Draft intervention
World Human Rights Cities Forum
Gwangju
6 October 2023

The right to health of migrants in international human rights law
Contribution to the World Human Rights Cities Forum

Introductory remarks

The right to the highest attainable standard of physical and mental health is a fundamental human right intertwined with other human rights, such as the right to life. States have undertaken the obligation to respect, protect and fulfil the right to health, without any discrimination, under various international human rights instruments. Despite these abundant provisions on equality and non-discrimination in the enjoyment of the right to health, migrants experience various challenges in exercising this right due to their migratory status and other grounds of discrimination, such as race, colour, ethnic or national origin, descent, religion, language, gender and gender identity, sexual orientation, disability. The COVID-19 pandemic tragically exposed how States, our societies and our cities were unprepared to protect migrants. At the same time, the response to the pandemic deepened structural inequalities, by exacerbating the specific vulnerability of migrant women and girls, children, and persons with disabilities, leading to multiple or intersecting forms of discrimination. [1]

Key definitions

We often discuss migrants' health and other human rights, as if the term "migrants" denotes a group of persons sharing only one characteristic, i.e. the migratory status. However, the term "migrant" is an umbrella term. Who is a *migrant* under international human rights law? A commonly accepted definition of a migrant is "any person who is outside a State of which he or she is a citizen or national, or, in the case of a stateless person, his or her State of birth or habitual residence. The term includes migrants who intend to move permanently or temporarily, and those who move in a regular or documented manner as well as migrants in irregular situations"[2]. Article 2 (1) of the International Convention on the Protection of the

[1]Statement on the coronavirus (COVID-19) pandemic and its implications under the International Convention on the Elimination of All Forms of Racial Discrimination (3/2020).
[2] IOM, Glossary on Migration, p. 132.

Rights of All Migrant Workers and Members of Their Families provides that the term “migrant worker" refers to a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national”. So, the first point to be made is that migrants are not necessarily workers in the sense of the Convention. Secondly, migrants’ access to the right to health is determined by their legal status. A *migrant in an irregular situation*, i.e. a person who moves or has moved across an international border and is not authorized to enter or to stay in a state pursuant to the law of that state and to internatioal agreements to which that state, is often under ordinary circumstances excluded from public health policies. *Third*, migratory movements may involve force, compulsion, or coercion. Although no strict dichotomy may exist between voluntary movement and forced movement, public health must take into account that, throughout the migration cycle, migrants can be victims of serious human rights violations, such as torture, and trafficking, or they may be displaced persons by disasters, development projects or related conflicts.

Migratory status as a determinant of health

Apart from individual characteristics and behaviours, physical environment (safe water and clean air, healthy workplaces, safe houses, communities and roads, and food and nutrition), social and economic environment (education, health literacy, income and social status, employment and working conditions, social support networks, culture, and health services) determine the status of health. Migration patterns and travel routes vary from region to region and carry important information on the group of migrants residing in one country. Age and gender determine health needs and require additional medical services in some instances, such as prenatal, labour and delivery care. Occupational hazards also vary in accordance with gender and age. All these determinants are strongly influenced in the context of migration.

Findings on discrimination against migrants in the right to health

Under the reporting procedure, the Committee on the Elimination of Racial Discrimination (CERD) has identified the trajectories racism and racial discrimination affects health and the enjoyment of the right to health of migrants. Health laws and policies fail to measure and mirror how the migratory status and race, colour, descent, or national or ethnic origin, gender, age, disability, class, social status, or income, religion, language result in lower availability of health and in strengthening racial barriers. From a human rights-based approach,

migrants face racial discrimination as a separate health risk and as a structural social determinant of health with concrete negative outcomes.

Although national legislations increasingly repeal directly discriminatory provisions which explicitly reserve access to public health only to nationals, indirect discrimination remains an important challenge. Seemingly neutral policies or measures, regulating health insurance, access to services, or social security schemes, place migrants at a particular disadvantage despite absence of explicit distinction. States often consider that the legal status of migrants, namely their residency and work status, classifies migrants in various categories of rightsholders. In other words, only migrants who move in a documented manner are in practice recognized as holder of the right to health.

However, even in these cases, migration law often allows systemic flaws: the live-in requirement for migrant domestic workers as well as situations reported to the UN CERD of physical and mental abuse and confiscation of their passports by their employers expose migrants to systemic racial discrimination in the right to health.[3] Migrants, in particular women, are at increased risk of sexual violence. Criminalisation of access to sexual and reproductive health further exposes them to health risks.

Migrants in irregular situations are systemically deprived of their liberty, as the attention is often shifted from migrants' right to health to other concerns, such as security or demographic balances in specific regions, without providing any alternative path of protection or mitigation of health risks and outcomes. In many contexts, migrants do not enjoy the right to occupational health and safety, as they are often involved in informal labour markets.

