

Health of refugees and migrants

Regional situation analysis,
practices, experiences, lessons
learned and ways forward

WHO Western Pacific Region
2018



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ABBREVIATIONS

ASEAN	Association of Southeast Asian Nations
CALD	culturally and linguistically diverse
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
ILO	International Labour Organization
IOM	International Organization for Migration
JUNIMA	Joint United Nations Initiative on Migration, Health and HIV in Asia
SDG	Sustainable Development Goal
STI	sexually transmitted infection
TB	tuberculosis
UHC	universal health coverage
UN	United Nations
WHO	World Health Organization

EXECUTIVE SUMMARY

The principle of leaving no one behind is central to the Sustainable Development Goals and universal health coverage. Attention to the health of migrants and refugees is timely as the Western Pacific Region advances this vision. In May 2017, resolution WHA 70.15 on 'Promoting the health of refugees and migrants' was endorsed at the 70th World Health Assembly. The resolution requests WHO to identify and collect information, practices, experiences and lessons learnt on the health of refugees and migrants, in order to contribute to the development of a draft global action plan on promoting the health of refugees and migrants, to be considered for adoption at the Seventy-second World Health Assembly in 2019, and to report back to the World Health Assembly in 2018. In line with this resolution, WHO has strengthened this area of work globally, regionally and in countries and collected information from Member States and partners. While this report does not aim to present a complete picture, it provides an overview of regional issues, primarily drawing on information shared by Member States and partners.

In the Western Pacific Region, the health of migrants is an issue of growing importance. The Region has many experiences, lessons and practices to share with and to inform global discussions. As this report describes, migration in the Region takes multiple and diverse forms, including internal migration, casual cross-border migration, international migration, climate-related migration as well as some refugees. The variability and dynamic nature of migration makes it difficult to estimate the impact on health. Broadly, health is influenced by the structural nature and experiences of the migration process, and the characteristics of the person or group, for example sex, age or socioeconomic status. Health risks and vulnerabilities exist for migrants with regards to population risk factors, material and working conditions and broader social determinants. Migrants may also face barriers in access to needed health services, including policy and legal, economic, geographical and physical, information and sociocultural barriers.

This report describes examples of responses to promote the health of migrants and refugees in the Region, including good practices and lessons learnt. Examples include increasing attention to migrants and refugees in a number of national policies and legal frameworks on health-related concerns. Substantial work is also ongoing through programmatic interventions, for example in communicable diseases. Given the complexity of migration, effective responses rely critically on collaboration, including collaboration across borders, sectors, regional and provincial governments and non-government stakeholders. The report concludes by highlighting three potential ways forward, including strengthening the evidence base, strengthening health systems responses, and developing partnerships, networks and multi-country dialogue. It is envisaged that the information contained in this report will help to inform ongoing dialogue about the health of migrants and refugees specifically and leaving no one behind more broadly.

I. INTRODUCTION

Attention to the health of migrants^a is timely as the Western Pacific Region advances universal health coverage (UHC) and the Sustainable Development Goals (SDGs) (1,2). World Health Assembly resolution WHA70.15 of 2017 requests WHO to identify and collect evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants, to inform the development of a draft global action plan by 2019 (3).

In line with this request, this report discusses migration and health in the Western Pacific Region, including (i) current situation and migration trends, (ii) health issues, status and outcomes of migrants, (iii) health risks and exposures including social determinants of health, (iv) access barriers to health services experienced by migrants, (v) responses to migrants' health including good practice examples and lessons learnt, and (vi) suggested ways forward.

The report is not a comprehensive review and draws on (i) inputs by Member States and partners received through the WHO online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants, (ii) information collected through small stakeholder consultations via video and teleconferencing and (iii) selected peer-reviewed academic literature and grey literature. Inputs received by Member States and partners are gratefully acknowledged.^b

II. CURRENT SITUATION

Population mobility is on the rise both within and across countries in the Western Pacific Region, with migration taking diverse forms including internal, subregional and cross-border, international, and climate-related migration (4,5). This is not an exhaustive list, and patterns overlap in practice.

2.1 Internal migration

Internal migration refers to the movement of people within the same country. Internal migration is common within the Western Pacific Region with many countries transitioning from rural to urban living, and with economic development a key driver of urban growth (6). For example, China has the world's largest migrant population with the number of domestic migrants increasing from more than 6 million in the early 1980s to 245 million in 2016 (7). During a consultation in Viet Nam, participants mentioned that special economic zones attract internal migrants (8).

^a The terms "migrant" and "migration" are used as a generic umbrella term in this report. It can refer to both emigration and immigration, internal as well as external migrants and refugees. There are varied definitions and uses across countries and literatures in the Region.

^b The report draws on inputs received through the WHO online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants. Inputs were received from Governments in Australia, China, the Marshall Islands (in coordination with IOM), the Federated States of Micronesia, Mongolia, the Republic of Korea and the Philippines. Other respondents included Access Australia, Brunei Darussalam Red Crescent Society, Korean Red Cross, International Labour Organization (ILO), International Organization for Migration (IOM), Monash University (Australia), Mongolian Red Cross Society, New Zealand Red Cross and Philippine Red Cross. In addition, small stakeholder consultations with national counterparts, United Nations (UN) and development partners and WHO country offices took place with Cambodia, China, the Lao People's Democratic Republic, Tuvalu and Viet Nam.

In the Western Pacific Region, 54% of the population lives in urban areas (6). A feature of urbanization in Asia is the emergence of megacities with 10 million or more inhabitants (9), a number of which will be in the Western Pacific Region. Rural-to-urban migration plays a significant role in the above-mentioned statistics. In China, for example, rural–urban migration constitutes the most common form of internal migration, often for business or labour (10,11). Internal migration was also mentioned during consultations in Viet Nam and Cambodia (8,12). Mongolia is experiencing high rates of rural–urban migration (13), with more than 70% of the country’s population now living in urban areas (14). The transition from rural to urban living may occur over an extended period, including due to difficulties securing stable full-time work or integrating into urban society (7). While economic growth and opportunity is a key driver of internal migration, there are other reasons such as seeking educational opportunities for children (for example, in the Pacific) (15,16).

2.2 International migration

International migration involves people moving from one country to another to establish themselves either permanently or temporarily, often for employment purposes (17). Table 1 provides an overview of international migrants in Member States of the Western Pacific Region (4). In 2017, international migration from Asia to Asia was particularly common (4), with large contributions from countries within the Western Pacific Region. With almost 10% of its population living and/or working overseas (18), the Philippines had the seventh highest level of net emigration in the world between 2010 and 2015 (5). There are currently just over 9 million Filipinos living and/or working overseas in 200 countries, mostly residing in the United States of America, Saudi Arabia and Canada (4,18). Although the Philippines is primarily considered a migrant sending country, there are refugees and migrants residing in the country (see Annex 1.7 and 3). Another country with a high proportion of out-migration is the Marshall Islands, with approximately 40% of Marshallese living in the United States (19). In 2015–2016, the total permanent migration programme outcome for Australia was 189 770 places (20), with four of the top 10 source countries being from within the Region (China, Malaysia, the Philippines and Viet Nam) (20).

Member States in the Western Pacific Region have established different schemes to facilitate and manage immigration, including labour mobility schemes in New Zealand or Australia (16). In some countries, immigration is not a significant issue, such as in the Federated States of Micronesia where there are only occasional arrivals by fishers who drift ashore and are provided with medical care and other services until they can be repatriated (21).

2.3 Subregional and cross-border migration including casual migration

Subregional migration is another important trend (22). Malaysia, Singapore and Thailand are considered regional migration hubs with 6.5 million migrants accounting for 96% of migrant workers in the Association of Southeast Asian Nations (ASEAN) region (23). In the Greater Mekong Subregion, there are approximately 3–5 million labour migrants (24), with participants of consultations giving examples of Chinese migrants in the Lao People’s Democratic Republic (25) or of Cambodian and Lao migrants in Thailand (12,25). In the Greater Mekong Subregion,^c cross-border migration is shaped by a long history related to contested frontiers, mobility linked to family and ethnic ties, civil conflict, and changing economic opportunities (24). Migrant

^c The Greater Mekong Subregion includes Cambodia, the Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam, as well as Yunnan Province and Guangxi Zhuang Autonomous Region in China.

patterns in the Greater Mekong Subregion include casual cross-border migrants who cross country borders formally or informally to access employment, resources and services (17).

Table 1: Overview of international migrants in Member States of the Western Pacific Region

Major area, region or country of destination	Number of international migrants (thousands)		International migrants as percentage of total population		Females among international migrants (percentage)		Median age of international migrants (years)	
	2000	2017	2000	2017	2000	2017	2000	2017
American Samoa	24.9	23.6	43.3	42.3	48.2	49.0	32.0	39.1
Australia	4386.3	7036.6	23.0	28.8	50.1	51.1	45.8	44.4
Brunei Darussalam	96.3	108.6	28.9	25.3	44.1	43.4	33.7	35.8
Cambodia	146.1	76.3	1.2	0.5	51.0	46.1	17.9	34.9
China	508.0	999.5	0	0.1	50.0	38.6	34.8	36.8
Hong Kong SAR (China)	2669.1	2883.1	40.1	39.1	54.1	60.5	47.9	46.1
Macao SAR (China)	240.8	353.7	56.3	56.8	54.6	54.6	40.6	43.9
Cook Islands	2.8	4.2	15.4	24.2	44.3	49.9	20.6	28.3
Fiji	12.7	13.9	1.6	1.5	48.1	46.0	34.9	35.8
French Polynesia	30.3	30.7	12.8	10.8	4.0	43.0	36.5	42.1
Guam (USA)	74.1	78.0	47.7	47.5	48.3	48.4	34.9	36.7
Japan	1686.6	2321.5	1.3	1.8	52.7	55.0	33.1	34.3
Kiribati	2.3	3.0	2.7	2.6	48	47.3	23.7	30.9
Lao People's Democratic Republic	21.9	45.5	0.4	0.7	47.3	46.3	29.5	36.8
Malaysia	1277.2	2703.6	5.5	8.5	44.2	39.6	27.6	33.0
Marshall Islands	1.9	3.3	3.6	6.2	38.4	38.8	32.8	33.2
Micronesia, Federated States of	3.1	2.8	2.9	2.6	44.8	46.5	32.1	37.3
Mongolia	8.2	18.2	0.3	0.6	44.4	27.0	36.9	38.8
Nauru	2.4	3.7	23.9	32.7	46.4	37.5	33.9	35.1
New Caledonia (France)	49.7	66	23.3	23.9	45.8	46.1	39.8	44.5
New Zealand	678.8	1067.4	17.6	22.7	51.4	51.6	41.1	42.8
Niue	0.5	0.6	26.2	34.2	46.2	45.8	21.0	22.5
Northern Mariana Islands, Commonwealth of the (USA)	40.1	21.8	58.1	39.5	56.7	58.0	34.5	38.5
Palau	6.3	5.0	32.9	23.0	38.1	43.2	33.0	38.7
Papua New Guinea	25.1	32.4	0.5	0.4	37.8	36.5	33.8	31.6
Philippines	318.1	218.5	0.4	0.2	49.1	48.2	31.0	34.0
Pitcairn Islands (UK)	not available							
Republic of Korea	244.2	1151.9	0.5	2.3	41.4	43.9	30.3	35.4
Samoa	6.0	4.9	3.4	2.5	48.3	49.9	18.0	22.5
Singapore	1351.7	2623.4	34.5	46.0	55.5	55.9	37.0	39.4
Solomon Islands	4.0	2.5	1.0	0.4	44.1	43.9	33.0	38.5
Tokelau	0.3	0.5	16.9	38.8	45.0	52.0	16.6	20.2
Tonga	3.7	5.0	3.8	4.6	46.2	45.7	25.9	31.6
Tuvalu	0.2	0.1	2.3	1.3	44.2	44.8	34.4	37.0
Vanuatu	2.6	3.2	1.4	1.2	49.7	50.3	33.8	35.2
Viet Nam	56.8	76.1	0.1	0.1	42.2	42.1	27.2	36.5
Wallis and Futuna (France)	2.0	2.8	13.9	23.6	49.5	49.5	25.4	32.5

Source: UN Department of Economic and Social Affairs, Population Division. Trends in International Migrant Stock: The 2017 Revision. New York: UN; 2017 (<http://www.un.org/en/development/desa/population/migration/data/index.shtml>, accessed 15 January 2018).

2.4 Environmental and climate-related migration

Environmental migrants leave their habitual homes either temporarily or permanently, moving within their country or across borders because of a sudden or progressive change in the environment (17). Broadly, climate change impacts are anticipated to shape and increase migration and displacement through: an increase in the intensity and frequency of extreme weather events and climate-related disasters; loss of arable and inhabitable land, including through sea-level rise and flooding; and adverse impacts on ecosystems. The Western Pacific Region is highly prone to extreme weather events, with floods, droughts, rising sea levels and storm surges including cyclones and typhoons expected to become more frequent and more severe due to the impacts of climate change. Climate change can also affect human displacement (26). In 2015, approximately 85% or 16.2 million of the world's internally displaced population was caused by natural disasters in Asia and the Pacific (10). For example, in Fiji in 2016, Cyclone Winston affected 40% of the population, increasing existing vulnerabilities, with young children and pregnant and lactating women particularly vulnerable to malnutrition (27). In the same period, the Marshall Islands, the Federated States of Micronesia, Papua New Guinea and Vanuatu all experienced drought periods, which led to food and water insecurities (27). In Mongolia, changes in climate and weather, most notably droughts and *dzud* (severe winter following a summer drought), have affected traditional livelihood systems, impacting particularly those who rely on livestock as their main source of food and cash (13,14,27,28). Rural–urban migration in Mongolia is also influenced by mining and related loss of fertile pastoral lands and freshwater sources to owners of mining licenses and contamination of soil and water (13).

2.5 Refugees

Refugee and asylum seekers within the Western Pacific Region include people from inside and outside the Region seeking refuge in a country within the Region. In the Republic of Korea, for example, 2266 refugees came under refugee protection in 2017, primarily from China, Egypt, Kazakhstan, Nigeria and Pakistan (29). In 2015–2016, Australia's Humanitarian Programme comprised 17 555 places, reducing to 13 750 places (including 1200 places for vulnerable women and children) in 2016–2017, with progressive increases scheduled to reach a minimum of 18 750 places in 2018–2019 (20, 30). There are 451 refugees and 214 asylum seekers in the Philippines from the Syrian Arab Republic, Iran and Pakistan (18).

