, she advocated better protection of migrants against deportation, stigmatising attitudes and discriminatory treatment. Linked to this, she recommended developing culturally adapted health services including culture-sensitive health professionals, information material in several languages, multicultural staff at public health services, and cultural mediators.



To conclude, Dr de la Mata offered an outlook on the approach the EC is planning to take in this area in the immediate future (Annual Work Plan 2012). This plan will identify the causes of, address and reduce health inequalities within and between Member States in order to contribute to prosperity and cohesion, supporting co-operation on issues of cross-border care and patient and health professional mobility. To reach this objective, the EC co-operates with IOM to offer health provision for migrants, Roma and other vulnerable groups. In addition, joint action is planned on the improvement of HIV prevention in Europe. The EC and the Member States will fund this in equal parts. Besides aiming to improve HIV prevention programmes, the joint action is also intended to contribute to overcoming discrimination and increasing the integration of persons most at risk of contracting HIV. These include people with disabilities, ethnic minorities and migrants, men practicing same sex intercourse and other vulnerable groups.

Discussion

A participant from the Netherlands stated that an important issue in terms of monitoring migrant health was the lack of data on ethnicity within the routine health data collection in many countries in Europe. In consequence researchers were not able to identify migrants and to distinguish different groups from different backgrounds. As he explained, over the last decade the advantages and the risks of including such information have been discussed in detail, yet so far without concrete results. While he understood that the European Commission could not interfere with national health policies of the Member States and stressed that he was fully aware of the risk of misuse and instrumentalisation of these data, he also defended the idea that it might be a responsibility of the EC to generate and to continue the discussion on this sensitive but important issue, as many researchers in epidemiology or in genetics are in favour of such request.

In response to this comment, Dr de la Mata explained that the discussion was still going on but that to date there had not been a positive decision. While she recognised the advantage disaggregated data collection could bring for research and analysis, she also explained that the ethnic genocide of the Second World War and of the Balkan war were still in the mind of many people and officials hence blocked any agreement on this issue. She also added that it could be difficult to know what data to collect (e.g. birth country or country of nationality), as ethnicity is a very complicated issue.

Another participant from the Netherlands noted that there was strong emphasis on communicable diseases in EU policies dealing with migration health and asked if this choice was linked to the concept of migrants as newcomers. He explained that this perception trickled down into the research programmes as programmes on migrant health were often targeted at newcomers, thus neglecting health problems they might develop later such as NCDs. Dr de la Mata answered that out of twenty-eight projects financed by the EC, fifteen focused on communicable diseases. The participant reacted by saying that the other projects actually focused on access to healthcare and not NCDs. Dr de la Mata agreed and went on to say that the reason for this was that health threats like communicable diseases were considered a competence of the EU. Therefore the EU possesses legislation on communicable disease reporting but has only published communications, white papers and declarations on NCDs.

Highlighting another area of the EU migration policy, a participant from Hungary pointed out that when talking about migration in Europe, one of the major issues to discuss is local integration. In this realm, the DG Justice and DG Home Affairs of the EC shared certain

competencies over European migration policy. However, he argued, there are no provisions to measure the degree of integration although various policy instruments exist as well as the “solidarity fund”, which may be used to finance programmes and projects for the integration of non-European migrants.

He further noted that a closer look at the policy framework and the discourses around migration revealed a rather ambiguous picture. On the one hand, in 2010, in Saragossa, European ministers responsible for integration issues published a declaration⁹, which included recommendations for setting standards and indicators to measure the level of integration of non-European migrants in the Member States. In this declaration, four priority policy areas were identified, with related indicators that are comparable and available across countries (see Table 2.1). The declaration also recognised the importance of developing standardised data for seven other areas or indicators (see Table 2.2). However, he regretted that health was not part of the proposed priority policy areas or of the proposed seven areas and indicators of development. Health is only mentioned as one of the indicators on migrants' social inclusion.

On the other hand, he drew attention to a comprehensive report on these indicators, published by Eurostat in 2011¹⁰. Out of 260 pages, forty pages deal with the health situation of migrants. Similarly, a look at the EC website listing all EU projects on integration reveals again that health is subsumed under the heading of social situation along with hundreds of other sub-items. Nevertheless, the participant recognised that this website on EU integration programmes informs the reader that there are 300 projects related to health throughout the twenty-seven EU Member States.

Table 2.1: Policy areas identified as priority areas and related indicators that are available and comparable across countries

Policy Area	Indicators
Employment	<ul style="list-style-type: none"> • Employment rate • Unemployment rate • Activity rate
Education	<ul style="list-style-type: none"> • Highest educational attainment (share of population with tertiary, secondary and primary or less than primary education) • The share of low-achieving 15-year-olds in reading, mathematics and science • The share of 30 to 34-year-olds with tertiary educational attainment • The share of early leavers from education and training

Social Inclusion	<ul style="list-style-type: none"> • Median net income – the median net income of the immigrant population as a proportion of the median net income of the total population • At risk of poverty rate – share of population with net disposable income of less than 60 per cent of national median • The share of population perceiving their health status as good or poor • Ratio of property owners to non-property owners among immigrants and the total population
Active Citizenship	<ul style="list-style-type: none"> • The share of immigrants that have acquired citizenship • The share of immigrants holding permanent or long-term residence permits • The share of immigrants among elected representatives

Note. Adapted from Council of the European Union (April, 2010). *European Ministerial Conference on Integration (Zaragoza, 15 and 16 April, 2010) Draft Declaration*. Available at: http://ec.europa.eu/ewsi/UDRW/images/items/docl_13055_519941744.pdf

Table 2.2: Seven areas and indicators of development proposed

Areas and indicators
<ul style="list-style-type: none"> • The share of employees who are overqualified for their jobs • Self-employment • Language skills • Experiences of discrimination • Trust in public institutions • Voter turnout among the population entitled to vote • Sense of belonging

Note. Adapted from Council of the European Union (April, 2010). *European Ministerial Conference on Integration (Zaragoza, 15 and 16 April, 2010) Draft Declaration*. Available at: http://ec.europa.eu/ewsi/UDRW/images/items/docl_13055_519941744.pdf