Migrants are subject to structural discrimination. Due to unequal distribution of resources with the State[4], areas where migrants reside are often underserved, although with high exposure to environmental health hazards. Migrants do not have access to skilled medical personnel, scientifically approved and unexpired drugs, and hospital equipment. Moreover, privatisation and commercialisation of health disproportionately affects migrants who cannot afford treatment and medicine, including undocumented pregnant women, with increased risk of obstetric emergencies and complications during childbirth.[5] At the same time, clinical algorithms reproduce structural inequalities outcomes in hospitals by translating them into health indicators.

[3]CERD/C/CHN/CO/14-17, paras. 30-31.
[4]CERD/C/BRA/CO/18-20
[5]CERD/C/CZE/CO/12-13, para. 23.

Lack of integration of all migrants into local health systems contributes to deteriorating their physical and mental well-being and understanding of diagnoses, treatment options and use of medicines. Migrants are subject to discrimination due to lack of information in their languages and the digital divide. Structural discrimination reinforces institutional and interpersonal bias and lack of trust due to negative experiences. Migrants often rely on civil society initiatives, or they have access to lower standards and not culturally appropriate, disability-inclusive, and gender-sensitive health facilities, goods, services, and information. Failure to integrate them in public health policies further exposes them to fake news and propaganda.

States' obligations under international human rights law

UN treaty bodies and special mandate holders have recognised that the principle of non-discrimination also applies to migrants. The Committee on Economic, Social and Cultural Rights (CESCR) has clarified that all persons, including migrants, have an equal right to access preventive, curative, and palliative health services, regardless of their residence status and documentation.[6] In 2004, the Committee on the Elimination of Racial Discrimination (CERD) adopted a General Recommendation No. 30 on discrimination against non-citizens and clarified that states must: i) remove the obstacles that prevent non-citizens from enjoying the right to health (para. 29); ii) respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services (para. 36). The more the international community understands the link between racism and health, and between the migratory status and health, the more precise the content of migrants' right to health becomes in international human rights law.

In the first draft of the General Recommendation No. 37 on racial discrimination and the right to health, the CERD recalls that Article 5 (e)(iv) of the UN Convention on the Elimination of All Forms of Racial Discrimination provides for an *individual right to equal and unhindered access to a whole range of culturally appropriate, disability-inclusive, and gender-sensitive health facilities, goods, services, and information, as well as the protection of the migrant's right to privacy and confidentiality*. The status of the prohibition of racial

[6] General Comment No. 14 (2000), para. 34, General Comment No. 19, para. 37, General Comment No. 20, para. 30, General Comment No. 23, para. 5.)

discrimination in international law, as one of the most egregious forms of discrimination, and the link between the right to health and the right to life leave States a very narrow margin of appreciation in differentiations of treatment between nationals and migrants. A combined reading of the interpretation by the CESCR and the CERD allows for a constructive understanding of migrants' right to health. In the following section, I will focus on States' obligations and will provide examples of good practices adopted mostly during the pandemic. I would like to clarify that these practices are by no means exhaustive and must be integrated in ordinary policies as measures of compliance with obligations under international human rights law. Equality in the right to health is achieved through legislative, administrative and other measures combining resources, institutions and systems across all sectors related to the right to health.

Obligation to respect migrants' right to health: States must refrain from adopting and enforcing discriminatory policies which exclude migrants or limit their equal access to the right to health. Heath insurance policies must be accessible for all, taking into account accessibility concern of migrants related to their employment status or tac status. Emergency health care must be ensured for all in practice and must include a wide range of services reflecting the migrant population of the State. Access to primary care must not depend on registration on a list as this requirement exposes migrants in an irregular situation to expulsion. Medical confidentiality is important in case of reimbursement for migrants in irregular situation. Migration law must not exclude migrants from access to health. National law must explicitly prohibit discrimination against migrants, in accordance with Article 1 (1) of the ICERD and extend the prohibition of racial discrimination to all State authorities, public institutions, and private persons, natural and legal, in accordance with Article 2. Explicit reference to intersectionality recognising the prohibition of racial discrimination based on the migratory status, intersecting with other grounds of discrimination, such as gender, age, disability and class, social status or income, is strongly encouraged, as it will strengthen effectiveness in broader groups of migrants and will ensure compliance with more international human rights treaties.

On the other hand, States must ensure that they do not interfere with the right of migrants to control their health and body, including sexual and reproductive freedom. Depriving migrants from their liberty involves serious health outcomes that States must take into account before adopting or implementing such measures. Migrants must not be exposed

to further stigmatization, marginalization, and disadvantage due to criminalization of health services or traditional medicine.

Examples of good practices: slide 11 (Access of migrants in an irregular situation to vaccination)

Obligation to protect migrants' right to health against violations by third parties: States must act upon the knowledge of correlation between migratory status, racism and negative outcomes in health by adopting and implementing preventative, protective, mitigating, and restorative measures to ensure equality and non-discrimination in health provided by third parties. This obligation entails measures to ensure that privatization of the health sector, the marketing of health equipment and medicines or vaccines does not exclude migrants. States should adopt regulations to monitor and ensure compliance by third parties, private business enterprises, private health-care facilities, insurance and pharmaceutical companies, manufacturers of health-related goods and equipment and other relevant organizations. Moreover, States are required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. Their national occupational safety and health strategy must involve realistic disaggregated data on migrant population of workers. States must monitor occupational hazards to pair them with appropriate measures. State must adopt measures to prevent non-consensual medical treatment and experimentation and States must adopt measures to ensure that migrants have access to information on their health condition and treatment to avoid forced treatment.

