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A CHW Model for Migrant Health in the Context of South Korea*

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| Abstract |

In the midst of a global pandemic due to the outbreak of Coronavirus Disease-19, what became clear is that a government's response to a global pandemic must include migrant health, especially the undocumented migrants. Even before the global pandemic, there was a recognition that the world entered an era when more people are on the move than ever before and these migrants continue to be overlooked in many countries where access to health care often remains limited and conditional. In addition, there are various misperceptions about migrants around the world such as a claim that migrants place a heavy financial burden on the host society and the state's health system. Misperceptions like these not only can have a negative effect on migrant's health but also have a dire consequence during the timeof global pandemic which we are currently in right now. A consensus was made that excluding migrants from a rights-based approach to health is a blatantly poor public health practice and is, in general, a violation of migrants' rights.

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Based on informal participant observations, surveys conducted by the research team, forums and discussions with migrant health support groups namely WeFriends, visiting various free migrant health clinics such as Ansan Vincent's Clinic, and literature review, this paper examines the current status and issues of migrant health in South Korea and considers how the Community Health Worker (CHW) model of the US can be applied in the South Korean context. Specifically, the paper proposes the 5 key features of CHWs (migrant culture, leadership, holism, integration with a health care team, bridge) and as a holistic practice, what human rights that are interdependent to the rights to health marriage migrant women as migrant community health workers can promote to improve the migrant health in South Korea from right-based and preventive healthcare approaches.

▪ Key words: Community Health Workers, Migrant health, Right-Based Approach, Migrant Workers, Marriage Migrant Women

Ⅰ. Introduction

On April 29, 2020, at an intra-governmental meeting for Coronavirus Disease-19 (hereafter, COVID-19) response, Prime Minister Chung Sye-kyun of South Korea addressed the rising concerns of infections in migrant worker communities, especially, undocumented workers. A reporter of KBS World Radio (*KBS World Radio News* 2020/04/29) estimates that there are 380,000 undocumented workers in South Korea. They are completely outside the government's quarantine system. On a positive note, Prime Minister Chung stated that undocumented migrants should be able to get tests for coronavirus and related treatments when necessary without worries of deportation or legal punishments. Prime

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Minister Chung cited the cases of Singapore and Thailand where infections among migrant workers were high.

When South Korea is recovering from the COVID-19 outbreak and preparing to make the transition from strict social distancing to relaxed social distancing and reopening of businesses as it witnesses a zero to single digit cases of the domestic infection since the beginning of May 2020, a collective infection or a single community-based infection among undocumented migrant would quickly undo the exemplary works of South Korea to overcome COVID-19 and once again push South Korea back into the center of the global pandemic. More importantly, migrant worker communities would be hit the hardest due to economic, social, and health inequalities that already exist. Thus, turning a blind eye to migrant communities in South Korea at the time of the global pandemic is not only a violation of migrants' rights but also a dangerous practice. IOM (2013) clearly states "excluding migrants from a rights-based approach to health is a blatantly poor public health practice as it increases migrant's vulnerability, creates and amplifies discrimination and health inequalities, and incurs higher health costs for migrants."

Even before the global pandemic, there was a recognition that the world entered an era when more people are on the move than ever before and these migrants continue to be overlooked in many countries where access to health care often remains limited and conditional. The concept of the health of migrants discussed by the international community for the first time was when the World Health Organization (WHO) passed Resolution 61.17 on the Health of Migrants in 2008 (IOM 2013, 11). In addition, there are various misperceptions about migrants around the world such as a claim that migrants place a heavy financial burden on the host society and the state's health system. It is widely recognized that many health outcomes are better among migrants

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than among the native population, the so-called healthy migrant paradox (Schenker 2014, 8; Kim 2018). In the context of South Korea, it is shown that migrant workers pay more in health insurance than they take through hospital visits. Seo (*Yonhap News* 2020/02/13) reported that the fiscal balance of health insurance for migrant workers recorded a surplus of almost 1 trillion won in the last 4 years. Misperceptions like these may lead to increases in xenophobic attitudes and discrimination within the healthcare system. Furthermore, misperceptions not only can have a negative effect on migrant's health but also have a dire consequence during the time of global pandemic which we are currently in right now.

Therefore, there is an urgent need to monitor migrant health, adopt policy and legal frameworks at national and international levels, establish migrant-sensitive health systems, and create partnerships, networks, and multi-country frameworks to ensure cross-border and intersectoral cooperation and collaboration on migrant health (IOM 2013). A consensus was made that excluding migrants from a rights-based approach to health is a blatantly poor public health practice, as it increases migrants' vulnerability, creates and amplifies discrimination and health inequalities, incurs higher health costs for migrants, and is, in general, a violation of migrants' rights. The definition of migration health given by IOM (2013) is that it pertains to the health of migrants and how migration affects people in countries of origin, transit, and destination, as well as how migration affects the children of migrants. Given the breadth of populations and factors affecting health among migrants in their countries of origin and destination, a variety of approaches are needed to understand the complex web of causation among factors affecting the health of immigrants (Schenker 2014).

