

Ensuring health equity of marginalized populations: experiences from mainstreaming the health of migrants

KAISA KONTUNEN, BARBARA RIJKS*, NENETTE MOTUS, JENNA IODICE, CAROLINE SCHULTZ and DAVIDE MOSCA

Migration Health Division, International Organization for Migration, Geneva, Switzerland

*Corresponding author. E-mail: brijks@iom.int

SUMMARY

Migrants around the world significantly contribute to the economies of countries of origin and destination alike. Despite the growing number of migrants in today's globalized world, the conditions in which migrants travel, live and work can carry exceptional risks to their physical and mental well-being. These risks are often linked to restrictive immigration and employment policies, economic and social factors and dominant anti-migrant sentiments in societies, and are often referred to as the social determinants of migrants' health. These social determinants need to be addressed in order for migrants to attain their development potential and to concurrently contribute to sustainable development, while reducing the health costs of migration for both migrants and societies of origin and destination. A multi-sectoral approach is required to effectively address

the social determinants of migrants' health, as many of the solutions to improving migrants' health lie not only in the health sector but in other sectors, such as labour and immigration. This requires collaboration across the different sectors and integrating migrants' health issues in different sectoral policies to avoid marginalization and exclusion of migrants and ensure positive health outcomes for migrants and their families. The paper will discuss a 'Health in All Policies' (HiAP) approach to migrants' health as, to date, there has not been much discussion on framing migrants' health within an HiAP approach. The paper will also present some examples from countries who have addressed different aspects of migrants' health in line with the recommendations of the 61st World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (2008).

Key words: multisectoral policy response; social exclusion; migrant health; inequalities in health

INTRODUCTION

In today's globalized world, human mobility and migration are more common than ever before. Globally, one out of seven persons is a migrant on the move; there are an estimated 1 billion migrants worldwide, of which 214 million are international migrants (see Table 1). People move within countries and across international borders and are driven by complex and inter-related factors, such as economic factors, geo-political dynamics, demographic disparities, labour market demands, disparity of wealth distribution and opportunities, natural disasters and made-made conflicts. Movement is facilitated by

migrant networks, ease of communications and travel, amongst others.

Since the beginning of mankind, people have moved to find 'greener pastures', and many migrants move to improve their material or social conditions and prospects for themselves or their family.

Migration, at its best, can be a powerful force for economic and social development in countries of destination, and through remittances, a force for poverty reduction and development in what are often poorer countries of origin. Migration can also provide important human development outcomes for migrants and their families. This is usually the case for skilled migrants

Table 1: Global estimates of migrants

Migrant categories	Population estimates
Internal migrants	740 million in 2009 (UNDP, 2009)
International migrants	Annual flow between 2005 and 2010, ~2.7 million, 214 million international migrants in 2010 (UNDESA, 2008)
Migrant workers	100 million (ILO, 2010)
International students	3.4 million 2009 (UNESCO, 2009)
Internally displaced persons	32.4 million displaced by natural disasters (IDMC, 2013) and 26.4 million displaced by conflict (IDMC, 2012)
Refugees	15.2 million by end of 2011 (UNHCR, 2012)
Asylum seekers or refugee claimants	895 000 by end of 2011 (UNHCR, 2012)
Temporary—recreational or business travel	983 million in 2011 (WTO, 2012)
Trafficked persons (across international borders)	Estimated 12.3 million in 2010 (IOM, 2011)

who benefit from well-managed migration processes, facilitated by more open immigration policies, favourable working and living conditions, inclusive labour laws and social protection schemes, including access to health insurance.

Yet in the case of lower skilled migrant workers or migrants fleeing conflict or natural disasters, the movement and migration process, as well as the socio-economic living and working conditions, exposes migrants—especially women, children and those with an irregular status—to negative health and development outcomes. In many countries, undocumented migrants do not have access to health services and have to pay out-of-pocket for health care. Some countries practice measures like the automatic detention of migrants and asylum seekers on the basis of treatable infections, or deportation and work or residence limitations based on various health grounds. These health grounds can include pregnancy, for example, which highlights the links between immigration practices and migrants' right to health. Often, migrants do not have the power to negotiate, or lack a voice in decision-making processes that affect them. Moreover, migrants are often not represented in trade unions that could improve their health and well-being (Report of Special Rapporteur on Right to Health (A/HRC/23/41) Anand Grover on Health of Migrant Workers. Available at: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session23/A_HRC_23_41_ENG.pdf).