III. HEALTH ISSUES AND OUTCOMES ASSOCIATED WITH MIGRATION

Migration and health intersect in multiple ways in the Western Pacific Region. The variability and dynamic nature of migration trends, however, makes it difficult to estimate the overall health impact. Broadly speaking, the health of migrants is influenced by:

- (1) the structural nature and experiences of the migration process, for example across different phases of the migrant journey; and
- (2) the characteristics of the migrant, for example age, sex, health or socioeconomic status.

It is important to recognize that migration can be a positive experience that can create opportunities for health and development (31). In some cases, better access to health services, healthier diets, cleaner environments, health-promoting economic benefits and increased opportunities for social mobility in places of destination can produce health benefits.

Migration and health intersect at each phase of the migrant journey (32). Before departure, poor availability or low quality of health services in places of origin can create an incentive for migration (33). For example, casual cross-border migrants in the Greater Mekong Subregion live near borders and move across borders to access needed resources (24,34). These groups usually live in hard-to-reach areas, where access to health services and other resources may be especially challenging for both local residents and migrant groups on both sides of the border (35). The mobile nature of migrant populations may create challenges for health systems and programmes particularly when care over time or across the continuum is required. For example, access to appropriate follow-up care and treatment across borders was mentioned during both the Cambodian and Lao consultations. During transit, migrants' mode of travel can influence health outcomes, with some rendered more vulnerable during attempts to cross borders. Exposure to violence, risks of injury and drowning may also be a concern during transit (36,37).

Working and social conditions at destinations can affect migrants' health (16). For example, factors influencing poor self-reported health of internal Chinese migrant labourers were associated with age, working hours, marital status, illness and hospitalization. Factors associated with good self-reported health included income, number of friends, levels of trust, education and appropriate alcohol consumption (38). Long working hours and income dissatisfaction were associated with poor mental health among rural–urban migrants in Guangzhou, China, while higher income and social support were associated with reduced risk (39). In China, rural–urban migrants' psychosocial well-being was associated with perceived discrimination, economic integration and good self-identity (40,41). Older rural–urban migrants showed better mental health outcomes than younger rural–urban migrants in China (39). A study in Guangzhou, China, found rural–urban migrant children had poorer mental health than local children (42). Associated factors included single parent families, low family income and poor perceived health status (42). At destinations, increased populations due to migration may place pressure on existing services. For example, as many Tuvaluans migrate from the outer islands to the main island of Funafuti, this urban drift places pressure on public health services including the island's hospital and two health clinics and suggests the rearrangement of health service delivery given migration-related changes to the distribution of the population (16).

The experience of migration is, in turn, influenced by the characteristics of the migrants themselves. The “healthy migrant” effect refers to the phenomenon whereby migrants may be healthier than the population in the destination country or location. For example, self-reported health was better among internal migrant populations when compared to local residents in Zhongshan, China (41), and mental well-being among internal migrants in Guangzhou city was found to be slightly better when compared to urban local people (39), although this effect may be temporary (32).

The “feminization” of migration has been a distinctive feature in the Western Pacific Region (4). Member States with the highest percentage of women among international migrants are Hong Kong SAR (China) (60.5%), the Commonwealth of the Northern Mariana Islands (58%), and Singapore (55.9%) (4,5). Female migrant workers work in domestic, hospitality, health care, labour-intensive garment manufacturing and entertainment sectors, and they may experience poor working conditions, poor remuneration, a lack of legal protection and poor access to health services, exacerbating their vulnerability to poor health, gender-specific discrimination, exploitation and abuse (43,44,45). In Cambodia, a woman must be in continuous employment for nine months or more to be entitled to maternity leave. Participants of a consultation in

Cambodia mentioned that given the unstable nature of migrant work, many female migrants are consequently ineligible for maternity leave (12).

Female migrants from the Philippines, for example, were found to experience significant stress in their first year living abroad (46). For women, acculturation stressors are often exacerbated by the various gender roles and responsibilities (47). Child separation is also reported as a cause of stress among rural–urban migrants in Wuhan, China, particularly women (48). A study showed that mothers who stayed behind in the Philippines and Viet Nam while their partner worked overseas were more likely to experience poor mental health (49). Another study found being married was a protective factor against mental health concerns for foreign-born men in Australia (50).

Gender and marital status intersect with other sociocultural factors, such as ethnicity, age and disability (45). In the Republic of Korea, the association between being a migrant and ethnic discrimination was related to poor self-rated health among female married migrants, but not among male married migrants (51). A study on female migrant workers in four cities in China found that one quarter had poor mental health, with financial and employment-related difficulties, cultural differences, and gender-specific stressors contributing key risks to mental health (52).

The impact of migration on child health has also been documented: For example, a study found that children, who remained behind in Indonesia, the Philippines and Viet Nam, with migrant parents, especially migrant mothers, were less likely to report being happy than children in non-migrant households (53). Similarly, adolescents in the Philippines with a parent abroad reported a high level of loneliness, higher than adolescents with a parent at home (54). Studies have reported poorer mental health of rural–urban migrant children compared to local children in China (42,55). Migration has also been found to decrease children’s physical activity (56), increase prevalence of anaemia (57) and influence immunization (58,59) in China, and to influence oral health (60) in Australia.

3.1 Population risk factors

Vulnerability and exposure to risk is influenced by migration. One study found perceived work and life stress among rural–urban migrants in two provinces in China to be a risk factor for smoking (61). Another reported lower smoking rates among rural–urban migrants in Shenzhen, China, compared to national averages, but identified a high-risk migrant group that smoked heavily (62). A study reported higher prevalence of type 2 diabetes mellitus among some migrants in Victoria, Australia when compared to a sample population born in Australia (63). Polynesian immigrants living in Australia have particularly high rates of type 2 diabetes mellitus, hypertension and cardiovascular disease with culture, poverty and limited uptake of prevention and treatment being contributing factors (64).

Risky sexual practices were a cited determinant for exposure to HIV among rural–urban migrants in China (65,66). In Cambodia, a large segment of the sex work sector is comprised of migrants from Viet Nam who face a high risk of HIV due to their irregular migration status, unsafe working and living conditions, policies that may confine migrants to a specific location, and stigma and discrimination (67). The International Organization for Migration (IOM) underlined similar vulnerabilities of migrants across Asia (22).

Vaccination coverage was found to be slightly lower among immigrants to Australia who spoke a language other than English at home, compared to immigrants who only spoke English (68). In general, refugee populations are often under-vaccinated compared to hosting and receiving communities, their vaccination records may be lost or incomplete and their vaccinations may not be in line with recommendations of receiving countries (22). Refugees may live in overcrowded or unsanitary conditions prior to resettlement, increasing risk of exposure to vaccine-preventable diseases (22). Additionally, refugees may have been exposed to violence, torture, imprisonment, civil unrest and other trauma in the past (69), with potentially long-term consequences for mental health (70,71).

Health risks also exist for migrants' children: for example, it was reported by participants in a consultation with Cambodia that children left with secondary carers may face challenges related to infant breastfeeding, exposure to poor-quality substitutes to replace breast milk, low resources for the provision of appropriate foods, a lack of support for secondary parents and delays in seeking health care (12).

3.2 Material and working conditions

The material circumstances of migrants in the Western Pacific Region also contribute to their health. Migrants often work within unregulated sectors characterized by low skill activities, intensive labour and poor working conditions (72,73). Across the Region, hazards at work may relate to physical issues (e.g. poor ventilation, lighting and safety; noise; extreme temperatures and humidity; overcrowding; and inadequate sanitation); biological issues (e.g. pathogenic bacteria, fungi, parasites); exposure to chemicals and dust; and ergonomic concerns. A consultation in the Lao People's Democratic Republic mentioned that Chinese migrant workers sometimes live on construction sites and may not always have access to adequate sanitation (25). Such working conditions can contribute to poor health outcomes with exposure to infectious diseases such as malaria, tuberculosis (TB) and HIV; poor rates of immunization; malnutrition and undernutrition; poor mental health; and occupational injuries (35,74).

Exposure and transmission of TB among migrants has been linked to social, legal and economic circumstances (75), including working and/or living conditions, which are often overcrowded and poorly ventilated (74,76). In a consultation with Tuvalu, urban overcrowding was highlighted as a concern (16). Exposure to TB has been linked to a migrant's vulnerability to undernutrition, substance misuse, HIV and low socioeconomic status (74,76). Migration-related risk factors for TB transmission and development of drug resistance include lack of access to care, poor adherence to treatment and gaps in care continuity (77). In New Zealand, TB is noted as affecting the poorest and most vulnerable communities (78), with almost 80% of all TB cases in 2016 found in foreign-born individuals (79).

Work stresses among rural–urban migrants in two cities of China were found to include: long working hours and excessive workload; poor working conditions; low salary; job insecurity; and poor relationships with co-workers and/or boss, while life stresses included instability of living and employment; poor living conditions; poor food quality; perceived discrimination; sexual oppression; poor health of themselves and family; financial difficulty; obstacles to children's education; and being in an unhappy marriage (61). Evidence also suggests that housing affordability, suitability and overall condition can influence migrant health (22,80,81,82). Conversely among rural–urban migrants in China, positive perceptions of neighbourhood social environments were linked to better self-rated health and lower levels of perceived stress (80).

Limited housing space and unsafe communities were found to negatively influence ability to engage in healthy behaviours among child migrants from Kiribati residing in New Zealand (82).

3.3 Broader social determinants

The broader social environment in which a migrant lives, works and interacts is a significant determinant of health and health inequities in the Western Pacific Region. In the Lao People's Democratic Republic, for example, malaria is most prevalent in the southern parts of the country, where many communities are engaged in forest-related work (83). Unregulated deforestation, land clearing for development projects and changes in climate conditions have all been linked to an increased risk of exposure (83). A report of an outbreak in 2011 suggested internal and cross-border migrants accounted for 70% of confirmed malaria cases in the Lao People's Democratic Republic (83). In Viet Nam and Cambodia, living and working in forest areas has been recognized as an important risk factor for exposure to malaria (8,12,84,85,86). High rates of antimalarial drug resistance are a concern in border areas in the Greater Mekong Subregion (87). In Viet Nam, high rates of malaria have been reported among Vietnamese migrants returning from Africa (8,88).

In the Pacific, exposure to extreme weather events and other climate impacts and low adaptive capacity increases vulnerability to the negative effects of climate change (89). In the Marshall Islands, climate change is predicted to lead to more frequent, longer and unpredictable drought periods which may result in increased dependence on food aid including food with poor nutritional content (90). Following an environmental disaster, migrants may travel back to their place of residence before there is access to adequate nutrition, sanitation and health services. Migration due to natural disasters can lead to excess illness and death from common causes and risk of ill health from vector- and waterborne diseases due to disrupted public health systems (91). In addition, a consultation in Viet Nam suggested Zika, influenza and other emerging infectious diseases are an increasing challenge (8). Sexual and gender-based violence can also increase during and after an environmental (or humanitarian) disaster, with wide-ranging health consequences (92,93).

3.4 Access to health services

In the Western Pacific Region, migrants may face barriers in accessing needed health services.

Legal and policy barriers

Legal and policy barriers to health services include situations where laws or policies explicitly exclude migrants, or specific groups of migrants, as well as situations where migrants are excluded indirectly, for example because the legal or policy framework is unclear or weakly implemented (35,94). For example, refugees or migrants may experience barriers with birth registration, which in turn may hinder access to newborn and other health services (95). Policy and legal barriers may also be temporary and/or be of an administrative nature, for example, if migrants or their households are required to re-register in order to access services, as mentioned in consultation with Viet Nam and China (8,11). This may lead to delays in health insurance enrolment or health-care seeking (96). In Mongolia, herders pay their own health insurance premiums as they are considered self-employed. When they lose their source of income (livestock) due to harsh winter and *dzud*, they still pay these premiums as they are not included in the groups subsidized by the Government (97). In Australia, migration status may determine access to publically funded health care (20). To prevent stress on health services in

the Marshall Islands, non-resident workers and their families are required to be certified as free of infectious disease to retain their entry permits (19).

Economic barriers

Financial and economic barriers faced by migrants include both direct and indirect costs of accessing health services (94,98). Out-of-pocket payments, particularly when migrants are not covered by existing health financing schemes, can make health services less accessible (35,99,100). Guinto et al. compared five ASEAN Member States and concluded that while all have health financing schemes that cover migrants to varying extents, coverage could be enhanced and implementation remains a challenge in some settings (99). A consultation in China mentioned, for example, that migrants can access and be reimbursed for health-care costs only if they have been living in their new place of residence for six months, although there are exceptions for some basic services such as childhood vaccinations, health education and prevention of infectious disease (11). Despite substantial achievements in health insurance coverage in China, some internal migrants still face institutional barriers to accessing benefits (101) and improving the portability of insurance has been suggested (102). In Mongolia, formal registration of residency is a prerequisite for obtaining health insurance, and failure to register within the given time period can lead to a fine (103). A consultation in Viet Nam mentioned health service fees can be higher in urban than rural areas, placing an additional financial burden on rural–urban migrants until registration details have been changed (8). One study found a correlation between health insurance coverage and lower health service utilization among internal migrants in Hanoi, Viet Nam, with seasonal migrants using services the least, followed by migrants working in private small enterprises and migrants in industrial zones (104). Chinese migrant workers in Singapore experienced difficulty getting their work injuries reported, receiving compensation (including for medical costs) or obtaining wages while on medical leave (105).

Geographical and physical barriers

The mobility and geographical location of migrants can have significant implications for their access to health services (8,12,25,106). For example, forest workers in Cambodia were found to be at increased risk of receiving late and substandard treatment for malaria due to poor geographical access to health facilities (85,107). High levels of mobility can reduce access to health care for people requiring ongoing treatment, such as those with TB (108). As indicated by participants in a consultation with Cambodia, even for migrants in urban areas where health services are typically available, accessibility may still be limited particularly among temporary rural–urban migrants and those residing in slum areas (12). For instance, in Mongolia, many rural migrants reside in suburban *ger* districts where access to health services can be limited (14,109).