In this regard, this paper is part of a 4-year interdisciplinary research project on migrant health in South Korea titled "the Creation of the

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Korean Model of Migrant Health-Medical Care System." The researchers participating in the project are from medicines and social sciences including cultural anthropology. Initially, the research project began in 2015 with the 1-year pilot research titled "An Interdisciplinary Study on Health and International Migration" in search of an interdisciplinary framework for migrant health and medical care in South Korea. During the full 3-year research starting in 2016, the research team examined, from a cultural epidemiological perspective, major social determinants related to migrant health in South Korea such as social capital, ethnicity, gender, stress, and the health and medical system for migrants using both quantitative and qualitative research methodologies. Such an attempt can be distinguished with an existing small volume of literature dealing with the health of immigrants and migrants which focuses on empirical aspects of migrant health asking questions like what happens to migrants' health as they spend more time in the host country, whether their degree of assimilation improves or diminishes their health, and what kinds of health gap exist (Kim 2018).

The project aimed to survey and explore the health and medical conditions of migrant workers, refugees, and international marriage migrants in South Korea through so called 'interdisciplinary epidemiological fieldwork' with right-based and preventive health perspectives centered on free migrant health clinics and migrant communities. Interdisciplinary epidemiological fieldwork is designed by an epidemiologist, a psychiatrist, a cardiovascular medical doctor, a gynecologist, sociologists, and cultural anthropologists combining medical examinations and in-depth interviews and considers not only structural but also mental issues, body politics, and practices related to health and medical cares of migrants. Based on informal participant observations, surveys conducted by the research team, forums and discussions with migrant health support groups namely

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WeFriends, visiting various free migrant health clinics such as Ansan Vincent's Clinic, and literature review, this paper examines the current status and issues of migrant health in South Korea and considers how the Community Health Worker (CHW) model of the US can be applied in the South Korean context. Specifically, the paper proposes the roles of marriage migrant women as migrant community health workers (MCHW) to improve the migrant health in South Korea from right-based and preventive healthcare approaches.

Ⅱ. The Current Status of Migrant Health in South Korea

As of February 2020, the number of foreigners living in South Korea surpassed 2.5 million that is almost 5% of the total South Korean population (*Yonhap News* 2019/05/28). It was 2007 when the number of foreigners in South Korea reached 1 million and South Korean media celebrated the mark as a sign of South Korea becoming a multicultural society. It was also a sign that South Korea, which traditionally has been a labor migrant-sending country, has joined the rank of labor migrant-receiving countries. In the same year, the South Korean ministry of the interior and safety announced it will give the resident status to foreigners residing in South Korea for more than 3 months (WeFriends 2009, 21-22). Be that as it may, Chung and Hosoki (2017) reported that South Korea along with Japan maintains restrictive immigration policies that discourage or prohibit immigrant permanent settlement. In other words, South Korea does not have immigration policies, instead there is a labor migration control system.

In fact, South Korea appears to be going against the trend among

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industrialized nations that have much higher percentages of the total population as foreigners to converge toward increasingly open immigration and citizenship policies. Rather than opening its border to low-skilled foreign labor, South Korea opted for piecemeal solutions that would temporarily meet domestic demands for labor while maintaining relative state control over the groups of laborers who were allowed to enter the country. In 1991, South Korea began with the industrial trainee system, a guest-worker program whereby foreign workers were initially granted one-year visas to acquire technical skills.

Regarding the South Korean laws and institutions related to health rights of migrants, there is no substantial change in the last 20 years to the existing system that recognizes the right to receive emergency medical services, implements prevention of infectious diseases to protect the domestic nationals, and seeks to integrate legal migrants into the national health insurance. Policy-wise, there is no concrete long-term and comprehensive health policy for migrants in South Korea.

Medical services and insurances for migrants who do not have national health insurance or undocumented migrants are provided by medical volunteer organizations in cooperation with private hospitals in a limited capacity. Two main mutual aid medical insurance systems are Jubliee Medical Insurance and WeFriends Aid. In addition, there are free medical clinics such as Raphael Clinic founded by Catholic Christian medical students at the Seoul National University College of Medicines, Jubilee Free Medical Clinic operated by Christian Medical Fellowship Korea (CMFK), and Ansan Vincent's Clinic run by the Sisters of Charity of St. Vincent de Paul of Suwon. While most of the free clinics function as primary care hospitals run by mostly volunteer medical professionals, Ansan Vincent's Clinic providing free medical services for undocumented migrants was founded in 2004 in Ansan city with the highest concentration of migrants and functions as a secondary care hospital

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operating at the level of a general hospital. Ansan Vincent's Clinic is staffed by a few doctors and nuns and 40 or so volunteer medical professionals including nurses and pharmacists (Choi 2011). Many other free clinics send their patients requiring further examinations and treatments.

