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Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*

Summary

The present report, submitted in accordance with Human Rights Council resolutions 15/22 and 6/29, considers issues concerning the right to health of migrant workers. It focuses on low-skilled migrant workers as well as irregular migrant workers, and outlines the responsibility of States as well as of non-State actors to respect, protect and fulfil the right to health of migrant workers.

The Special Rapporteur also explores a number of substantive issues in this regard, including the sending State's responsibility to provide access to information to migrant workers and to regulate recruitment agencies; right to health concerns regarding immigration policies, such as compulsory medical testing, detention and deportation of irregular migrant workers or migrant workers with specific health status; access to health facilities, goods and services, especially by irregular migrant workers; specific industries comprising jobs usually shunned by the local population and considered degrading; mental health of migrant workers; as well as the issue of women migrant workers and their right to sexual and reproductive health.

The Special Rapporteur concludes his report with a set of recommendations aimed at ensuring that the enjoyment of the right to health of all migrant workers is respected, protected and fulfilled.

* Late submission.

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I. Introduction

1. Contemporary international labour migration is propelled by globalization and neo-liberal economic policies that promote deregulation of labour markets, including the flow of cheap, low-skilled labour.[1] An estimated 105 million individuals currently work outside their country of birth.[2] Remittances from migrant workers, which exceed Official Development Assistance to developing countries,[3] contribute significantly to growth in household economies and improve the underlying determinants of health such as housing and education. The impact of the migration process on a migrant worker's health can be significant, and where poorly managed, may outweigh any economic and social benefits.

2. This report addresses the enjoyment of the right to health of individuals who migrate from one country (sending State) to another country (receiving State) for paid employment and who work in low-skilled or semi-skilled industries in receiving States. The scope of the report is restricted to migrant workers because certain issues, like those related to recruitment agencies, compulsory testing and occupational health, give rise to serious violations of the right to health and therefore warrant a separate inquiry. Nonetheless, concerns such as access to health care in receiving States are faced similarly by other migrants, such as refugees, and the analysis can indeed be extended to all groups of migrants. Some individuals migrate through official channels, others through informal ones, while others ebb in and out of both. The term "irregular" has been used to cover migrant workers who live or work in the receiving State without authorization, whereas "regular" refers to migrant workers with authorization to live and work in the receiving State. The report pays particular attention to work in construction, domestic work, sex work and agriculture, as examples of dirty, dangerous and degrading jobs (3D jobs) that these migrant workers frequently fill.

3. Migrant workers often commence the migration process as relatively healthy individuals.[4] However, the complexity and diversity of circumstances throughout the various dimensions of the migration cycle may render them highly vulnerable to poor physical and mental health outcomes, compromising the enjoyment of other rights.[5] For instance, irregular migrant workers may face extreme health risks during transit owing to hazardous conditions such as being cramped or hidden in boats or trucks.[6] They may also face physical and sexual violence during transit.[7] Limited or no health care during transit and in transit countries may further increase the burden of disease, including untreated non-

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[1] Mode 4 of the General Agreement on Trade in Services, for example, aims to free up borders for services without requiring States to guarantee protections for migrant workers. See Tomer Broude, "The WTO/GATS Mode 4, International Labour Migration Regimes and Global Justice," Research paper No. 7-07 (May 2007), p. 28.

[2] International Organization for Migration (IOM), Labour Migration web page, available from http://www.iom.int/cms/en/sites/iom/home/what-we-do/labour-migration.html.

[3] World Bank (WB), Migration and Development Brief 19 (2012), p. 1.

[4] A/HRC/14/30, para. 23.

[5] IOM, Migrant Health for the Benefit of All (2004), document MC/INF/275.

[6] IOM, "Migration: A social determinant of the health of migrants," Background paper (2006), p. 8, available from http://www.migrant-health-europe.org/files/FINAL%20DRAFT%20-%20IOM%20SDH.pdf..

[7] IOM, *Migrants' needs and vulnerabilities in the Limpopo Province, Republic of South Africa*, Report on Phase Two, February-March 2009 (2009)..

communicable diseases.[8] Camps in transit countries[9] or assisted voluntary returns to the sending State[10] may help in reducing health vulnerabilities of irregular migrant workers.

4. Economic necessity, lack of information and low educational and skill levels can drive migrant workers towards hazardous and poorly regulated 3D jobs. An the absence of effective safeguards to protect the rights of migrant workers in such industries – coupled with exploitative practices by unscrupulous recruitment agencies, intermediaries and employers – create living and working conditions that hinder the full realization of the right to health.

5. Cultural and linguistic differences may magnify the vulnerability of migrant workers in receiving States, especially in the absence of family or social support networks. Legal, information and employment-related barriers to accessing health facilities, goods, and services also heighten vulnerability. For irregular migrants, the challenges are even greater because they are likely to have lesser, if any, health care entitlements, protection under occupational health and safety laws or access to redress mechanisms, while constantly facing the threat of detention and deportation. Laws linking immigration control and health systems are particularly damaging as they are a direct barrier to accessing health care, and perpetuate discrimination and stigma rather than promote social inclusion.

II. Conceptual framework

6. The right to health framework is primarily grounded in article 12 of the International Covenant on Economic, Social and Cultural Rights, which recognizes the right of everyone to the enjoyment of the highest attainable standard of mental and physical health. General comment No. 14 of the Committee on Economic, Social and Cultural Rights elaborates upon, and interprets, the right to health. It mandates States to respect, protect and fulfil the right to health of everyone, including migrant workers. States are also required to improve the underlying determinants of health – prerequisites for the realization of the right to health – such as education, nutritious food, potable water, adequate sanitation, and safe and healthy work and living conditions. Migration should be seen as an underlying determinant, as the processes of pre-departure and reintegration in sending States, and arrival, stay and integration in receiving States determine health outcomes of migrant workers.

7. Rights of migrant workers are explicitly recognized under a number of international law instruments. The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families details the rights of migrant workers and their families throughout the entire migration process, tailoring the obligation of States according to the stage of migration, including departure from and return to sending States, and transit and employment in receiving States.

8. The International Labour Organization (ILO), through various conventions and recommendations places obligations on States[11] and certain duties to recruitment agencies,

[8] WHO, Health of Migrants, (April 2008), document A61/12, para. 17, available from http://www.iom.int/jahia/webdav/shared/shared/mainsite/microsites/IDM/workshops/migrant_human_rights_032509/nygren_krug_en.pdf.

[9] IOM, *Migration Health*, Report of IOM Activities 2011 (2011).

[10] IOM, Tanzania's Mixed Migration Unit, prospectus, available from http://www.iom.int/files/live/sites/iom/files/Country/docs/IOM-Info-Sheet-MMU-221012-Final.pdf.

[11] International Labour Office (ILO), Equality of Treatment (Accident Compensation) Convention, 1925 (No. 19) , Migration for Employment Convention (Revised), 1949 (No. 97), Equality of Treatment

requiring them to take steps to prevent abuse and exploitation of migrant workers.[12] It focuses on occupational health and safety of migrant workers and recommends measures to promote reunification of families,[13] which can have a positive effect on mental health as it provides social support to migrant workers.

9. The World Health Assembly resolution on the health of migrants recommends that States promote migrant-sensitive health policies, including information and service provision, and to promote equitable access of public health resources.[14]

10. By mandating that non-discrimination inform all aspects of State policy, the right to health framework does not allow for any distinction between regular and irregular migrant workers on the one hand, and nationals of States, on the other. In this aspect it differs from the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families which allows irregular migrant workers access to health facilities, goods and services only when urgently needed.[15] Non-discrimination requires that socio-economic rights, such as access to health facilities, goods and services, be equally available to nationals and non-nationals, including irregular migrant workers.[16]

A. State obligations

11. Fulfilling the right to health requires States to adopt and implement an evidence-based national health policy which does not discriminate against non-nationals[17] and addresses the needs of irregular and regular migrant workers, at all stages of the migration process, including pre-departure and return. As an aspect of their right to health obligation, States should ensure availability and accessibility of quality health facilities, goods and services, including existing health insurance schemes, to migrant workers, on the basis of equality with other nationals.

12. Each State involved in the migration process should comply with its obligation to respect, protect and fulfil the right to health of all persons within its jurisdiction, including migrant workers. Bilateral agreements and non-binding memoranda of understanding between States are commonly used to govern labour corridors and terms and conditions to be abided by them.[18] The regulatory structure contained in such arrangements should be enforceable and reflect principles of the right to health, especially non-discrimination, empowerment, participation, transparency and accountability of State and non-State actors.

