

Health of refugees and migrants

Practices in addressing the health needs
of refugees and migrants

**WHO South-East Asia Region
2018**

Table of Contents

COUNTRIES HIGHLIGHTED

Bangladesh		4
India		5
Maldives		6
Myanmar		7
Nepal		12
Sri Lanka		17
Thailand		20
Regional Initiatives		24

In response to a request, in World Health Assembly resolution 70.15, the World Health Organization issued a global call for information, including case studies, on current policies and practices and lessons learned in the promotion of refugee and migrant health. This document is based on information gathered from the contributions from Member States, IOM, UNHCR, ILO, other partners and WHO regional and country offices, in response to that global call, as well as from literature searches and reports available in the public domain. They are therefore presented without any claim to completeness. Furthermore, WHO has not independently verified the information from the contributions unless otherwise stated. Moreover, this is a “living” document which will be updated periodically as new information becomes available.

BANGLADESH

Promoting occupational safety and gender equality and empowerment

CONTEXT: Bangladesh is a major country of origin of migrant workers. According to current data, in 2017, there were 7.2 million Bangladeshi migrants. Over 80 percent of Bangladeshi migrant workers are employed in Gulf countries, a significant percentage of which are women working in the domestic sector. Despite the economic advantages of working abroad, Bangladeshi migrant workers often experience unsafe and indecent working and living conditions.

PRACTICES:

Develop, reinforce and implement occupational health safety measures: The Government Bureau of Manpower, Employment and Training (BMET) has developed and implemented training programs and pre-departure briefing sessions to prepare intending migrants for employment abroad and inform them of their rights as well as specifically raising awareness on disease risks and prevention, including HIV.

Promote gender equality and empower refugee and migrant women and girl: BMET provides training through thirty-eight Technical Training Centres, of which six are exclusively for female workers. The course curriculum is developed according to requirements outlined by foreign employers and its content covers languages, rights, information on the migration process, and personal safety. The twenty-one-day household-training curriculum includes modules of varying duration on HIV/AIDS that provide an overview of the ways through which the virus spreads and available preventive measures. The trainees are given a handbook with additional information on HIV/AIDS. Trainers are professional instructors, and doctors and health caregivers are invited as guest lecturers. In addition to the official program, the Bangladeshi Ovhibashi Mohila Sramik Association (BOMSA) offers female migrant workers a two-day pre-departure training programme that covers financial and personal management, and information on rights and health, including HIV/AIDS. Annually, 7,000 to 8,000 women are trained in different technical areas at these centres.

Prevention and control of HIV/AIDS: Roadside centres are a considered a solution to issues faced by road transport workers, particularly truck drivers. A joint programme by the International Transport Workers' Federation and Care-Bangladesh led to the setting up of an estimated network of 45 drop-in centres nationwide with a system of condom distribution through peer outreach to workers and more than 200 depot-holders (workers promoting good health practice and use of clinics in the communities), which helped avoid stigmatization and empower truck drivers' HIV protection abilities. Four thousand transport workers received services every month from the programme and were able to spend leisure time in these centres with their friends while receiving general medical services and HIV information and treatment.¹

(Source: Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action; International Labour Office – Geneva: ILO, 2016)

Bangladesh-Jordan: Bilateral Agreements

Practices: The bilateral agreements have been signed between the governments of Bangladesh and Jordan, in effect enabling Bangladeshi women aged 25–46 years to be legally recruited as domestic workers for households in Jordan. The governments agreed that the Jordanian employers should pay the full cost of recruiting women from Bangladesh, including paying their visa fees and airfare. The agreement also stipulated that the employers should provide employees with private sleeping quarters and food, purchase a life insurance policy for the employee that covers the entire period of employment, and should open a bank account into which the domestic worker's salary should be deposited each month. These types of bilateral agreements overlay existing labour and migration legislation and compensate for the fact that certain sectors, most notably domestic work, are frequently not covered by national labour law. They also provide a framework for redress, both by individual workers and also by states. However, these agreements must be underpinned by consular resources and investment in outreach to foreign workers, along with effective monitoring and dispute resolution mechanisms².

¹ New Tactics in Human Rights. 2006 *Engaging Key Stakeholders: Ensuring the Rights to HIV/AIDS education and health care services*. <https://www.newtactics.org/tactic/engaging-key-stakeholders-ensure-right-hiv-aids-education-and-healthcare-services> [accessed 25 September 2015].

² Women on the move: Migration, care work and health

INDIA

Intervention on HIV and AIDS by Trade Union

CONTEXT: HIV risk among migrant construction workers in India is especially high. A 2008 study in Panvel, Maharashtra revealed that 25 per cent of workers reported having unprotected sex with sex workers and low or inconsistent condom use. A number of women reported facing regular sexual harassment at work and engagement in sex work as a result of force or coercion. Nirman Mazdoor Sangh (NMS), an Indian trade union, has taken up a project in collaboration with the ILO in order to organize construction workers, and improve their conditions of employment, welfare, social security and enhance their access to health care.

PRACTICE: Prevention strategies included behaviour change communication, condom promotion and management of sexually transmitted infections, along with improving access to care and support services through a referral network in collaboration with the Maharashtra State AIDS Control Society. It has also formed workers' committees, through which peer education sessions and comprehensive training enhance workers' knowledge and awareness of HIV prevention, treatment and care strategies.