As the world is currently debating the post-2015 UN development framework, the discussion on health goals focuses on 'universal health coverage' as an end in itself and a means to achieve the objective of maximizing healthy life expectancy. For a truly 'universalist'

approach, it is essential however that migrants, regardless of their legal status, are included in the target population of these development goals.

FRAMING MIGRANT HEALTH IN HEALTH IN ALL POLICIES

Even though migration is a fact of life and societies are increasingly diverse, public policies have, as yet, not sufficiently integrated the health needs of migrants. Policy-makers within the health sector as well as outside the health sector, such as the labour, immigration and foreign affairs sectors should take into account the impacts of public policies on the health determinants of migrants, as well as on health systems across sectors, in order to realize health-related rights and improve accountability for population health and health equity (Health in All Policies Definition Consultation, 2013). This will ensure policy coherence and a more effective and focused response to migration-related health challenges at country, regional and global levels.

The World Health Organization (WHO) has identified the following four basic principles for a public health approach to addressing the health of migrants and host communities (WHO, 2008):

- (1) Avoid disparities in health status and access to health services between migrants and the host population.
- (2) Ensure migrants' health rights. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions, which are the basic health entitlements of the host population.

- (3) Put in place lifesaving interventions so as to reduce excess mortality and morbidity among migrant populations. This is of particular relevance in situations of forced migration resulting from disasters or conflict.
- (4) Minimize the negative health outcomes of the migration process on migrants' health outcomes. Migration generally renders migrants more vulnerable to health risks and exposes them to potential hazards and greater stress arising from displacement, and adaptation to new environments.

All policies, whether in the health sector or in other relevant sectors should consider the possible negative impacts on these four public health objectives and apply a Health in All Policies' (HiAP) approach to migration-related health issues. To date, however, policy responses have not kept pace with growing challenges related to volume, speed and diversity of modern migration. Moreover, they do not sufficiently address the existing health inequalities and social determinants of health, including barriers to accessing health services. For example, migrants and migration are not routinely integrated in Health Impact Assessments (HIAs) of new public policies, migrants and migration are not often adequately considered in health policies, disease control programmes and social protection in health measures and there is a lack of mechanisms facilitating dialogue between policy-makers from different sectors such health, labour, foreign affairs and immigration.

In some countries, especially those affected by the recent economic crisis, we see restrictive immigration policies affecting the health outcomes of migrants, especially those who are in an irregular situation (Royo-Bordonada *et al.*, 2013) (Benítez, 2013). For example, in Spain the government enacted a Royal decree-law (16/2012) in 2012 which stipulates that undocumented immigrants over 18 shall receive only emergency health care in cases of serious illness or accident due to any cause, until they are medically discharged. As a result, most undocumented immigrants have limited access to health care. In addition to an infringement of migrants' right to health, increased undiagnosed diseases, and possible negative impacts on the public health, this new law has put health professionals in a difficult position where they have to choose between their ethical obligation to recognize and uphold the rights of the patient and abide by Spanish law ('The European

Declaration of Health professionals towards non-discriminatory access to health care' was launched by Médecins du Monde in May 2010 and was signed by 141 health organisations, representing over 3 000 000 health professionals. Prominent European associations of health professionals, including the Standing Committee of European Doctors (CPME), the European Council of Medical Orders (CEOM) and the European Federation of Nurses Associations (EFN) signed the Declaration. <http://mdmeuroblog.files.wordpress.com/2014/01/european-declaration-health-professionals.pdf> <http://pr.euractiv.com/pr/european-health-professionals-call-non-discriminatory-access-healthcare-90933>).

In addition, even though an increasing number of countries have adopted an inclusive approach and abolished health-related travel and entry restrictions for migrants (For example, a number of countries, including the USA, China and Korea have more recently abolished the entry restrictions based on HIV status. see: 'UN lauds China's decision to remove travel restrictions based on HIV status', 27 April 2010 (<http://www.un.org/apps/news/story.asp?NewsID=34494#.U0unNzH8IW0>) (GLOBAL REPORT, UNAIDS Report on the global AIDS epidemic 2013, p. 92, see: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf), there are still plenty of countries that apply health-related travel and entry restrictions on health conditions that have no public health rationale (UNAIDS/IOM statement on HIV/AIDS-related travel restrictions, June 2004) (global report, UNAIDS Report on the global AIDS epidemic 2013, p. 93, see: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf).