(Social Security) Convention, 1962 (No. 118), Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143), Domestic Workers Convention, 2011 (No. 189).

[12] ILO, Private Employment Agencies Convention, 1997 (No. 181).

[13] ILO, Migrant Workers Recommendation, 1975 (No. 151), para. 13.

[14] Sixty-First World Health Assembly, Health of Migrants resolution (24 May 2008), document WHA61.17.

[15] International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, art. 28.

[16] Committee on the Elimination of Racial Discrimination (CERD), general recommendation No. 30 (2004) on discrimination against non-citizens, paras. 29 and 36.

[17] Committee on Economic, Social and Cultural Rights(CESCR), general comment No. 20 (2009) on non-discrimination in economic, social and cultural rights, para. 38.

[18] ILO, Model Agreement on Temporary and Permanent Migration for Employment, including Migration of Refugees and Displaced Persons, Migration for Employment Recommendation (Revised), 1949 (No. 86), annex.

B. Participation

13. Participation of affected communities in decision-making processes is critical to the right to health framework. States should not discriminate on the basis of nationality or legal status[19] and should pay special attention to vulnerable groups, such as low-skilled and irregular migrant workers, to protect them from rights violations by third parties, such as private recruitment agencies, intermediaries and employers.

14. Accordingly, States should ensure the participation of migrant workers, including irregular migrant workers, in the formulation, implementation, monitoring and enforcement of laws and policies, including in the negotiation of bilateral agreements. As trade unions are considered fundamental in promoting workers rights,[20] including occupational health,[21] regular and irregular migrant workers, should be encouraged to participate in or form unions. Effective participation, especially of irregular workers requires positive measures by States to create an environment in which these groups can participate without fear of sanctions. Access to timely and accurate information is a prerequisite to meaningful participation in health-related decision-making.

15. States, including receiving States, should ensure involvement of migrant workers in decision-making processes and awareness-raising strategies, particularly in relation to accessing health services. Participation will also raise awareness among potential migrant workers about issues such as migration stress factors, illegal recruiting practices, their rights in sending and receiving States and obligations of foreign employers.[22] Community participation will assist in making health services culturally and linguistically appropriate for migrant workers.[23] In some States, civil society organizations have successfully involved migrant workers in outreach and referral programmes resulting in culturally and linguistically appropriate information for migrant workers,[24] thus encouraging community-led initiatives.

C. Accountability

16. The right to health mandates States to put in place effective and accessible mechanisms to hold all duty bearers to account. Non-citizens, such as migrant workers also have the right to access legal remedies to challenge violations against them.[25] Although States are the primary duty bearers under the right to health, they have a concurrent obligation to ensure that non-State actors, such as recruitment agencies and employers, are held accountable for violations of the right to health of migrant workers.

17. Accountability requires robust regulatory frameworks across all sectors of employment, with independent mechanisms, to enforce rights and monitor compliance.

[19] CESCR, general comment No. 20, para. 36.

[20] CESCR, general comment No. 18 (2006) on the right to work, para. 54.

[21] A/HRC/20/15, para. 35.

[22] CARAM Asia, *From Voices to Actions: Empowering Migrant Communities through Participatory Action Research* (2009), p. 60.

[23] IOM, Thailand Mission, *Healthy Migrants, Healthy Thailand: A migrant health program model* (2009), p. 87, at http://publications.iom.int/bookstore/free/Healthy_Migrants_Healthy_Thailand.pdf

[24] Brahm Press (Raks Thai Foundation), *Migrant's Health and Vulnerability to HIV/AIDS in Thailand* (n.d.), p. 28, available from http://ns4439.ukserverhosting.net/dmdocuments/Migrant_health_and_HIV_vulnerability_in_Thailand_phamit.pdf.

[25] CERD, general recommendation No. 30, para. 18.

Strict monitoring will encourage transparency and deter exploitation, collusion and mistreatment by recruitment agencies, employers and government authorities.[26]

18. Sending and receiving States should also ensure legal redress through quasi-judicial or judicial mechanisms to enable migrant workers to enforce their rights against State and non-State actors. States should also provide for appropriate relief, by way of compensation, restitution or non-repetition, for violations of the right to health. Such relief should also include temporary measures such as shelters for abused domestic workers.

III. Specific issues

A. Pre-departure obligations of States

Access to information

19. The full realization of the right to health is closely dependent on the State's obligation to ensure availability and accessibility of meaningful information to support decision-making in respect of migration. Providing information to potential migrant workers, particularly about their rights, is also necessary for empowering them against possible abuse and exploitation by actors involved in the migration process.

20. Information about costs assumed in the migration process, recruitment agencies, terms and conditions of work in and practical information about receiving States, potential dangers and benefits of migrating to a particular country, risks associated with migration and employment and ways to counter them should be provided before a commitment to migrate has been made.[27] Potential migrant workers should also be made aware about policies of receiving States, such as compulsory health testing, entitlement to and accessing health-care services. Common methods to spread such information have included issuing warnings, publishing a list of licensed and blacklisted agencies on websites and in newspapers[28] and mass media information campaigns.[29]

21. Closer to the time of departure, pre-departure orientation sessions are conducted in some countries to prepare migrant workers for their time in the receiving State[30] and to train them for their jobs.[31] During these sessions, migrant workers should be provided with understandable information regarding their rights, health information, such as preventing the transmission of communicable diseases like HIV, and health facilities available in receiving States. Pre-departure training sessions are critical for informing migrant workers about their rights vis-à-vis the receiving State and the employer.[32] Pre-departure sessions should also be used to provide information on recourse mechanisms, such as consular

[26] Migrant Forum in Asia, *Labour Recruitment to the UAE: Gaps between policy and practice in Sri Lanka, Nepal, Bangladesh, and the Philippines* (2011).

[27] ILO, *Protecting the Rights of Migrant Workers: A Shared Responsibility* (2009), p. 7.

[28] Philippines Overseas Employment Administration, Status of Recruitment Agencies, available from http://www.poea.gov.ph/cgi-bin/aglist.asp?mode=all.

[29] Development Research Centre on Migration, Globalisation and Poverty, Information Campaigns on Safe Migration and Pre-Departure training (2008), p. 22.

[30] Farooq Azam, "Public Policies to Support International Migration in Pakistan and the Philippines", Arusha Conference, *New Frontiers of Social Policy* (12-15 December 2005).

[31] A.K. Masud Ali, *Pre-departure Orientation Programme: Study of Good Practices in Asia, A comparative Study of Bangladesh, the Philippines and Sri Lanka* (n.p., n.d.), p. 88.

[32] ILO, *Multilateral Framework on Labour Migration: Non-binding principles and guidelines for a rights-based approach to labour migration* (2006), guideline 12.

protection, available in the event of abuse, exploitation or other rights violations.[33] States should ensure information is accurate and relevant during pre-departure sessions, including those conducted by private agencies.

22. Returnee migrant workers along with organizations working with migrant workers should be encouraged to hold training and informational sessions to make outgoing migrant workers aware of situations and experiences they are likely to face in receiving States and recourse available to them in times of abuse, exploitation and distress.[34] However, as pre-departure sessions frequently take place only a short time prior to departure,[35] this does not give migrant workers enough time to process the information. Pre-departure sessions and trainings should, therefore, be designed and conducted in ways that ensure maximum understanding of the information by migrant workers. Post-arrival orientation sessions that reinforce and contextualize information received during pre-departure sessions should also take place to support migrant workers with integration in receiving States.[36]

Regulation of recruitment agencies

23. States are obligated to protect the right to health of individuals from interference by third parties. Recruitment agencies, which are mostly private enterprises, are typically the first point of contact in the formal migration process for low-skilled migrant workers, many of whom are illiterate and poor. They provide information to migrant workers about job opportunities and living and work conditions in receiving States for a fee. They also arrange documentation necessary for migration, thus playing a crucial role in guiding migrant workers through important phases of migration.[37] Dependence on recruitment agencies may render migrant workers vulnerable to exploitation and abuse, necessitating regulation of recruitment agencies by sending States.