RESULTS: This intervention reached construction workers and their families in six *nakas* (market places), three *bastis* (workers communities) and six construction sites. By 2009, 6,598 workers had been enrolled under the insurance scheme of the Government. From October 2008 to May 2009, 566 workers were referred for treatment of sexually transmitted infections, 354 workers were referred for counselling and 5 workers started to receive free antiretroviral therapy. This union-led intervention on HIV and AIDS served as an inspiration for other ILO projects in India under the grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria (e.g. in Andhra Pradesh and in Delhi). In Delhi, the project works in close collaboration with a non-governmental organization that carries out interventions with sex workers. The union-centred approach enables participating organizations to reach out to the clients of sex workers, most of whom are employed at nearby construction sites. The National Policy on HIV and AIDS and the World of Work (2009) covers both internal as well as international migrants.³

(Source: Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action; International Labour Office – Geneva: ILO, 2016)

MALDIVES

Improving communication and counter xenophobia

CONTEXT: Migrants in the Maldives comprise approximately a quarter of the country's total workforce, with the majority originating from South Asian countries, including Bangladesh (58%), India (24%) and Sri Lanka (10%). Many migrant workers are engaged in low-skilled labour in the construction and tourism industries. Migrant workers are often exposed to various vulnerabilities. This situation is further exacerbated by the very centralized and overwhelmed basic resources and services in the country. Poor living conditions, inadequate regulatory frameworks and issues relating to human trafficking have further compounded concerns for the health and safety of migrant workers. A study into the life of Bangladeshi workers in Maldives observed that an alarming 78% were unaware of health and safety issues. Furthermore, 56% of migrant workers reported being dissatisfied with their living, working and relationship conditions – including concerns linked to sexual and reproductive health. Poor living and working conditions for migrant workers often exacerbate their health and safety vulnerabilities. This also leads to the prevalence of communicable diseases including vector borne diseases such as Dengue and Chikungunya. Previous emergency response operations have shown that foreign workers are often marginalised in these operations, particularly those who do not hold a valid work permit.

PRACTICE: In 2016, the Maldivian Red Crescent (MRC) undertook a two-month project on increasing awareness of migrant rights, dissemination of information on communicable diseases, public health and human trafficking through partnership with IOM. Through this project, MRC Male' Branch reached out to the migrant population to recruit MRC volunteers who are migrants themselves. This resulted in new MRC volunteers from Bangladesh, India, Nepal and Sri Lanka who expressed an interest in participating in branch

³ ILO: Reaching out to migrant construction workers in India (1 January 2009) http://www.ilo.org/aids/good-practices/WCMS_161169/lang--en/index.htm [accessed 25 September 2015].

activities. A key achievement has been the recruitment of volunteers from migrant communities, and the relationship built with these groups. The benefits of a truly diverse volunteer base were seen when the Maldives experienced an outbreak of the H1N1 Influenza virus in March 2017. Reports showed that throughout the country, more than 185 people tested positive for H1N1 and four people died from the virus. In response, the Maldivian authorities declared a national alert (level 3) to prevent the spread of the virus, and Maldivian Red Crescent staff and volunteers supported the national efforts by developing and disseminating information, including to migrants, on protecting themselves from infection. This was done by developing a communications package which included flyers, posters and videos. Materials were also developed in nine languages commonly used by migrants, including Bengali, Chinese, Filipino, Malayalam, Nepali and Tamil. Volunteers from migrant groups were involved in the development, translation, dissemination and explanation of the information, as well as the education and communications (IEC) materials. The Male' Branch of MRC also established an Information Dissemination Centre in the capital and volunteers contacted 98 private companies where migrant workers were employed to assess their health status and information needs. These companies were also provided with IEC materials for dissemination. MRC emailed the communications packages to more than 500 companies (including 60 tourist resorts). With the proactive efforts of MRC, more than 4,500 migrant workers were contacted through the outreach efforts, and more than 12,690 flyers in different languages were distributed throughout the Maldives.

At the end of 2016, an event to "Celebrate Diversity" was held in conjunction with International Migrants' Day. The purpose of the event was to celebrate the diverse cultures and nationalities of people living in Male', by creating an environment where migrants and locals can meet and socialise. Several government agencies and foreign embassies participated in the event, including the Maldivian Health Protection Agency, Department of Immigration and Emigration, Ministry of Economic Development Police Service, Labour Relations Authority, Human Rights Commission of Maldives, Transparency Maldives, the Society of Health Education (NGO), as well as the Embassies of China, India and Sri Lanka. Highlights of the event included the sharing of food, music and dances of different migrants' groups, as well as free HIV testing, and information about legal aid services for migrants. An estimated 1,000 people attended the event, including the Minister of Health as the Chief Guest, the Indian and Chinese Ambassadors, and other dignitaries.

Lessons learned and challenges: The H1N1 prevention activities highlighted the many challenges and barriers migrants in the Maldives face in accessing health services. MRC had been working with the Policy level of the Ministry of Health and other Government partners to develop a regular service that can cater to the health needs of the migrants. Challenges include: migrant volunteers have constraints on their available time for MRC activities, unfavourable policy environment for working with irregular migrants, lack of resources and skills in the MRC to work with migrants, reaching migrants in more remote islands, and limited data available on migrants and their health and social wellbeing.