1. Migrant Workers

There are three major categories related to migrant health in South Korea. The first and the largest with 549,991 as of 2018[1] is migrant workers who came to South Korea first as industrial trainees starting in 1993 and as workers under the Employment Permit System (EPS) in 2004. Due to continuous violations of human rights of migrant workers, abusive labor practices, and corruption in recruitment, the industrial trainee system was abolished in 2007 making the EPS the only channel for foreigners to come to South Korea for work (Chung & Hosoki 2017). The EPS treats migrant workers as Korean workers by guaranteeing their protection under labor laws such as the Labor Standards Act. It also provides migrant workers with three-year visas that can be renewed for an additional two years. There is also the Special Employment Permit System for overseas Koreans mainly from China and former USSR countries. If qualified they can come to South Korea with H-2 visas and work for 3 years (WeFriends 2009).

When it comes to the health of migrant workers, the biggest and most problematic issue is the deaths and injuries from work accidents as most of the works carried out by migrant workers are 3D (dirty, demeaning, and dangerous) jobs in agricultural, construction, and manufacturing sectors (Choi 2011; Joung et al. 2019; WeFriends 2019). Similar to migrant workers

1) MOJ (2020), "Chulipguk tonggye (Entry and Exit Statistics)," http://www.moj.go.kr/moj/2412/subview.do. (accessed on May 2, 2020)

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in the agriculture, forestry, and fishing industries (AgFF) in the US (Frank et al. 2013), migrant workers in South Korea are affected disproportionately by the number of work injuries. Unfortunately, another similarity is that there is very little data specific to AgFF migrant workers in South Korea despite the increase in the number. According to Lee (2019), the work environment for migrant workers worsened since the introduction of the EPS in 2005 to a point where the mortality rate of work accident deaths for migrant workers reached 60% whereas the rate for Korean workers was recorded to be 13.5%. According to a survey conducted in 2006, migrant workers worked on an average of 58 hours per week while undocumented workers worked 1.1 hours more handling more dangerous machines or equipment at inadequate work settings (Kim J.-U. 2009, 5).

At the time of writing, there was a huge fire at the construction site of a logistics warehouse where 38 workers including migrant workers from China and Kazakhstan died (*The Korea Times* 2020/05/01). In addition, aside from psychological abuses and discriminations from Korean employers that affect the mental health of migrant workers, the most common injuries requiring medical treatments were musculoskeletal illnesses followed by digestive illnesses, respiratory illnesses, and dermatological illnesses (Choi 2011; Kim & Park 2014; Joung et al. 2019; Shin et al. 2019). Even for a regular medical check-up, which is essential for maintaining good health and prevention, migrant workers (36.9%) get far less than Korean workers (Yeo 2003, 12-13; Choi 2011, 309).

Another issue that caught the research team's attention was the fact that there was a slow increase in the cases of childbirth that needed interventions from the migrant support groups. Kim and Park (2014) also reported that along with musculoskeletal and dermatological illnesses, childbirth complications recorded the highest for migrants' secondary hospital visits. According to Lee (2019), from 2013 WeFriends began

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offering supports to undocumented migrant women's pre and postnatal care and medical care for newborn babies. Most migrant women lose their jobs when they become pregnant and are forced to become undocumented migrants without health insurance and visa status. Consequently, they cannot get proper pre or postnatal care and even a maintain healthy diet and safe housing. From a health care access point of view, there is also a very limited number of public hospitals with an obstetrics and gynecology department with a delivery room. There is only one in the Seoul area, 2 in Gyeonggi Province, 1 in Gangwon Province, 1 in North and South Chungcheong Provinces, 1 in North and South Gyeongsang Provinces, 2 in North and South Jeolla Provinces and 1 in Jeju Island (Kim & Park 2014, 43).

This was why the research team included a gynecologist who examined the medical records of pregnant migrant women at Ansan Vincent's Clinic from 2017 to 2019 and surveyed childbearing age (15-49) migrant women. Although the research has not been published, she surveyed a total of 67 migrant women who visited Ansan Vincent's Clinic with an average age of 29.9 (Park et al. 2020, 5). Among them, 42 were pregnant and 25 were not. The country of origin included Uzbekistan (15 respondents), Cameroon (10 respondents), the Philippines (9 respondents), Kazakhstan (8 respondents) and Russia (7 respondents). As a result, her findings show that among the pregnant women, 18 indicated that the pregnancy was planned and only 7 (16.7%) took folic acid during the pregnancy even though 88.8% of the pregnant women knew that taking folic acid before and during pregnancy can help prevent a birth defect of baby's brain and spinal cord. She concluded that there might be an economic factor for the low intake of folic acid by the pregnant women since the medicine costs 5,000-10,000 won (around US$5-US$10) per month but, most importantly, it may be due to language barrier and the limited availability of and access to information regarding maternal and child healthcare and services (Park et al. 2020, 6). She recommended that the

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existing education and campaign for folic acid in South Korea should also consider migrant women as their target audience (Park et al. 2020, 6).

