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In line with Giorgio Cometto and colleagues' Comment,¹ we suggest that the Global Fund should open three additional funding windows.

First, a health systems window would finance training and salaries of community health workers and other professionals, alongside construction, equipping, and maintenance of primary health facilities.

Second, a maternal and child survival window would enhance facility-based services for antenatal care, safe delivery (including emergency obstetric interventions), and newborn care,² and structural interventions to address major causes of child mortality including diarrhoea, respiratory infections, and undernutrition.³

Finally, a neglected tropical disease window would finance an integrated delivery package to control soil-transmitted helminths, lymphatic filariasis, schistosomiasis, onchocerciasis, and trachoma.⁴

The Comment, however, misrepresented the perspective of the Harvard Consensus Statement, suggesting it assumed that Africa's health systems "were working reasonable well". The dismal state of public health in Africa was in fact well known. Expanding antiretroviral treatment was advocated because of the possibility to stop mass deaths from a treatable disease. Furthermore, the Commission on Macroeconomics and Health advocated a general scale-up of

support for primary health, including AIDS and other disorders. The Commission called for donor support of 0.1% of donor gross national product (roughly US\$36 billion in current dollars).⁵ Actual donor aid lags at around 0.04% (\$12 billion). We are not overspending on AIDS but underspending on the rest.

These needed sums are paltry relative to military spending or the bank bailouts. The Global Fund offers an effective financing mechanism. The choice is not between AIDS, health systems, and other Millennium Development Goals. We can and must support them all.

We declare that we have no conflicts of interest.

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Access to health care for undocumented migrants in Italy

In Italy, since 1998, undocumented migrants have had the right to receive health care under national law, without being reported to immigration authorities. This aspect of the legislation is in line with Article 32 of the Italian Constitution, which states that health is a fundamental right of the individual

(not only of the citizen) and statutes free health care for the poor.

An amendment to the law concerning public order measures, approved on May 14, 2009, by the Chamber of Deputies and now to be approved by the Senate, introduces the crime of illegal immigration, and consequently obliges by law all civil servants to report undocumented migrants. Public health workers are civil servants. Notwithstanding previous legislation forbidding them to report undocumented migrants, this new legislation risks creating fear among migrants, preventing them from attending health facilities and exposing both migrants and the whole community to higher health hazards.

Since 2003, Médecins Sans Frontières has been working in Italy, offering assistance at landings, and in public health centres for undocumented migrants. Migrants often present with disorders related to the hardships of the journey (trauma, dehydration, etc), the difficult working and living conditions (eg, osteoarticular diseases), and the stress caused by social exclusion, uncertainty of income, and changes in eating habits (gastritis and duodenal ulcers). Women mainly attend for gynaecological problems. Cross-cultural mediation services and outreach activities, aimed among other things at raising awareness about the availability of health care without the risk of being reported, have proven to be key factors for achieving effective access to health care.¹

If the Senate approves the current proposal, the obligation for civil servants to report undocumented migrants would undermine any confidence they might have had in the public health system. This will increase exclusion and worsen their already unacceptable living and working conditions,^{2,3} with serious health consequences for the whole community.



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Italian policymakers tend to treat immigration as a public order issue rather than a humanitarian issue, as shown recently by the decision to send migrants back to Libya without checking for minors, vulnerable groups, and asylum seekers. This is alarming when considering that migrants are often fleeing situations of conflict and extreme poverty so dramatic that they do not hesitate about embarking on a long and perilous journey. Assisting them and ensuring the respect of the principles of the Italian Constitution is a public health and an ethical obligation.

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Migrants, detainees, and misconceptions

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The Editorial "Inadequate health care for migrants in the USA" (March 28, p 1053)¹ paints a broad, inaccurate, portrayal of US health care for migrants. Although we do not refute the inequitable treatment of detainees, the Editorial implicitly and explicitly extends assertions to all migrants: legal and undocumented immigrants, migrant workers, and refugees, among others. Generalising

detainee experiences to all migrants is misleading.

Refugee resettlement shows how federal, state, and local efforts are addressing migrants' health needs through system changes, education, and development of clinical best practices. The US Refugee Act of 1980 established refugee resettlement programmes and domestic health screening. Although serving public health, domestic screenings focus on individual refugees' health. The Centers for Disease Control and Prevention is developing evidence-based pre-departure and post-arrival guidelines, and implementation has reduced disease and proven cost-effective.²

Many non-federal efforts seek quality care. Over four decades, Minnesota has promoted culturally competent and linguistically appropriate care as a core value. In 2005, migrant health best practices were published³ and additional resources made available online. Academic institutions have produced the first immigrant medicine textbook,⁴ and developed training programmes, courses, and curricula to improve care for mobile populations, much of which is open access. Finally, integrated health systems are using electronic medical records to implement best practices in migrant health.⁵

We must defend the thousands of US health professionals who dedicate their careers to developing and disseminating best practices and decreasing disparities of care in vulnerable migrant populations.

PFW is one of the editors of the immigrant health textbook listed in the text (she receives a small royalty for textbooks sold) and WMS and PFW developed the course and curricula referenced (but receive no direct funding from them).

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Figure: Refugees serving refugees—Cambodian nurse with a new-arrival Ethiopian patient

Chris Newberry, Medicine Box Project