24. As an essential aspect of protecting the right to health of migrant workers, States should ensure monitoring and accountability of recruitment agencies. States may monitor recruitment agencies through legislation, providing for mandatory licensing requirements, regular reporting and independent monitoring and inspections.[38] Monitoring is also necessary to prevent illegal recruitment agencies from entering the market and exploiting migrant workers.[39]

25. To prevent exploitation, States should ensure that written employment contracts address issues such as the underlying determinants of health, including occupational health, access to health facilities, goods and services, and compensation for employment-related injury and death, as well as mechanisms for settling disputes.[40]

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[33] Ibid., guideline 12.8.

[34] IOM, *Migrant Resource Centres, An Initial Assessment*, IOM Migration Research Series No. 40, (2010), available from http://publications.iom.int/bookstore/free/MRS_40.pdf.

[35] A.K. Masud Ali, *Pre-departure Orientation Programme*, p. 104 (see footnote 31).

[36] Farooq Azam, *Public Policies to Support International Migration*, p. 107 (see footnote 30); ILO, *Multilateral Framework on Labour Migration*, guidelines 12.1-12.2 (see footnote 32).

[37] Dovelyn Rannveig Agunias, *Migration's Middlemen: Regulating Recruitment Agencies in the Philippines - UAE Corridor*, (2010).

[38] Committee on the Protection of the Rights of all Migrant Workers and Members of Their Families (CMW), general comment No. 1 (2010) on migrant domestic workers, para. 34; ILO, *Guide to Private Employment Agencies: Regulation, Monitoring and Enforcement* (2007), p. 13.

[39] Organization for Security and Co-operation in Europe (OSCE), ILO, IOM, *Handbook on Establishing Effective Labour Migration Policies in Countries of Origin and Destination* (2006).

[40] ILO, *Guide to Private Employment Agencies*, p. 26 (see footnote 38); Farooq Azam, *Public Policies to Support International Migration*, p. 11 (see footnote 30).

26. Some States prohibit agencies from recruiting workers or a class of workers, such as domestic workers, to countries or employers who habitually deprive migrants of adequate rest, nutritious food, medical care and sleep.[41] However, as this may result in migrant workers seeking riskier routes to foreign employment, sending States should ensure that bilateral agreements with receiving States provide for strong protections and enforcement mechanisms against abuse and exploitation.

27. States should ensure that migrant workers have access to legal remedies, including compensation, in cases where recruitment agencies have contributed to the violation of rights or have not complied with requirements under national law or policy.[42]

B. Immigration policies

28. Immigration policies, such as compulsory medical testing, detention and deportation, especially when contained in bilateral arrangements between States, require the involvement of sending and receiving States in enforcing them. Such immigration policies, including those contained in bilateral agreements, should be in conformity with States' (both sending and receiving) obligation to respect, protect and fulfil the right to health of migrant workers.

Compulsory medical testing

29. Many receiving States require migrant workers to undergo compulsory medical testing for certain conditions such as HIV,[43] tuberculosis[44] and pregnancy[45] as part of their immigration policy. Though quite a few countries have eased HIV-related travel restrictions, compulsory testing for HIV for residence and work,[46] especially for low-skilled migrant workers,[47] continues in over 40 countries. This is despite commitment by States to enact legislation eliminating all forms of discrimination against persons living with HIV[48] and recommendations against compulsory tests for migrant workers.[49]

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[41] Philippines Commission on Audit, *Sectoral Performance Audit Report on the Overseas Workers' Welfare Program of the Government (CYs 2005 and 2006)* (Quezon City, 2008), pp. 24–25, see www.coa.gov.ph/GWSPA/GWSPA.htm.

[42] ILO, *Multilateral Framework on Labour Migration*, guideline 10 (see footnote 32).

[43] ILO Sub-regional Office for East Asia and IOM, *Mandatory HIV testing for employment of migrant workers in eight countries of South-East Asia: From discrimination to social dialogue*, (2009), available from http://www.biomedcentral.com/content/pdf/1758-2652-13-2.pdf.

[44] John Welshman and Alison Bashford, "Tuberculosis, migration, and medical examination: lessons from history," *Journal of Epidemiology and Community Health*, vol. 60, No. 4 (April 2006), pp. 282-284.

[45] United Nations Development Programme (UNDP), *HIV Vulnerabilities of Migrant Women: from Asia to the Arab States, Shifting from silence, stigma and shame to safe mobility with dignity, equity and justice* (2008), p. 32.

[46] UNAIDS, HIV-related restriction on entry, stay and residence (July 2012), available from http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120724CountryList_TravelRestrictions_July2012.pdf; Jeffrey V. Lazarus and others, "HIV-related restrictions on entry, residence and stay in the WHO European Region: a survey", *Journal of the International AIDS Society*, vol. 13, No. 2 (January 2010).

[47] Joseph J. Amon and Katherine Wiltenburg Todrys, "Fear of Foreigners: HIV-related restrictions on entry, stay, and residence", *Journal of the International AIDS Society*, vol. 11, No. 8 (December 2008).

[48] General Assembly resolution 65/277, para. 79.

[49] See ILO Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200).

30. Justifications for compulsory testing revolve around protection and preservation of public health and resources in the receiving State.[50] However, compulsory testing, especially for HIV, is not only counterproductive to the public health approach but is in violation of the right to health. Compulsory medical testing does not consider the window period required for an accurate test.[51] Further, in cases of false negative results, individuals may engage in unsafe sexual practices, exposing sexual partners to increased risk.[52] False positive results may lead to mental trauma among migrant workers, considering the stigma that may be associated with particular health conditions. Additionally, as both their immigration from sending States and stay in receiving States is dependent on these tests, migrant workers may avoid getting tested, forge documents or even stop treatment,[53] thus driving the disease underground. Compulsory testing is also no guarantee against transmission of communicable diseases once migrant workers are inside the receiving State.

31. Compulsory testing is also inconsistent with the right to health, as it is done without informed consent and fails to respect the rights to autonomy, privacy, dignity and confidentiality of health information.[54] Limitations on the right to health and informed consent, including for public health reasons, should be based on scientific evidence, must be the least restrictive alternative available and respect human dignity, rights and freedoms.[55]

32. In some cases, even where prohibited under the laws of the sending States, outbound migrant workers may be subjected to compulsory testing because the receiving State may require it before granting work permits to migrant workers.[56] Policies of receiving States that require compulsory tests for exclusively incoming migrant workers may be additionally discriminatory if similarly situated foreign nationals such as tourists or even diplomats[57] may not be required to undergo compulsory testing.

33. Furthermore, test results are passed on to employers or recruitment agencies without the migrant worker's consent,[58] breaching the requirement of confidentiality and contrary to international recommendations.[59] Additionally, pre- and post-test counselling protocols may not be followed, even when required by law.[60] A right to health approach, however, requires that counselling, voluntary testing and treatment be treated as a health-care continuum.[61] Migrant workers who test positive for HIV may remain in an irregular situation, making them more vulnerable to abuse by employers and less likely to access

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[50] Richard Coker, "Migration, public health and compulsory screening for TB and HIV", Asylum and Migration Working Paper I (Institute for Public Policy Research, 2003).

[51] See A/64/272.

[52] Phillip Nieburg and others, "Moving Beyond the U.S. Government Policy of Inadmissibility of HIV-Infected Noncitizens", A Report of the CSIS Task Force on HIV/AIDS (March 2007), p. 6.

[53] Irving E. Salit and others, "Travel patterns and risk behaviour of HIV-positive people travelling internationally", *Canadian Medical Association Journal*, vol. 172, No.7 (March 2005), pp. 884-888.

[54] A/64/272.

[55] Ibid., paras. 30-31.

[56] ILO and IOM, *Mandatory HIV testing*, p. 55 (see footnote 43).

[57] John Welshman and Alison Bashford, "Tuberculosis, migration, and medical examination", p. 282 (see footnote 44); Immigration New Zealand, "General Medical Certificate", available from http://www.immigration.govt.nz/NR/rdonlyres/DE431E92-0ADE-4B5F-81F9-18DF08E5B2EA/0/INZ1007November2012.pdf.

[58] ACHIEVE and CARAM, *Health at Stake: Access to Health of Overseas Filipino Workers,* 2005 Report (2006), p. 16.

[59] WHO, UNAIDS, *Guidelines for using HIV Testing Technologies in Surveillance: Selection, Evaluation and Implementation* (2001), document WHO/CDS/CSR/EDC/2001.16-UNAIDS/01.22E.

[60] CARAM Asia, *State of Health of Migrants 2007: Mandatory testing* (2007), p. 41.