On the other hand, three research team members composed of a sociologist, an anthropologist, and a cardiologist examined the health behavior and socio-cultural dynamics of Nepalese migrant workers in Jeju Island, South Korea (Joung et al. 2019). Specifically, they examined how these migrant workers manage and maintain their health highlighting the various social networks that contribute to the health statuses of Nepalese migrant workers. From July 28, 2018, to January 14, 2019, they conducted a mental health survey in two intervals together with measuring central blood pressure (76 respondent and 65 respondents), and a short fieldwork including in-depth interviews (35 persons) and participant observation visiting some of the Nepalese workers' homes and workplaces.

The main reasons our research team decided to conduct fieldwork on Nepalese migrant workers in Jeju Island were 1) location: there is almost no research on migrant workers working on an island, 2) work type: the majority of migrant workers in Jeju Island can be classified as AgFF workers, and 3) media attention: it was reported that there was a high rate of suicide among Nepalese migrant workers. Initially, the research team was surprised to find the report saying around 130 Nepalese died in South Korea from 2007 to 2017 and suicide was the highest with 36 deaths (Joung et al. 2019, 393). The aim of the fieldwork was to approach the suicides of Nepalese from the perspectives of migrant health and sociology which treat suicide as a social phenomenon. As such our fieldwork demonstrated that the issues of suicide and health of Nepalese migrant workers are complex social processes related to family relations that connect South Korea and Nepal, marginalization and discrimination in South Korea, work culture, communication, personal illness, and many other factors.

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2. Children of Multicultural Families and Migrant Families

The second category is children of multicultural families and migrant families. According to the 2018 South Korean Census, there are just over 1 million multicultural households. They define multicultural households as households with a naturalized person, households where a foreigner is married to a Korean, households formed by naturalized Koreans, households with multicultural children (cases where divorced Korean parents or grandparents raising the children), and households formed by naturalized Koreans and marriage migrant. Within the multicultural households, the number of children who are enrolled in schools (grades 1-12) in 2018 is 122,212 (2.2% of the total student population).

An Hyeon-suk (2010) distinguishes three groups of multicultural children when focusing on psychological and emotional supports. The largest group is the children of international marriage. They are subdivided into three types depending on the types of international marriage: Korean men and foreign women, Korean women and foreign men, and remarriages between Korean men and foreign women who have children from the previous marriage. The second group is the children of migrant workers. They are also divided into three types. The first type is the children who migrated with their parents who are both working in South Korea because it is very difficult for migrant workers to bring their spouse and children unless the spouse also has a working visa. The second type is the children of single-parent (father or mother) who came to South Korea after separation and invited the children later or when the first type couples divorce and one of them stayed in South Korea with the children. The third type is divorced migrant parents with children remarrying Koreans while living in South Korea. This is distinguished with children who come after the remarriage mentioned above. The third group is the children of North Korean migrants who are called by many

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names like Saeteomin (literal translation is a person starting a life in a new setting) or North Korean escapees. Due to the Cold War legacy and division, North Korean migrants are a controversial and complex case, therefore, will not be considered in this paper.

Sangmi Lee (2020) reported that multicultural children are at risk of having poor health behavior practices. They have a high risk of not being able to receive proper health care starting early in their lives. In addition, the major predictors of health behaviors of multicultural children are perceived health status, the mother-child relationship such as mother's language and culture which partly correlates to the urban or rural residency, and school adjustment. In regards to the residency, there is a tendency that cities have greater proportions of students with Chinese or Korean Chinese mothers relative to students with Vietnamese mothers (Lee 2020). She concludes that multicultural children were identified as a disadvantaged group in terms of health behaviors since their level of health behaviors was lower than that of non-multicultural children. This goes to show that the social determinants of health for the children of multicultural families are much more complex and require further research.

As for the children of migrant worker families, most of them would have entered South Korea with a tourism visa and become over-stayers and undocumented since the EPS and migration policy of the South Korea do not permit family migration and reunion (WeFriends 2009). In addition, the children of undocumented migrants would not be able to register their birth in South Korea or their home countries making them stateless persons. So, it could be said that they are the most vulnerable population related to migrant health and further researches and interventions are urgently needed.