Informational barriers

Barriers to health care are also linked to migrants' access to information on health and the host country's health system as well as their education status (100,101,110,111) and their awareness of their legal rights to health and safety (112). Several studies indicate that higher levels of information about sexual health and access to commodities and services are associated with safer sexual practices among migrants (111,113,114). Communication difficulties, including language issues, can create barriers to accessing health services (100,115,116). Migrant workers may also be afraid or embarrassed to ask questions about their health (112).

Sociocultural barriers

Sociocultural barriers include factors associated with culture, gender and ethnicity, as well as actual or perceived discrimination and stigma (32,98). Common barriers to help-seeking behaviours for sexual health in Australia included sociocultural and religious influences (111). Filipino migrants working in Malaysia reported social stigma as a barrier to accessing reproductive health services (117). In Australia, cultural differences and beliefs, language, and stigma were identified as important barriers among culturally and linguistically diverse (CALD)^d populations accessing services for viral hepatitis (118). Perceived low quality of public services and difficulties with interpreters were some of the factors influencing access and acceptability of dental services by some migrants in Australia (119). There is a growing body of literature highlighting the importance of culturally sensitive service access and delivery, for example, pointing to possible concerns related to privacy, language and limited access to translating services, different perceptions of ill health and limited knowledge of traditional medicine among providers (69,120-124). Acculturative stress and depression was a challenge for Filipino migrants in Australia, resulting in lower health-seeking behaviours (125).

IV. CURRENT RESPONSES TO PROMOTE THE HEALTH OF MIGRANTS

There has been increasing attention at the national, regional and global levels to respond to migration within the context of health and promote the health of migrants. These responses, policies and actions to promote the health of migrants present valuable lessons for advancing migration and health in countries and the Western Pacific Region more broadly.

In the Western Pacific Region, attention to migrant health is core to advancing UHC and the SDGs. For example, *Universal Health Coverage: Moving Towards Better Health – Action Framework for the Western Pacific* (98) outlines a whole-of-system approach to improve health system performance by focusing attention on people and communities, including disadvantaged groups. The *Regional Action Agenda on Achieving the SDGs in the Western Pacific* (2) underlines the economic, environmental, political and social factors that may create or perpetuate ill health, including among migrants (126). Core to advancing the SDGs is the fulfilment of the urban health agenda: the *Regional Framework for Urban Health in the Western Pacific 2016–2020: Healthy and Resilient Cities* (6), and WHO's work on Healthy Cities more broadly, guides Member States in considering how to anticipate, mitigate and adapt to new urban health challenges. In 2015, the *Western Pacific Regional Framework for Action for Disaster Risk Management for Health* was developed to guide national and regional efforts, with the ultimate goal to enhance health and human security in the Region (127).

4.1 National policy and legal frameworks on migration and health

A number of national policies and legal frameworks have been developed by Member States in the Western Pacific Region relating to migration and health.

Legislation and policy can be a valuable tool to protect and promote the health of migrants. Laws may focus on specific migrant groups – for example the *Framework Act on Treatment of Foreigners* (128) and the *Refugee Act* (129) in the Republic of Korea, and the *Migrant Worker and Overseas Filipinos Act* in the Philippines. Or they address migrants' needs as part of broader

^d CALD populations is a term commonly used in policy, research, and practice in Australia when referring to non-indigenous ethnic groups from non-English speaking countries. Not all CALD populations are necessarily migrants.

legislation or policy – for example the *National Strategic Development Plan 2014–2018* (130) in Cambodia and the *8th Five-Year National Socioeconomic Development Plan 2016–2020* in the Lao People’s Democratic Republic’s (131). Laws and policies in other government sectors may also be useful for advancing the health of migrants. For example, the *Labour Migration Policy for Cambodia 2015–2018* includes references to access to health services for migrant workers (132). Additional examples for Australia, the Philippines and the Republic of Korea can be found in Annexes 2–4.

Laws and policies in the health sector increasingly address migration. In Viet Nam, the national health plan refers to migrants (133). In Mongolia, the *Government Action Plan 2016–2020* and the *State Policy on Health (2016–2026)* provide a framework for action on migration and health (13). In the Philippines, the *National Policy on Addressing the Health of Migrants and Overseas Filipinos* guides the National Migrant Health Programme, including actions to strengthen access to quality health services, support systems and resources (18). Overseas Filipino workers can access PhilHealth benefits abroad and at home (including for dependents), and rapid response teams can be sent internationally to assist them during crisis situations (18).

In China, the *Management Plan for the Health and Family Planning Services for Migrant Population in the 13th Five-Year Plan* includes provisions for access to health services (7). China is improving migrant population monitoring and statistics and decision support along with strengthening governance, regional cooperation and information sharing to promote improved health service provision and social integration of migrants (7). There are also increased community health family planning services in in-flow areas. Migrants are entitled to free access to 12 basic public health services including health education, maternal and child health care, family planning, immunization, and prevention and control of infectious diseases (7). Basic medical insurance rights of migrants are protected through accelerated cross-province medical expense verification and settlement and establishment of a unified medical insurance system for urban and rural residents (7). China has also conducted a needs assessment of health services for left-behind children living in impoverished areas, strengthened capacity to support health education and communication for these children including in relation to nutrition, hygiene, psychology, health behaviours, injury prevention and self-protection (7).

Technology may provide new tools for advancing the health of migrants. For example, the Government of Mongolia is working with WHO to introduce mobile health at the primary health care and community levels to improve access to needed services and ensure that no one is left behind (13). In Viet Nam, a multifaceted e-health intervention providing sexual and reproductive health services to female migrants increased women’s knowledge of sexual and reproductive health and improved practices related to gynaecological check-ups and use of condoms (134). Participants of a consultation in China highlighted a new IT system that is currently being piloted in eight provinces to enable the transferring and sharing of patient health information across provinces to support continuity of care and ensure reimbursement of health services (11).

Work is also occurring at the subnational level. The Ministry of Health of Mongolia has worked with WHO and other partners on subnational health system strengthening with attention to health equity. In Australia, many states have taken steps: for example, New South Wales has a Refugee Health Nurse Program where nurses assess the health of newly arrived refugees and asylum seekers and refer them to migrant-specific and mainstream health services (135). In Victoria, refugees can access specialized mental health services for those who have experienced

torture and/or hardship brought on by war and/or violence (20). In Queensland, the Multicultural Action Plan outlines a number of actions to increase the health and well-being of refugees and migrants (20), and Access Australia is working to strengthen culturally-appropriate service delivery (136). In South Australia, free training is provided on working with students who have experienced trauma, including refugees, and in Western Australia, Diversity Cafés are held where staff from a range of agencies come together to share knowledge about health of people from CALD backgrounds (20).

4.2 Programmatic interventions to meet the health needs of migrants

Substantial work is ongoing to improve the health of migrants through programmatic interventions, primarily in the area of communicable diseases. This is a useful basis to learn from to strengthen system-wide responses to migration and health.

Communicable diseases

Malaria programmes in many countries, particularly in the Greater Mekong Subregion, demonstrate valuable experiences in responding to the needs of migrant and mobile populations (137). The WHO *Regional Action Framework for Malaria Control and Elimination in the Western Pacific 2016–2020* stresses the need to strengthen health services to meet the specific needs of mobile, migrant and hard-to reach populations and for further research on the malaria burden among migrant populations (138). All Greater Mekong Subregion countries have adopted national strategies for elimination of malaria in accordance with WHO frameworks and all specifically recognize migrant and mobile populations as particularly vulnerable (22). For example, Cambodia's *National Malaria Elimination Action Framework (2016–2020)* emphasizes mapping of population movements and related malaria transmission, including mapping large-scale private sector worksites, as well commitment to ensure regular cross-border dialogue (139). There are multiple tools and resources providing guidance on meeting the needs of migrants and mobile populations in malaria response efforts in the Greater Mekong Subregion (140,143).

Similarly, the WHO *Regional Framework for Action on Implementation of the End TB Strategy in the Western Pacific, 2016–2020* (76) recognizes the relationship between increased risk of exposure to TB and vulnerable populations, including migrants. TB programmes increasingly pay attention to linkages between migration and health. For example, *Tuberculosis Control in Migrant Populations: Guiding Principles and Proposed Actions in the Western Pacific* guide Member States regarding (i) monitoring migrant health; (ii) policy and legal frameworks; (iii) migrant-sensitive health systems; and (iv) partnerships, networks and multi-country frameworks (108). The Philippines has decentralized access to TB diagnostics, and has built the capacity of and expanded services to more facilities (144,145). In 2015, Viet Nam set up the Viet Nam Integrated Centre for TB and Respiratory Research, a collaborating hub for government agencies, nongovernmental organizations, research centres, hospitals, universities and the private sector (144). In Cambodia, IOM partnered with the Cambodian National TB Programme, the Centre for Tuberculosis and Leprosy Control, and WHO, with support from TB REACH, to pilot a TB screening strategy targeting casual, cross-border migrants returning to Cambodia. As described during a consultation with Cambodia, rapid diagnostic testing allowed for quick TB diagnosis and referral to local services (12). Similarly, participants in a consultation with the Lao People's Democratic Republic mentioned that TB screening was set up for migrants in border areas, although not all entry/exit points were covered (25).

Good practice examples also exist in the area of HIV and sexually transmitted infections (STIs). For example, the Mongolian Red Cross Society ran a project on STI/HIV prevention for migrants in China (see Annex 1.4) (146). A consultation in the Lao People's Democratic Republic mentioned a project on HIV education that targeted prevention activities at sex workers who work near migrant communities (25).

Occupational health and safety

Health and safety at work is another important programmatic area in the context of migration. In the Republic of Korea, the Government provides a variety of on-site safety and health education programmes to prevent industrial accidents among foreign employees (29). This includes disseminating materials in different languages and conducting safety inspections of companies with a large number of foreign workers (29). These initiatives are supported by the country's *Occupational Safety and Health Act* (147), which stipulates employees' right to safety and health education, measurement of working environment, health screening and other health measures. The Act applies to both Korean and foreign employees (29). The Republic of Korea also supplies occupational health and safety materials and education to job training centres and worksites, targeting areas with large numbers of foreign workers (29).

China has issued its *National Plan of Prevention and Control of Occupational Diseases (2016-2020)* that outlines simplified diagnostic procedures, enhanced treatment services, promotion, prevention, and control of occupational diseases and encourages employers to provide occupational health education in the workplace (7). In Brunei Darussalam, the Red Crescent Society runs awareness programmes on health and safety for labour migrants (112) (see Annex 1.1).

Safe Work Australia has developed a strategy to address workplace health and safety risks of migrant workers, which includes developing information for migrant workers and their employers (20,148). The Australian Government established the Migrant Work Taskforce in 2016 to provide expert advice on improving protections for overseas workers, including work health and safety. Model Work Health and Safety laws (149) articulate rights to safe and healthy workplaces and workers' compensation for all, regardless of visa status. Injured workers receiving compensation benefits are still "employed" for the purpose of their visa (20).

Mental health

Entry points for strengthening services for migrants may also exist in the area of mental health. In Australia, the Programme of Assistance for Survivors of Torture and Trauma provides free and confidential mental health and other support to refugees experiencing psychological and/or psychosocial difficulties resulting from their pre-migration experiences of torture and trauma at any time after arrival (20,30). A holistic approach is taken and a range of culturally appropriate, gender-sensitive interventions can be provided (20). In addition, the Mental Health in Multicultural Australia programme aims to strengthen capacity to address mental health needs, including among migrant and refugee populations, in a culturally inclusive and responsive manner. This includes resources to assist mainstream mental health services achieve cultural competency; sector and community development to improve CALD communities' understanding of mental health; mental health promotion; and suicide prevention activities (20). In New Zealand, the Red Cross runs a Refugee Trauma Recovery programme providing specialist mental health services (see Annex 1.6) (70).

Gender-based violence

Experience of gender-based violence can be a significant issue for migrants and refugees. In Australia, all governments (federal and subnational) have agreed to the *Third Action Plan of the National Plan to Reduce Violence against Women and their Children 2010–2022*, which specifies actions to improve the quality and accessibility of services for women from CALD backgrounds (20). The Australian Government also supported the development and implementation of a National Framework to improve accessibility to justice for migrant and refugee women with the aim of achieving equality before the law and focusing on adapting court policies, procedures and resources (20). Australia also supports work to prevent female genital mutilation/cutting (20). Participants in a consultation in the Lao People's Democratic Republic mentioned that the Lao Women's Union supports the response to trafficking including provision of shelters and vocational training for trafficked women (25). The *Prohibition of Trafficking in Persons Act 2017* in the Marshall Islands includes provisions that victims of trafficking regardless of immigration or citizenship status are eligible for basic benefits and services including medical treatment and counselling assistance (19).

Social determinants of health

Social determinants have significant impacts on the health and well-being of migrants. Several examples are discussed here.

The Western Pacific Region has a long history of fostering Healthy Cities, including efforts to engage mayors and bring different sectors together to work towards healthy urbanization (150,152).

Member States have also developed a range of programmes to facilitate and support migrants in accessing relevant services and resources. For example, the Australian Government's strategy to boost women's workforce participation includes programmes to support CALD women prepare for, enter and remain in the workforce and materials to promote the value of fostering a diverse workplace to employers (20). In Mongolia, the Health Insurance Council, which consists of representatives of the government, insured people, and employers, made a decision to increase the number of pharmacies eligible to receive reimbursement from the Health Insurance Fund to improve access to discounted medicines in suburban areas of Ulaanbaatar (97).

In China, the Government is committed to promoting the concept of equality between men and women with particular attention to the rights of migrant women and girls (7). The Government is also implementing people-oriented urbanization, which enables equitable access to primary public health services for all permanent residents, including rural–urban migrants. Schools in areas with large numbers of migrant children conduct youth health education and training for migrant adolescents and unmarried young people and facilitate the establishment of youth networks for mutual support (7). Various health-related programmes have been offered to migrant populations in China through a social integration demonstration project in 22 cities (7).