[61] A/64/272, para. 93.

medical treatment. In cases of pregnancy, women may resort to risky illegal abortion to avoid deportation.[62] Further, compulsory testing stigmatizes those who are deported based on positive test results.

Detention and deportation

34. Receiving States frequently use the public health rationale to detain and deport migrant workers with specific health statuses, such as HIV, Hepatitis C or Hepatitis B.[63] In linking immigration policies with health status, the right to health requirements of confidentiality, counselling and referral are overlooked.

35. To qualify as a public health exception, restrictions must be: provided by law, strictly necessary, for the least possible duration, based on scientific evidence and the least restrictive alternative available. As there are less restrictive, non-custodial alternatives available to detention,[64] isolation, rather than detention, must be supported by law and used only when necessary as a measure of last resort, especially in cases of communicable diseases.[65]

36. Detention centres are often overcrowded, lack basic standards of hygiene, nutritious food and water. They have been described as centres of abuse and violence against migrant workers.[66] Long periods of detention and poor living conditions in detention centres facilitate the transmission of communicable diseases and can have a devastating effect on the mental health of migrant workers.[67] Health-care services in some detention centres are reportedly unavailable, difficult to access and of poor quality, which is particularly concerning for migrant workers detained due to health status.[68] Migrant workers living with HIV have faced stigmatization and harassment as a result of lack of confidentiality in detention.[69] Where States persist with immigration detention, they should, at the minimum, provide detainees with adequate living conditions, consensual medical check-ups and make quality and confidential physical and mental health facilities available and accessible in a timely manner.[70]

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[62] Human Rights Watch (HRW), *Singapore - Maid to Order: Ending Abuses against Migrant Domestic Workers in Singapore*, vol. 17, No. 10 (C) (December 2005), p. 92.

[63] Sevil Sönmez and others, “Human rights and health disparities for migrant workers in the UAE”, *Health and Human Rights*, vol. 13, No. 2 (2011); UNAIDS, *The impact of HIV-related restrictions on entry, stay and residence: an annotated bibliography* (2009), p. 5.

[64] A/HRC/13/30, paras. 52-61; Inter-American Court of Human Rights, *Vélez Loor* v. *Panama*, judgement of 23 November 2010; A/HRC/20/24, p. 4.

[65] WHO, “Guidance on human rights and involuntary detention for XDR-TB control” (2007).

[66] International Federation for Human Rights and Suara Rakyat Malaysia, “Undocumented migrants and refugees in Malaysia: Raids, Detention and Discrimination, No. 489/2 (March 2008); HRW, *Ukraine - On the Margins: Rights Violations against Migrants and Asylum Seekers at the New Eastern Border of the European Union* (November 2005).

[67] A/HRC/14/20/Add.4, para. 92; Cathy Zimmerman, Ligia Kiss and Mazeda Hossain, “Migration and Health: A Framework for 21st Century Policy-Making”, *PLOS Medicine*, vol. 8, No. 5 (May 2011), pp.1-6.

[68] HRW, *Discrimination, Denial and Deportation, Human Rights Abuses Affecting Migrants Living with HIV*, (June 2009).

[69] HRW, *United States - Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States* vol. 19, No. 5 (G) (December 2007).

[70] General Assembly resolution 43/173, annex, principles 24-25.

37. The fear of detention and deportation prevents migrant workers from accessing health care,[71] which may endanger their health and that of the broader population, thereby undermining public health justifications for detention and deportation. Further, employers may misuse laws providing for detention and deportation to exploit migrant workers.[72] Fear of detention and deportation renders migrant workers more vulnerable and unable to enjoy the right to health and its underlying determinants. To fulfil the right to health of migrant workers, States should try to develop alternative detention policies more in line with the right to health.[73] Additionally, without referral for counselling and treatment, deported migrant workers may also face difficulties in accessing health facilities, goods and services upon return to the sending State.

C. Access to health facilities, goods and services

Discrimination

38. Ensuring the availability, accessibility, acceptability and quality of health facilities, goods and services on a non-discriminatory basis, especially for vulnerable populations like migrant workers, is a core obligation under the right to health. Non-discrimination requires that regular and irregular migrant workers be equally entitled to freedoms and entitlements available to nationals of States. Access to health care in many receiving States, however, is dictated by restrictive immigration policies and public perceptions of 'non-deserving' migrant workers, particularly those in an irregular situation.[74] In the wake of the global economic crisis and associated austerity measures, States have legislated limitations on previously available health-care benefits for migrant workers.[75] Such limitations are contrary to States' obligation to desist from taking retrogressive measures that impact on health.

39. Further, equitable distribution of health facilities, goods and services is required to ensure that the most vulnerable are not disproportionately burdened beyond their means. It is regrettable that in many States, discriminatory laws largely undermine health care for migrant workers, especially irregular migrant workers.[76] Even where legally required of employers, health-care coverage may cover only basic services and may be inadequately enforced by authorities.[77] Consequently, migrant workers are forced to pay for health-care expenses, including emergency care, at rates that are sometimes disproportionately high compared to their income.[78]

40. The principle of non-discriminatory access is eroded when irregular migrant workers are not allowed to access non-emergency health-care services. Notably, mental illness is

[71] FACHC, *Farmworkers in the Southeast:Alabama, Florida, Georgia, Mississipi* (November 2011), available from http://www.fachc.org/pdf/Farmworkers%20in%20the%20Southeast.pdf.

[72] HRW, *For a Better Life: Migrant Worker Abuse in Bahrain and the Government Reform Agenda* (October 2012).

[73] Lutheran Immigration and Refugee Service, *Unlocking liberty: A way forward for U.S. immigration detention policy* (n.d.).

[74] Sarah Willen, "Migration, "illegality" and health: Mapping embodied vulnerability and debating health-related deservingness", *Social Science & Medicine*, vol. 74, Iss. 6 (March 2012) pp. 805–811.

[75] IOM, "Health in the Post-2015 Development Agenda: The importance of migrants' health for sustainable and equitable development", Position paper (2012), p. 4.

[76] Platform for International Cooperation on Undocumented Migrants (PICUM), *Access to Health Care for Undocumented Migrants in Europe* (2007), p. 7.

[77] CARAM Asia, Submission to CMW for the development of a general comment on migrant domestic workers (28 August 2002), p. 5.

[78] PICUM, *Access to Health Care*, p. 8 (see footnote 76).

rarely considered an urgent health issue.[79] Such insufficiencies lead to unacceptable gaps in the implementation of minimum health guarantees for irregular migrant workers.[80] Further, the denial of access to health care until an emergency situation arises is incongruent with the right to health and counter-intuitive,[81] as it imposes longer-term health and financial costs for individual migrant workers and society.

41. Policies linking access to health systems with immigration control discriminate against irregular migrants. In some countries, health-care providers are required, under threat of criminal sanction, to report irregular migrants to immigration authorities,[82] which may lead to detention and deportation. As a result, instead of seeking formal channels of care[83], irregular migrant workers resort to unsafe and illegal options. This renders them vulnerable to abuse, exploitation and increased health risks.

Administrative barriers

42. The right to health obligates States to protect migrant workers against non-State parties that restrict their access to health care. Migrant workers are often refused health services, particularly specialized referral services on the basis of income qualification, and sometimes even because of incomplete paperwork.[84] For irregular migrant workers, administrative barriers associated with their uncertain legal status are often an impediment to health care.[85] Additionally, issues such as limited office hours or caps on the number of applications processed,[86] may also act as barriers to access.

Language and cultural barriers

43. A right to health approach requires States to disseminate culturally appropriate health-related education and information to both regular and irregular migrant workers. Anti-immigrant austerity measures in some States, however, have reduced subsidies for interpretation and translation services in health-care settings.[87] Lack of familiarity with the local language may put migrant workers at a disadvantage, as they may not be able to sufficiently describe symptoms to enable accurate diagnosis and quality treatment.[88] Furthermore, an inability to understand health-related information and education may result in migrant workers unwittingly engaging in risky health behaviours. States should therefore

[79] Ibid., p. 9.

[80] Ibid.

[81] Anahi Viladrich, "Beyond welfare reform: Reframing undocumented immigrants' entitlement to health care in the United States, a critical review", *Social Science & Medicine*, vol. 74, Iss. 6 (March 2012), p. 824.

[82] PICUM, *Access to Health Care*, p. 45 (see footnote 76).