States should develop and offer human rights education and training with a focus on racial discrimination to a wide range of actors involved in health. Health professionals, social workers, and other key civil servants and third parties involved in health, including in humanitarian settlements, at local, regional, and national level should be provided with mandatory training. Hospitals, primary healthcare centres and social services should ensure that training is complemented by institutional interventions regarding limiting discretion and increased oversight in areas vulnerable to stereotyping and biases. Human rights education should be included as mandatory course in curricula of medical schools and other health related schools and departments. Medical schools are encouraged to review their curricula and identify bias and stereotyping in medical training approaches and materials. Health providers should be conscious about racial discrimination and prevent race-based simplifications.

Examples of good practices: slides 14 (Occupational Health and Safety), 15 (culturally appropriate and gender-sensitive health care), 16 (Tackling social determinants of health and accelerating progress towards the Sustainable Development Goals, including universal health coverage)

Obligation to fulfil migrants' right to health: States must adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures to facilitate and promote migrants' right to health. National legislation should provide the framework to adopt *special and concrete measures* to ensure the adequate development and protection of disadvantaged groups such as migrants (Article 2(2) ICERD). In other words, special measures are strongly recommended to redress migrants' disadvantage, address and counter stigma and prejudice against migrants, enhance their participation and accommodate their diversity to achieve structural change (Sara Fredman) Migrants must be facilitated and assisted to have access to public health system and States must provide them with the right to health in case migrants are unable to exercise their right (Example good practice slide 17- Improving evidence-based health communication and to counter misperceptions about migrant and refugee health). Local and regional authorities must be involved in identifying risks and needs, in allocating resources and providing health services and goods, in particular in rural areas, taking into consideration environmental harms on health and land rights.

Monitoring of inequalities in health: No policy can be effectively designed, implemented, and assessed, without continuous monitoring of how discrimination affects migrants 'right to health. States must be in position to measure if and to what extent migrants have access to the right to health in order to adopt specific and concrete measures within a broader policy. Statistics related to migrants' right to health should be available and should rely on comparable periods of time, relevant geographic scope, and population groups. In absence of comprehensive statistics, it is impossible to assess effectively if laws, health policies and programmes, apparently neutral, result in racial discrimination. States must respect and ensure the right of migrants to self-identify as such anonymously and combine these statistics with other types of social surveys related to the right to health.

Representation of migrants in health is crucial for identifying health risks and outcomes, improving their quality of health, building trust with their communities and cultivating a culture of equality and non-discrimination. States must actively encourage representation of migrants, taking into account their migratory patterns and routes, their age

and gender, other characteristics, such as employments, language, religion, disability, education level, and life-cycle requirements.

Accountability: States must assure to migrants within their jurisdiction effective protection and remedies against any acts of discrimination which violate his or her right to health, as well as the right to seek just and adequate reparation or satisfaction for any damage suffered as a result of such discrimination. Effective and independent monitoring and accountability mechanisms, both internal in health-care installations and external, must be established and disciplinary measures in cases of misconduct must be envisaged. Healh-care facilities should also carry out periodic audits, with the help of independent experts, to identify gaps in internal policies and practices. Transparency about the outcomes of these procedures is strongly recommended as it may strengthen accountability and strengthen individuals' and communities' trust. Migrants' representative organisations must be integrated in accountability and redress mechanisms. These mechanisms are strongly encouraged to adopt a victim-centred and community-driven approach by empowering migrants to participate actively and support actual and potential victims and survivors of discrimination in the right to health. Where appropriate, the structural and intergenerational nature of the harm should be recognised and redressed, by prioritising general measures or by complementing individual reparation.

International cooperation in health is a key element. Guided by the principle of international solidarity through international assistance and cooperation, States should take all necessary national and multilateral measures, including temporary waivers of intellectual property protections on healthcare technologies, to mitigate the disparate impact of global challenges, such as pandemics, climate change and disasters, and their socioeconomic consequences on vulnerable groups, such as migrants.

Concluding remarks

In 2020, there were 281 million international migrants in the world and represented 3.6% the global population. About 48% of international migrants are women and some 36 million are children (WHO). In May 2022, UNHCR announced that the number of people forced to flee conflict, violence, human rights violations and persecution had surpassed 100 million for the first time on record. Combatting discrimination against migrants and adopting migrant-sensitive health policies and practices is a tool for advancing the right to health of

migrants and for reaffirming that "[a]ll human beings are born free and equal in dignity and rights", 75 years after the adoption of the Universal Declaration of Human Rights.