Specific provisions have been made to support refugees. For example, in accordance with the *National Basic Living Security Act* in the Republic of Korea, refugees may receive livelihood, housing, education, childbirth, funeral and self-sufficiency benefits depending on their needs and eligible refugees are entitled to the same level of benefits as Korean nationals under the

Framework Act on Social Security (29). In Australia, refugees are eligible to participate in a programme giving job seekers employability skills training and internships (20).

Laws and programmes to promote multiculturalism and tolerance of diversity among the public have also been implemented. For example, the *Framework Act on the Treatment of Foreigners Residing in the Republic of Korea* stipulates that authorities take action to prevent discrimination against foreigners (29). Australia's multicultural statement commits to condemn those who incite racial hatred and xenophobia, and the *Racial Discrimination Act 1975* makes it unlawful for someone to act in a way that is reasonably likely to "offend, insult, humiliate or intimidate" someone because of their race or ethnicity (20). The Australian Government's Strong and Resilient Communities programme provides resources to strengthen the capacity of communities experiencing disadvantage, including migrant and refugee communities, to become more resilient and inclusive by fostering community cohesion and engagement and whole-of-community approaches (20).

4.3 Partnerships to promote the health of migrants

Responses to migration are complex and rely on partnerships, including across government sectors, regional and provincial governments and nongovernmental stakeholders.

The Philippines Migrant Health Network is an inter-agency, multi-stakeholder network for migrant health (18) providing a valuable platform for discussion. The Philippines also has an Intra-Agency Task Force on Migrant Health to provide technical policy direction (18) and has several other committees and programmes on migration as well as some non-health agencies with health-related functions.

Partnerships are also critical to share information. Under the Shared Government Information System for Migration in the Philippines, international migration data are generated and shared by different government agencies (18,153). An electronic database on medical repatriation has been developed to provide standard reporting and monitoring, facilitate harmonized information sharing among government agencies, and enable easy retrieval and disaggregation of data. The Philippines has also established a HIV/AIDS Registry, which includes information on overseas Filipino workers. This provides real-time information regarding HIV cases (18).

Partnerships between Member States and other partners can also positively contribute to promoting migrant health. For example, the Hometown Fellows Campaign in China aimed to disseminate HIV-prevention messages to migrants (see Annex 1.2) (113). In 2013, collaboration between IOM and the Philippines Department of Health resulted in a situational analysis and stakeholder mapping to take stock of existing policies, programmes, institutions and mechanisms that support migrants' health; to identify challenges and opportunities and to make recommendations for the advancement of migrant health (see Annex 1.6) (22). In the Republic of Korea, the Healthy Neighbourhood Centre was established to improve the quality of health care for vulnerable groups, including migrants (see Annex 1.3) (154). A number of partners, for example IOM and the United Nations High Commissioner for Refugees, provide guidance on responding to the health needs of migrants and refugees (155,156).

4.4 Collaboration on migration and health across borders

Addressing migration and health relies on partnerships and dialogue across borders. Specific challenges for regional cooperation on migrant health include: gaps in evidence; regional and bilateral collaboration and multisectoral coordination; mainstreaming migrants into national health systems and health security strategies and programmes; and harmonization of disease strategies, protocols and programmes (22).

Migration is increasingly a topic for bilateral dialogues and collaboration, particularly in border areas with high population mobility. Collaboration may be informal, for example through increasing dialogue or sharing of information or more formalized, often in the form of agreements such as a memorandum of understanding between two or more countries. As indicated by participants of a consultation in the Lao People's Democratic Republic, such agreements can be an opportunity to raise health-related questions, including access to insurance schemes for migrants in destination countries and cross-border responses to trafficking (25). Examples include agreements between the Lao People's Democratic Republic and Thailand and between Cambodia and Thailand on employment and on trafficking, between Malaysia and Cambodia on employment, and between Viet Nam and Cambodia on trafficking. Similarly, the Philippines has promoted bilateral labour agreements with host countries, as well as regional and multilateral agreements and dialogue with countries of destination and international organizations (18).

Subregional dialogues may involve selected Member States in the Western Pacific Region, for example those sharing a border, or go beyond the Region, given economic or other linkages with Member States of the South-East Asia Region or beyond. Historically, the focus of such collaboration has often been on labour, employment and economic development, for example the Colombo Process in 2003 (157), the Abu Dhabi Dialogue in 2008 (158) as well as growing collaboration between ASEAN Member States. The *ASEAN Socio-Cultural Community Blueprint (2009–2015)*, for example, placed regional migration high on the political and development agenda of Member States, while the *ASEAN Post-2015 Health Development Agenda (2015)* highlights migrants' health, particularly in the context of health systems strengthening (159). In 2017, the *ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers* was signed (160).

Increasingly these dialogues deal with health and health-related issues. For example, the Joint United Nations Initiative on Migration and Health in Asia (JUNIMA) was established in 2009 (see Annex 1.9) (22). Experiences from JUNIMA offer useful lessons for advancing partnerships on migration and health. In 2013, the Biregional Meeting on Healthy Borders in the Greater Mekong Subregion strengthened multi-country dialogue and multisectoral collaboration on improving the health of mobile and migrant populations and people living in border areas (161).

Similarly, cross-border strategies have been established to address specific high-priority health issues related to migration, such as the *Strategy for Malaria Elimination in the Greater Mekong Subregion (2015–2030)*, *Emergency Response to Artemisinin Resistance in the Greater Mekong Subregion (2013–2015)* and the Coordinated Mekong Ministerial Initiative against Trafficking (COMMIT process) (see also Annexes 1.8 and 1.10) (22,162,163,164). Funding provided by development partners, for example the Global Fund to Fight AIDS, Tuberculosis and Malaria, has provided opportunities to strengthen multi-country responses to malaria and TB with attention

to migrants. For example, a recent meeting on developing a multi-country funding proposal on TB among migrants in the Greater Mekong Subregion highlighted a number of examples of good practice and discussed next steps (165). Australia and New Zealand are part of the Five Country Conference's Immigration and Refugee Health Working Group, which works towards aligning and improving immigration health standards between countries (Australia, Canada, New Zealand, United Kingdom of Great Britain and Northern Ireland, and the United States of America) through a range of actions including sharing policies, practices and lessons learnt (for example on pre-migration TB screening and on Ebola response) (20).

V. WAYS FORWARD AND CONCLUSION

In the Western Pacific Region, the health of migrants is an issue of growing importance. Some potential ways forward include the following.

5.1 Strengthening the evidence base on migration and health

Sound information is critical to inform policy and action on migration and health. A key challenge at country and regional levels is the lack of information, often due to a lack of civil registration, unclear legal or administrative status of migrants, and gaps in coordination and information sharing between sectors and countries. The dynamic and sometimes short-term and hidden nature of migration presents challenges for collecting sound information and developing system responses. Efforts are needed to strengthen institutional frameworks for improved collection and monitoring of data on migration flows and health. Strengthening information systems is a priority in many countries and particularly important to advance monitoring and evaluation for UHC and the SDGs. This includes better collection, analysis and use of quantitative data disaggregated by key social stratifiers relevant to migration as well as other types of evidence-based situation analysis. It also includes better information on policy and programme responses, and migrants' experiences in accessing them, including investment in implementation research, social impact assessments and mapping of health services. A number of countries (for example, China, the Philippines and Viet Nam) have methods of information collection on migration that could be expanded to improve the information produced. More broadly, in developing this report, many valuable experiences and practices were shared. While the report can only summarize some of these, it highlights the added value of documenting and sharing experiences across countries and partners in the Western Pacific Region.

5.2 Strengthening health systems responses to migration and health

There is growing global, regional and national commitment to developing equity-focused and migrant-sensitive health systems. Ensuring that health services are affordable, accessible and acceptable to all population groups is central to effective health programmes and services. It requires action across the health system – improving policy and governance structures, building the capacity of health workers, and strengthening financial protection and acceptability of services. A focus on migrants specifically is timely because it reiterates the importance of comprehensive, integrated and people-centred solutions. This highlights the value of understanding diverse contexts and designing and adapting services for various social settings and groups. In particular, primary care services are important entry points for meeting the needs of migrants. There are opportunities to learn from existing successes in service and programme delivery and to strengthen collaboration on shared social determinants of health for priority groups, including migrants. As several examples highlight, making health services more equity focused and migrant sensitive is an achievable strategy and not necessarily more costly. It

places emphasis on reorienting mainstream services towards a whole-of-system approach that leaves no one behind while strengthening targeted efforts to meet the needs of disadvantaged groups of migrants.

5.3 Develop partnerships, networks and multi-country dialogue

Migration is a development challenge that cuts across health issues and programmes, government sectors, diverse stakeholders and partners – and, in many cases, across borders. Given the complex and dynamic nature of migration in the Region, ways forward include developing and strengthening whole-of-government and whole-of-society responses. Countries may have existing multisectoral frameworks or mechanisms that could be strengthened, or may develop higher-level policy frameworks on migration, including health. The health sector can play a convening role in bringing different partners together and in strengthening Health in All Policies approaches. The way forward may include strengthening partnerships with nongovernmental stakeholders, including migrants themselves. Opportunities for partnership may also exist at subnational and local levels, including in urban settings. Finally, examples in this report have highlighted the importance of bilateral, multi-country, subregional and regional collaboration, including collaboration with and between development partners. There are many shared issues and concerns with neighbouring countries and regions, with opportunities to strengthen the exchange of learnings through dialogue and research.

5.4 Conclusion

This report has provided an overview of migration and health in the Western Pacific Region. It outlined migration patterns, health outcomes, risks and determinants, access barriers to health services, as well as examples of responses and lessons learnt and ways forward. It is hoped that the information contained in this report will help to inform ongoing policy discussions at global and regional levels on the health of migrants and refugees. The SDGs and UHC challenge Member States, WHO and partners to move towards inclusive societies that leave no one behind. Attention to the health of migrants is at the centre of this vision.

VI. STRENGTHS AND LIMITATIONS OF THE REPORT

Owing to the limitations of the available evidence, the results of this report should be interpreted with the following limitations:

- There is a lack of a shared definition of migrants across different types of literatures, sectors, countries and partners. In this report the term migrant has been used as an umbrella term to include all types of migrants and refugees, in an effort to be as comprehensive as possible. Future research may be useful with attention to the health of specific groups.
- The report is not a comprehensive review and draws on selected peer-reviewed academic literature and grey literature, submission by governments and partners, as well as video and teleconference consultations with selected Member States in the Western Pacific Region. It therefore provides a snapshot of issues for migrants in the Region rather than being a complete report on all situations and practices related to migration and health across the Region
- Migration in the Western Pacific Region has diverse implications for the health of migrants and their host communities. The variability and dynamic nature of migration trends, however, makes it difficult to estimate the overall impacts of migration on health.

- Since the implementation of policies takes place at local level with the involvement of different actors and Ministries (e.g. health, labour, foreign affairs, NGOs), it was not possible to ensure that all existing information had been collected, nor to claim the completeness of the report.

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^e Information contained in the annex are good practice examples and other submissions received by Member States and partners in response to the WHO online survey. Submission were edited for language only and not validated further. The views expressed in these annexes are those of the submission authors and do not necessarily reflect the views and policies of the World Health Organization.

Annex 1: Additional examples submitted by Member States and partners

1. Example by the Brunei Darussalam Red Crescent Society: health and first aid for labour migrants

Brunei Darussalam is a small kingdom, situated in the north-west of Borneo on the South China Sea coastline. The total population of Brunei Darussalam is 406 000 people. Brunei Darussalam relies heavily on foreign labour with almost 40% of the workforce being made up of foreign workers. Many of these migrants are in lower-skill and lower-paying positions with approximately 12 000 migrants working in construction, wholesale and retail trade, and professional, technical, administrative and support services. Many low-skilled workers in Brunei Darussalam are migrants from Bangladesh, India, Indonesia, Malaysia and the Philippines.

The Brunei Darussalam Red Crescent Society (BRCS) provides services for migrant workers, including: first aid training, knowledge and skills; and health and safety awareness programmes. Target groups for the training programmes are construction workers, domestic helpers, care assistants for the elderly, nannies and childcare assistants.

The message of the BRCS is that it's great to have a job and it's exciting to start a new one, but workplaces can be dangerous. Injuries can happen, but they don't have to, so be aware!

Workers can be injured, fall ill or even suffer fatalities on the job. These are some of the situations that the BRCS is trying to prevent, through training and awareness-raising programmes. Experienced workers tend to have fewer injuries than less experienced workers. This might be due to lack of proper training or because new workers are not aware of potential workplace hazards. All workers in Brunei Darussalam have legal rights that protect their health and safety. However, often workers are not aware of their rights. Many workers are afraid or embarrassed to ask questions, afraid to "rock the boat" at work, or to appear incompetent. The BRCS awareness programme on health and safety for labour migrants provides knowledge on the rights and responsibilities of both the employer and the employee. These include that the employer must: establish a health and safety policy programme; provide required training; provide information, instructions and supervision for safe job performance; provide necessary safety equipment; provide information on hazards in the workplace; display important health and safety information where everyone can see it; and keep employee health and medical records. Employees' responsibilities include: obeying the law; using machines and work equipment safely; wearing required personal protective equipment; reporting hazards to their supervisor; working safely at all times; and not "fooling around on the job". Employees have the right: to know about dangers in the workplace; to receive induction training before starting the job; and to receive on-the-job training, work supervision and hazard information to be able to perform the job safely.

Even though not all hospital visits can be avoided, occupational first aid and basic cardiac life-saving training can reduce the morbidity, disability and mortality of workers. The BRCS has been providing free first aid and CPR training and certification to labour migrants since 2015. In Brunei Darussalam, first aid and CPR are rarely taught in the workplace. However, since 2015 the BRCS has been providing free first aid and CPR training and certification to labour migrants. Having employees trained in first aid and CPR can make a substantial difference in their ability to maintain a safe working environment. Employees will be able to respond faster and more effectively when medical emergencies occur. As staff become more prepared and responsive, they also become more aware of their surroundings and more likely to spot potential hazards. The BRCS health awareness programme also includes information on non-communicable diseases including hypertension, diabetes, heart attack, cardiac arrest and cancer, as well as information on communicable/outbreak diseases such as Zika, chikungunya, influenza (H1N1) and malaria. To date, approximately 500 labour migrants have been trained by the BRCS and this training will go a long way to ensuring the health and safety of migrant workers.