(Source: Maldivian Red Crescent)

MYANMAR

Promoting refugee and migrant health

CONTEXT: According to the UNOCHA report in 2017, there are about 644,000 migrants and internally displaced people in Myanmar due to natural disasters and conflicts. Most of them are in conflict affected Rakhine, Kachin and Shan (North) States, and flooding-affected Regions like Ayeyarwaddy, Mandalay, Magway and Bago Regions. Economic City Yangon also has migrant populations in slum areas.

Promote refugee- and migrant-sensitive health policies, legal and social protection and programme interventions

PRACTICE: Health Care Management Working Committee has addressed the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants. A Disaster and Public Health Emergency Response Unit under Department of Public Health has been established as a focal point to manage the health aspect of disasters including social disaster and internally displaced persons' camps. The unit takes guidance from health care management, receives reports from State and Regional Health Departments and disseminates guidelines, policy and standard operation procedures, cooperates with other government and non-government sectors and develops immediate, short- and long-term plans for refugees and migrants.

Lessons learned and challenges: There are limited technical, human and financial resources.

Addressing the social determinants of health and health inequality for refugees and migrants: The Ministry of Health and Sports (MOHS) in cooperation mainly with the Ministry of Social Welfare, Relief and Resettlement and the Ministry of Labour and other Ministries has clear legal frameworks, regulations and policies in place, altogether addressing the social determinants of health and health inequality for refugees and migrants.

PRACTICE: Local and international NGOs in cooperation with government officials address accessibility, availability, acceptability of housing, water and sanitation, nutrition, environment and employment. Initiatives include primary health care services by mobile health teams in temporary camps, community clinics in rural migrant areas ensuring public health services including nutrition, water and sanitation. Furthermore, accessibility to housing and employment are addressed by the Social, Relief and Resettlement Scheme.

Lessons learned: Community awareness to health services and community involvement is very low as migrants and refugees are usually low-educated and more interested in daily work than health. Differences in needs persist to be a challenge in providing health services to diverse migrant and refugee populations. Health literacy promotion, creation of supportive environment to draw more interest in health scheme, and more cooperation and coordination of related sectors are vital.

Provision of equitable access to universal health coverage, including access to quality essential health services, medicines and vaccines, and health care financing for refugees and migrants: UHC, SDGs and Essential Health Services Access Project are included in National Health Plan of MOHS to be achieved in 2030.

PRACTICE: The initiative has focused on nine strategic areas to implement UHC and has worked to establish building the country's health system and in all townships of the country. It has also worked to establish frontline primary health care and service delivery readiness. Over a four-year period, US\$ 100 million will be spent for the Essential Health Services Access Project. Furthermore, advocacy meetings and capacity building training will be conducted in all states and regions and will not be limited to areas with a high percentage of migrants.

Promoting people- centred, gender-, refugee- and migrant -sensitive health policies and health systems and programme interventions: Ministry of Health and Sports (MOHS) has developed frameworks, regulations and policies in cooperation with other local nongovernmental organizations (NGO) and international nongovernmental organizations (INGO) forming a Health Cluster to promote migrant health system and programme interventions.

PRACTICE: A Health Cluster meeting was held in July 2017 to promote health policies, systems and programme interventions in IDP areas. Intervention of INGOs have somewhat overlapped in some areas as they have targeted the same population.

Recommended future priority actions: Equal distribution of programmes and project to all migrants according to health needs is required.

Provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants: MOHS in cooperation with other local NGO and INGO provide short-term and long-term public health intervention to reduce mortality and morbidity among refugees and migrants. Mobile health teams provide primary health care services, including medical care and transfer of patient, routine and supplementary immunizations, child health and nutrition programs, maternal and reproductive health services, and the TB/HIV/Malaria Project.

Promoting continuity and quality of care for refugees and migrants: MOHS, in cooperation, with WHO and other INGOs developed many health care plans to promote continuity and quality of care for migrants.

PRACTICE: For continuity, local people are being selected and trained, giving opportunity to health staffs. Quality of care is strengthened by orientation training to newly health staff and reorientation as well as refresher training to existing health staff. Additionally, the Field Epidemiology Training Program and EWARS Training are provided to mobile teams. Dissemination of revised and updated guidelines as well as standard operating procedures (SOP) is carried out.

Lessons learned: Due to the multitude of risks in migrant areas, security of health staff is very important in order to achieve continuity of care.

Prevention and control of communicable and non-communicable diseases, including mental health for refugees and migrants: MOHS has introduced the WHO early warning alert and response system to prevent and control communicable diseases in migrant areas. Furthermore, an Early Warning Alert and Response System (EWARS) for communicable disease surveillance in IDP Camps has been established. Guideline and

standard operation procedures for health management of IDP Camps are revised. Furthermore, the PEN project for prevention and control of non-communicable diseases was not limited to migrant areas.

PRACTICE: The EWARS system is being used in IDP camps, and there is dissemination of information to IDPs. Mobile health teams also provide health knowledge about communicable and noncommunicable diseases. Furthermore, the Central Epidemiology Unit in conjunction with State and Region Special Disease Control Unit is always ready to respond to any outbreak of communicable diseases in migrant areas. Mental Health services are provided by social health workers and psychiatrists.