A participant from Singapore enquired about the relationship between the EU and the WHO Regional Office for Europe and wondered how to strengthen health projects. In response to this, Dr de la Mata stressed that financial resources for health projects are usually very limited and that there are specific procedures to be respected before a project may be created; for one, proposals need to be presented by three countries and are then evaluated according to EU priorities. She also recalled the fact that health had not been a priority at the establishment of the European Union, which was founded

⁹ Council of the European Union (April, 2010). *European Ministerial Conference on Integration (Zaragoza, 15 and 16 April, 2010) Draft Declaration*. Available at: http://ec.europa.eu/ewsi/UDRW/images/items/docl_13055_519941744.pdf (accessed 20 September, 2012)

¹⁰ European Commission, *Indicators of Immigrant Integration – A Pilot Study* (Luxembourg: Publications Office of the European Union, 2011). Available at: *Indicators of Immigrant Integration* (accessed 20 September, 2012)

as the European Economic Community. Health came into the competence of the EU when health problems were perceived as a threat to European economies (for instance thorough mad cow disease or the dioxin crisis). It was only then that European politicians recognised the need to integrate health into policies and treaties.

Regarding the relationship between WHO Regional Office for Europe and the EU, she first explained that they share common areas of work, however, she also underlined that, contrary to WHO, the EU was endowed with the ability to create legally binding directives and that the EU had more financial resources than the WHO Regional Office for Europe.

A participant from the Philippines asked if any mechanism existed at the EU level to complain about the non-implementation of legislation, directives or recommendations as well as about deportation and discrimination against migrant workers. Dr de la Mata responded that there was an independent procedure open to any member state or citizen of a member state to complain about a breach of the EU legislation. This complaint could be made to the national or the European court or to the EC. Regarding the so-called soft legislation such as the recommendations of the Council of Europe, which are not directives and therefore not binding, the European Court of Justice has agreed that if recommendations have been approved by the Member States, citizens are allowed to complain about the disrespect of such recommendations through a member state to the Court of Justice. However, so far this situation has not yet occurred.

On the issue of deportation, a participant from Hungary explained that has been a directive on return and expulsion of third country citizens staying irregularly in the EU Member States in place since 2010. It is a detailed regulation, which provides criteria for detention and expulsion. It also establishes a category called “vulnerable persons” and considers issues related to health, especially reproductive health and HIV/AIDS.

A participant from Singapore made a final comment on the existence of regional migration-related bodies in Asia by providing the example of the ASEAN inter-governmental commission on human rights, under which two commissions are subsumed: the commission on the right of women and children and the commission on migrant workers.

Part 2

Following the break, **Dr Elia Rosalina Sunityo**, Deputy director for facilitation of migrant health at the National Board for Placement and Protection of Indonesian Overseas Workers (Indonesia) gave a presentation about

the “Policy and strategy of Indonesian Government in promoting migrant labour health”.

Dr Sunityo started her presentation by offering an overview of the legal and organisational structure of Indonesian migration policy. She explained that implementation of placement and protection of Indonesian overseas workers is the responsibility of the Government and that the different agencies involved considered dignity, human rights and law protection as priorities. Based on the vision of “creating qualified and dignified Indonesian workers”, she emphasised that the mission of Indonesian authorities was to implement policies on placement and protection of Indonesian overseas workers in coordinated and integrated ways. The objectives of this are: 1) to expand overseas job opportunities, 2) to improve quality and placement services for Indonesian workers, 3) to strengthen the security, protection and empowerment of Indonesian workers, and 4) to increase capacity of placement and protection for Indonesian workers.

She then provided some very informative data concerning Indonesian migrants. According to the official statistics, there are currently around six million Indonesian overseas workers (4.2 million registered and +/- 2 million unregistered). Of these, 64% are women. The Indonesian migrants work in forty-one countries in 181 types of jobs. In terms of placements, Saudi Arabia is the most important destination country, followed by Malaysia, Taiwan and Hong Kong. In 2009, the remittances amounted to US\$ 6.615 billion.

In the second part of her presentation, Dr Sunityo discussed the main problems and challenges Indonesian workers face, particularly in relation to health. The most frequently encountered problems include sickness due to work, congenital illness, sexual abuse, work accidents and difficulties due to pregnancy.

She continued to go into detail on the way the placement of migrant workers is organised by the Indonesian Government and how migrants’ health was taken into consideration. The Indonesian placement policy is composed of a three-phase process consisting of a pre-placement phase, a placement period and an after-placement phase. In the first phase, workers have to pass a health examination. During the placement period, the migrant workers will be examined at their arrival by the health authorities of the receiving country. Dr Sunityo then focussed on the last phase where the workers often encounter various problems.

These include:

- The ineffective implementation of health examination services for Indonesian workers in health facilities,

- The ineffective accounting and reporting system, the ineffective health referral system for Indonesian workers, insufficient access to health services for Indonesian workers, insufficient knowledge, understanding and skill of debarkation officers in relation to accessing health services;
- Lack of information received by Indonesian workers about access to health services in health facilities in their neighbourhood;
- Inefficient role of local government in relation to providing access to health services for Indonesian workers;
- Insufficient numbers of health facilities for Indonesian workers and inappropriate attendance to their needs.

Finally, Dr Sunityo presented activities implemented by the Indonesian Government to deal with migrant health issues. One of these is a tool created and used by the National Board For Placement and Protection of Indonesian Overseas Workers, namely a computerised data system of overseas employment (SISKO TKLN), which connects all the departments and agencies dealing with migration in Indonesia. Among the benefits of such a system, Dr Sunityo underlined the accessibility of this system to all the Indonesian migration and overseas employment agencies, the creation of biometric data saving photo and fingerprints of Indonesian workers and the monitoring of migrant health. Concerning the biometric data, she emphasised that this tool avoided falsification of health certificates and is expected to increase the quality of the health examination results of Indonesian work placement candidates.

To conclude, she underlined that the system and the whole placement policy and strategy would benefit from better coordination among relevant agencies and civil society at both central and district levels.