For more information on the work of the Brunei Darussalam Red Crescent Society with and for migrants, please contact: Isham bin Ismail, Director of Community and Resilience Empowerment (Email: care@bruneiredcrescent.com).

Source: Brunei Darussalam Red Crescent Society submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

2. Example by the International Labour Organization: Hometown Fellows Campaign, China

Context

Although the overall prevalence of HIV is relatively low in China, there are pockets of high levels of infection – both regarding populations and localities. Internal migrant workers are seen as at higher risk of HIV exposure due to the precarious conditions many face, including lack of access to health prevention and care services. Research conducted through the Workplace AIDS Education Programme in China by the International Labour Organization (ILO) and the United States Department of Labor suggested that a majority of young migrant workers were sexually active, yet lacked sufficient knowledge on HIV transmission and prevention.

Purpose and objectives

The Hometown Fellows Campaign in China was a multimedia campaign launched by the ILO and the Chinese State Council AIDS Working Committee Office in 2008, aimed at disseminating HIV prevention messages to migrant workers. It was implemented in partnership with the Ministry of Labor and Social Security, employer and worker bodies, and 19 large-scale enterprises in the construction, mining and transport sectors based in provinces identified as being most affected by HIV.

Activities

Messages were delivered by migrants themselves, acting as peer educators in workplaces, dormitories and nearby entertainment areas, through company-owned television and radio channels. The centrepiece of the campaign was a short film produced with the support of the renowned director Gu Changwei and the famous actor and former migrant worker, Wang Baoqiang. The film was screened in 850 train stations, on Shenzhen buses, and in workplaces, vocational training centres and employment agencies across China. The initiative featured a prominent gender dimension to ensure that young women migrants were aware of their basic employment, sexual and reproductive health rights.

Outcomes

The strategy of screening the film in public transportation sites that are highly frequented by migrant workers contributed to the campaign's success in reaching as many as 50 million migrant workers in 2009. In 2008, 20 000 migrants were trained on HIV at employment agencies, and 29 large-scale state and private partner enterprises installed behavioural change programmes.

Source: ILO submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

3. Example by the Republic of Korea National Red Cross: Healthy Neighbor Center in Seoul

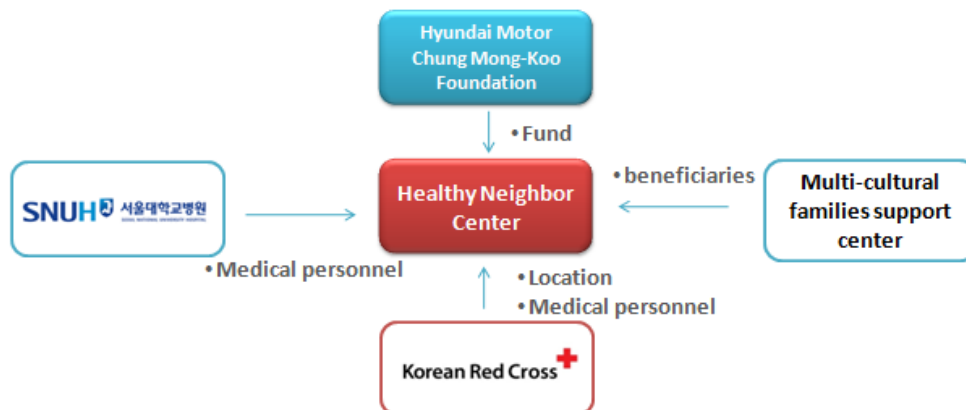
Introduction

More than 2 million foreigners^f (nearly 4% of the population) live in the Republic of Korea. There are a further 211 320 irregular migrants. More than half of the registered foreigners are migrant workers, with only 4.6% in highly skilled sectors. Many migrant workers are employed in unskilled and so-called 3D sectors –dangerous, dirty and difficult. This means that many foreign workers and undocumented workers in factories and farms endure low salaries as well as poor working and living conditions. The majority of migrants come from Asian countries, including Bangladesh, Cambodia, China, Indonesia, Japan, Mongolia, Myanmar, Nepal, the Philippines, Sri Lanka, Thailand and Viet Nam.

Healthy Neighbor Center

In order to address the limited access of many vulnerable migrants to health care, in June 2012 the Republic of Korea National Red Cross (KNRC) established the Healthy Neighbor Center (see figure below) in its Seoul Red Cross Hospital. The Healthy Neighbor Center was established based on a tripartite memorandum of understanding (MoU) between the KNRC, Seoul National University Hospital (SNUH) and Hyundai Chung Mong-Koo Foundation. The aim of the Healthy Neighbor Center is to improve the quality of health and care for vulnerable people, including migrants. All parties to the tripartite MoU contribute their own resources and expertise to run the Healthy Neighbor Center; Hyundai Chong Mong-Koo Foundation provides financial support, the SNUH provides high-quality medical personnel, and the KNRC provides facilities and space for the Center and medical personnel. The KNRC also cooperates with local communities, international/nongovernmental organizations (INGOs/NGOs) and the United Nations High Commissioner for Refugees (UNHCR) to ensure that people in need are able to utilize the services of the Healthy Neighbor Center.

Figure: Overview of the Healthy Neighbor Center



The Healthy Neighbor Center provides affordable or free medical services for vulnerable migrant workers – irrespective of their legal status – refugees, asylum seekers, marriage migrants and other vulnerable groups. Migrants who stay in the Republic of Korea for more than 90 days and submit medical records and other required documents are eligible for medical services. On an exceptional basis, people in the process of applying for asylum can be granted benefits from the Healthy Neighbor Center regardless of the length of their stay. The Healthy Neighbor Center has five departments including family medicine, gynaecology, internal medicine, paediatrics and psychiatry. Other types of medical treatment are provided by Seoul Red

^f 2 024 813 (as of 30 April 2017), based on the Monthly report on statistics of legal foreign immigrants in the Republic of Korea, Korea Immigration Service, Republic of Korea Ministry of Justice.

Cross Hospital and SNUH. From 2012 to 2016, 41 943 people benefited from medical services provided by the Center (see table below).

Table: Statistics on number of beneficiaries

Period	Number of beneficiaries
Jun to Dec 2012	3 165
Jan to Dec 2013	8 067
Jan to Dec 2014	11 948
Jan to Dec 2015	8 999
Jan to Dec 2016	10 364

Furthermore, the Center provides basic health education for multicultural families, delivery items, milk powder and diapers for refugee mothers and children, and free vaccinations for migrant workers at their workplaces. The Centre also provides basic health knowledge and information about other international and local organizations helping vulnerable migrants through its website: <http://www.hncenter.or.kr>

As of 2017, the KNRC is running five Healthy Neighbor Centres within its five Red Cross Hospitals across the country.

Lessons learnt

Through the Healthy Neighbor Center, the KNRC can cover a health “blind spot” where the Government and other organizations cannot reach the most vulnerable. Also, the KNRC can strengthen partnerships with relevant authorities and other stakeholders. However, the KNRC still has many challenges to overcome:

- promoting services to irregular migrants
- providing health and care to undocumented people
- securing sustainable funding and partnerships
- language barriers – it can be difficult to explain medical terminology to patients who cannot understand Korean or English.

For more information on the work of the Republic of Korea National Red Cross with and for migrants, please contact: Yoonkyung Kim, International Relations Team (Email: rosarossa@redcross.or.kr).

Source: Republic of Korea National Red Cross submission the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

4. Example by Mongolian Red Cross Society: STI/HIV prevention among mobile and most at-risk populations: a cross-border project

Mongolia is the third most sparsely populated country in the world, with a total population of 3.13 million people and is located in Central Asia, bordering Russia and China. The Mongolian Red Cross Society’s (MRCS) STI/HIV Prevention Among Mobile and Most At Risk Populations project started in 2012 and was completed in 2016. It was supported by the Luxembourg Government and the United Nations Population Fund (UNFPA) Mongolia. The aim of the project was to decrease the risk of STI/HIV infection among youth, female sex workers, mobile populations and people living in border regions, by conducting promotion of behaviour change activities. A cross-border agreement was reached so that staff and volunteers from MRCS could work in the city of Erlian China. The population of Erlian is approximately 100 000, of whom 40 000 are permanent residents and 60 000 are temporary residents staying in the city for trade and business purposes. Erlian is the main economic and trade border town between Mongolia and

China. There is a constant movement of people from Mongolia as well as from different provinces in China to Erlian for the purpose of trade and business.

Sex work is illegal in China; however, sex work is conducted in a relatively organized manner, with established networks with hotels in Erlian. The targeted population of the project was female sex workers in the city, with the aim to prevent STI/HIV infection, raise awareness of safe sex and condom use, and provide mobile voluntary counselling/testing (VCT) and treatment services. MRCS staff and volunteers visited Erlian every two months with a team comprised of doctors and lab technicians from the National Center for Communicable Disease. In 2016, MRCS delivered mobile VCT and treatment services as well as condom promotion to 614 female sex workers.

Challenges related to the project

In terms of medical services, MRCS did not have their own capacity to conduct all services needed and therefore had to cooperate with external actors. There were challenges in reaching female sex workers in Erlian city, because sex work is illegal and performed in hidden locations.

Project activities and achievements

- Distribution of information, education and communication materials
- Sexual and reproductive health/STI/HIV prevention awareness sessions
- Voluntary VCT
- Peer-to-peer education
- Advocacy to local authorities
- Establishment of a project support group
- Cooperation with the National Center for Communicable Disease and local health centres to conduct mobile VCT in Erlian
- Cooperation with private clinics and the Center for Disease Control in Erlian
- Quarterly and bimonthly visits to Erlian for VCT
- Pre-visit information to target population
- Blood and rapid test for most common STIs and HIV and pap smear
- Test results given to female sex workers
- Start treatment and provide medication, free of charge
- Provide female and male condoms
- Re-testing and follow-up visits for clients with positive test results
- Monitor for re-infection
- Client confidentiality
- Surveillance for the “bridge” population
- Syphilis cases among female sex workers decreased by 60% between 2014 and 2016
- During the cross-border programme, no HIV positive cases were detected and syphilis prevalence has decreased dramatically since 2014.

For more information on the work of the Mongolian Red Cross Society with and for migrants, please contact:

Gantulga Batbyamba, Health Manager (Email: gantulga.b@redcross.mn) or Davaajargal Batdorj, Director of Programmes and Cooperation (Email: davaajargal.batdorj@redcross.mn).

Source: Mongolian Red Cross Society submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

5. Example by New Zealand Red Cross: Refugee Trauma Recovery services

People from refugee backgrounds are ordinary people who have faced extraordinary circumstances. With their lives disrupted by conflict or persecution, refugees simply seek a safe environment in which they can resettle and freely engage in society. Each year, New Zealand resettles 1 000 people through a refugee quota. New Zealand Red Cross is the lead resettlement service providing support to refugees for the first 12 months after arrival. Former refugees are resilient, having survived persecution and conflict and been forced to flee from their homeland. Families and individuals have generally had to leave their homes quickly and under extremely stressful conditions. The experience can be both traumatic and one of great loss as they have often left behind belongings, homes, jobs, friends and family members. The journey to settlement in New Zealand is often long and treacherous and it can take months or, more often, years to reach New Zealand. During this time, refugees may cross several borders or continents and spend time in various refugee camps. Former refugees may have endured or been exposed to organized violence, torture, harassment, imprisonment, war conditions and civil unrest. People who have experienced torture or trauma may carry the effects of these experiences for many years. A small number of people who arrive through the refugee resettlement quota require specialized mental health support due to these experiences.

Refugee Trauma Recovery

The Refugee Trauma Recovery (RTR) team provides specialist mental health services for former refugees who have experienced trauma and torture. Comprised of psychotherapists, psychologists, counsellors and social workers, the team provides multidisciplinary support for clients helping them move towards wellness and enabling them to integrate into their new community. What makes RTR unique compared to mainstream mental health services is that it provides a cultural competent to its service through the use of interpreters, cultural advisors and practitioners specially trained in refugee experiences and resettlement. Treatment methods are tailored to an individual's needs and can include:

- cognitive behavioural therapy (CBT), a structured, short-term, present-oriented psychotherapy for depression, directed towards solving current problems and modifying inaccurate and/or unhelpful thinking and behaviour
- gestalt therapy, a form of psychotherapy that emphasizes personal responsibility, focusing upon an individual's experience in the present
- narrative therapy, a form of psychotherapy using narrative
- problem solving approaches
- eye movement desensitization and reprocessing (EMDR) trauma therapy, useful with clients who have suffered for years from anxiety or distressing memories, nightmares, insomnia, abuse or other traumatic events
- body therapy.

The RTR team works with approximately 120 people each year who present with severe symptoms related to torture or trauma, the refugee journey or the resettlement experience. The process includes screening, assessment, treatment, community care coordination and referral to other services. Beyond treatment, the service also provides social work assistance, advocacy and coordination of support to other services as required. Referrals are not accepted for people who present with:

- acute mental health issues including psychotic illness; people in acute, critical conditions and at high risk of self-harm and harm to others will be referred to crisis intervention teams
- alcohol and drug problems
- domestic violence and other marital issues, unless they are clearly the consequence of torture and trauma and not an acute presentation.

New Zealand Red Cross have had many positive interactions with clients who having used the service are able to manage their lives successfully and integrate into the community:

- *"I feel a great burden has fallen off my shoulders and that feeling of depression is gone. You have helped me make that positive step toward the future and given me a sense of hope."*
- *"You have a very hard job, because it is your job to put the soul back in the body."*
- *"I thank you from the bottom of my heart for helping me with my sorrow. Because of you, I now lead a normal life".*

Challenges

- As with many health services, funding remains a key challenge. The RTR work is fully funded by a contract with the New Zealand Ministry of Health. This contract historically has not been enough to provide adequate support and additional fundraising has occurred to cover the gap.
- The cross-cultural nature of this work can also be a challenge. The understanding of health and well-being is different across cultures, and the provision of counselling is primarily based on western concepts of well-being. The cross-cultural interactions require both in-depth professional development for practitioners as well as the use of professional interpreters.