[83] Heide Castañeda, "Illegality as risk factor: A survey of unauthorized migrant patients in a Berlin clinic", *Social Science & Medicine*, vol. 68, Iss. 8 (2009), p. 1559; IRIN, "South Africa: Migrants' health care hit by deportations", (Johannesburg, 20 December 2011), available from http://www.irinnews.org/Report/94511/SOUTH-AFRICA-Migrants-health-care-hit-by-deportations.

[84] Richard Mines and others, *Pathways to Farmworker Health Care*, Case Study No. 1: The East Coachella Valley, A baseline report of the Agricultural Worker Health Initiative (California Institute for Rural Studies, September 2002), pp. 20-21; Médecins du Monde, European Observatory on Access to Healthcare, *Access to healthcare for undocumented migrants in 11 European Countries* 2008 Survey report (September 2009), p. 69.

[85] PICUM, *Access to Health Care*, p. 8 (see footnote 76).

[86] Ibid.

[87] IOM, "Health in the Post-2015 Development Agenda", p. 4 (see footnote 75)

[88] Solidaritas Perempuan, *State of Health of Indonesian Migrant Workers: Access to Health of Indonesian Migrant Workers*, 2005 Report (2006).

ensure budgetary support for linguistically appropriate health services, interpreters and information and education.

44. Health-seeking behaviour can be influenced by a migrant worker's cultural background. Cultural misunderstandings and apprehension of procedures which they are not traditionally and culturally familiar with act as barriers to access.[89] Migrant workers may therefore prefer doctors who practise their native traditional systems of medicines and who better understand their diseases, as opposed to the host State's health-care providers, who are perceived to lack cultural sensitivity to their health problems and sometimes racist and therefore discriminatory.[90]

Treatment interruption

45. Ensuring continuous access to treatment and medicines on a non-discriminatory basis is crucial to the right to health framework. Migratory processes and pressures can expose migrant workers to increased risk of contracting communicable diseases particularly HIV.[91] There is therefore a need to ensure that continuous treatment is available to these populations throughout the entire process. Treatment interruptions, lack of follow-up and treatment failures are documented at higher rates among migrants than the stationary population.[92] Some States have adopted regional frameworks, such as the Ibero-American Social Security Convention,[93] and bilateral social security agreements[94] to ensure "portability" of social security, including health-care benefits, from sending to receiving States, which allows migrant workers to enjoy such benefits, independent of their immigration status. States are encouraged to adopt such approaches with respect to access to treatment for chronic diseases, such as HIV, in order to maximize adherence rates in both sending and receiving States.

D. 3D jobs and occupational health

46. Occupational health is integral to the right to health. States should ensure that occupational health laws and policies address the unique vulnerabilities of migrant workers in dirty, dangerous and degrading (3D) industries and are implemented, monitored and enforced.[95] The vulnerability of migrant workers in 3D jobs may be further intensified in cases of irregular migrant workers, who, due to their legal status are in a weaker position to negotiate their rights with employers.[96] Furthermore, lax enforcement of laws and

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[89] European Health Management Association, "Barriers to Healthcare Services for Migrants", Policy Seminar Report (n.d.), available from http://www.ehma.org/files/A2%20report-migrants.pdf.

[90] Ibid., pp. 24-26.

[91] UNDP and Secretariat of the Pacific Community, *Migration, Mobility and HIV: A rapid assessment of risks and vulnerabilities in the Pacific*, (April 2010), pp. 10-12.

[92] Médecins Sans Frontières, *Providing antiretroviral therapy for mobile populations: Lesson learned from cross border ARV Programme in Musina, South Africa* (July 2012), p. 6, available from http://www.msfaccess.org/sites/default/files/MSF_assets/HIV_AIDS/Docs/AIDS_report_ARTformobilepops_ENG_2012.pdf..

[93] The Convention came into force in 2011 following ratification by seven States.

[94] Robert Holzmann, Johannes Koettl and Taras Chernetsky, "Portability Regimes of Pension and Health Care Benefits for International Migrants: An Analysis of Issues and Good Practices", Social Protection Discussion Paper No. 0519, (May 2005), p. 4.

[95] See A/HRC/20/15, para. 5.

[96] Godfrey Kanyenze, "African migrant labour situation in Southern Africa", Paper presented at the ICFTU-AFRO conference on Migrant Labour, Nairobi, 15-17 March 2004.

mechanisms like sponsorship systems in some countries, encourage exploitative practices.[97] Sponsorship ties a migrant's authorization to work with one specific employer, and in some States, sponsorship gives an employer the power to refuse a migrant worker's request to transfer to another employer – such transfer may be sought due to abusive or unsafe working conditions.[98]

Construction work

47. Construction work is inherently hazardous because it involves working on scaffolding and unfinished structures and using powerful machinery. Falls have been found to be more common among migrant workers,[99] while hand injuries from power tools and eye injuries from building materials lodging in unprotected eyes are also frequent occurrences.[100] In hot climates, heat stroke, exhaustion, dehydration and heat-related cardiac conditions are of particular concern, especially for those compelled to work excessive hours.[101] In addition, physical abuse by employers, overcrowded and unsanitary accommodation, non-payment of wages, confiscation of passports and contract substitution further increase health risks posed by construction work.[102]

48. The provision of on-site training and protective equipment is necessary for the enjoyment of the right to a healthy working environment. Migrant construction workers often enter construction sites without appropriate training or sufficient protective equipment, for example safety ropes when working from heights.[103] Further, instruction or training may not be provided in a language understandable to migrant workers, which may lead to greater occupational injuries and death among migrant workers.[104]

49. States should ensure relief and remedies for migrant workers injured due to violation of their right to occupational health.[105] However, a lack of coverage under workers' health insurance or compensation schemes has often afflicted migrant workers, particularly irregular migrant workers.[106] Additionally, the preponderance of sub-contracting

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[97] HRW, *Building a Better World Cup: Protecting Migrant Workers in Qatar ahead of FIFA 2022* (2012), p. 6; Simona M. Gallo Mosala, "The Work Experience of Zimbabwean Migrants in South Africa", Issues Paper No. 33, (ILO Sub-Regional Office for Southern Africa, 2008), p. 23.

[98] HRW, *Slow Movement: Protection of Migrants' Rights in 2009* (December 2009), p. 8.

[99] Xiuwen Dong and James W. Platner, "Occupational fatalities of Hispanic construction workers from 1992 to 2000", *American Journal of Industrial Medicine,* vol. 45, Iss. 1 (January 2004), pp. 50-51.

[100] Sevil Sönmez and others, "Human rights and health disparities", p. 5 (see footnote 63).

[101] Ibid., p. 4.

[102] HRW, *Slow Movement*, p. 8 (see footnote 98); HRW, *"Are You Happy to Cheat Us?": Exploitation of Migrant Construction Workers in Russia* (2009); HRW, *United Arab Emirates. "The Island of Happiness": Exploitation of Migrant Workers on Saadiyat Island, Abu Dhabi* (2009); A/HRC/14/30, paras. 44 and 49.

[103] HRW, *Building a Better World Cup*, pp. 4 and 68 (see footnote 97); Xiuwen Dong and James W. Platner "Occupational fatalities", p. 48 (see footnote 99).

[104] Marc B. Schenker, "A Global Perspective of Migration and Occupational Health", *American Journal of Industrial Medicine,* vol. 53, No. 4 (April 2010), p. 331; Manuel Carballo, Jose Julio Divino, Damir Zeric, "Migration and health in the European Union", *Tropical Medicine and International Health*, vol. 3, No. 12 (1998), p. 939.

[105] A/HRC/20/15, para. 59.

[106] HRW, *United Arab Emirates. Building Towers, Cheating Workers: Exploitation of Migrant Construction Workers in the United Arab Emirates*, vol. 18, No. 8 (E) (November 2006), p. 49; Lori A. Nessel, "Disposable Workers: Applying a Human Rights Framework to Analyze Duties Owed to Seriously Injured or Ill Migrants", *Indiana Journal of Global Legal Studies*, vol. 19, Iss.1 (2012), p. 62.

arrangements in the construction industry denies coverage, which is otherwise available.[107] For severely injured workers, compulsory or voluntary repatriation may mean access to a lower standard of health care and inability to hold duty bearers in receiving States accountable.

Agricultural work

50. Agricultural work is associated with particular occupational health risks. For example, exposure to pesticides and other farm chemicals has been linked to elevated distress levels,[108] depression, neurological problems and miscarriages.[109] Heavy and repetitive manual work also places great strain on the body, with associated risks of musculoskeletal injuries. Such risks must be addressed legislatively through enforceable occupational health and safety regulation and mechanisms for remedial action.