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3. Marriage Migrant Women

The third category is marriage migrant women numbering 159,206 as of 2018.[2] The term 'marriage migrant women' refers to women from relatively less developed countries married to Korean men who are much older and predominately live in rural areas of South Korea. More importantly, for these women, marriages are a means to migration for work as part of feminized migration (Kim et al. 2006). As such the majority of marriage migrant women come from China, Vietnam, the Philippines, Thailand, Mongolia, etc. They are distinguished from somewhat traditional international marriages that are between foreign men and Korean women. Another distinct feature of marriage migrant women is that their marriages were arranged by brokers or financially supported by the local municipal governments in rural areas where the fertility rate and population growth are in dire crisis to a point where the municipality may dissolve and merge with others (Kim et al. 2006).

Many of these marriage migrant women experience difficulties such as cultural shock, isolation, domestic abuse, etc. They must adjust to not only the lifestyle of Korean rural families, but also to new roles as wives and mothers, and often daughter- and sister-in-law that are heavily patriarchal and nationalistic. They are expected to become pregnant and give birth, preferably a son, early on in their marriage. As such, the health of marriage migrant women is very closely related to the marriage life-cycle of marriage, pregnancy, birth, and child care that unfolds in a strange country (Kim M. 2009).

Chu et al. (2017) reported that these women have their first child during the first year after migrating to South Korea, regardless of their readiness to become a mother or degree of adjustment to a new host

2) MOJ (2020), "Chulipguk tonggye (Entry and Exit Statistics)," http://www.moj.go.kr/moj/2412/subview.do. (accessed on May 2, 2020)

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society. Therefore, they also experience many difficulties like language barriers and cultural differences that prevent them from receiving sufficient prenatal and postnatal care. To receive assistance, marriage migrant women contacted their families and friends through international calls or Internet resources in their own language. For those with some degree of Korean fluency, Internet portal sites like Naver and Daum are main sources of health information while migrants who are not fluent in Korean search Google, Youtube, etc. in English or their native language if available (Jung et al. 2012).

Two anthropologists in the research team examined what medical experiences marriage migrant women had and what cultural differences and conflicts they faced in South Korea (Kim & Joe 2016). Although international marriage has been around for a long time in South Korea with the majority being marriages between Korean women and foreign men, the international marriages between Korean men and foreign women who consider marriage as a means of migration are a new trend that emerged in 1995 when the number reached 10,365 and continued to grow greatly (Seol et al. 2006). In 2014, the number of marriage migrants increased almost 15 times to 149,764 with the highest number from Vietnam (39,422) followed by China (Han Chinese 36,017 and Korean Chinese 26,273), Japan (12,209), and the Philippines (10,039). The country of origin has diversified to include Thailand, Mongolia, Uzbekistan, and Cambodia. They conducted two focus group interviews with a total of nine marriage migrant women, who were from China, Uzbekistan, Cambodia, and Japan. The interviews showed that they had difficulty communicating with doctors and nurses from the language barrier and had a lack of understanding of the complex organization of the specialized medical system. Secondly, they felt burdened to use a general hospital because they do not have any information or get any explanation about the ways of using a general hospital such as making an appointment,

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finding doctor's office, paying the examination fees, and so on. Thirdly, they felt dissatisfied with doctors' appointments because of doctors' short advice and insincere attitudes. Furthermore, they also experienced a cultural gap in the awareness of medicines and the ways of prescribing medicines. Lastly, they experienced cultural conflict between the medical treatment methods of their home and host country.

Ⅲ. A CHW Model for Migrant Health in South Korea

During the research, the research team found out a couple of pilot programs related to migrant health that caught the attention. One is a training and caregiving service program for marriage migrants as 'migrant care specialists' offered by WeFriends. The other is the post-natal care-giving service of marriage migrant women organized by a team at Hallim University Kangnam Sacred Heart Hospital (HUMC) from 2015 to 2017. With funding from the Seoul Metropolitical City government, the main part of the program was to train marriage migrant women volunteers as medical translators and interpreters to assist in pre and post-natal care of marriage migrant women (HUMC 2017). Unfortunately, these programs are terminated as they failed to secure funding.

In 2008, a migrant health support organization WeFriends, former known as Migrant Health Association in Korea, started a training and caregiving service program for marriage migrants. Founded in 1999 as the Medical Mutual Aid Union for Migrant Workers in Korea to provide support for medical expenses of vulnerable migrants, WeFriends is one of the key migrant health support organizations in South Korea. After receiving basic training to be caregivers in hospitals and medical

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interpreters, marriage migrants would provide caregiving services to migrant workers. From 2008-2009, around 210 migrant workers from 17 countries received free caregiving services provided by 10 trained marriage migrants from 4 countries (China, Mongolia, Philippines, Thailand) (Kim 2010, 67).