Ministries of health should be given the mandate and political support to take a lead role and coordinate with other sectors, such as labour and immigration, to ensure migrant-friendly policies and health systems that will reduce disparities in health status between migrants and the local population (WHO, 2010). Improving the health and well-being of migrants and their host communities will contribute to the realization of global health goals aimed at preventing HIV, containing tuberculosis, malaria and the human influenza pandemic and reducing the burden from non-communicable diseases.

The WHA Resolution on the Health of Migrants recognized that health outcomes can be

influenced by multiple dimensions of migration and highlighted the need to take into account the determinants of migrants' health in developing inter-sectoral policies to protect their health. Although not legally binding for member states, Resolution 61.17 is politically and morally significant, as it is the first global recognition by all WHO member states that the health of migrants is important and gives clear guidance on priority recommendations that member states need to implement.

In 2010, the International Organization for Migration (IOM), the WHO and the Government of Spain organized the Global Consultation on the Health of Migrants in Madrid to take stock on progress made on the implementation of the resolution and to develop an operational framework based on the resolution. This meeting brought together ~100 participants from all geographical regions, representing various arms of governments, non-governmental organizations, international organizations, regional institutions, academics and experts, as well as professional and migrant associations.

The gathering identified priorities and key actions to promote the health of migrants along the four pillars of the WHA resolution:

- (1) *monitoring migrant health*—aimed at strengthening the knowledge on the health of migrants via research and information dissemination to ensure evidence-based programming and policy development;
- (2) developing and implementing *migrant-sensitive policies and legal frameworks* that ensure the health of migrants, their families and communities in countries of origin and destination;
- (3) *promoting migrant-sensitive health systems*—aimed at delivering, facilitating and promoting equitable access to migrant-friendly and comprehensive health services; and
- (4) ensuring *partnerships, networks and multi-country frameworks*—aimed at establishing and supporting ongoing relevant dialogues and cooperation (WHO, 2010).

This 'four-pillar' framework reflects the main recommendations of the WHA resolution and, since its adoption, WHO and IOM and other partners have been advocating for the adoption and implementation of this framework by WHO member states at country level (in addition, IOM has aligned its strategic objectives on migration and health to the four pillars of the WHA resolution, see: <http://www.iom.int/cms/migration-health>).

The next section illustrates some country examples where different actors, including governments and non-governmental agencies, have implemented components of this operational framework, including through multi-sectoral actions consistent with the HiAP approach. This list of examples is by no means meant to be exhaustive but is meant to illustrate how different actors in various regions have implemented actions along the four pillars of the WHA Resolution on the Health of Migrants. The examples presented below have been identified after rigorous and careful review.

EXAMPLES OF MIGRANT HEALTH ACTION ACROSS SECTORS

Domain of action: 1. Monitoring migrant health

Finland: the Maamu study

The aim of the Migrant Health and Wellbeing Study (Maamu), launched in 2010, is to provide information on the health status of migrants in Finland and the factors influencing it. The study collects information of Russian-speaking, Somali and Kurdish origin adults in Finland and research is carried out in the municipalities of Helsinki, Espoo, Vantaa, Turku, Tampere and Vaasa. The study collects needed information on the health and well-being of migrants, including data on general health, major chronic conditions, functional capacity and work ability, determinants of health, diseases, health and service needs and their satisfaction, experiences of discrimination and violence and social well-being. With the results of this study, comparisons will be able to be made between data from the host and migrant population, which can serve to advance the integration and employment prospects of migrants and to promote the well-being of migrants and their families (National Institute for Health and Welfare, 2013).

This example is a good illustration of data collection on health aspects of migration with the aim to achieve health equity through evidence informed labour and health sector policies.

Domain of action: 2. Develop and implement migrant-sensitive policies and legal frameworks

USA: integrating health in immigration policies and resettlement process

Each year, the USA provides resettlement opportunities for ~70–90 000 of the world's most

vulnerable refugees through a programme that seeks to provide protection, ease suffering and resolve the plight of persecuted and uprooted people around the world. Health is fundamental to the successful resettlement of refugees. The administration of health services and support to resettling refugees involves multiple organizations (including the United Nations High Commissioner for Refugees and IOM) and government agencies. Through its regulatory authorities, the Division of Global Migration and Quarantine (DGMQ) of the US Centers for Disease Control and Prevention (CDC) develops guidelines and monitors the implementation of overseas health assessments that refugees receive prior to resettlement to the USA. Overseas health assessments are essential to detect conditions of public health concern with the primary scope of protecting the public in immigration countries. Over the years this programme has increasingly developed preventative and curative care for refugees such as tuberculosis treatment prior to travel, or large programmes of immunization that benefit both the refugee and the receiving community. Where in the past health assessments of immigrants and refugees were done with the scope of identifying medical grounds for excludability, these days they are done to foster integration of refugees and migrants and reduce the costs of immigration.