Opportunities

- While funding remains a challenge, there is also the potential for this work to provide opportunities for supporters to give generously. This work has attracted financial supporters who feel passionate about rehabilitation and recovery from torture and trauma.
- For New Zealand Red Cross, RTR provides the opportunity for greater dignity and care in the provision of health care.
- Sharing about the RTR work is an opportunity to highlight the resilience of former refugees, which contributes to the strategy of social cohesion. New Zealand Red Cross workers also experience vicarious resiliency through supporting people who have demonstrated courage to overcome significant challenges.

For more information on the work of New Zealand Red Cross with and for migrants, please contact: Rachel O'Connor, Head of National Refugee Programme (Email: rachel.oconnor@redcross.org.nz).

Source: New Zealand Red Cross submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

6. Example by the Philippines Department of Health and the International Organization for Migration: Supporting the national migration health policy agenda

Context

In 2015, the Department of Foreign Affairs reported that 9.1 million Filipinos live and work abroad. The scale and complexity of international migration of Filipinos poses important health issues in: 1) infectious diseases, 2) noncommunicable diseases, 3) maternal, sexual and reproductive health, and 4) access to health care and financial risk protection. Based on the WHO *Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants* 1, 2, 4 and 12, the International Organization for Migration (IOM) and the Department of Health of the Philippines signed a memorandum of agreement in 2013. This collaboration aimed to improve the health status of international migrants to and from the country, as well as internally displaced persons within the country.

Practices

A situational analysis and stakeholder mapping was carried out to map and describe the existing policies, programmes, institutions and mechanisms that support migrants' health; to identify both challenges and opportunities in the Philippines' approach to migration health; and to make recommendations for strategies and policies for the advancement of migration health. A desk review, a series of consultations and interviews, and an interagency validation workshop were conducted to achieve these aims.

Results

The situational analysis demonstrated: 1) health concerns of overseas Filipinos; 2) policy-legal frameworks in place and those under development; 3) monitoring frameworks on migrants' health; 4) migrant-sensitive health services in place; and 4) current partnerships, networks, and multi-country frameworks. As a result of this project, the Philippines has officially taken on migration health as a priority agenda. The Philippine Migrant Health Network was established, and national conferences on migrant health were successfully held in 2014 and 2017. In 2017, the first National Conference on Migrant Health was undertaken.

Lessons learnt and recommendations

As one of the major sending countries in the world for international migrants, the Philippines serves as a champion in advancing migrants' rights to health and put in place domestic policies and programmes on migrant health. The Philippines has the opportunity to demonstrate how a sending country can ensure the protection of health rights of migrants overseas. It is now critical that all stakeholders, led by the Department of Health, take the necessary approaches to ensure that the recommendations are implemented, partnerships and collaborations are sustained, and the health of all Filipino migrants are protected and advanced. Strategies to improve the health dimensions of international migrants fall under the following headings:

- policy-legal frameworks
- monitoring migrants' health
- migrant-sensitive health system and services
- partnerships, networks, and multi-country frameworks
- migration health as global health diplomacy
- advocate the migration–health nexus in international and regional platforms.

Reference materials:

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<https://www.iom.int/news/philippines-department-health-iom-hold-migrant-health-conference>

<https://cfo.gov.ph/news/cfo-news-and-events/3042-cfo-advocates-for-filipino-migrants-health-supports-doh-s-philippine-migrant-and-health-network.html>

Source: IOM submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

7. Example by Philippine Red Cross: Supporting returning migrant workers

Since the start of 2017, there has been a rapid increase in the number of migrants returning from Sabah in Malaysia and arriving in Zamboanga City, and island provinces of Tawi-Tawi, Basilan and Sulu in the island of Mindanao, Philippines. Most of the returnees are coming from the eastern part of Sabah.

Although repatriation has been common in the past, the sinking of a vessel that transported the returnees prompted the suspension of the exercise in September 2016. This led to a backlog of approximately 7 000 undocumented Filipino migrant workers in Sabah, Malaysia. Repatriations resumed in February 2017, after a staggered repatriation of the 7 000 undocumented Filipino migrants had been agreed upon.

The Philippine Red Cross (PRC) chapters in Zamboanga City, Basilan, Tawi-Tawi and Sulu have been supporting the provision of health, safety, sanitation and welfare services to the returnees, complementing the assistance provided by the public authorities. These chapters have also identified a need to enhance their capacity to respond to the anticipated increase in returnees.

To further support the PRC chapters' activities, financial support from the IFRC Disaster Relief Emergency Fund was requested in March 2017. Based on assessments conducted through key informant interviews with returnees, immediate needs of the returnees upon arrival included access to basic health services, welfare and safety information, temporary accommodation, food and water, sleeping materials, and hygiene kits.

Between February and July 2017, almost 4 000 migrants returned to the Philippines and were provided with essential services, including provision of hot meals, first aid and psychosocial support. Usually, Red Cross medical technicians are also present with an ambulance on stand-by to undertake triage before referring cases requiring medical assessment and assistance to the government health authorities. Free phone calls to send "safe and well" messages to families (both locally and internationally) are offered to the returnees, through the PRC's Restoring Family Links (RFL) programme. People who do not originate from Zamboanga City are supported with onward transportation arrangements. The PRC chapters in other provinces stand by to receive returnees and provide them with support.

Aside from access to their basic services, returnees are also provided with non-food items like sleeping materials and hygiene kits. Alongside distribution, hygiene promotion activities have been conducted and clothes distributed to people in need. An additional estimated 3 000 returnees were expected to arrive in Zamboanga during August 2017.

By collaborating with different actors on the ground, and with the support of the IFRC, the PRC has been able to deliver its services in provincial chapters with the help of trained Red Cross volunteers.

At the field level, the PRC chapter in Zamboanga City, where most of the returnees arrive, is coordinating closely with the Department of Social Welfare and Development (DSWD) on the provision of immediate relief and with the health authorities on medical assessments and assistance. The National Society is coordinating with relevant public authorities in Manila (through its National Headquarters) and local government units in Basilan, Sulu, Tawi-Tawi and Zamboanga City (through its chapters) to call for adequate support by the authorities for returnee reintegration, while the PRC National Headquarters is coordinating and collaborating with the Department of Foreign Affairs through its Office of the Undersecretary for Migrant Workers' Affairs (OWWA) in Manila.

Challenges

- **Language barriers:** This is especially in providing psychosocial support. Most of the returnees speak Malay, Tausug and Yakan and there are only several Red Cross volunteers and staff who can speak one or both.
- **Timing of arrivals:** The schedule of arrival of the returnees is irregular and usually falls between midnight and dawn. The PRC chapters are only informed of the schedule seven hours before arrival of the vessel carrying the returnees in Zamboanga City. One of the challenges faced by the chapters is having too little time to inform volunteers and having very limited time to prepare the necessary ingredients (from purchase to preparation) for the hot meals.
- **Coordination:** This could be improved, especially with the local government agencies. Availability of naval transportation to ferry returnees from the State of Sabah to the Philippines.

"I haven't heard from my family for ten months. When I found out that the Red Cross had free phone call and tracing services, I immediately asked for their assistance. I cried when I finally heard my son's voice over the phone." Michelle

"The first thing they do when they arrive at the terminal is ask where the nearest phones are. After they call their loved ones to let them know they are safe, well and alive, they pull out pieces of paper where some of the returnees still waiting for their turn in Sabah have scribbled down the numbers to call to

assure their loved ones that they will be home eventually.” Mary Ann Bernardo, PRC Zamboanga Chapter Service Representative

For more information on the work of the Philippine Red Cross with and for migrants, please contact: Welfare Services Department, Philippine Red Cross’ National Headquarters (Email: welfare@redcross.org.ph).

Source: Philippine Red Cross submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

8. Example by IOM: Population mobility and malaria: review of international, regional and national policies and legal frameworks that promote migrant and mobile populations’ access to health and malaria services in the Greater Mekong Subregion

Context

The Greater Mekong Subregion has experienced consistent economic development in the last decade coupled with the opening of borders and economic corridors, emergence of mega-cities, ease and speed of travel, and accessibility to digital information, thus resulting in an exponential increase in intraregional migration.

The region shows a primary clear pattern of migration characterized by population movements from Cambodia, the Lao People’s Democratic Republic and Myanmar to Thailand. Malaria is endemic in five of the six Greater Mekong Subregion countries – Cambodia, the Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam – with specific high-prevalence areas in the Myanmar–Thailand border and in some provinces of Cambodia.

Practices

As part of a comprehensive strategy to address the issues of migrant and mobile populations (MMPs), within the framework of the goal of global malaria elimination in accordance with the 2008 World Health Assembly resolution on the health of migrants (WHA61.17) and its operational frameworks, the 2015 World Health Assembly resolution on the global technical strategy and targets for malaria 2016–2030 (WHA68.2), the Roll Back Malaria Partnership’s Action and Investment to Defeat Malaria 2016–2030 (AIM) and the Strategy for Malaria Elimination in the Greater Mekong Subregion (2015–2030); and in order to provide an evidence base and guidance for malaria programme managers at the national level, the IOM and WHO collaborated on the review of legal frameworks to provide up-to-date recommendations on the technical implementation and policy implications of addressing malaria for MMPs. The report, therefore, reviews existing national laws, policies and legal frameworks in the five Greater Mekong Subregion countries of Cambodia, the Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam as well as regional and international legal frameworks and policies as they relate to the access of migrants (internal, inbound and outbound) to health services, particularly those for malaria. This initiative addresses priorities 2, 5, 9 and 12 of the WHO framework to promote the health of refugees and migrants.

Results

The use of the term “migrant and mobile populations” appears to have been interpreted in national malaria strategies as exclusively including internal migrants or citizens, but specific reference to inbound migrants is not made. Legal and policy frameworks specifically related to the health of inbound migrants was found to be very limited in Greater Mekong Subregion countries that are predominantly countries of origin, with the exception of Thailand, which is a main country of destination. However, even in Thailand, complete equality of treatment of inbound migrant workers with that of national workers has yet to be achieved. As of 2007 estimates, the Universal Coverage Scheme in Thailand covers 74.6% of the

population. In Cambodia, the Strategic Framework for Health Financing (2008–2015) and the draft Social Health Protection Master Plan are intended to further develop and expand universal coverage of social services – aimed at Cambodian nationals only – using a combination of different approaches, to improve the quality of public and private health services and overall access to them, especially for poor and disadvantaged groups. In Myanmar, commitment has been made to attain universal health coverage (UHC) by 2030. While migrants have been mentioned in initial planning meetings, as of the time of review there are no formal legislative or legal policy frameworks to ensure the inclusion of migrants in UHC activities. The Lao People’s Democratic Republic has no health-care laws that include foreigners and Viet Nam has committed to attaining UHC for at least 80% of its population by 2020. However, as of 2015, all Greater Mekong Subregion countries had adopted national strategies for the elimination of malaria in accordance with WHO malaria frameworks, and all of them specifically recognize MMPs as particularly vulnerable.

Lessons learnt and ways forward

IOM and WHO working together on this activity was considered a significant success and example of close cooperation between the agencies. The joint approach capitalized on IOM’s expertise in migration and multisectoral engagement and harnessed WHO’s expertise in malaria and health policy. It is important that the Greater Mekong Subregion countries amend laws restricting access to health services that are based on hospital or residence registration, and ensure inclusive social protection mechanisms and universal health coverage. A more complete review should be undertaken to examine current efforts of countries on these fronts, while examining how these are guided by the 2030 Agenda for Sustainable Development Goals (Goals 3, 8 and 10) and the 2008 World Health Assembly resolution on the health of migrants (WHA61.17) – particularly regarding key operational frameworks.

Reference materials:

<https://www.iom.int/human-mobility-and-malaria>

http://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/MMP_GMS_Legal%20Frameworks_2017.pdf

Source: IOM submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

9. Example by IOM: JUNIMA – Joint UN Initiative on Migration and Health in Asia

Context

The key drivers of migration are linked to the security, social and economic disparities between countries. Increasing numbers of migrants from Asia have been filling critical labour gaps and providing essential contributions to national economies. However, despite their value, migrants are often exploited, marginalized, experience violations of their basic human rights in terms of pay, working conditions and lack of access to essential health services throughout their migration journey. Migrants throughout Asia engage in a broad range of activities; their working environment, housing conditions and often the absence of family impact on the development of health and psychosocial challenges and make them particularly vulnerable to communicable diseases like HIV, TB and malaria. The Joint UN Initiative on Migration and Health in Asia (JUNIMA) evolved in 2009 from the former United Nations Regional Task Force on Mobility and HIV Vulnerability Reduction in South East Asia (UNRTF), as there was an ongoing need for an effective regional coordination mechanism to advocate for access to health for migrants in Asia.

Practices

Specific challenges identified in regional cooperation on migrant health include:

- lack of migration-related disaggregated data and evidence base for policy and programme development;
- lack of strong regional and bilateral coordination and collaboration on international migration and health issues;
- lack of mainstreaming migrants into national health systems and health security strategies and programmes;
- lack of multisectoral coordination and cooperation on international migration health issues; and
- lack of harmonization of national disease strategies, protocols and programmes.

JUNIMA's vision is for all migrants and their families to have equal access to health care throughout the migration process and to live healthy, productive lives.

JUNIMA's mission is to support multisectoral partners to share strategic information on migration and health, advocate migrant-inclusive, gender-sensitive health policies, and increase investment in migrant health and access to health services at all stages of the migration process for improved regional health security.

Results

The JUNIMA Steering Committee forms the primary governance structure of JUNIMA and is comprised of representatives from governments, civil society organizations, regional associations, development partners and UN agencies.

The Secretariat provides technical assistance and administrative management to support JUNIMA in continuing work towards achieving the following key objectives:

- (1) to ensure that strategic information informs decision-making, policy-making and programming across the region to improve the health of migrants;
- (2) to strengthen multisectoral and multi-stakeholder partnerships to link and operationalize regional and national strategies and action plans on access to health for migrants; and
- (3) to facilitate and advocate regional instruments and national laws and policies, which ensure equal access to health and social services at all stages of the migration process.

Recent programme achievements of JUNIMA involved the development and implementation of an Asian Development Bank-funded memorandum of understanding (MOU) for HIV vulnerability reduction for mobile populations in the GMS. Following the signing of the five-year MOU by all six governments in December 2011, a joint action programme (JAP) to operationalize the MOU was developed in 2012.