Although it is far from promoting the health of migrants, these marriage migrants trained as caregivers and medical interpreters, similar to CHWs, provided emotional and psychological supports to migrant patients receiving medical treatments in the hospitals. The image of the bridge is also found in these marriage migrant caregivers who assisted both the patients and the hospitals by providing medical translation and interpretation. Most important, they were able to provide emotional supports to the migrant patients on the ground that they share a common background of being migrants and most likely from the same country (Kim 2010, 68).

After some discussions with the people directly involved in the two programs, the research team decided to focus on the Community Health Worker Model in the US, specifically focusing on immigrant communities and examine the possibility of creating a CHW model in the context of South Korea. In this section, after discussing the concept and the key features of community health workers for the health of immigrants in the US, a preliminary model of migrant community health workers (MCHW) for South Korean migrant communities will be examined from right-based and preventive health perspectives.

1. Who are CHWs?

The term community health workers is associated with many different names and roles: health navigators, community health advocate, 'promotores de Salud' (health promotor) in Spanish speaking communities,

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lay health workers (Hohl et al. 2016). Many sources point to the Chinese barefoot doctors of the 1950s as the origin of the CHW in the US while people who fit the role of CHW becoming involved in community development programs in the US around the same time (Findley & Matos 2015, 64). It was the Alma Ata 1978 Declaration that proposed national CHW programs as part of the goal of achieving health for all. Afterward, CHWs have become more focused on health promotion with more training and formal linkages to the primary health care system on a global scale in the 1980s.

In the 2000s, CHWs have been identified as critical frontline public health workers in the US (Islam et al. 2017). This is because a significant body of evidence demonstrated that adding CHWs to the primary care team can improve care for patients with chronic disease at a low cost and be effective in health promotion and prevention efforts. A good example is when the Community Health Worker Section obtained approval from the American Public Health Association for the official definition for community health workers, submitted for use by the Bureau of Labor Statistics for the 2010 Standard Occupation Classification revision prior to the 2010 Census and included as a health profession and not volunteers in the Patient Protection and Affordable Care Act popularly known as the Obamacare Act (Sabo et al. 2017, 1964). Despite the existing challenge in agreeing on a single definition, the APHA definition is the most widely used and accepted by members of the CHW workforce (Sabo et al. 2017, 1965). The APHA defines a CHW as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity

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by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy."[3] In a global context, the Global Health Workforce Alliance set a definition of CHWs that aimed to synchronize under the CHW banner both volunteer and remunerated health providers who work within and among the community.

According to Findley and Matos (2015, 67), the people around the world who become CHWs are more likely to be female and male reflecting the types of programs for which they are recruited to work in a low-income rural setting; to promote reproductive, newborn, maternal, and child health, all of which involve work with mothers. In the case of New York, the survey conducted by Findley and Matos (2015) shows that the majority of the CHWs are women, most being Latino and just under half being immigrants.

More importantly, the primary reasons why people became CHWs are to work with people and to work for their community. Half of the people responding to Findley and Matos' survey said they became a CHW to give back to the community or to address health concerns important to the CHW or his or her family. As such the primary reason for becoming a CHW to work for ones' own community is one of the main attributes of CHWs which leads to another important attribute of CHWs, a good networker. Findley and Matos (2015, 71) write that it is important to create linkages or ties between fellow immigrants and the health system, to help them know their rights and help them get what they are entitled to. Subsequently, another important attribute of CHWs is that they are residents of the community where they work.

Globally, apart from being a member of the community they serve, the most important attribute of the CHW is to be respected, to be considered

3) APHA (n.d.), "Community Health Workers," https://www.apha.org/apha-communities/member-sections/community-health-workers. (accessed on June 11, 2020)

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trustworthy (Islam et al. 2017). Without this trustworthiness, the CHW will find it difficult to fully engage the community residents in open discussions about how they might make changes in their lives.

According to Findley and Matos (2015), features that enable the CHWs to work effectively with immigrants are as follows: Immigrant culture, Leadership, Holism, Integration with Health Care Team, and Bridge. First, the CHWs are often immigrants themselves, and if not immigrants, they are often second-generation immigrants and have a set of shared life experiences, perhaps including language, culture, and community. Second, CHWs are given responsibility for leading educational, support, or discussion groups with the immigrants. They are considered natural leaders and advocates for the health and other rights of their communities as they lead the communities through organization, mobilization, and empowerment activities (Villa-Torres et al. 2015). Third, the CHWs support the immigrants holistically, not just on the specific health problem area for which they have primary responsibility. This holistic approach is reinforced by popular education techniques used by several programs, whereby the participants set their own goals and agenda for change, which can include a wide range of issues, not just health-related. Fourth, the CHWs appear to be more effective when they are nested within a system of supportive supervision, with adequate training and support to give them the confidence to not only work in the community but to be viewed by the health care team as “their” community representative, a feature identified as critical to success by several programs addressing diabetes, chronic disease prevention, and asthma management. Fifth, the CHWs do appear to function as a bridge between the immigrant community and the medical providers and the larger health system including the researchers by facilitating access to health care, providing health care system navigation, and conducting outreach and/or enrollment in services.