51. As with other 3D jobs, informal arrangements and lack of coverage under labour and occupational health and safety laws are common, leaving little room for migrant farm workers to negotiate working and living conditions necessary to facilitate the realization of their right to health.[110] Inadequate and unhygienic living conditions, food insecurity, underpayment of wages and excessive hours among migrant farm workers[111] increase the risk of illness and work-related injuries, while decreasing their capacity to access health care. High vulnerability to HIV has been recorded among migrant farm workers in some regions, due to lack of access to information and knowledge about HIV, availability and use of condoms, voluntary testing and health care.[112]

52. Even when workers' compensation and health insurance are available, irregular migrant farm workers have been found to be less aware of their rights,[113] and therefore less likely to make a claim and seek medical attention. This indicates the need for both sending and receiving States to provide accessible and comprehensible information about rights to health care, insurance and workers compensation for migrant farm workers.

53. Difficulties commonly experienced by migrant workers in accessing health care are exacerbated for farm workers because of high mobility driven by seasonal work and rural or remote settings. The migrant and community health centre is a successful model for providing physically and economically accessible health care for migrant farm workers. Programmes and services are tailored to a mobile multicultural population by way of outreach clinics, community health workers, patient navigation systems, out-of-hours services and low-literacy education. Participation has been key to the success of such

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[107] HRW, *"Are You Happy to Cheat Us?"*, p. 64 (see footnote 102); Marc B. Schenker, "A Global Perspective", p. 331 (see footnote 104).

[108] Jennifer Griffin and Varda Soskolne, "Psychological distress among Thai migrant workers in Israel", *Social Science & Medicine,* vol. 57, Iss. 5 (September 2003), p. 773.

[109] Ann E. Hiott and others, "Migrant Farmworker Stress: Mental Health Implications", *Journal of Rural Health*, vol. 24, no. 1 (2008), pp. 32-39.

[110] Amnesty International (AI), *Exploited Labour: Migrant Workers in Italy's Agricultural Sector* (2012), p. 16.

[111] Ibid.; Kristen Borre, Luke Ertle and Mariaelisa Graff, "Working to Eat: Vulnerability, Food Insecurity, and Obesity among Migrant and Seasonal Farmworker Families", *American Journal of Industrial Medicine*, vol. 53, No. 4 (2010), p. 444.

[112] IOM, *Briefing Note on HIV and Labour Migration in Mozambique*, (n.d.), p. 4, available from http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/events/docs/Briefing_Notes_HIV_Mozambique.pdf.

[113] Don Villarejo and others, "The Health of California's Immigrant Hired Farmworkers", *American Journal of Industrial Medicine*, vol. 53, (2010), p. 395.

centres, with a requirement that 51 per cent of governing board members be from the community.[114]

Domestic work

54. Women make up a significant proportion of the estimated 52.6 million migrant domestic workers worldwide.[115] Domestic work provides economic and social independence for migrant women, accounting for 7.5 per cent of women's wage employment globally.[116] It is, however, largely undervalued and confined to the hidden informal economy of the home, reinforcing gender disparities in accessing underlying determinants of health, including decent work conditions.[117]

55. Discrimination and prejudice based on gender, ethnicity and socio-economic status intersect, causing chronic stress and making migrant domestic workers a highly vulnerable and marginalized group.[118] Owing to their vulnerability, isolation and dependence, migrant domestic workers experience a range of violations[119] which negate their enjoyment of the right to health and its underlying determinants. Violations include food and sleep deprivation, denial of medical treatment, squalid living conditions, non-payment of wages, excessive work hours (increasing the risk of accidents) and psychological, physical and sexual abuse.[120] Cardiovascular, endocrine, skin, musculoskeletal, and psychological conditions have also been documented among migrant domestic workers, with worst cases resulting in death, including suicide.[121]

56. Migrant domestic workers are frequently excluded or inadequately covered by the receiving State's labour laws and social protections, including health insurance.[122] Sponsorship systems, debt, language barriers, fear of arrest, detention or deportation and a lack of effective recourse for violations interact to varying degrees in different receiving States to facilitate the systematic exploitation and abuse of domestic workers.[123] The situation of some migrant domestic workers has even been described as "modern-day slavery".[124] In order to fulfil the right to health, States are obligated to address the particular

[114] Candace Kugel and Edward Zuroweste, "The State of Health Care Services for Mobile Poor Populations: History, Current Status and Future Challenges", *Journal of Health Care for the Poor and Underserved,* vol. 21, No. 2 (May 2010), pp. 421-429.
[115] ILO, *Domestic workers across the world: Global and regional statistics and the extent of legal protection* (2013), p. 39.
[116] Ibid., p. 2.
[117] CMW, general comment No. 1, paras. 25-26.
[118] E/CN.4/2004/76, para. 26; Maria Theresa Ujano-Batangan, *Women and Migration: The Mental Health Nexus: A research on Individual and Structural Determinants of Stress and Mental Health Problems of Filipino Women Migrant Domestic Workers* (Quezon City, ACHIEVE, 2011), p. 32.
[119] CMW, general comment No. 1, para. 7.
[120] E/CN.4/2004/76, paras. 25-35; A/HRC/14/30, para. 30; CARAM Asia, *Reality Check: Rights & Legislation for Migrant Domestic Workers Across Asia* (2011); ILO, "Decent work for domestic workers", Report IV (1) (August 2010); HRW, *Singapore - Maid to Order*, pp. 35-36 (see footnote 62).
[121] Sevil Sönmez and others, "Human rights and health disparities", p. 6 (see footnote 63); OHCHR, "Saudi Arabia: UN experts outraged at beheading of a Sri Lankan domestic worker", Press release (11 January 2013), available from http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=12922&LangID=E.
[122] ILO, *Domestic workers across the world* (see footnote 115); Committee on the Protection of the Rights of all Migrant Workers and Members of Their Families, general comment No. 1, paras. 18-24.
[123] CMW, general comment No. 1, para. 7.
[124] Sevil Sönmez and others, "Human rights and health disparities", p. 3 (see footnote 63); Nisha Varia, ""Sweeping Changes?" A Review of Recent Reforms on Protections for Migrant Domestic Workers

vulnerability of migrant domestic workers under labour, occupational health and safety and social protection laws.

57. The Special Rapporteur is pleased to observe the adoption by the International Labour Office (ILO) in 2011 of Domestic Workers Convention No. 189 and Recommendation No. 201, which details requirements for protection from harassment and violence, occupational health and safety, written contracts and protection under labour laws. This follows general comment No. 1 (2010) on migrant domestic workers of the Committee on the Protection of the Rights of all Migrant Workers and Members of Their Families, which pays particular attention to the vulnerability of migrant domestic workers throughout the different stages of migration. Implementation of these instruments would provide greater protection to migrant domestic workers at all stages of the migration process, thereby creating an enabling environment consistent with the obligation to fulfil the right to health.

Sex work

58. States have a responsibility to respect, protect and fulfil the enjoyment of the right to health of migrant sex workers, regardless of whether they have been trafficked or not. Migrant sex workers are a highly stigmatized population as sex or sex-related work may be criminalized in many countries. Occupational health hazards for sex workers include a disproportionate risk of HIV and other sexually transmitted diseases, violence and often rape.[125] Criminalization perpetuates discrimination, stigma and violence towards sex workers[126] and is a barrier to accessing health-care services, which leads to poorer health outcomes.[127] When combined with xenophobia, criminalization may legitimize harassment, intimidation and violence against migrant sex workers, especially by law enforcement authorities, without mechanism for protection or redress.[128] The nature of the occupation is also used to justify compulsory testing for HIV and other communicable diseases.[129] Additionally, human traffickers may take advantage of the illegality of sex work and migration and exert undue influence and control over sex workers.[130]

59. The possibility of arrest, detention and deportation due to immigration status further discourages access to health facilities, goods and services, particularly for transgender sex workers who may face severe discrimination and abuse in their home country.[131] Health needs of migrant sex workers are poorly understood in many countries, resulting in policies that fail to address their needs and vitiate the right to health. For example, possession of a condom as evidence of sex work-related criminality actively deters migrant sex workers from carrying condoms, which results in risky sexual behaviour and exposure to HIV and other sexually transmitted infections.[132]

in Asia and the Middle East", *Canadian Journal of Women and the Law,* vol. 23, No. 1 (2011),,p. 272.