The next presentation was delivered by **Ms Kadri Soova**, Advocacy officer for the Platform for International Co-operation on Undocumented Migrants (PICUM) on "The role of civil society in securing access to healthcare services for undocumented migrants in Europe".

She started by presenting PICUM, a network organisation based in Brussels and established in 2001, which links around 150 organisations. The main aim of PICUM is to promote respect for the human rights of undocumented migrants (UDM) within Europe. PICUM tries to give visibility to the reality of undocumented migrants through monitoring, research, evidence-based advocacy, awareness-raising and capacity-building activities with the objective of bringing undocumented migrants to policy agendas (at national and at EU level).

To summarise PICUM's research findings, no EU Member State specifically forbids access, however, publicly subsidised healthcare is not entirely guaranteed in Europe and healthcare is often used as an instrument of immigration control. Moreover, migration policies are increasingly restrictive although some efforts to the contrary exist on the local level. According to Ms Soova, this situation engenders incoherence between the areas of public health, social cohesion, and medical ethics. It also creates an enormous strain on frontline service providers and a significant increase in healthcare costs by withholding access to primary healthcare.

To distinguish levels of access to healthcare services in national legislation, PICUM proposed a typology of five main groups of countries: Countries where all care is provided only on payment basis (Austria and Sweden, with the exception of children), countries allowing free health care in cases of emergency (Hungary, Germany), states granting free access to some services (UK - only primary care), governments proposing mainstream care but with a parallel administrative systems (France, Belgium, Netherlands), and finally, countries offering wide public healthcare coverage (Spain, Italy).

In the following, Ms Soova provided a summary of PICUM's findings about barriers to access and use of healthcare services. She explained that many UDM do not access services even if legally entitled to care because of numerous factors. These include fear of being reported to the police (legal obligation of public authorities in Lithuania, Germany), financial strain, lack of information, language and communication difficulties and being met with dismissive attitudes. Talking about the role of health professionals and hospitals, she highlighted the fact that sometimes they have to treat people but are not reimbursed the costs. In general, medical staff apply a professional code and perform their medical duties, but hospital administration often does not seem to be bound by the same professional ethics and may refuse treatment or denounce undocumented migrants to the authorities. As a consequence, Ms Soova explained, UDM tend to go to certain specific "undocumented migrant-friendly hospitals" – mainly private/religious hospitals and NGO providers.

In summary, PICUM has found that undocumented migrants mainly seek health care when they are seriously ill, a high percentage do not access healthcare even if entitled, and most frequently UDM go to NGO clinics or the emergency system as many of them are unable to pay the medical fees.

In this context, NGOs who help UDM gain access to health services are under enormous pressure as they mediate access to mainstream medical services, provide direct and volunteer-based medical assistance (clinics and mobile units), refer UDM to other health care

providers within networks, provide medicines (mainly from donations, including HIV treatment) and assist with the payment of bills (health care, medicines, tests and exams). In many cases, NGOs and religious hospitals are the only providers of care for UDM, which is, according to Ms Soova, a rather problematic situation, as it should be the responsibility of the State to provide healthcare.

Finally, she provided some good practice examples of activities on the local level. For instance in Italy regional governments have taken legislative steps to advance the human rights of all migrants irrespective of status. In Germany, local governments have created consultation services to improve access to health care for undocumented migrants, specifically targeting undocumented women. And in Belgium local social welfare offices have established specific services to improve undocumented migrants' access to mainstream healthcare services.



Concluding her presentation, Ms Soova put forward some recommendations in the name of PICUM, urging to:

- Respect international human rights obligations, professional ethics and the demands of public health
- Protect vulnerable undocumented migrants
- Ensure that entitlements are implemented and that the access to information on entitlements is available
- Lobby governments to ask them to detach healthcare from immigration control and to stop the criminalisation of humanitarian assistance to undocumented migrants.

Discussion

Sharing his experiences in working with UDM in Europe, a participant from Spain made a short comment stressing the importance of distinguishing between national legislations and the real implementation of these legislations.

A participant from Austria observed that in most European countries, health professionals working with UDM found themselves trapped in a difficult situation because whatever they do is wrong: when they give care to UDM they act against the law, but if they do not provide care to these migrants, it is against their professional ethics. In this context, she said that health professionals are left with this dilemma, which cannot be solved unless there is change in national legislation. She recommended preparing an economic analysis of the costs linked to the exclusion of migrants from primary care. For, her own preliminary research revealed that it was significantly more expensive to delay access to care until emergency services are necessary, as emergency services belong to the most costly segment of healthcare provision.

Responding to a question asked by a participant from Thailand, concerning the existence of a compulsory health component during pre-departure training given to Indonesian migrants and on the existence of a follow-up on migrants' health when they returned in Indonesia, Dr Sunityo explained that there is a health component focusing on HIV/AIDS and drug use. She confirmed that during the training, migrants receive information on health from the recruitment agencies. Regarding a follow-up on the health status of migrants returning to Indonesia, she pointed out that many recruitment agencies were in fact illegal and therefore it was difficult to have a clear picture of the health status of returning migrants. However, the Indonesian Government has published hospital guidelines on addressing migrants' health.

A participant from Hungary enquired about the collection of social-demographic data concerning return migrants (age, education, employment abroad, country of employment) as he considered this relevant to the establishment of particular health risk factors. Dr Sunityo explained that such data existed in principle but was very difficult to collect for unregistered migrant workers.

Regarding PICUM's presentation, a participant proposed to set a certain standard for access to healthcare which could be somewhere in between emergency care and full access to all treatments. Ms Soova responded by pointing out that any strategy respecting human rights needed to take a non-discriminatory approach; she thus preferred to lobby for equal access to healthcare for all people who are uninsured and face barriers in accessing care at the national level.

A participant from Japan shared how Japanese authorities approach health protection of undocumented migrants. She explained that a privatised health insurance scheme covering several clinics had been developed in the Tokyo and Yokohama areas. Migrants were asked to pay thirty euro per month as a private insurance and in return were given the same level of access to the healthcare system as Japanese citizens. According to

the participant's research, this system, which had been developed by Japanese health workers and Filipino migrants working in the Tokyo area, was very efficient. She invited European countries and cities to think about employing a similar scheme.