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2. An MCHW Model in South Korea

The studies reviewed by Findley and Matos (2015) clearly demonstrate that CHWs with five features can play a strong role in promoting the health of migrants and in prevention efforts. They presented abundant evidence from around the world and across many cultures that CHWs are effective at improving health outcomes, particularly in the prevention of illness, both infectious and chronic disease. More importantly, they assert that the same processes serve them well in working with immigrants in nine basic health problem areas: diabetes prevention and control, cardiovascular disease prevention and control, general chronic disease prevention, cancer screening, and care, HIV/STI prevention and treatment adherence, asthma self-management, mental health, maternal and child health, and environmental justice/advocacy (Findley & Matos 2015, 60).

As discussed above, the current status of migrant health in South Korea shows that these basic health problem areas in the US are quickly becoming basic migrant health problems in South Korea. To recap, the most pressing issues related to migrant health in South Korea are discrimination, various illnesses caused by work accidents for migrant workers, lack of information, and various cultural gaps. From right-based and preventive healthcare perspectives, the immediate task to ameliorate the health situations of migrants should not be limited to medical and healthcare responses. In fact, migrant health should be approached from an interdisciplinary framework and partnership where medical professionals, migrant support organizations, and migrant communities work in unison to tackle work environmental issues and discrimination and work for education, communication, and, most importantly, empowerment of migrants.

Accordingly, our research team proposes a migrant community health worker (MCHW) model starting with marriage migrant women,

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especially, those who have naturalized to South Korean nationality. Eventually, the MCHW model would need to expand the composition of the MCHW to migrants in general including migrant men. Nevertheless, considering the context of South Korea with no immigration policy, marriage migrant women with South Korean nationality may be most effective in playing the five roles of CHW mentioned above and successfully establishing the right-based MCHW system.

Marriage migrant women as MCHWs would have the language fluency and cultural understanding of migrants from the same country of origin and with proper training they can be a bridge between the patients and the health care system. Moreover, MCHWs can also play the role of health promotor by educating their migrant community on various preventive medicines in collaboration with South Korean health care teams. A research (Kim et al. 2018) showed that a targeted and culturally tailored policy, systems, and environmental approach was very effective in increasing the rates of healthy behaviors for Korean Americans who may be socially and linguistically isolated from mainstream campaigns and programs. Similar programs such as promoting healthy diets for migrant workers can be implemented in South Korea also. The success of these programs would depend on MCHWs playing the 5 key roles mentioned above with firm supports from health professionals, migrant support organizations, and, most importantly, migrant communities.

In addition, considering the current status of migrant health in South Korea, to support migrants holistically, MCHWs would need to consider the following aspects of human rights closely linked to the right to health. First, the right to adequate food and housing which derives from the right to an adequate standard of living must be promoted by MCHWs. During fieldwork, Joung, Lee, and Kim (2019) noticed that some Nepalese migrant workers in Jeju Island lived in container box accommodation without an air conditioner or heating. Aside from the

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lunch provided by the employers, most of them ate simple breakfasts or ramyeon (Korean instant noodle soup) in the morning, and fried and salty foods for dinner which is one of the main causes of high blood pressures found among Nepalese migrant workers. One can easily expect that a campaign to reduce salt intake using a targeted and culturally tailored PSE nutrition strategy with MCHWs would be effective.

Second, especially considering the current situation of COVID-19, MCHWs should play the role of protecting the right to seek, receive, and impart information. According to IOM (2013), "ensuring that necessary information is both available and understood by a diverse population is an increasingly important consideration for public health planning and preparedness in countries with large groups of migrants. MCHWs could play an effective and important role in making sure the availability of health-related information such as sexual and reproductive health issues and emergency information on earthquakes or disasters or health crises like COVID-19 which is central to ensuring equality and non-discrimination in the access to health care.

Third, MCHWs as leaders of their migrant communities can play an important role in promoting the right to family life of migrants. It is widely recognized that long-term separation from family members and loved ones may lead to psychological problems, substance abuse, and high-risk-taking behaviors. Therefore, family ties are strongly connected to the physical and mental health of family members, in particular children, and those in situations of vulnerability. With cooperation from migrant support organizations and civic society, MCHWs could spearhead the campaign for the introduction of immigration policies that respect the right to family life and family reunion.