This example illustrates that through policy coherent immigration and health sector policies, governments and partners can effectively monitor and address refugee and migrants' health to ensure successful integration in host communities.

Argentina: migration law (2004)

Argentina hosts over half of South America's migrant population; the majority coming from neighbouring countries such as Paraguay, Bolivia, Chile, Uruguay and Brazil. In January, 2004 it enacted the Argentine immigration law 25.871, which represents a major step forward for the rights of migrants in Argentina. The new law establishes that migration is a human right—a principle that is not found in the immigration laws neither of any other large immigrant receiving country nor explicitly in any international human rights conventions. Law 25.871 extends constitutional and human rights protections to all immigrants within the country, regardless of their legal status, and guarantees immigrants the rights to equal treatment, non-discrimination

and access to educational, medical and social services. The law guarantees that 'in no case should access to the right to health, social assistance or sanitary care be denied or restricted to any foreigner who requires it regardless of his/her immigration status', and 'the authorities of health care institutions must offer orientation and information about the necessary steps to solve the irregular migration status'.

This example illustrates HiAP, as protection measures on health are considered and integrated in the immigration law.

Sri Lanka: a whole-of-government approach to migrant health

In Sri Lanka, an estimated 1.8 million Sri Lankans, or the equivalent of 18% of the total labour force, are temporarily employed abroad and collectively send ~5.1 billion USD back home in remittances (2011). In addition, Sri Lanka hosts a large number of foreign migrant workers, internal migrants and displaced persons as a result of years of civil strife, returning refugees and failed asylum seekers. The Government of Sri Lanka recognized that assessing and addressing migration-related social and health consequences is a vital step in health protection and human development; consequently, it was the first country to report on its progress on the *WHA Resolution 61.17 on the Health of Migrants* in the 2010 World Health Assembly.

Sri Lanka is an interesting case study due to the fact that it acknowledged at an early stage that migration health is a theme that cuts across many different sectors and actors, and that vertical and horizontal approaches were needed to ensure that migration does not negatively affect the development of migrants, their families left behind or source and destination countries. An Inter-Ministerial '*whole of Government approach*' involving 12 key Government Ministries was adopted to advance Sri Lanka's Migration Health Agenda at the end of 2009 (Fig. 1). This involved an inter-ministerial coordinating framework on migration health, engaging the key government ministries involved at the interface of migration, health and development. The MOH has a strong coordinating role, but migration health is a shared responsibility: for example, for outbound migration, the Ministry of Foreign Employment Promotion and Welfare and the Sri Lanka Bureau of Foreign Employment are key actors involved.

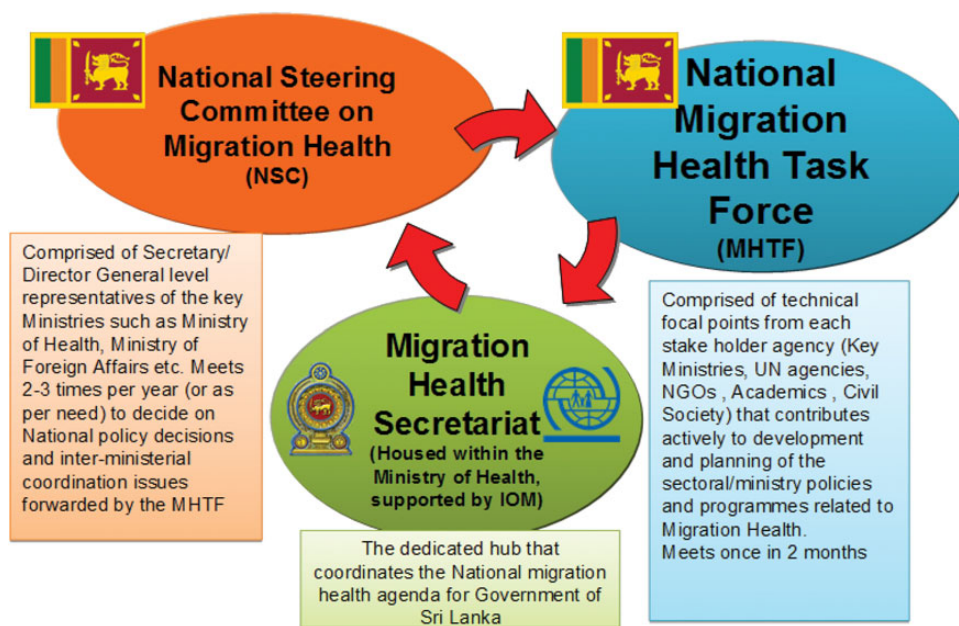


Fig. 1: Inter-ministerial and inter-agency coordination framework for migration and health, Sri Lanka.