Recommended future priority actions: A Supportive environment to establish a healthy lifestyle should be established as well as an increase in community involvement.

Improving the health and well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee and migrant women and girls: MOHS closely in contact with Ministry of Social Welfare, Relief and Resettlement, and other local NGOs such as Myanmar Maternal and Child Welfare Association and INGOs ensure the improvement of health and well-being of all women, children and adolescents, not limited to migrant settings.

PRACTICE: Maternal and reproductive health programmes providing family planning and unmet needs and a child health programme providing the minimum essential package of interventions as well as integrated intervention packages have been implemented. Additionally, a nutrition programme providing iron supplement to adolescent girls and women have been put in place.

Addressing the health of migrant workers, occupational health safety measures, including improving working conditions addressing health workforce shortages:

PRACTICE: The Occupation and Environmental Health Division under the Department of Public Health in cooperation with the Ministry of Labour is improving working conditions and health of workers, not limited to migrant workers. Regular and surprise checking of safety and health of workers according to occupational risk, and health education of workers for their safety according to hazard expose.

Lessons learned: A challenge persists in addressing the health of cross-border migrants.

Health monitoring and health information systems for refugees and migrants: The Relief and Resettlement Department under the Ministry of Social Welfare as well as the Relief and Resettlement Department of Public Health under the Ministry of Health and Sports (MOHS) monitor the health status and health information of migrant populated areas. The Health Management and Information System (HMIS) and the Early Warning Alert and Response System (EWARS) for communicable disease surveillance are in place.

PRACTICE: The health status and information of migrants and refugees reported by the respective regional Public Health Department are being monitored by the Disaster and Public Health Emergency Response Unit.

Communication and countering xenophobia: Ministry of Health and Sports (MOHS) counter xenophobia of migrants whenever providing health care services.

PRACTICE: Advocacy meetings with local community leaders and holding of awareness campaign. Furthermore, recruitment of voluntary workers from the migrant community has helped to provide health care services as well as to overcome language barriers.

Lessons Learned: Escorting of the local authority and security can increase safety for health care providers, however, this can lead to decreased utilization of services.

Partnerships and cooperation, intersectoral, intercountry, in-country and interagency coordination and collaboration mechanisms: MOHS has been partnering with many local NGOs and INGOs to promote migrant health. A Health Cluster unit which consists of the MOHS and INGOs, such as WHO and UNICEF, was organized in addressing migrant health. Frequent health cluster meetings are held at various levels.

(Source: Disaster and Public Health Emergency Response Unit, Department of Public Health, Ministry of Health and Sports)

Establishment of a Migrant Health Unit within the Ministry of Health and Sports

CONTEXT: Myanmar shares borders with 5 neighbouring countries (China, India, Thailand, Bangladesh, Laos) and is an ethnically and culturally diverse country. Migration is considered to be one of the defining issues in Myanmar in the next decade. The level of both internal and international migration is expected to increase in

all states and regions of Myanmar, with likely changing patterns and implications. Myanmar is primarily a migrant sending country, with significant internal migration. Migration patterns include seasonal, long-term, urbanization and cross-border, and is increasing as development increases. Forced migration due to natural disasters, climate change, trafficking and conflict-related displacement are also present in several areas. Migrants and Mobile Populations are considered key populations for Malaria, TB and HIV intervention programs. There is some evidence that internal migrant women and children have less access to MNCH services compared to host communities.

Advocate mainstreaming refugee and migrant health in the global, regional and country agendas and contingency planning

PRACTICE: In December 2015, a multi-sector consultation meeting to create such a working group was held. Following inclusion of Migration Health in the 100-day plan of the new administration, in June 2016, a technical consultation workshop was conducted to ensure the engagement of the relevant ministries in the Migration Health Agenda as well as to prioritize the actions to ensure an operational framework for a national migrant health policy in Myanmar. The following bodies were agreed to be established:

- *National Migrant Health Steering Committee:* High level, decision-making body, DG level for Strategic decisions & recommendations.
- *Migrant Health Task Force:* Technical level focal points, action-oriented for multi-sectoral ministry involvement.
- *Migrant Health Desk:* Within the MOHS, supported by IOM, this serves as the secretariat and information repository and coordinator within the MOHS and with other ministries, countries, the UN, and external partners.

Promote refugee- and migrant-sensitive health policies, legal and social protection and programme interventions

PRACTICE: Recognizing the growing importance of migration health for Myanmar citizens abroad and for internal migrants, as well as the increasing prospect of greater regional population flows to Myanmar, the Ministry of Health and Sports (MOHS) expressed its desire to promote the Migration Health Agenda under the auspices of the International Relations Division of the Ministry of Health and Sports. IOM has been providing technical and financial support to MOHS through its country office and by mobilizing resources.

Strengthen partnerships, inter-sectoral, intercountry and interagency coordination and collaboration mechanisms. In November 2014, the MOHS conducted a Preliminary Workshop for Strengthening Migration Health Management with the support of IOM. Following this, MOHS proposed to move forward with the creation of a Multi-Sector working group which included representatives from various relevant ministries in order to increase awareness around the importance of Migration Health, identify technical focal points and to work towards the development of a Migration Health Policy Framework for the country.