Most importantly, as CHWs in the US need to be nested within a

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system of supportive supervision, with adequate training and support to give them the confidence to not only work in the community but to be accepted as the part of the health care team, the MCHW model needs to be implemented by an interdisciplinary community-based participatory research team with researchers from social sciences, medicines, and humanities in close collaboration with CHW activist organizations and migrant communities (Trinh-Shevrin et al. 2007). Subsequently, what is further needed is to continue research on standardizing the framework within which researchers and health teams recruit, hire, supervise, and train MCHWs.

Ⅳ. Conclusion

As discussed above, due to different circumstances and conditions, the health of migrants in South Korea can be further categorized into migrant workers, marriage migrant women, and the children of multicultural families and migrant families, a small but fast-growing group that lacks data and research. Although undocumented migrants have been mentioned, they are a vulnerable group in need of attention and further research. With an estimated figure of 270,000, they are not a small group. Nevertheless, due to the South Korean government's strict labor migration control, they live in constant fear of arrest and deportation and without any proper access to health and medical care (Shin et al. 2019). There is also another important group that deserves attention. It is asylum seekers and refugees. Unfortunately, undocumented migrants and refugees were not a focus in this paper.

Having reviewed the current status of the health of major migrant groups in South Korea, the paper examined the possibility of constructing a migrant community health worker (MCHW) model in the context of

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South Korea by adapting the community health worker model in the US. The five key features such as immigrant culture, leadership, holism, integration with the health care team, and bridge were highlighted.

The main limitation of this paper is that it lacks empirical data collected from engaging and surveying the workforce to discuss the concrete roles, contribution, and efficacy of MCHWs, Nevertheless, the idea of designing and implementing the MCHW model in South Korea is not impossible. There is a sort of proof of concept. Not surprisingly, there were already recommendations and pilot programs that resembles part of the community health worker model mainly focused on improving the language barrier and access to information and trying to resolve a problem that comes with a unique Korean hospital culture where hospitalized patients require a caregiver who may be a hired person or a family member (Kim 2010; WeFriends 2009; HUMC 2017; Shin et al. 2019). In this context, this paper proposes a migrant community health worker model with the five key features and an emphasis on major human rights interdependent on the right to health, namely, the right to adequate food and housing, the right to seek, receive and impart information, and the right to family life with link to the campaign for immigration policy. The next task would be to plan a training program of MCHW, execute the program to produce MCHWs who can be sent out to migrant communities and hospitals, and lastly, continue the research on the contribution and efficacy of MCHWs in improving the health of migrants in South Korea.

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| 국문초록 |

한국사회 맥락에 맞는 이주건강 커뮤니티헬스워커 모델

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코로나-19로 인한 글로벌 팬데믹 속에서 이에 대한 정부의 대응에서 이주민의 건강, 특히 미등록 이주민이 포함되어야 한다는 것이 분명해졌다. 글로벌 팬데믹 전부터 전 세계는 현 시대가 그 어느 때보다 많은 사람들이 이동을 하는 시대라는 것을 인정하지만 많은 나라들이 여전히 보건의료 접근성이 제한적이거나 조건적인 이주민을 외면해 왔다. 또한 이주민이 호스트 사회와 국가의 보건의료 체제에 큰 재정적 부담을 준다는 잘못된 인식을 포함하여 많은 오해가 존재한다. 이 같은 오해는 이주민의 건강에 부정적 영향을 가져다줄 뿐만 아니라 현재 진행 중인 글로벌 팬데믹 같은 상황에 큰 위험을 가져올 수 있다. 이미 보건의료에 대한 권리 기반 접근에서 이주민을 제외하는 것은 매우 잘못된 공공보건의료 실천뿐만 아니라 이주민 권리를 침해한다라는 합의가 존재한다.

본 논문은 비공식 참여관찰, 정신건강 설문조사와 희망의친구들과 같은 여러 이주민 건강 지원단체들과 안산빈센트의원 같은 무료진료소 관계자들과의 토론과 문헌조사를 바탕으로 한국 이주민건강의 현황과 이슈를 검토한 후 미국 커뮤니티헬스워커(CHW) 모델을 한국 맥락에서 적용하는 방안을 고려하고자 한다. 구체적으로 본 논문은 권리 기반 및 예방적 보건의료 관점에서 이주민건강을 개선하기 위하여 이주민 커뮤니티헬스워커(MCHW)로서의 결혼이주여성들의 역할을 제안하고자 한다. MCHW의 역할은 미국 CHW의 5가지 핵심역할인 이주문화, 지도력, 총체주의, 보건의료팀과의 통합, 가교를 한국사회에서 실행하는 것이며 총체주의적 역할의 일환으로 건강권과 밀접한 관계를 가지고 있는 인권을 학제적 지역사회참여연구팀과 보건의료 관계자, 이주

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민 공동체 및 지원단체와 협력하여 증진시키는 것이다.

▪ 주제어: 커뮤니티헬스워커, 이주민 건강, 권리 기반 접근, 이주노동자, 결혼이주여성

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