Closing the session, chairperson **Dr Maruja M. B. Asis** concluded by thanking all the speakers and participants, and suggested that in future, multi-stakeholder approaches to the healthcare of migrants should involve employers since they play an important role in the process of migration and because they are the ones directly involved with migrants. She also underlined the importance of considering migrant associations as partners in order to work on the establishment of migrant-friendly services and informative brochures for migrants, *inter alia* in the area of health. Rather than solely focusing on the role of the state for protection of migrant health, attention should be given to local governments and experiences at the local level, which could be useful references for action at national, regional and international levels (bottom-up approach). Finally she proposed to use a life-cycle approach¹¹ when discussing migration, in order to accommodate the complexity of migration experiences.

Session 4: Recommendations for Asia-Europe Cooperation on Migration and Health

After a presentation delivered by **Dr Vincent Rollet**, Associate researcher at the French Centre for Research on Contemporary China (CEFC), summarising the main conclusions of previous sessions, the participants were divided into two working groups moderated by **Ms Aleksandra Chrzanowska**, Co-ordinator of the foreigners section of the Association for Legal Intervention (Poland) and **Dr Phua Kai Hong**, Associate professor, health policy and management, Lee Kuan Yew School of Public Policy (Singapore) in order to discuss new/further areas for research in the field of migration and health and to propose some recommendations.



Areas of new/further research on health and migration

The participants recommended amplifying research in the following domains:

- **Mental health of migrants:** The participants underlined that while a large body of literature recognises that the process of migration can be stressful and can impact negatively on mental health, further research should be conducted on the effect of migration on mental health, specifically across Asia and Europe. They proposed to focus on the impact that different conditions of migration might have on mental health and mental illnesses, and on the identification of factors, which may under certain conditions imply a risk of psychiatric disorders, as well as on prevalence and associated factors of different mental health problems. It was suggested that research should be dedicated to gathering information comparing migrants' state of mental health in destination countries and in the country of origin. This was considered necessary information in order to fully understand the impact of migration on migrants' mental health.

The participants also thought it important to assess national policies targeted at migrants' mental health, and to evaluate migrants' needs on the one hand and the functionality of services dealing with mental health in Europe and in Asia on the other hand. This would help to highlight good practice examples and identify areas in which stakeholders in the two regions may co-operate.

- **Dynamics and nature of lifestyle changes:** Since migrants often experience radical changes in their lifestyles during the migration process and afterwards, the participants deliberated on the need for research to focus on the nature and dynamics of these changes as well as their effect on migrants' health. This was expected to help better understand the impact of migration on NCDs related to dietary habits and lifestyle, and to strengthen prevention campaigns in this area. The participants emphasised the importance of conducting comparative studies on the effect of migration on weight and morbidity linked to NCDs among Asian migrants in European countries, and on the potential influence of socio-economic and individual lifestyle factors.
- **Illegal abortion:** The participants discussed the lack of data on illegal and unsafe

¹¹ The World Bank. "Life-cycle Approach, A Framework to identify Vulnerabilities and Opportunities." Accessed 21 September, 2012. <http://go.worldbank.org/GIPDY7HG30>.

abortions amongst migrant women – including undocumented women – in Europe. They emphasised that media throughout the EU had reported on the occurrence of unsafe abortions amongst migrants but that too little academic research to this point had looked into this issue. They agreed that research was necessary in order to better understand the factors leading to these unsafe abortions and to strengthen reproductive health and sexual education campaigns.

- **Occupational ailments:** Existing data reflects higher rates of fatal and non-fatal injuries amongst migrants in general than amongst native populations. This is largely a result of the fact that migrants tend to work in higher risk occupations. The participants of the workshop felt that few studies have investigated occupational injury and illness rates specifically amongst Asian migrant populations in Europe. They therefore suggested that research should be conducted to identify factors contributing to the risk of occupational ailments among these migrants as well as among undocumented migrants who are not covered by the European Convention on the Legal Status of Migrant Workers. This is expected to help develop effective social and public health interventions. The participants also highlighted the importance of assessing national policies of European and Asian governments related to occupational ailments in order to get a clearer picture of the actual level of migrants' protection from occupational health hazards.
- **Mapping accessible and "migrant-friendly" health facilities:** With the aim of creating a handbook for migrants, the participants proposed to conduct research on health facilities accessible to migrants in the EU. The research should investigate two aspects: one, the accessibility of health institutions in the destination country through national health insurance, and two, accessibility of health institutions labelled as "migrant-friendly" for having implemented initiatives and services addressing cultural and language barriers that (Asian) migrants face when they interact with health providers.
- **Development of migrant youth and children of migrants:** The group discussed challenges and opportunities related to the health and social development of migrant youth and children of migrants, particularly children of Asian origin in Europe. Explaining that a large number of migrant youth and children of migrants experience difficulties with regard to education, physical and mental health, poverty, and integration in society, participants expressed an urgent need to examine

the well-being and the development of Asian migrant youth and children of migrants in Europe compared to native-born youth and children in destination societies. They also agreed that it was important to foster research on unaccompanied minors in Europe who have escaped war, violence and/ or extreme poverty, as they are often forced to cope with difficult living situations, health problems, abuse and neglect. Unaccompanied minors also run the risk of becoming victims of criminal networks including human trafficking. The participants thus highlighted the necessity to assess and evaluate relevant European responses, which vary from country to country.

- **Health of returning migrants:** Considering that so far the health of returning migrants has received little attention in research and in policy, the participants proposed to examine how risk factors and social determinants of health may impact the health of returnees and how return migration can have an influence on the health of migrants. During the discussion, reference was made to the fact that migrants are likely to suffer from poor living and housing conditions and face various barriers to accessing health services; thus they are often less healthy upon return than before they left. Therefore, migrants may be in need of medical care when they return to their countries of origin. However, appropriate health services may not exist or be unaffordable to the migrants. The participants thus recommended that new research on the health of returning migrants be conducted to help governments develop policies and strategies addressing the needs of returning migrants and to facilitate the continuity of care across borders, in this case particularly across Europe and Asia.
- **Cost-effectiveness of limiting undocumented migrants' access to free primary care:** According to the *Nowhereland* project supported by the European Commission, which analyses access to healthcare for undocumented migrants in the EU, twenty EU Member States refuse regular primary care to undocumented migrants. Only emergency care is covered by the state, although this is in fact recognised as the most expensive segment of care. By contrast, preventive treatment would be significantly more efficient and less expensive for the health system. Since economic and financial arguments were felt to perhaps be more persuasive to EU governments than arguments relying on a human rights approach, the participants proposed to conduct cost-effectiveness analyses of not allowing undocumented migrants to get access to free primary care.