Remarkable progress has been made since 2009. In line with the 2008 WHA Resolution, the Ministry of Health (MOH) developed a *National Policy for Migration Health* in 2012, based in part on a number of research studies it conducted between 2010 and 2012. In addition, a number of studies were conducted and the MOH initiated a programme to offer free health checks to returning Sri Lankan refugees and failed asylum seekers from India, after which measures were taken to integrate the returnees within the routine health system to ensure a comprehensive health package for returnees, as well as to avert any public health risks. As part of the health package for returnees, a health awareness booklet entitled *Welcome Home* was developed and distributed to raise awareness about the health services available for them upon their arrival to the country. Furthermore, information brochures including information on health issues related to the migration process in both Tamil and Sinhalese languages were developed by the MOH, Ministry of Foreign Employment Promotion and Welfare and IOM, and distributed at pre-departure training centres with the aim of allowing potential migrants to make informed choices on migration,

and to understand the potential social and health consequences of this decision.

This example illustrates how multiple actors from different government line ministries and non-governmental partners can collectively develop a coherent migrant-sensitive policy.

Domain of action 3: migrant-sensitive health systems

The Philippines: ensuring health of Filipino migrants abroad

The Philippines addresses the protection challenge, including migrant's health, in an integrated manner and through close partnership of several local governments, national agencies and bilateral partners and international organizations. The Department of Labour and Employment (DOLE), the Philippine Overseas Employment Administration (POEA), the Overseas Workers Welfare Administration (OWWA), the Commission on Filipinos Overseas (CFO), the Insurance Commission and the Department of Foreign Affairs are some of the national line agencies that are seamlessly working together for the health and well-being of Filipino migrants abroad. Below are some examples of

the mechanisms that have put in place in the Philippines:

Pre-Departure Orientation Seminar. In the Philippines it is mandatory for all departing migrants, whether they are leaving the country to work abroad, to emigrate or to join their foreign spouse to undergo the Pre-Departure Orientation Seminar (PDOS). During PDOS, migrants are briefed about the living and working conditions, their rights and obligations, as residents and as workers abroad. PDOS also includes topics as safe work practices, HIV prevention, first aid and stress management.

Compulsory insurance for agency-hired migrant workers. It is also mandatory for agency-hired or those migrant workers that are deployed through the facilities of accredited recruitment agencies to be covered by an insurance policy at no cost to the worker. This mandatory insurance policy is effective for the duration of the workers employment contract and will cover, among others, natural and accidental death, permanent total disability, repatriation, including repatriation of human remains. It also includes payment of cost for compassionate visits by a family member in the case of hospitalization of workers, and if needed, the cost of medical evacuation.

Pre-employment medical examination. Agency-hired workers undergo physical and psychological medical examinations prior to deployment abroad. The laws in the Philippines require that since this health examination is to be paid for by the migrant worker, it is only to be done when there is certainty that the migrant worker will be hired and deployed abroad. These health examinations must only be for the purpose of determining migrant worker's fitness for the particular job or employment the migrant worker will perform. The migrant worker can decide if they would like to have the pre-employment medical examination done by a government regional or provincial hospital or by a private hospital or medical clinic. The Philippines Department of Health inspects, certifies and accredits these medical clinics that conduct pre-employment medical examination in accordance with internationally accepted standards.

Overseas Workers Welfare Administration/Philippine Health Insurance Corporation (Philhealth). While on site at work abroad, Filipino migrants may avail of social and medical benefits through their membership with the

OWWA and the Philippine Health Insurance Corporation (Philhealth). Both these benefit claim mechanisms complement the benefits that may be obtained by Filipino migrants through the compulsory insurance for agency-hired migrant workers. Under OWWA, members may avail of disability/dismemberment benefit for injuries sustained due to accident while working abroad. In case of death, the heirs may claim for natural death due to natural causes and accident. Under Philhealth, social and health benefits extend to the migrant worker's spouse and dependents. These include, among others, in-patient cost subsidy for hospital room, board, medicines, laboratories and medical professionals' fees, out-patient cost subsidy for day surgeries, dialysis and cancer treatment, and special benefit coverage for tuberculosis, SARS and avian influenza and H1N1 virus infections.