Lessons learnt and ways forward

The approach of including governments, civil society and development partners is considered key to the partnership aspect of JUNIMA. This model should be encouraged. There are, however, challenges in mobilizing collective action with different stakeholders.

Reference materials: available upon request.

Source: IOM submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

10. Example by IOM: Malaria in migrant and mobile populations – operational research and migrant mapping to provide targeted response recommendations

Context

Over the past decade, national estimates of malaria morbidity and mortality in the Greater Mekong Subregion has fallen tremendously due to intensified malaria control efforts. However, Greater Mekong Subregion countries still face key challenges such as multidrug resistance, counterfeit antimalarial drugs, widespread population mobility and inadequate coverage of health services among ethnic minorities. Myanmar and Viet Nam have identified migrant and mobile populations (MMPs) as key risk groups vulnerable to malaria, with limited evidence-based interventions being employed by national programmes to reach these populations. In support of national strategic and operational plans, IOM conducted operational research to map migrant populations and identify specific vulnerabilities and barriers to access to inform national malaria control programmes and partners' strategies regarding how to provide migrant sensitive health services.

In the south-eastern region of Myanmar, IOM conducted a mapping study from 2011 to 2013. This study was to map population movement to locate migrant pockets, estimate the size of these populations, assess their migration pattern, determine malaria risk and vulnerability factors, and explore possible mechanisms for control. In Viet Nam, a large-scale knowledge, attitudes and practices (KAP) household survey complemented by an in-depth qualitative study was conducted by the National Institute of Malariology, Parasitology and Entomology in Ho Chi Minh City supported by the IOM and WHO. The focus of this study was to determine the demographics of the MMPs in Binh Phuoc and how and why they are more vulnerable to malaria.

Practices

In the Myanmar mapping project, the lack of clarity on the definition of migrants proved to be a challenge. There was also limited information on migration patterns and flows, as well as on malaria knowledge and prevention among the targeted MMPs. To mitigate this, several rounds of verification and triangulation of available data from this mapping and other sources were conducted to ensure the accuracy of the data and their interpretation to the most possible extent. Similarly, in Viet Nam, the lack of reliable and existing data on migrants and mobile populations due to irregular and short-term movements and the remote locations of these populations proved to be a challenge. The definition and categorization of occupations in relation to malaria risk were also difficult due to the complexity of the forms of livelihood within this population.

Results

The mapping study in south-east Myanmar identified the demographics, migration flows and migrants' access to public health and malaria services, as well as reported malaria epidemic in the region and hotspot locations. The study results were shared widely with the National Program and partners and have been used in planning for improved service coverage in these populations. The surveys conducted in Viet Nam contributed to a better understanding of migration flows and mobility patterns, and how these factors were crucial to malaria prevention. The study also informed a framework to understand vulnerability from an occupational, exposure and access lens. The results were utilized by the National Malaria Program to improve targeting with appropriate interventions of MMPs.

Lessons learnt and recommendations

The two studies described above fulfil priorities 2, 4, and 6 of WHO's framework for promoting the health of refugees and migrants.

The mapping study in Myanmar informed the future design and implementation of mapping study and programmatic response. The summarized study recommendations are:

- Clearly define targeted MMPs in protocols and tools.
- Map the full migration cycle process (departure, transit, arrival and return).
- Work environment instead of occupation is more of a determinant of vulnerability.
- Include relevant information relating to migration and malaria (e.g. forest coverage and behavioural data).
- Integrate qualitative methods.
- Identify higher-risk groups.
- Promote a national malaria campaign and safe migration.
- Conduct targeted interventions in key source communities.
- Conduct routine reporting of population movement at the village level.

The surveys in Viet Nam produced the following recommendations for targeting MMPs:

- Design and conduct behaviour change communication programmes.
- Raise awareness of the role of village health workers.
- Adapt malaria prevention services in line with survey results.
- Improve monitoring record templates and processes at the community level.
- Formulate a long-term malaria control strategy targeting MMPs at national, provincial and community levels.
- Replicate and enhance research methodology especially migrant classification methods.
- Conduct further research on the links between malaria and migration status, and malaria vulnerability and occupation.
- Conduct operational research to investigate specific vulnerability of those traditional vector control methods that are less effective.

Reference materials:

<http://publications.iom.int/books/migration-mobility-and-malaria-study-migrants-vulnerability-malaria-and-epidemiology>
https://reliefweb.int/sites/reliefweb.int/files/resources/Report_Migrant_Malaria_Mapping_SE_2012.pdf

Source: IOM submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

Annex 2: Additional information on Australia

Addressing the health of migrants in Australia

In Australia, the Department of Immigration and Border Protection (DIBP) (incorporated into the Department of Home Affairs in December 2017), conducts pre-migration health screening for most visa applicants. A Health Risk Matrix, based on the tuberculosis risk levels of different countries is used to determine which health examinations are required. An initial medical examination (IME) is part of the visa application process and a voluntary departure health check (DHC) is recommended three days prior to departure to Australia to determine whether the migrant is fit to travel. The information gained from this health assessment is then used to assist in the provision of medical services as part of settlement support and for consideration of continuity of care arrangements after a client's arrival in Australia. Consideration is currently being given to making DHCs mandatory, as without them humanitarian migrants have arrived in Australia with urgent medical needs that had not been identified resulting in delays to the provision of medical attention and interruption to provision of settlement support. The Australian Government contracts IOM panel doctors to undertake the IME and DHC for humanitarian entrants while they are offshore. The costs associated with health conditions are automatically waived in respect of visa consideration for health screening for refugees specifically. This is supported by IOM's submission, which states that they have worked with Australia to build a comprehensive vaccination programme, introducing vaccination against many vaccine-preventable diseases affecting refugee populations early in the process to ensure their protection during resettlement and upon arrival.

Regarding mental health screening for refugees and migrants in Australia, on 20 November 2015, the then DIBP introduced an enhanced mental health-screening assessment to be conducted during the DHC examination for Syrian and Iraqi refugees. The purpose of this enhanced pre-migration mental health screening assessment is to identify any significant mental health conditions in refugees prior to arrival in Australia. This ensures that any mental health conditions in refugees are identified prior to migration, so that they receive appropriate treatment before travel and arrangements can be made for follow-up and specialist appointments on their arrival in Australia. This pre-migration mental health screening assessment was expanded to all refugee and humanitarian subclasses in all locations on 30 June 2017, and includes mental health-screening questions tailored for children. Similarly, Department of Home Affairs reviews all refugee and humanitarian entrants' immunization statuses at the time of the pre-migration IME and provides poliomyelitis (polio) vaccinations to all refugee and humanitarian visa applicants if they have no evidence of previous immunization, and one dose of measles–mumps–rubella vaccine at the DHC. The Department of Home Affairs is looking to strengthen the risk-based approach to immunizations by providing additional immunizations at the time of the IME and DHC for all refugees and humanitarian entrants to cover 10 diseases including MMR, diphtheria, pertussis, tetanus, polio and haemophilus influenza type B in line with the Australian Government's National Immunisation Program (NIP). The expansion of pre-migration vaccinations for the refugee and humanitarian cohort will support the Australian Government in maintaining herd immunity, reduce the risk of onshore outbreak of vaccine-preventable diseases, facilitate streamlined settlement into Australia and reduce the cost burden on Australia's public health system. For all other migrants, Australia encourages immunization of visa applicants, prior to arrival in Australia.

The new Humanitarian Settlement Program (HSP) commenced on 30 October 2017. The streamlined HSP merges existing settlement services into one comprehensive programme that will provide individualized case management support, based on need. It also has a renewed focus on English language, education and employment and introduces new methods to track outcomes over time. Under this programme, all participants receive a case management plan tailored to their specific needs as individuals and more intensive one-on-one support. Case managers work with participants to identify their individual needs and goals and provide support to achieve outcomes including in physical and mental health and well-being, community participation and networking, family functioning and social support, language services, education and training, and employment. HSP service providers will equip clients to be able to

independently access mainstream services to maintain and improve their physical and mental health and well-being. In Australia, migrant and refugee health is a cross-sectoral issue, and, as such, the different branches of government will continue to work closely with each other to identify and communicate all health issues pre-arrival in order to improve settlement outcomes for humanitarian entrants. For example, under the Australian Government's settlement support arrangements, Humanitarian Settlement Services (HSS) providers assist newly arrived humanitarian entrants, based on an assessment of the entrants' needs. This assistance might include securing appropriate accommodation, enrolment in Medicare (the publicly funded universal health care system), and services that assist with securing employment. Participation in the HSS programme is voluntary for migrants and support is provided on a needs basis, which means that not all humanitarian entrants will require all available services.

The provision of services under the Australian Government's settlement support arrangements includes linking clients to relevant health professionals upon arrival. Settlement service providers must book clients in for a comprehensive health assessment (CHA) within four weeks of arrival in Australia. The settlement service provider will assist clients to attend this CHA and any follow-up appointments identified as a result (e.g. immunizations, optical, dental). The CHA will often take place at a refugee health clinic, or if possible, utilizing a general practitioner (GP) specializing in refugee health. Where clients arrive with urgent medical needs, settlement service providers are also responsible for meeting these needs upon arrival (this could be transporting the client to hospital or booking urgent specialist appointments). Settlement service providers are also responsible for referring clients to mental health services (if assessed as required and the client consents to the referral) and for registering a client's health undertaking with the Health Undertaking Service. A health undertaking is an agreement between visa applicants and the Australian Government, primarily designed to ensure that visa holders with a significant health condition are followed up by a subnational government health authority for post-arrival monitoring and treatment, where necessary. Such agreements mainly relate to visa applicants who might be at increased risk of developing active TB as well as some other medical conditions requiring following up, including HIV, hepatitis B or C, syphilis and Hansen's disease.

Refugee health specific services, in partnership with GPs and other primary care health professionals in the community provide health assessments to refugees who have arrived in Australia within the last 12 months. Further, bodies such as the Royal Australian College of General Practitioners Refugee Health Specific Interests Network assists general practitioners who require guidance treating clients with specific issues related to being a migrant and/or refugee.

In addition, the Australian Government funds service providers through the Settlement Grants programme to undertake a range of activities for eligible clients, including workshops designed to educate on a range of issues, such as health, employment, housing and education, available services and how to access them. Workshop topics could include nutrition, the importance of physical health and hygiene, mental health and the importance of health checks. Referrals to appropriate services are also made by service providers where required. The Australian Government provides information in different languages to assist with accessing services through the Beginning a Life in Australia webpages. This includes basic information on accessing health services for all migrant populations.

Sources:

Government of Australia, Department of Health, submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

Monash University submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

IOM submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

Annex 3: Additional information on the Philippines

Table 1: Philippine national laws, plans, and executive orders related to migration health

Name	Year	Provisions that are related or may contribute to migration health
Philippine Immigration Act (Commonwealth Act No. 613)	1940	Section 15-17: Documentation of immigrants to the Philippines, including presentation of unexpired passport and visa Section 28 & 29: Subjecting arriving foreign nationals to medical examination and determining grounds for exclusion from entry to the Philippines Section 35: Owner or owners of vessels transporting any alien to the Philippines shall bear the maintenance cost, including medical treatment in hospitals if needed, while the foreign national is temporarily removed from the vessel during examination of immigration officers.
Labor Code of the Philippines	1974	Article 3: State's assurance of just and humane work conditions Article 12 (b): Securing best possible terms and conditions of employment among Filipinos who aspire to work overseas Article 17, 19, 20: Creation of Boards tasked to protect the migrant workers' right to fair and equitable employment practices
An Act Creating the Commission on Filipinos Overseas and for other Purposes (Batas Pambansa Bilang 79)	1980	Section 3 (b,c,d): Formulation, implementation, and monitoring of integrated welfare programmes for overseas Filipinos
Reorganizing the Ministry of Labor and Employment, creating the Philippine Overseas Employment Administration, and for other purposes (PD797)	1982	Section 4 (a): Formulation of a systematic programme for promoting and monitoring the overseas employment of Filipino workers, including seamen, and protection of their work rights
Constitution of the Philippines	1987	Article II, Section 15 and Article XIII, Section 11: The State's obligation to protect and promote the right to health of all people Article II, Section 18 and Article XIII, Section 3: The State's obligation to protect the rights and welfare of workers, including migrant workers
Directing the Adoption of Country-team Approach in the conduct of Development Diplomacy (EO 74)	1993	Section 1: On a per country basis, all government representatives from the Philippines in foreign service posts will act as one-country team under the leadership of the Ambassador Section 3. Establishment of the Development Diplomacy Committee from selected existing Cabinet clusters as a technical adviser in the formulation and implementation of work programmes
Directing the Deployment/Posting of Social Welfare Attaches in Selected Diplomatic Posts (EO 287)	2004	Section 1: Deployment of social welfare attaches to countries with highest concentration of overseas Filipino workers (OFWs) Section 2: Social welfare attaches are tasked to respond to and monitor the resolution of problems and complaints of OFWs and their families
Magna Carta of Women	2008	Section 22: The State's obligation to protect and promote the rights and welfare of migrant women Section 37: Designation of Gender Focal Point Officer in Philippine embassies and consulates
Philippine Development Plan 2011-2016	2010	Improving access to quality health and nutrition services by increasing the National Health Insurance coverage and enrolment and enhancing other social security programmes, including for migrant workers