[125] A/HRC/14/20, para. 36.

[126] TAMPEP International Foundation, *Sex Work, Migration, Health: A report on the intersections of legislations and policies regarding sex work, migration and health in Europe* (2009), p. 10.

[127] A/HRC/14/20, para. 36.

[128] HRW, *Sex Workers at Risk: Condoms as Evidence of Prostitution in Four US Cities* (2012).

[129] Ibid., p. 47.

[130] Kamala Kempadoo, "Globalizing Sex Workers' Rights", *Canadian Woman Studies/Les Cahiers de La Femme*, vol. 22, Nos. 3-4 (Spring/Summer 2003), p. 145.

[131] HRW, *Sex Workers at Risk*, p. 22 (see footnote 128).

[132] Ibid.

60. Ensuring non-discriminatory access to health care both in law and practice requires States to decriminalize consensual adult sex work, enact and implement laws extending labour rights, occupational health and safety and access to affordable health care, with particular focus on irregular migrant sex workers.

61. Participation of migrant sex workers in the formulation and implementation of health laws, programmes and collection of disaggregated data is required to ensure that health concerns of sex workers are addressed.[133] Measures that provide a confidential and supportive environment for voluntary testing, treatment, referral and counselling, that educate sex workers about sexual and reproductive health rights, including preventing the transmission of HIV, and that tackle the marginalization experienced by sex workers are consistent both with epidemiological evidence and the right to health framework.[134]

E. Mental health

62. The provision of timely, affordable and non-discriminatory access to preventative, curative and rehabilitative mental health services and information forms part of the normative content of the right to health. The general stigma and lack of awareness surrounding mental disability,[135] together with restricted access to health facilities, goods and services by migrant workers, means that their mental health may often be neglected.

63. Migration is a stressful experience due to dramatic changes to an individual's cultural, environmental and social landscape. Its impact on mental health will vary between individuals, due to differences in personal experiences and characteristics, such as age, gender, medical history, cultural background and agency in the migration process.[136]

64. Within receiving States, immigration status, social exclusion, living and working conditions, communication with family, integration and access to health services are factors relevant to the mental health of migrant workers.[137] Migration may also induce depressive symptoms in families left behind in sending States.[138] Stigma, marginalization and discrimination are socially embedded and experienced regularly by migrant workers, particularly those who are in an irregular situation.[139] Both sending and receiving States

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[133] H. Yang and others, "Workplace and HIV-related sexual behaviours and perceptions among female migrant workers", *AIDS Care,* vol. 17, no. 7 (October 2005), pp. 819-833,; UNAIDS, *UNAIDS Guidance Note on HIV and Sex Work* (2009); A/HRC/14/20, para. 36.

[134] Agnes Binagwaho and others, "Developing human rights-based strategies to improve health among female sex workers in Rwanda", *Health and Human Rights*, vol. 12, No. 2 (2010); IOM and UNAIDS, *Assessment of Mobility and HIV Vulnerability among Myanmar Migrant Sex Workers and Factory Workers in Mae Sot District, Tak Province, Thailand* (2007), pp. 26-27.

[135] E/CN.4/2005/51.

[136] Nazilla Khanlou, "Migrant mental health in Canada", *Canadian Issues/Thèmes canadiens*, (Summer 2010), pp. 9-16; Fang Gong and others, "A life course perspective on migration and mental health among Asian immigrants: The role of human agency", *Social Science & Medicine*, vol. 73, Iss. 11 (2011), pp. 1618-1626.

[137] H.B.M. Murphy, "Migration, culture and mental health", *Psychological Medicine,* vol. 7, no. 4 (1977), pp. 677-684; D. Bhugra, "Cultural identities and cultural congruency: a new model for evaluating mental distress in immigrants", *Acta Psychiatrica Scandinavica*, vol. 111, No. 2 (2005), pp. 84-93; Lorena de los Angeles Núñez Carrasco, *Living on the Margins: Illness and Healthcare among Peruvian Migrants in Chile* (2008), p. 162.

[138] Yao Lu, "Household migration, social support, and psychosocial health: The perspective from migrant sending areas", *Social Science & Medicine*, vol. 74, Iss. 2 (January 2012), p. 141.

[139] Ilan Meyer, "Prejudice as Stress: Conceptual and Measurement Problems", *American Journal of Public Health*, vol. 93, No. 2 (February 2003), pp. 262-265.

should address the psychosocial costs of migration faced by migrant workers and their families at all stages of the migration process. States should also invest in social support programmes with the participation of migrant workers to counter negative consequences of social exclusion, homesickness and family pressures.[140]

65. Migrant workers in 3D jobs, face occupational risk as an additional stress factor, while exposure to pesticides has been linked to anxiety, depression, irritability and restlessness in agricultural workers.[141] For domestic workers, isolation and psychological trauma caused by abuse are occupational risks,[142] and suicide has been associated with harsh working conditions of migrant construction workers.[143] Effective implementation and enforcement of labour and occupational health and safety laws can contribute to reducing the risk of mental illness as well as physical injury.

66. Due to poor public funding of mental health services,[144] psychological symptoms may go untreated or be inappropriately treated. Medicines are prescribed when counselling or psychosocial support services would be more appropriate.[145] Even when mental health services are available, under-utilization and premature dropout from services have been recorded among migrants, including migrant workers.[146] Constant fear of deportation may also be a stress factor,[147] and discourage workers from accessing mental health facilities, goods and services, where available.

67. To effectively prevent and respond to mental illness, the right to health requires receiving States to take steps to identify and monitor stress factors and provide non-discriminatory access to affordable, acceptable and quality psychosocial and mental health services. Sending States should also ensure that support services within embassies and consulates are accessible and that outgoing migrant workers comprehend the potential impact of migration on mental health and ways to access mental health care in receiving States.

68. Immigrant-specific health policies focusing on linguistically and culturally sensitive services have increased access to mental health services by migrants.[148] Culturally and linguistically proficient community health workers can also play an important role due to

[140] Laura Simich and others, “Providing Social Support for Immigrants and Refugees in Canada: Challenges and Directions”, *Journal of Immigrant and Minority Health*, vol. 7, No. 4 (October 2005), p. 260.

[141] J. Mearns, J. Dunn and P.R. Lees-Haley, “Psychological effects of organophosphate pesticides: A review and call for research by psychologists”, *Journal of Clinical Psychology*, vol. 50, No. 2 (March 1994), pp. 286-293.

[142] Maria Theresa Ujano-Batangan, *Women and Migration,* p. 22 (see footnote 118).

[143] Sevil Sönmez and others, “Human rights and health disparities”, p. 5 (see footnote 63).

[144] E/CN.4/2005/51, para. 64.

[145] Heide Castañeda, “Illegality as risk factor”, p. 1559 (see footnote 83).

[146] Francis Sanchez and Albert Gaw, “Mental Health Care of Filipino Americans”, *Psychiatric Services,* vol. 58, No. 6 (June 2007), p. 815.

[147] UC Davis Center for Reducing Health Disparities, *Building Partnerships: Conversations with Latina/o migrant workers about mental health needs and community strengths* (March 2009), p. 7, available from http://www.dhcs.ca.gov/services/MH/Documents/BP_Migrant_Workers.pdf.

[148] Todd P. Gilmer and others, “Initiation and Use of Pubic Mental Health Services by Persons with Severe Mental Illness and Limited English Proficiency”, *Psychiatric Services,* vol. 58, No. 12 (December 2007), p. 1561.

their understanding of the underlying determinants of mental health for migrant workers, in accordance with the right to health.[149]

69. For returnee migrant workers, the lack of psychosocial services may result in mental health issues being severely ignored. Where it is recognized that migrant workers in particular sectors or countries are exploited and abused, sending States should implement measures to effectively address their mental health concerns. Such policies should be developed, implemented and monitored in consultation with returned migrant workers.

F. Women and sexual and reproductive health

70. States should undertake a gender analysis to identify and address health vulnerabilities of female migrant workers resulting from different biological and sociocultural factors that influence their health. Women comprise a significant percentage of migrant workers but often face greater health vulnerabilities due to gender inequalities.[150] Poverty, family responsibilities and barriers to education and information make women more vulnerable before departing; while violence against women is pervasive during transit in some regions.[151] Systematic exploitation and abuse within informal industries dominated by migrant women, such as domestic work and sex work, stems from and reinforces women's vulnerability during the migration process.