- **Impact of dissemination of health information to migrants:** During the course of the workshop presentations had shown that the distribution of health information (public health prevention, rights related to healthcare, a map of health institutions) could make a difference to migrants' health and migrants' access to health. However, the participants felt that scientific data confirming the positive impact of health information dissemination was needed. Research was recommended in order to better understand how migrants perceive, use and share this information and how communication on health issues can be improved.
- **Health of elderly migrants:** Since the proportion of elderly migrants in Europe is growing, participants pointed out that research on the health of elderly persons from culturally and linguistically diverse backgrounds was needed, notably on the factors affecting their physical and mental health, on their use of healthcare services as well as on the issues of health dependency and vulnerability.
- **Women migrants' health:** Migrant women and girls are often disproportionately affected by exploitation, violence and abuse throughout the migration process. This situation is aggravated by the lack of access to appropriate reproductive and paediatric health services. Undocumented women and girls are particularly vulnerable to violence and abuse, including sexual assaults, while at the same time unable to access appropriate health services such as pre-natal care and psychological assistance. Participants proposed to conduct further research focussing especially on Asian women's health in Europe, to assess health problems they encounter and the influence of legal status and living and working conditions on their illnesses.
- **Consequences of the migration journey on migrants' health:** It was agreed that determinants of migrants' health are shaped by their experiences and the situation in the countries of origin and destination. However, participants noted that the impact of the travel phase during the migration process was very often neglected in the study on migration health and needed further research. According to them, the influence of living and eating conditions combined with limited or no access to health care during this transit period needs to be examined. Furthermore, participants felt that in cases where irregular migrants fall ill during the migration journey, the circumstances surrounding this should be investigated. For, it was agreed that this situation could potentially have detrimental effects on migrants' health both in the short and long term if diseases remain undetected and/or untreated.
- **Reasons for the non-ratification of international instruments related to migrants' health protection:** While some countries have ratified international instruments related to migrant health protection, other countries have not. The participants suggested further research on the factors and dynamics (social, economic, political; national, regional and international) inducing a government to ratify such tools. They estimated that a better understanding of these factors might be useful to convince those countries, which have not yet ratified relevant international instruments to do so.
- **Civil society involvement in sending and receiving countries and its limits:** The participants supported further research on the role of civil society towards migrants' health protection and promotion in Asia and in Europe. The participants identified a need to exchange good practices between NGOs working with undocumented migrants, and migrants in both regions. Moreover, it was suggested that research be conducted on the main obstacles confronting Asian and European NGOs with regard to assisting and advising migrants in the field of health, and finding ways to overcome these barriers.
- **Interactions between the various actors involved in migrant health across Asia and Europe:** At local, national, regional and global levels, many governmental and non-governmental actors are involved in migration issues, including health issues. The participants proposed to strengthen research on the role of these stakeholders, to examine levels of collaboration between agencies of the same sector or from different sectors (inter-sectoral), their level of integration and their will to co-operate internationally. In addition, the participants felt that the role of the private sector as well as public-private partnerships on migration and health should be further investigated.
- **Level of integration:** Considering the need for integration from the international to the local level, participants proposed to conduct further research focusing on the role of regional bodies (ASEAN, European Commission) in health and migration, the bilateral mechanism between sending and receiving countries on migrants' health, intra-national migration in countries like China or India and its impact on migrants' health. Finally, the degree of implementation and enforcement of rules, law and rights concerning the protection of migrants' health at the local level should also be explored.

Furthermore, participants stressed the importance of conducting **evidence-based** and **policy-oriented research**, to use a holistic and realistic approach, which would take into account **living, working, economic and family conditions** in any research on health and migration, and finally to promote **greater collaboration between Europe and Asia** in the domain of migration and health research.

Recommendations

♣ Improve the inclusivity and the accuracy of data related to migrants' health

The discussions made clear that one of the main obstacles for researchers and policy-makers in the area of migration health was the general lack of adequate published data, i.e. regional and national level data disaggregated by sex. Information is needed on patterns of migrants' health and illnesses as well as health service utilisation, including clinic consultations and levels of satisfaction with services. The unavailability of information concerning ethnicity in health data in many countries in Europe was felt to be a significant challenge. Moreover, it was suggested to strengthen the monitoring and evaluation of migration health programmes through the identification and retrieval of appropriate indicators. In this context, it is crucial to specify the definition and standardisation of data or indicators to improve comparability of information between countries. This would allow for a better follow-up of information on under-represented communities and migrant populations as well as the development of economic analysis of current migration health interventions.

♣ Enhance the quality of care for migrant populations through "migrant-friendly" policies and services

As recently conducted research presented during the workshop shows, healthcare services for migrants are frequently not appropriate and even the most highly developed healthcare systems in Europe fail to provide high quality care to migrant populations. Specifically, evidence from quantitative and qualitative research indicates that migrant status and ethno-cultural diversity increase the risk of treatment errors and that patients with language barriers have a significantly increased risk for serious medical occurrences during hospitalisation. In this context, there is an urgent need to improve the quality of care for migrants through the implementation of migrant-friendly national policies and services (cultural competencies, interpretation).

♣ Develop outreach activities in migrant communities to deliver information on health and service entitlements

Research has revealed that amongst certain Asian populations in Europe, utilisation of healthcare services is incoherent and recourse to the family doctor is poor. Many migrants are not aware of their rights in terms of access to health services. Based on these research results, outreach activities should thus be developed and implemented in the communities concerning information on the health system and migrants' rights as well as health promotion and specific health issues.