Challenges: Specific challenges identified in addressing migration health in Myanmar included: Long-standing underinvestment in health systems which has led to weak health system capacity. There is lack of awareness of the importance and complexity of migration and health particularly among service providers, limited capacity of services to adapt to migrant-sensitive health systems, lack of data, information and research on migration and health, multiple typologies of migration, irregular migration being predominant and high mobility in non-government-controlled areas, as well as other more significant and visible health priorities.

(Source: International Organization for Migration)

Addressing Migration and Displacement along the Thailand-Myanmar Border

CONTEXT: Following decades of conflict between the Myanmar military and armed ethnic groups in the south-east of Myanmar, 102,412 people remain in refugee camps on the border with Thailand. Throughout the conflict, an additional 400,000 people were reportedly displaced internally (8,767 are currently living in IDP camps) in the south-east of the country. There are an estimated 4 million undocumented Myanmar migrants living abroad (mainly in Thailand and Malaysia), many of whom come from the southeast border regions of Myanmar. The region is characterized by high levels of in-and-out migration which includes cases of human trafficking and smuggling. Communities in the south-east of Myanmar are socially and economically marginalized and suffer low access to basic services, particularly health and education. The pervasive presence of landmines makes many areas inaccessible, further limiting economic development opportunities for remote agricultural communities. With the reduction in hostilities and signing of ceasefire agreements in the 1990s,

coupled with increasing democratization since 2011, there has been growing interest in the possibility of the return of IDPs and refugees from Thailand.

Enhance capacity to address the social determinants of health

PRACTICE: In 2016, 71 refugees opted for a UNHCR-facilitated return, and left the refugee camps in Thailand to restart their lives in south-eastern Myanmar. While the wider peace process and security concerns are still at the centre of many refugees' reluctance to return, the low levels of health social service delivery and poverty in the south-east of the country are also considered to be barriers. Myanmar Red Cross Society (MRCS) has been working with its partners to address these chronic challenges. For over 13 years, MRCS has partnered with UNHCR to raise the health and education status of vulnerable communities in the southeast. Specifically, since 2004, MRCS has worked in over 1,000 villages to build rural health sub-centres, trained over 45,000 people in life skills, health, and water and sanitation and hygiene (WASH) practices, constructed primary schools in remote locations, built latrines in schools, and conducted Mine Risk Education (MRE) sessions. In 2016, as part of a UNHCR-facilitated refugee pilot programme, MRCS assisted with the reintegration of 44 out of a total of 71 refugees from Thailand in four villages. Health, nutrition and livelihoods are key concerns for returnees. MRCS supported returnees with establishing livelihoods through livestock breeding or homestead gardening which also contributed to improved family nutrition. Additionally, 152 vulnerable community members in the same return location were also provided with this assistance as well as solar lamps. MRCS and partners are working on "Building Resilient Communities" in 28 locations in the south-east of Myanmar expected to see high numbers of returning refugees and IDPs. The project has a specific focus on improving health, the nutritional and income status of vulnerable households with over 16,000 people and strengthening resilience in rural communities in Kayin State.

Strengthen health monitoring and health information systems

PRACTICE: In addition, MRCS maintains up to date records of spontaneous IDPs and refugee returns, has facilitated *go and see visits* for prospective returnees and has supported the livelihoods of vulnerable groups including returning IDPs and refugees.

Reduce mortality and morbidity among refugees and migrants through short- and long-term public health interventions

PRACTICE: In partnership with the ICRC, MRCS manages the Hpa-An Orthopaedic Rehabilitation Centre which provides prosthetics, orthoses, wheelchairs and physiotherapy to landmine victims and people with disabilities. To date, over 6,000 people have been provided with artificial limbs. In addition, with support from the ICRC, MRCS has provided 500 people with Mine Risk Education (MRE) to reduce further exposure to landmines. This is particularly important in the context of returning IDPs and refugees who may not be aware of the location and impact of the landmines.

Overall impact and lessons learned.

Inadequate access to basic healthcare in south-eastern Myanmar is a significant constraint to refugee returns. Community-based approaches have been positive – communities are empowered and have become focal points for protection. Forming Community Based Organizations (CBOs) has led to community self-management, local ownership, and sustainability. In addition, health-seeking behaviour has significantly increased among participating communities. Children have improved access to basic education and landmine victims were identified for immediate response.

Recommendations.

Integrate migration and displacement issues including SGBV/child protection/trafficking into wider health and resilience programmes in areas with high population movements and promote safe labour migration and raise awareness of dangers of irregular migration.

(Source: Myanmar Red Cross Society)

NEPAL

Promoting refugee and migrant health

CONTEXT: Migration is a common phenomenon in Nepal. Overseas Migration, especially labour migration is an increasing trend in Nepal. Poverty, limited employment opportunities, a fragile political situation, natural disasters and deteriorating agricultural productivity are the major reasons for this. According to the Ministry of Labour and Employment, every day, 1,600 Nepalese leave Nepal to various destination countries for labour migration. Approximately 4 million Nepalese are working abroad. Malaysia and the Gulf Co-operation Council (GCC) countries are the major destination countries for Nepalese labour migrants. Nepalese migrant workers send over US\$ 4 billion back home every year, comprising 28% of Nepal's gross domestic product (GDP), according to the Ministry of Finance (2015). In Nepal, there are also Tibetan refugees and refugees from other countries. As per the IOM Nepal Displacement Tracking Matrix report, as of 30 December 2016, a total of 15,595 internally displaced persons (IDPs) were living in temporary settings as a result of the earthquake in Gorkha in 2015. A total of 20,888 families are temporarily displaced due to recent floods and landslides in Nepal in 2017.