71. Domestic and sexual violence, lack of redress for rights violations and lower wages than male counterparts reflect gender-based discrimination and aggravate its negative effects in the health-care setting and access to health care faced by migrant workers generally.[152] Furthermore, gendered power imbalances and lack of access to health services, information and redress affects the ability of women, especially sex workers, to negotiate safe sex, which increases their vulnerability to HIV.[153] Sending and receiving States should therefore address the compounded vulnerability of female migrant workers, particularly those with irregular status, in the development and implementation of evidence-based and participatory health policies and strategies.

72. The right to health requires States to ensure access to health facilities, goods and services, especially for vulnerable groups, such as migrant women workers. Health services, information and education should be tailored to the specific needs of women – such as sexual and reproductive health needs, including access to contraception and safe legal abortion – and pay attention to the special vulnerability of low-skilled migrant workers, regardless of immigration status.

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[149] Leda Perez and Jacqueline Martinez, "Community Health Workers: Social Justice and Policy Advocates for Community Health and Well-Being", *American Journal of Public Health*, vol. 98, No. 1 (January 2008), pp. 11-14.

[150] Committee on the Elimination of Discrimination against Women (CEDAW), general recommendation No. 26 (2008) on women migrant workers, para. 5; Gloria Moreno-Fontes Chammartin, "Female migrant workers' situation in the labour market (ILO, 2006), available at http://www.ilo.org/public/english/protection/migrant/download/unfpa_newyork_report_2006.pdf.

[151] IOM, *Migration and Health in SADC: A review of the literature* (2010), p. 19.

[152] CEDAW, general recommendation No. 26, para. 2.

[153] United Nations Population Fund (UNFPA), *State of the World Population 2006, A Passage to Hope: Women and International Migration* (2006), pp. 38-9; Kenda Crozier, Pleumjit Chotiga and Michael Pfeil, "Factors influencing HIV screening decisions for pregnant migrant women in South-East Asia", *Midwifery* (2012), p. 1, available from http://dx.doi.org/10.1016/j.midw.2012.08.013.

73. Some States deport women migrant workers who are found to be pregnant during compulsory medical testing.[154] The women concerned may also be exposed to greater vulnerability in both sending and receiving States because of the stigma attached to pregnancy outside of marriage in many societies.[155] The practice of forced contraceptive injections have been reported during pre-departure in some sending States.[156] Such practices encroach upon rights to privacy, informed consent, confidentiality, dignity and non-discrimination and act as an impediment to seeking assistance from police or health systems.[157]

74. Higher abortion rates among migrant workers have been linked to low awareness about and socioeconomic barriers to accessing contraception and family planning services.[158] In countries which permit abortion but which prohibit migrant workers from becoming pregnant, the result is unequal access to legal reproductive health services due to apprehension of job loss and deportation, leading to risky treatment delays and unsafe abortions.[159] Where abortion is criminalized, resort to unsafe abortion is also driven by the threat of criminal prosecution.[160]

75. For women who carry a pregnancy to term in receiving States, difficulty accessing obstetric, pre- and post-natal and maternal health-care services and information[161] may result in adverse health outcomes for both the woman and child, including premature birth, low birth weight, congenital malformation and perinatal, infant and maternal mortality.[162] In contrast, it has been found that policies promoting social integration of the migrant community reduce unfavourable pregnancy-related outcomes for migrant women.[163] Extending the 14-weeks maternity leave required under the Maternity Protection Convention or the maternity leave granted to nationals to women migrant workers[164] would assist in making pregnancy-related health care and services accessible and in accordance with the right to health.

IV. Conclusion and recommendations

76. **The right to health approach to migrant workers fills gaps in existing frameworks that protect migrant workers and their families and bolsters protections**

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[154] HRW, *Singapore - Maid to Order,* p. 90 (see footnote 62).

[155] Ibid., p. 93; A/64/272, para. 75.

[156] HRW, *Sri Lanka/Middle East - Exported and Exposed: Abuses against Sri Lankan Domestic Workers in Saudi Arabia, Kuwait, Lebanon, and the United Arab Emirates,* Vol. 19, No. 16 (C) (November 2007), p. 38.

[157] A/66/254; Committee on the Elimination of Discrimination against Women, general recommendation No. 26, para. 18.

[158] UNFPA, *State of the World Population 2006*, p. 37 (see footnote 153).

[159] HRW, *Singapore - Maid to Order*, pp. 90-91 (see footnote 62).

[160] IOM, *HIV and Bangladeshi Women Migrant Workers: An assessment of vulnerabilities and gaps in services* (2012), p. 39.

[161] Gail Webber and others, “Facilitators and barriers to accessing reproductive health care for migrant beer promoters in Cambodia, Laos, Thailand and Vietnam: A mixed methods study”, *Globalization and Health*, vol. 8, No. 21 (July 2012).

[162] Paola Bollini and others, “Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature”, *Social Science & Medicine*, vol. 68, Iss. 3 (2009), p. 456; Manuel Carballo, Jose Julio Divino, Damir Zeric, “Migration and health in the European Union”, p. 938 (see footnote 104).

[163] Paola Bollini and others, “Pregnancy outcome of migrant women”, p. 456 (see footnote 163).

[164] ILO, Maternity Protection Convention, 2000 (No. 183), art. 4.

contained therein. It provides necessary safeguards to migrant workers by recognizing that migrant workers and nationals of a specific State have equal rights which must not be limited. The Special Rapporteur recommends that sending and receiving States take the following steps in order to realize the right to health of migrant workers:

(a) Institute, for regular and irregular migrant workers, evidence-based and gendered national health policies informed by the right to health framework, in particular non-discrimination and equality. Such policies should extend rights and entitlements – including underlying determinants of health – and redress mechanisms in cases of violation to migrant workers;

(b) Establish labour corridors through enforceable bilateral agreements, in accordance with the right to health framework, which clearly define the rights of migrant workers, obligations of recruitment agencies, employers and States, and remedies, including compensation for violations, in line with the right to health;

(c) Encourage collection of disaggregated data by age and gender of all migrant workers, to assess their level of health-related knowledge, health needs and occupational injuries and deaths, including suicide, and accordingly inform policies regarding migrant workers. Such information should be protected by adequate data protection measures to ensure privacy and confidentiality of the data;

(d) Provide potential migrant workers with information about their rights, particularly the right to health, as well as about recruitment agencies, employers and States, recourse for redress and protection from abuse;

(e) Regulate recruitment agencies through laws which discourage illegal recruitment and provide for rigorous monitoring and accountability mechanisms;

(f) Protect migrant workers from abuse by recruitment agencies and employers by ensuring employment contracts are in accordance with the right to health and are enforceable;

(g) Abolish discriminatory immigration policies that require mandatory testing for health conditions, such as HIV and pregnancy, which are not based on clearly established scientific evidence and violate the right to health;

(h) Delink access to health facilities, goods and services from the legal status of migrant workers and ensure that preventative, curative and emergency health facilities, goods and services are available and accessible to all migrant workers, including irregular migrant workers, in a non-discriminatory manner. States should endeavour to prevent treatment interruption for migrant workers and remove barriers to accessing health care, such as those that are linguistic, cultural, administrative and employment-related;

(i) Ensure access to mental-health facilities, goods and services, including social support groups and family reunification programmes, for all migrant workers – including irregular and returnee migrant workers;

(j) Extend existing domestic labour laws, occupational health and safety laws, social insurance schemes and other protections to all categories of migrant workers, including domestic workers, sex workers and irregular migrant workers;

(k) Ensure protection of migrant workers, especially those in dangerous industries, from abuse and exploitation by employers by providing accessible redress mechanisms and compensation in cases of violation;

(l) Prevent the detention and deportation of migrant workers based on their health status and ensure the provision of care and treatment to such migrant workers at the first instance. At minimum, States should ensure that migrant workers are not deported without referral for treatment or to States where the required treatment is not available and accessible;

(m) Prevent the detention and deportation of irregular migrant workers and instead regularize their stay on objective criteria, in order to protect them from exploitation and ensure their full enjoyment of the right to health;

(n) Encourage the establishment of migrant workers associations and trade unions to ensure effective representation and participation of migrant workers, including irregular and returnee migrant workers, in the formulation, implementation, monitoring and enforcement of laws and policies, including outreach and referral programmes, pre-departure sessions and social support groups.