♣ Stop criminalisation of humanitarian assistance to undocumented migrants

In most countries, health professionals working with undocumented migrants found themselves trapped in a dilemma: if they provided care to undocumented migrants (UDM) they were likely to act against the law, if they refused them care provision, they would act against their professional ethics. Until there is a revision of national legislation, health professionals are left to deal with this situation on their own. Therefore, legislative reform is urgently needed to protect the health of UDM and end the criminalisation of humanitarian assistance.

♣ Harmonise migration and health related laws and policies within countries

Contradictions and inconsistencies in national legal and policy provisions concerning migration and health need to be resolved as these divergences frequently have problematic results for migrants.

♣ Address violence against women migrants on the international level

While UN Women is to be congratulated for their efforts to put this issue on the agenda of the international community, actors concerned by the challenge of fighting violence against migrant women should work together at the regional and inter-regional levels to support these efforts and to improve the reporting of known cases.

♣ Improve the involvement of employers, migrant associations and local governments in policy-making and the implementation of services related to migration and health

In relation to multi-stakeholder approaches to addressing the health of migrants it is important to expand the involvement of employers because they have a stake in the process of migration and because they are often

in direct contact with the migrants. It is also crucial to consider migrant associations as partners in the creation of migrant-friendly services and informative brochures on health. In addition to national governments, local governments and civil society actors including migrant groups should be given a role in protecting migrants' health. In this context, the exchange of good practice examples of activities at the local level could be useful to inform policy-making and agenda-setting at national, regional and international levels (bottom-up approach).

♣ Support sustainable initiatives to improve difficult living conditions of migrants

Several factors jeopardise the health of migrants: adverse living conditions (overcrowded housing and poorly ventilated spaces), poor working conditions (low pay, physically challenging work, unsafe working conditions etc.), and psycho-social conditions (limited access to information and healthcare services, no community or family support, single entry policy). In many receiving countries, few initiatives have been implemented effectively and sustainably to improve these difficult conditions and to protect migrants' health. There is a clear need to support the development of sustainable initiatives in order to improve migrants' living and working conditions, which impact deeply on their health.

♣ Ratify existing international instruments for the protection of migrants' health

The international community has created a number of useful international instruments to protect migrants' health, however, these instruments are often not put into effect due to a lack of understanding of migration issues as well as a lack of political will. Therefore, more countries need to ratify international instruments; in addition governments and societies need to be better educated on migration issues, including difficult living situations of many migrants and their families, and causes thereof.

♣ Strengthen inter-regional collaboration on migrant health issues

While it is important to capitalise on hitherto achieved successes of inter-regional collaboration, it is not less important to continue strengthening this co-operation by building sustainable networks for the exchange of knowledge, skills and capacity, and to establish frameworks to ensure social and health protection throughout the migration process. In this respect, collaboration on the level of policy-making as well as in the field is recommended to develop and implement information, education and communication projects and materials for migrants and exchange best practices, all the while taking into account impact assessments, and innovation and sustainability aspects.

♣ Engage receiving and sending countries in policy-making and collaborative research

Sending and receiving countries in Asia and Europe should be more closely engaged in policy-making in order to reach the right balance between public health concerns and human rights. Most importantly, the health of migrants should not be misused as a tool for stricter immigration policy and border control. This concrete engagement of both sending and receiving countries should help to better protect migrants' health as well as to improve the management of migration, to ensure the coherence between migration policies among countries and to strengthen the role of research for policy-making. Stakeholders in sending and receiving countries need to be brought to the table of discussion to discuss sensitive issues and create a venue for consultations, which will produce concrete results.

Ms Sol Iglesias, Director of the Intellectual Exchange Department, Asia-Europe Foundation, concluded the workshop and thanked all participants for their contributions.



CONCEPT PAPER

Background

In a globalised world, many challenges to our societies require cross-border and cross-sectoral solutions. Among the challenges, public health issues should be addressed in terms of both generality and specificity. As stated in the World Health Organization's Constitution that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 1948), a rights-based approach to public health aims at achieving health equity. However, disparities in social and economic development among different segments of the societies in Asia and Europe, specific factors influencing the communities' health should be also addressed. Moreover, the recent significant increase of population mobility between the two regions needs a systematic response to these challenges by multiple sectors and sharing of more data and information on international public health.

Asia-Europe's response to health challenges

Considering that Asia and Europe become more interdependent and require closer collaboration and coordination on various issues, Asia-Europe Foundation (ASEF) embarked on creating a unique participatory platform which encourages public health dialogue in Asia and Europe. Through its Public Health Network, ASEF provides space for an array of actors from health and non-health sectors to share their knowledge and experience. ASEF's added value to the Asia-Europe dialogue on health is: 1) addressing challenges with an Asia-Europe perspective; and 2) identifying opportunities for further collaboration on public health issues. In order to maximise this value, the Network aims at contributing to policy development process and to implementation of evidence-based policies and programmes. To this end, facts, figures and analysis, based on reliable and valid research data, are required. The Network also saw the need for the exchange of knowledge and experience between researchers to enhance the bi-regional collaboration.

Cross-regional approach to health and migration

As a common public health challenge that both Asia and Europe face, the ASEF Public Health Network has prioritised the issue of health and migration. Migrants, who contribute to global economic and social development, are often prone to various risk factors of health, depending on types of health systems that they experience throughout the migration process. And how these systems, policies and practices address social determinants and needs of migrants, could result in having great impact on the overall public health in communities of origin, transit and destination. ASEF Public Health Network will address these issues through a multi-disciplinary and multi-sectoral approach.

Research exchange workshop series

The ASEF Public Health Network will organise a series of research exchange workshops from 2012 to 2013. Two workshops will be organised in March and September 2012 respectively. A public conference will be held in 2013 to present the initial outcomes of the workshops.

The 1st research exchange workshop is scheduled on 7 – 9 March 2012 in Barcelona, hosted by Casa Asia. The main issues will be addressed by exploring questions as below:

- What are the social, economic, cultural, structural and environmental determinants that affect migrants' health, in particular terms of health equity?
- What are the current initiatives and policies taken at multiple levels to address the issues on migration and health in Asia and Europe? What are the challenges to migrants' access to health?
- What are the areas that require further actions and research through Asia-Europe cooperation?