Promoting refugee and migrant-sensitive health policies, legal and social protection and programme interventions

PRACTICE: Despite the lack of legal frameworks, laws, regulations and policies, Nepal has committed to migrants' health in various national and international forums including the World Health Assembly. Some health programme acts and strategies are inclusive to cover refugees and migrants such as the National HIV Strategic Plan 2016-2021. All migration-related issues including health of foreign migrant workers are being covered by the Ministry of Labour and Employment (MoLE) with its existing Foreign Employment Act 2007 and Foreign Employment Policy 2012 which have devised some components of health of migrant workers. The main health programmes are the establishment of the foreign employment welfare fund, initiation of assisted voluntary return and referral mechanism to anyone with health issues, monitoring of existing pre-departure health assessment centres of Nepal and inclusion of health component in pre-departure orientation training package. With regards to international migrants, Nepal is very open to any kind of international migrants and they can have access to basic health services free of cost. To access primary health care services through government health facilities they do not need to provide proof of nationality and identity.

Lesson learned and challenges: With increasing inbound and outbound of migrants into Nepal, the existing migrant health programmes under the foreign employment policy are not adequate in terms of quality and coverage. The national health policies and acts mainly target citizens and exclude refugees and migrants.

Recommended future priority action: Health policies and service delivery mechanisms must recognize all people living in Nepal (not only citizens) to have access to basic health care services. The Ministry of Health in coordination with line ministries needs to monitor and regulate the quality and coverage of pre-departure health assessment guidelines and health components of pre-departure orientation training package. The National Migration Health Policy should be developed to support and promote the health of migrants. The migration health secretariat and high-level task force team comprising of many ministries and stakeholders should be established to work on migration and health.

Addressing the social determinants of health and health inequality for refugees and migrants: Referral mechanisms have been established for patients requiring secondary and tertiary health care services. UNHCR and partners are working in consultation with local government to increase refugees' access to nearby government health facilities while providing support to the government health sector in order to achieve sustainable health services for both refugees and local communities. Families and children of migrant workers are covered by existing national health programmes.

Lessons learned: There is a need for regular coordination with other ministries such as the Ministries of Agriculture, of Local Development, of Women, Children and Social Welfare, of Home/Social affairs to revise the migrant health component and integrated approach with involvement of local community and local health facilities facilitate the continuity and acceptability of quality health services for migrants and refugees.

Recommended future priority actions: Inter-ministerial coordination mechanisms to address the social determinants of health and promote the overall health of migrants and refugees, as well as capacity building of local community and health workers to provide migrant- and refugee-sensitive health services are recommended.

Provision of equitable access to universal health coverage: The Government has no specific provision to finance health care for refugees and migrants. Refugees and migrants can in general have access to free health services in government health facilities and with a pay from private health centres.

PRACTICE: Health services including TB treatment, medicines and vaccines for Bhutanese refugees are provided by IOM and partners. Refugees from other countries are supported by UNHCR for basic health care services. For specific types of TB cases such as return-after-defaulter and MDR-TB or disease conditions requiring high cost curative services for which the government provides some financial support, is not available to refugees since it targets only citizens.

Lessons learned and challenges: There should be no requirement of identification documents to access health services in order to promote non-discriminatory access to health services for refugees and migrants. Financial support for some expensive medical interventions and some forms of TB are needed for migrants.

Recommended future priority actions: Include refugee population into the local health systems in the region, in line with the Sustainable Development Goals, Universal Health Coverage and other relevant international laws to which Nepal is party to and provide access to financial support for specialized health care services for particularly vulnerable refugee populations needs to be established.

Promoting people-centred, gender-, refugee- and migrant -sensitive health policies and health systems: Nepal's international obligations and responsibilities to migrant workers are reflected in its domestic legislation, including its Constitution; the Foreign Employment Act (FEA); the Human Trafficking and Transportation (Control) Act (HTTCA); the Muluki Ain (General Code of Nepal); and other pieces of legislation that are applicable to the regulation of recruitment and foreign employment. Nepal has become the chair of the Colombo Process and has identified migration and health as one of the additional thematic priorities for further consultations and discussions. Few programs are designed and implemented through foreign employment policy and these are as follows: establishment of foreign employment welfare fund, initiation of assisted voluntary return and referral mechanisms to anyone with health issues, monitoring of existing pre-departure health assessment centres of Nepal and inclusion of the health component in pre-departure orientation training packages.

Lessons learned: Existing health policies and programme interventions are not adequate to meet the migrants' health needs and a comprehensive National Migration Health Policy is required to address these needs.

Recommended future priority actions: All health policies and programme interventions should mainstream migrant and gender-sensitive approaches.

Provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants: The Foreign Employment Act and Policy Infectious Disease Control Act have addressed this issue. MoLE through the foreign employment promotion board in close collaboration with the Ministry of Foreign Affairs is currently supporting a repatriation programme and operation of a safe-shelter house in destination countries. These programmes have been continuously assisting repatriation of those who are deported forcibly or due to medical causes. For those who migrated through formal channels, they are taken care by employers and the Nepalese embassies but those going through informal channels are not supported. Health care services to the crises-affected population are provided with support from IOM. Refugee camps have access to vaccination services and other public health interventions provided by the public health facilities.

Lessons learned and recommended future priority actions: The foreign employment promotion board needs to implement rehabilitation and re-integration activities for longer term positive health impacts. However, as planned the board is not able to implement the program. Due to inadequate funding, and adequate public health interventions could not be implemented to assist emergency and humanitarian support. There is a need to devise mechanisms to appoint labour and health attachés based on the ratio of migrants and increase domestic financing to scale-up voluntary return and the reintegration component.

Promoting continuity and quality of care for refugees and migrants: All refugees and migrants, regardless of their legal status can have access to basic health care services through public health facilities for continuity and quality of care except for some high costed medical interventions. UNHCR and AMDA and other partners work in consultation with local government to increase refugees' access to nearby government health facilities while providing support to the public health sector to provide health services to refugees and local communities.

Lessons learned and challenges: Involvement of local community and local health facilities for the continuity and acceptability of quality health services for migrants and refugees is critical.

Recommended future priority actions: Capacity building of local community and health workers to promote continuity and quality care for all residents including migrants and refugees.

Prevention and control of communicable and noncommunicable diseases, including mental health for refugees and migrants: The Infectious Disease Control Act has addressed this priority. The existing health facilities are able to provide prevention and control of communicable and non-communicable diseases for refugees and migrants. International Health Regulations (IHR) such as screening of migrants at the international airport is implemented by the Ministry of Health during the outbreak of communicable diseases. Accessibility and coverage of isolation and treatment centres for communicable disease conditions is however low. There is a widening scope of IHR 2005, even in border check points to manage diseases related to mobility. For Bhutanese refugees, there is a specific psycho-social and mental health support system with the help of trained psycho-social counsellors and periodic visits of psychiatrists. For cases undergoing resettlement health assessment, IOM organizes psychiatric consultations as requested by a panel physician. In addition, the Trans-Cultural Psycho-Social Organization (TPO) which is providing psycho-social counselling services to Bhutanese refugees in the camps is organizing capacity building activities for government health workers and community health workers.

Lessons learned: During the Ebola outbreak, the need for tertiary care facility and public health taskforce was felt. Other restrictions for isolation and treatment centres are unavailability of trained personal and protective equipment. Capacity of government health facilities and mental health services as well as involvement of non-governmental organization is needed to address needs.

Recommended future priority actions: Widen the scope of IHR 2005 to border check points and international airports. Capacity building of government health workers on mental health counselling and services is also recommended.

Improving the health and well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee and migrant women and girls: UNHCR supports activities to improve the health and well-being of women, children and adolescents living in refugee camps by providing community health workers for Integrated Management of Neonatal and Childhood illnesses, prevention and response to Sexual and Gender-based Violence and health education sessions among adolescents on reproductive health and substance abuse. There are several community-based organizations focusing on the issues of women and children.

Lessons learned: Community health workers have proved to be key players in health promotion among refugees and migrants. They have raised awareness in the community and have helped to identify and follow-up on cases.

Partnerships and cooperation, inter-sectoral, intercountry, in-country and interagency coordination and collaboration mechanisms: The Foreign Employment act and policy is addressing those bound to foreign employment. For migrants bound to Nepal or inbound migrants, there is no mechanism in place. IOM, UNHCR and partner organizations in collaboration with government have been actively involved in refugee camps to provide essential health care services. For the transition of health services for remaining Bhutanese refugees in the camps, a Health Task Force (HTF) has been established. The HTF has conducted assessment of overall quality and standard of services, and UNHCR and IOM are supporting to build capacity of nearby government health centres.

Lessons learned: Inter-agency coordination mechanisms of all agencies serving refugees living in the camps together along, and results-oriented coordination with government health authorities to ensure continued health services for the refugees in a sustainable manner.

Recommended future priority actions: Establishment of the migration health secretariat and high-level task force team to work on migration and health comprising of multi-ministerial and multi-stakeholder involvement. Hand over to Government of the existing primary health clinic in the camp and gradual reduction of parallel services in the camps, while increasing refugees' access to government health facilities. Technical enhancement of nearby government health facilities.