Philippine Foreign Service Posts and Philippine Overseas Labour Offices. Abroad, the Philippine Foreign Service Posts and Philippine Overseas Labour Offices worldwide are the backbone of the web of safety nets for those Filipino migrant workers in distress. Most of the time, they become 'first responders' for those Filipino migrants in need of assistance. The Philippines is one of the few countries that has explicitly identified assistance to nationals in distress abroad as one of three pillars of its foreign policy.

This is a good example of an HiAP approach to migration and health, and inter-sectoral collaboration as protection measures on health are considered and integrated in non-health policies and institutions.

Finland: interpretation services for immigrants in health services

Ministries responsible for the integration of immigrants and the reception of asylum seekers in Finland, together with local municipalities, which are responsible for organizing and providing interpretation services for refugees and immigrants, ensure that interpretation services are available for immigrants using health services. Interpretation services are offered for all curative and preventive health-care services as needed, and all municipalities in Finland are obliged to provide interpretation services to refugees and immigrants staying in the municipality. Based on several legal acts, both health-care staff and users of health-care services have the right to request interpretation services when there is a

perceived need for this in order to guarantee the quality of the service. When an immigrant has his/her first contact with the municipality health services, the authorities will make a note in their personal files on the need for interpretation services in the future. This is done in order to notify other health-care staff members to reserve an interpreter for future appointments. A referral to a secondary or tertiary health-care facility should include a request for interpreting services as well (Ministry of Labour of Finland, 2013).

This example illustrates how government partners from different sectors and working at different levels, i.e. national and sub-national, can collectively ensure the implementation of migrant-sensitive health systems.

Domain of action: 4. Partnerships, networks and multi-country frameworks

Canadian Collaboration for Immigrant and Refugee Health

Hosted by the University of Ottawa, the Canadian Collaboration for Immigrant and Refugee Health (CCIRH) is a national collaboration involving over 150 clinicians, primary-care practitioners, public and migration health experts, policy-makers, researchers, immigrant community leaders and health promoters. The goals of CCIRH are to synthesize evidence to improve the quality and delivery of primary health care, to develop evidence-based recommendations for practitioners with population-tailored checklists and routines and to support community-based stakeholders who advise immigrants on preventative services.

The collaboration focuses on identifying preventable and treatable health conditions relevant for immigrants and refugees, conducting high-quality evidence reviews, developing clinical preventive recommendations and disseminating research to primary-care practitioners and community-based multicultural implementers. The CCIRH Knowledge Exchange Network produced the 'Evidence Based Clinical Guideline for Immigrants and Refugees', which is an internationally unique production of peer-reviewed evidence-based clinical guidelines designed to guide primary-care practitioners in the care of newly arriving immigrants and refugees. The guideline is published in the Canadian Medical Association Journal (Pottie *et al.*, 2011).

This example demonstrates that partnership and multi-disciplinary collaboration can produce

practical evidence-based results which can be used to strengthen capacity of government, policy-makers and health-care practitioners.

CONCLUSION

Migration is an overarching social determinant of the health of migrants, communities of origin and host communities. HiAP is well suited for addressing migrants' health, as it requires multi-sectoral coordination among the most relevant sectors including health, labour and immigration. However, if migration-related health challenges are not considered and integrated in public policies, including public health strategies, requiring inter-sectoral collaboration and an HiAP approach, we will continue to see incoherent policies and ineffective, uncoordinated responses. Looking after migrants' health is cost-effective, facilitates migrants' social integration, ensures positive development outcomes, protects public health and is in line with commitments to international human rights obligations.

Peter Sutherland, UN Special Representative of the Secretary General of the UN for Migration, recently stated, 'migration is here to stay, and it is growing. There can be no return to a monoethnic past, so successful societies will need to adapt to diversity (Project Syndicate, 2013)'. For societies to successfully adapt to this increased diversity, governments should not only adopt a whole of government approach at a national level but they should also ensure inter-sectoral collaboration at an international level where vertical approaches are still the norm. The most relevant international platforms where migrants' health can be integrated are the Post 2015 development framework that is currently being discussed, especially within the health goals and targets and migration and development platforms, such as the Global Forum on Migration and Development that meets every year. If migration, labour and health actors are not represented in these global forums and collaborate at an international level we will not make progress in improving migrants' health outcomes.

CONFLICT OF INTEREST

None to declare.

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