Research exchange workshop will provide an avenue for exchanging research outcomes among Asian and European researchers dealing with international migration and health. In addition, participation of multi-disciplinary and multi-sector stakeholders will strengthen partnerships between various sectors going beyond the health sector. The outcomes of the workshop will be compiled into a report and the report will be disseminated to the relevant stakeholders in Asia and Europe.

PROGRAMME DETAILS

Main topic:

Social determinants of migrants' health across Asia and Europe

Objectives:

- Provide a better understanding of state of health of Asian migrants in Europe
- Share the information and experience of multiple stakeholders in addressing migrants' health issues
- Produce recommendations for Asia-Europe cooperation on migration and health

Day 1

Thursday 8 March

Venue: Samarcanda

Registration

Timing: 08h30 – 09h00

Welcome Remarks

Timing: 09h00 – 9h15

By **Mr Rafael Bueno**, Director of Politics and Society, Casa Asia

Session 1 – Overview of Migration and Health in Asia and Europe

Discussion points

- Paradigm shift in the issue of migration and health
- Migration trends in Asia and Europe, and their implications for the management of infectious diseases

Chair

Dr Manuel Carballo, Executive Director, International Centre for Migration, Health and Development, ICMHD

Presentation

Timing: 09h15 – 09h45

Topic

Paradigm shifts in the discourse on migration and health

By **Prof David Ingleby**, Emeritus Professor of Intercultural Psychology, Utrecht University

Question and Answers

Timing: 09h45 – 10h15

Break

10h15 – 10h30

Presentation

Timing: 10h30 – 11h30

Topic

Migration in Asia: Trends and Challenges

By **Mr Mohammad Harun-or-Rashid**, Regional Coordinator, Coordination of Action Research on AIDS and Mobility, CARAM Asia

Topic

Main social determinants of health of migrant populations in Europe

By **Dr Ursula Karl-Trummer**, Executive Director, Center for Health and Migration

Question and Answers

Timing: 11h30 – 12h10

Conclusion of Session 1

Timing: 12h10 – 12h30

Lunch Break

12h30 – 14h00

Session 2 – State of Health of Asian Migrants in Europe

Discussion points

- Patterns of infectious diseases in migrant populations
- Determinants that affect migrants' health in both sending and receiving countries
- Concomitant health outcomes of migrants: health literacy, health beliefs, health practices, help-seeking behaviour such as health service utilisation pattern and perceptions of health systems and providers etc.
- Issues of migrants' inclusion in the host community and their implications on migrants' health
 - To what extent does migrants' assimilation or non-integration in the countries of destination affect their health state as well as that of general population?

Chair

Dr Poonam Dhavan, Public Health Specialist, International Organization for Migration, IOM

Presentation

Timing: 14h00 – 15h00

Topic

Outcomes of the ASEF-commissioned joint research, “Public Health Challenges in the Era of Migration: The Health Dimension of Southeast Asian Migration to Europe”

By **Dr Trinidad Osteria**, President, Yuchengco Centre, De La Salle University

By **Dr Daniela Carrillo**, Researcher, Health and Welfare Sector, Fondazione ISMU

Question and Answers

Timing: 15h00 – 15h30

Break

15h30 – 16h00

Presentation

Timing: 16h00 – 16h20

Topic

Contraception and abortion patterns in Pakistani migrant women in Barcelona

By **Dr Elvira Méndez**, General Director, Health and Family Association

Question and Answers

Timing: 16h20 – 16h40

Conclusion of Session 2

16h40 – 17h00

Day 2

Friday 9 March

Venue: Tagore's Auditorium

Registration

Timing: 08h30 – 09h00

Session 3 – Multi-stakeholder Response to Migrants' Health Issues and Main Challenges

Discussion points

- Analysis of current policies at multiple levels aimed to address migrants' health issues
 - What are the most recent initiatives and policies taken across Asia and Europe to strengthen migrants' access to health care at the cross-regional, regional and national levels? To what extent do these initiatives address the health needs of migrants?
 - Besides these initiatives, what kind of barriers do the migrants still have to face in terms of health access?
- Involvement of civil society in enhancing migrants' access to health care
 - What is the role of civil society actors in addressing the migrant's health issues? How do they work and which kind of barriers do they face? How do they cooperate with the public institutions?

Chair

Dr Maruja M. B. Asis, Director of Research and Publications, Scalabrini Migration Center

Topic

Multi-stakeholder Responses in Migration Health - Selected Global Perspective

Presentation

Timing: 09h00 – 10h00

By **Dr Poonam Dhavan**, Public Health Specialist, International Organization for Migration, IOM

Topic

Actions Funded by the EU Health Programme Addressing Migrant and Communicable Diseases

By **Dr Isabel de la Mata**, Principal Advisor for Public Health, Directorate-General for Health and Consumers, European Commission

Question and Answers

Timing: 10h00 – 10h30

Break

10h30 – 10h45

Presentation

Timing: 10h45 – 11h45

Topic

Policy and Strategy of Indonesian Government in Promoting Migrant Labour Health

By **Dr Elia Rosalina Sunityo**, Deputy Director for Facilitation of Migrant Health, National Board For Placement and Protection of Indonesian Overseas Workers

Topic

The role of civil society in securing access to health care services for undocumented migrants in Europe

By **Ms Kadri Soova**, Advocacy Officer, Platform for International Cooperation on Undocumented Migrants, PICUM

Question and Answers

Timing: 11h45 – 12h15

Conclusion of Session 3

Timing: 12h15 – 12h30

Lunch Break

10h30 – 10h45

Session 4 – Recommendations for Asia-Europe Cooperation on Migration and Health

Discussion points

- Identification of areas which require (further) research
- Recommendation of possible actions for Asia and Europe cooperation to tackle the issues related to migration and health

Moderators

Group 1:

Dr Phua Kai Hong, Associate Professor, Health Policy & Management, Lee Kuan Yew School of Public Policy