Philippine Labor and Employment Plan 2011-2016	2010	Universal coverage of social services, expanded benefits in employment opportunities, accessibility of social protection and safe work for all, including labor migrants overseas
Migrant Worker and Overseas Filipinos Act (RA 8042), as amended (RA 9422 and RA 10022)	1995, 2006, 2010	RA 8042, Section 2: Upholding the dignity of Filipino migrants is the paramount interest of the State RA 8042, Section 4: Deploying Filipino workers only to countries that can assure the protection of the rights and welfare of OFWs RA 8042, Section 19: Establishing the Migrant Workers and other Overseas Filipinos Resource Center (MWOFRCS) in Philippine embassies RA 8042, Section 20: Establishment of the Shared Government Information System for Migration (SGISM) RA 8042, Section 27: Placing the protection of Filipinos abroad as the highest priority of the Philippine Foreign Service Post RA 8042, Section 28: Adoption of Country-Team Approach RA 10022, Section 16: Role of DOH in regulating OFW medical clinics RA 10022, Section 23: Provides compulsory insurance coverage for agency-hired workers
Anti-Trafficking in Persons Act (RA 9208), as amended (RA 10364)	2003, 2012	Section 2: Mitigating pressures for involuntary migration and servitude of persons and ensuring recovery and reintegration of trafficked persons Section 4: Recruiting a person, including those promised for overseas employment, for various forms of exploitation is deemed unlawful Section 10: Protection of the trafficked persons' right to 43 confidentiality Section 15 (a): DFA shall repatriate trafficked Filipinos with the consent of the victims Section 15 (b): DSWD shall implement protective and rehabilitative programs for trafficked persons, including psychological support and counselling Section 15 (h): POEA shall implement PEOS while PDOS shall be conducted by the OWWA Section 20: Establishment of IACAT, tasked to combat human trafficking activities Section 21 (h): Formulating a programme by IACAT for the reintegration of trafficked persons in cooperation with DOLE, DSWD, Technical Education and Skills Development Authority (TESDA), Commission on Higher Education (CHED), LGUs and NGOs Section 21 (j): Complementing the Shared Government Information System for Migration established under RA 8042 with data on cases of trafficking in persons
Guidelines on Maritime Occupational Safety and Health	2013	Rule I Section 4: Duty of the ship owner to arrange that work in the ship is carried out in a manner that does not endanger the health and safety of any seafarer Rule II Section 1: The ship owner shall adopt implement and promote occupational safety and health policies and programs on ships Rule II Section 5: Occupational Health Program to prevent accidents, illnesses or deaths and promote the health of seafarers
National Health Insurance Act (RA 7875), as amended (RA 10606)	1995, 2013	Section 6: Mandatory coverage by the National Health Insurance Programme to all citizens of the Philippines Section 12: Inclusion of a permanent representative of Filipino migrant workers in the Board of Directors
Philippine AIDS Prevention and Control Act (RA 8504)	1998	Section 7: HIV/AIDS education for all overseas Filipino workers and government officials to be assigned overseas

Transferring the Medicare funds and the Medicare functions of the Overseas Workers Welfare Administration to the Philippine Health Insurance Corporation (EO 182)	2003	Section 1: Coverage by PhilHealth to all Overseas Filipino Workers and their families Section 2. Transfer of Medicare funds from OWWA to PHIC Section 3. Transfer of Medicare operations from OWWA to PHIC
Quarantine Act (RA 9271)	2004	Section 3: Examination and surveillance of incoming and outgoing vessels and aircrafts at the Philippine ports for sanitary conditions Section 4: Enforcement of regulations and penalties to prevent the introduction and spread of "public health emergencies of international concern" Section 6: Establishment of quarantine stations under the supervision of the Director of the Bureau of Quarantine (BOQ)
DOH	AO 2008-0027	One-Stop Shop System for the Regulation of Medical Facilities for Overseas Workers and Seafarers, Non-Hospital-Based Dialysis Clinics and Non-Hospital-Based Ambulatory Surgical Clinics with Ancillary Services
DOH	AO 2008-0028	Schedule of Fees for the One-Stop Shop System for the Regulation of Medical Facilities for Overseas Workers and Seafarers and non-Hospital-Based Dialysis Clinics and Non-Hospital-Based Ambulatory Surgical Clinics with Ancillary Services
DOH	AO 2011-0015	Guidelines on the Prohibition of Referral / Decking Practice of OFW Clinics and Respecting the Right of Overseas Filipino Workers (OFWs) to Choose their Own OFW Clinics for Medical Examination pursuant to Republic Act No. 10022
DOH	AO 2013-006	Guidelines to "Rule XI: Role of DOH in the Omnibus Rules and Regulations Implementing the Migrant Workers and Overseas Filipino Act of 1995, as Amended by Republic Act No. 10022"
DOH	AO 2016-0007	National Policy on the Health of Migrants and Overseas Filipinos
DSWD	AO 6, S. 2008	Amendment to the Omnibus Guidelines on the Implementation of the International Social Welfare Services for Filipino Nationals (ISWSFN) Project
DSWD	AO 3, S. 2008	Guidelines on the Comprehensive Delivery of Reintegration Services for Deportees, Repatriates, and Returned Irregular Overseas Filipino Workers
DSWD	AO 6, S. 2013	Guidelines on the Management of Social Welfare Attache Office at the Philippine Embassy/Foreign Posts and Selection and Placement of Social Welfare Attaches
POEA	N/A	POEA Rules and Regulations Governing the Recruitment and Employment of Land-based Overseas Workers
POEA	N/A	POEA Rules and Regulations Governing the Recruitment and Employment of Seafarers
POEA	N/A	Insurance Guidelines on Rule XVI of the Omnibus Rules and Regulations Implementing Republic Act 8042, as amended by Republic Act 10022 Relative to Compulsory Insurance Coverage for
POEA	DO 130, S. 2013	Rules and Regulations on the Employment of Seafarers Onboard Philippine Registered Ships Engaged in International Voyage
OWWA	N/A	Omnibus Policies of the Overseas Workers Welfare Administration

Table 2: Government agencies involved in the governance of migration and refugee health in the Philippines

Name of Agency	Mandate	Role in Migration
Philippine Overseas Employment Administration (POEA)	Facilitate overseas employment and regulates private sectors, including recruitment agencies and employers from destination countries.	<p>Incorporate health information in Pre-Employment Orientation Seminars (PEOS).</p> <p>Ensure that the protection and promotion of the health of Filipino labour migrants are explicitly stated in bilateral labour agreements and employment contracts.</p>
Overseas Workers Welfare Administration (OWWA)	Provide welfare services such as reintegration, loans and insurance, education and training, including a Pre-Departure Orientation Seminar among Filipino migrant workers.	<p>Ensure that adequate disability and death benefits are provided on time when needed.</p> <p>Through its overseas workers welfare officers, provide holistic assistance, including psychosocial support, for overseas Filipinos in distress.</p> <p>Monitor and expand health-related content in the Pre-Departure Orientation Seminar (PDOS).</p> <p>In partnership with the DOH, conduct health activities for returning migrants i.e. medical repatriation assistance program.</p>
International Labor Affairs Bureau, Department of Labor and Employment (DOLE-ILAB)	Develop policies and programmes on international labour and employment in accordance to the standards and guidelines set by international commitments and declarations.	<p>Negotiate with destination countries for better access to health care for Filipino labour migrants overseas.</p> <p>Ensure that the protection and promotion of health of Filipino labour migrants are explicitly stated in bilateral labour agreements.</p> <p>Build capacity of POLOs and MWOFRCS to provide basic migrant-sensitive health services.</p>
Office of the Undersecretary for Migrant Workers Affairs, Department of Foreign Affairs (DFAOUMWA)	Support the formulation and execution of policies to protect and promote the welfare and dignity of overseas Filipinos.	<p>Advocate for more inclusive and health-promotive migration policies in international, regional and bilateral platforms.</p> <p>Coordinate between embassies/consulates and Philippine-based departments in addressing the health needs of migrants in destination countries and during transit.</p> <p>Through its embassies/consulates and with support from DOH, DOLE, and other agencies, conduct activities that promote health among Filipinos overseas.</p>

National Reintegration Center for OFWs (NRCO)	Provide a mechanism for reintegration, promotes employment in the country, and facilitate transfer of skills for national development among migrant workers.	In partnership with the DOH, conduct health activities for returning migrants.
Commission on Filipinos Overseas (CFO)	Provide a Pre-Deployment Orientation Seminar (PDOS) and other health promotion programmes to overseas Filipinos as well as strengthen the ties between them and their motherland (e.g. BalikBayan project).	Conduct health promotion activities for Filipinos overseas, in partnership with DFA and migrant associations.
Institute for Labor Studies (ILS)	Conduct policy research and advocacy to promote better labour policies in the country for the advancement of OFWs' welfare.	Perform research studies on the health and wellbeing of overseas Filipino workers.
Bureau of Immigration (BI)	Monitor and regulate the flow of international migration to and from the country among Filipinos and foreign nationals through the system of registration, exclusion, and repatriation.	Record health-related information in border control (i.e. arrival and departure cards). Train immigration officials on ethical and professional attitude towards migrants and travellers.
Inter-Agency Council Against Trafficking (IACAT)	Formulate and enforce policies and programmes in cooperation with various law enforcement institutions such as police and military units in order to combat any forms of human trafficking activities.	Coordinate with DOH and other health facilities in addressing the health needs of trafficked persons being rescued by any of its member agency.
Department of Social Welfare and Development (DSWD)	Provide various forms of assistance such as counselling and shelter to overseas Filipinos, especially the undocumented and the distressed.	Through its social welfare attaches, provide holistic assistance, including psychosocial support, for overseas Filipinos in distress, especially the undocumented.
Social Security System (SSS)	Facilitate a sound and viable tax-exempt social security system to Filipino workers and their dependents as a protection against financial burden caused by death, disability, and other contingencies.	Provide adequate and timely health-related benefits to OFW members.
Insurance Commission (IC)	Ensure availability of adequate and equitable insurance protection for every Filipino through regulation of insurance companies.	Monitor compliance among insurance companies offering compulsory insurance packages to OFWs to ensure adequate protection especially from health-related risks. Regularly publish list of insurance companies that provide adequate compulsory insurance and comply with the provisions of the RA 10022.

Civil Aviation Authority of the Philippines (CAAP)	Ensure a safe and efficient national air transport system through the formulation and enforcement of guidelines and standards of practice.	Maintain healthy and safe spaces and facilities in domestic airports, including detention areas. Train airport staff on ethical and professional attitude towards migrants and travellers. Ensure availability of first-aid medical facilities within airport premises.
Manila International Airport Authority (MIAA)	Control all the international airports in the Philippines and ensure safe and efficient air navigation.	Maintain healthy and safe spaces and facilities in international airports, including detention areas. Train airport staff on ethical and professional attitude towards migrants and travellers. Ensure availability of first-aid medical facilities within airport premises.
Philippine Ports Authority (PPA)	Develop and implement policies and programmes to improve seaport operations, including maintenance of the infrastructures and facilities.	Maintain healthy and safe spaces and facilities in Philippine seaports, including detention and holding areas. Train seaport staff on ethical and professional attitude towards migrants and travellers. Ensure availability of first-aid medical facilities within seaport premises.
Philippine Coast Guard (PCG)	Perform preventive measures to ensure the safety of merchant vessels navigating within the immediate seas surrounding the Philippine archipelago.	Perform ethical medical assessment of intercepted persons in Philippine waters.
Philippine Navy	Protect the seas of the country, especially the distal part under the Philippine economic zone as defined by the Constitution.	Perform ethical medical assessment of intercepted persons in Philippine waters.
Maritime Industry Authority (MARINA)	Implement an efficient Maritime Industry Development Programme (MIDP) in the country.	Consider health and safety in setting standards and monitoring ships and related facilities.
Local Government Units (LGUs)	Share with the national government the responsibility in implementing national health programmes and projects in municipalities and barangays.	Provide health services to migrants travelling or intercepted in nearby airports or seaports especially in times of emergency, as well as medically repatriated overseas Filipinos.
Department of Justice-Refugees and Stateless Persons Protection Unit (DOJ-RSPPU)	Lead agency that provides protection over the plight of asylum seekers, refugees, and stateless persons, through the RSPPU.	Refers persons of concern (POCs) who need health assistance to the Migrant Health Unit of the DOH.

Source: Government of the Philippines, Department of Health submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

Annex 4: Additional information on the Republic of Korea

Legal frameworks supporting the health of migrants

Infectious Disease Control and Prevention Act: supports some of the costs of inpatient care, investigation and diagnosis that are incurred by legal actions against infectious disease outbreaks.

National Health Promotion Act: has led to the running of health promotion programmes for marriage immigrants and multicultural families. Other services include nutrition management programmes.

Support for Multicultural Families Support Act: has led to the formation of a committee on multicultural family policy, chaired by the Prime Minister. Programmes and initiatives that have resulted from the Act and subsequent Committee include:

- Settlement support programmes: multicultural family support centres provide case management, interpretation and translation, and child development support (household outreach for life education and fostering a bilingual environment)
- Multicultural family support centres (21 in 2006, 159 in 2010, 217 in 2017) which provide Korean language courses, interpretation and translation, family education and counselling and other services
- The Republic of Korea is gradually expanding self-reliance support packages, which help marriage immigrants, develop their own settlement plan, explore relevant services and establish action plans.

The Act also seeks to support the healthy development of children from multicultural families and developing global talents. As part of this, the Republic of Korea:

- provides various programmes for children with multicultural backgrounds, which foster a healthy sense of identity, healthy relationships with parents, social skills and leadership;
- runs a household outreach programme for elementary schoolers or younger children to help them develop Korean language skills, acquire basic learning skills, and adapt to school; and
- fosters a bilingual home environment to strengthen bilingual skills and enhance communication among family members. In 2016, the Government established a database of bilingual talents.

Another aspect of the Multicultural Families Support Act included increasing multicultural education to promote diversity. As part of this, the Republic of Korea established an online education system to promote diversity tolerance among people in 2016. A public outreach programme for multicultural education is also run.

Sources:

Government of the Republic of Korea, Ministry of Health and Welfare submission to the online invitation to submit evidence-based information, best practices, experiences and lessons learnt on addressing the health needs of refugees and migrants.

Republic of Korea. Infectious Disease Control and Prevention Act. Wholly Amended by Act No. 9847, 29 Dec 2009

(https://elaw.klri.re.kr/eng_mobile/ganadaDetail.do?hseq=37239&type=abc&key=INFECTIOUS%20DISEASE%20CONTROL%20AND%20PREVENTION%20ACT¶m=1, accessed 9 March 2018).

Republic of Korea. National Health Promotion Act. Law No. 13986, Partially revised on 3 February 2016 [unofficial translation].

(<https://www.tobaccocontrollaws.org/files/live/South%20Korea/South%20Korea%20-%20National%20Health%20Promotion%20Act%20%28No.%204914%29%20of%201995.pdf>, accessed 9 March 2018).

Republic of Korea. Support for Multicultural Families Act. Act No. 8937, 21 Mar 2008.

(<http://www.moleg.go.kr/english/korLawEng?pstSeq=58481>, accessed 9 March 2018).