Group 2:

Ms Aleksandra Chrzanowska, Coordinator of the Foreigners Section, Association for Legal Intervention

Summary of Main Conclusions of Previous Sessions

By **Dr Vincent Rollet**, Associate Researcher, French Centre for Research on Contemporary China (CEFC) / Wenzao Ursulines College of Languages, Kaohsiung

Timing: 14h00 – 14h20

Working Group Discussions

Timing: 14h20 – 15h15

Break

Timing: 15h15 – 15h45

Working Group Discussions

Timing: 15h45 – 16h30

Presentation of Recommendation

Timing: 16h30 – 16h50

Closing remarks

16h50 – 17h00

By **Ms Sol Iglesias**, Director for Intellectual Exchange, Asia-Europe Foundation

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No.	Title	Name	Designation	Organisation
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3	Dr	Annavittoria Sarli	Researcher, Economy and Labour Market Sector	Fondazione ISMU
4	Dr	Daniela Carrillo	Researcher, Health and Welfare Sector	Fondazione ISMU
5	Prof	David Ingleby	Emeritus Professor of Intercultural Psychology	Utrecht University
6	Dr	Elia Rosalina Sunityo	Deputy Director for Facilitation of Migrant Health	National Board for the Placement and Protection of Indonesian Overseas Workers
7	Dr	Elvira Méndez	General Director	Health and Family Association (Asociación Salud y Familia)
8	Dr	Irudaya Rajan Sebastian	Head, Research Unit on International Migration	Centre for Development Studies
9	Dr	Isabel de la Mata	Principal Advisor for Public Health, Directorate-General for Health and Consumers	European Commission
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12	Ms	Kadri Soova	Advocacy Officer	Platform for International Cooperation on Undocumented Migrants (PICUM)
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15	Ms	Marie Lamy	Research Associate	Lee Kuan Yew School of Public Policy
16	Dr	Maruja M.B. Asis	Director of Research and Publications	Scalabrini Migration Center
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20	Dr	Piroska Östlin	Special Adviser for Social Determinants of Health	World Health Organisation - Regional Office for Europe
21	Dr	Poonam Dhavan	Public Health Specialist	International Organisation for Migration (IOM)

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23	Mr	Ramón Esteso Mesas	Technical Manager of the programmes of "Social Inclusion" (home programmes)	Doctors of the World Spain
24	Dr	Sirkka Komulainen	Senior Researcher	Institute of Migration
25	Dr	Tona Lizana	Immigration and International Health	Public Health Agency, Ministry of Health, Catalanian Government
26	Dr	Trinidad Osteria	President, Yuchengco Centre,	De La Salle University
27	Dr	Ursula Karl-Trummer	Executive Director	Center for Health and Migration
28	Dr	Vincent Rollet	Associate Researcher	French Centre for Research on Contemporary China (CEFC)
29	Prof	Walter Devillé	International and Migrant Health	NIVEL (Netherlands Institute for Health Services Research)
30	Prof	Yuko Hirano	School of Health Sciences	Nagasaki University
31	Ms	Yomi Ayu Lestari	First Secretary	Indonesian Embassy in Madrid

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PARTNERS

Asia-Europe Foundation

The Asia-Europe Foundation (ASEF) promotes greater mutual understanding between Asia and Europe through intellectual, cultural and people-to-people exchanges. Through ASEF, civil society concerns are included as a vital component of deliberations of the Asia-Europe Meeting (ASEM), which currently comprises 49 member states plus the European Commission and the ASEAN Secretariat (www.aseminfoboard.org). ASEF was established in February 1997 by the participating governments of ASEM and has since engaged over 17,000 direct participants through more than 600 projects in the realms of governance and human rights, economy and society, sustainable development and environment, public health, arts and culture and academic co-operation and education . www.asef.org

In 2012, ASEF is commemorating its 15th Anniversary and invites everyone to take part in celebrating 'Connected Histories, Shared Future'.

The Asia-Europe Meeting (ASEM) is an informal process of dialogue and co-operation. It brings together Austria, Australia, Bangladesh, Belgium, Brunei, Bulgaria, Cambodia, China, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, India, Indonesia, Ireland, Italy, Japan, Korea, Laos, Latvia, Lithuania, Luxembourg, Malaysia, Malta, Mongolia, Myanmar, the Netherlands, New Zealand, Norway, Pakistan, the Philippines, Poland, Portugal, Russia, Romania, Singapore, Slovakia, Slovenia, Spain, Sweden, Switzerland, Thailand, United Kingdom, Vietnam, the ASEAN Secretariat and the European Commission www.aseminfoboard.org

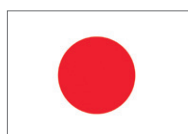
ASEF Public Health Network

The ASEF Public Health Network is a participatory platform which encourages public health dialogue, between actors from health and non-health sectors across Asia and Europe. The Network activities are primarily classified under three thematic areas: **1) Regional Integration and Public Health:** The Network facilitates collaboration and coordination between Asia and Europe through exchange of information and experience. This is done through research initiatives assessing the strengths and gaps in regional integration, resulting in public health policy options; **2) Multi-sector Pandemic Preparedness and Response:** Through the ASEF scenasi-based approach, health and non-health sector representatives look beyond today and address uncertainties around potential pandemics, developing long-term strategies for multi-sector pandemic preparedness and response; and **3) Public Health Dialogue:** Vulnerable groups such as young people, migrants and ethnic/sexual minorities are most affected during any public health crisis. The Network engages them through community-level initiatives so that their voice can be heard by policy makers.

Casa Asia

Casa Asia is a public consortium, made up of the Ministry of Foreign Affairs and Cooperation, the Catalanian Autonomous Government (Generalitat), the Barcelona City Council and the Madrid City Council, that aims at promoting the knowledge and development of the relations between Spain and the countries of Asia and the Pacific in the institutional, cultural, educational and economic fields. It develops cross-cultural dialogue and understanding through a wide range of activities such as Art Festivals, dialogues, lectures, courses, conferences, meetings and seminars. Casa Asia was created in Barcelona on November 2001. www.casaasia.es.

NOTES



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