(Source: Ministry of Health, Nepal)

Strengthening Government Capacity in the Development of a National Strategic Action Plan on Migration Health, Nepal

CONTEXT: International labour migration is an increasing trend in Nepal due to poverty, limited employment opportunities, natural disasters and deteriorating agricultural productivity. It is estimated that remittances sent by migrants are contributing to nearly one third of the GDP in Nepal (32.2% of total GDP of the country, according to the World Bank (2015). A total of 530,316 people migrated to foreign countries from Nepal in 2014/15. Despite recent trends, migration health has not been a priority for the Government of Nepal (GoN) throughout the years. The majority of migrant workers migrating from Nepal are of lower socio-economic status, often illiterate or have a limited educational background, and access to health information and services is extremely limited. As a result, migrants are mainly employed in semi-skilled or unskilled jobs, often with inadequate social protection and health insurance coverage increasing susceptibility to ill health compared with other migrant groups. Based on WHO's Framework of Priorities and Guiding Principles, this project will respond to a) promoting the right to health, and mainstreaming refugee and migrant health in the global, regional and national policies, planning and implementation; b) Promoting refugee- and migrant-sensitive health policies, legal and social protection and interventions to provide equitable, affordable and acceptable access to essential health services for refugees and migrants; c) enhancing partnerships, inter-sectoral, intercountry and interagency coordination and collaboration, enhancing better coordination between humanitarian and development health actors. In order to address these gaps, IOM provides technical and financial support to develop a National Strategic Action Plan on migrant health in Nepal.

Advocate mainstreaming refugee and migrant health in the global, regional and contingency planning: A newly promulgated Constitution (2015) has recognized health as a fundamental right. IOM Nepal has been engaging with the GoN on Migration Health, advocating the need of a holistic National Strategic Action Plan (NSAP) able to address the health needs of outbound, internal and inbound migrants. The project is designed as a capacity-building initiative, with the aim of strengthening the government's capacity to address migration-related health issues bringing together key stakeholders and non-governmental actors. It demonstrates a series of proposed actions designed to support the GoN on migration health to develop national programmes and policies of the NSAP, to implement selected key activities in the NSAP, to develop national guidelines on migration health screening services, to pilot migrant-friendly health screening services at selected centres in the city, to review and finalize pre-departure orientation training for labour migrants, and to conduct research on the health vulnerability for cross-border migrants.

Promote refugee- and migrant-sensitive health policies, legal and social protection: IOM Nepal also supported the GoN in the implementation of selected key activities outlined in the NSAP, such as a mapping of cross-border migrants, proper pre-departure orientation and engagement with labour migrants after arrival, conducting a pilot study and comparison with designated non-IOM supported health assessment centres and finally the development of a national guideline on migration sensitive health screening.

Strengthen partnerships, inter-sectoral, intercountry and interagency coordination and collaboration mechanisms: The desired outcome of this ongoing project is to implement a NSAP through a coordinated multi-sectoral, multi-agency approach leading to the enhancement of the benefits of outbound, internal and inbound migration and of the socioeconomic status of the country by promoting the beneficial aspects of migration, through integrating migrant health care with development, public health care, and social welfare.

Challenges: An analysis of migrant health progress in Nepal identified the following issues: lack of national public health act and policy to address migrants' rights to health, lack of inclusion of Migration Health issues in the national health policy, migrant's health rights and provision of health care are rarely addressed in bilateral agreements, lack of comprehensive standard national guideline and Standard Operating Procedure (SOP) for pre-departure health screenings and pre-departure orientation on health issues, limited efforts for coordination between the Ministry of Health (MOH) and the Ministry of Labour and Employment (MoLE), and limited evidence on cross-border issues (e.g. for migrants to India).

Lessons learned and ways forward: a) include public health policies in its national health regulations to address migrants' right to health; b) incorporate migrants' health rights and provision of health care in bilateral agreements; c) create a standard national guideline and a standard operating procedure for pre-departure health screenings and pre-departure orientation health issues; d) strengthen efforts for coordination between the MoH and MoLE; and e) track cross-border migration.

(Source: International Organization for Migration)

Reference materials: <https://www.iom.int/news/nepal-develops-national-migration-health-policy>

Promote gender equality and empower refugee and migrant women and girls

CONTEXT: The returned migrant population in Nepal is estimated by the project at half a million, many of whom have been in high HIV-incidence districts in India. Adding to concern are returned women migrants who suffered sexual and other forms of abuse in other countries. Improving coverage and promoting behavioural change are priority areas for HIV prevention in Nepal. National policy developments contributed to improving outreach to female and male sex workers in the country. However, reaching migrant and returned migrant populations has proved more challenging.

PRACTICE: The Women's Rehabilitation Centre (WOREC) is a non-governmental organization established in 1991 with the purpose of fighting violence against women, and to ensure their economic, social and cultural well-being. Through its 'Women Health Right Program' and 'Safe Migration Program', WOREC specifically targets migrant women, focusing on their labour, sexual and reproductive rights. WOREC initiated a National Alliance of Women Human Rights Defenders platform in 2005, through which advocates in 72 Nepalese districts share experiences and help develop the capacity of women human rights defenders in different communities. The centre has launched the 'Our Bodies, Ourselves' initiative to develop manuals introducing women to a more intimate understanding of their bodies, the workings of the body and body politics. WOREC adopts an integrated programmatic approach, providing health counselling along with training on bio-intensive farming and political engagement. (Website: <http://www.worecnepal.org>)

CONTEXT: Lack of employment in Nepal and the growing role of women in supporting their families economically has led women to leave the country to take up employment abroad. Gender inequalities persist in Nepal and destination countries, limiting women's access to services, limiting their access to decent work and their control over productive resources. *Pourakhi* – meaning “self-reliant” in Nepalese – was founded in 2003 with the support of UN Women to promote respect for the rights of women migrant workers throughout the entire process of migration from pre-departure to post-return support programs.

PRACTICE: Pourakhi runs a hotline providing psychosocial, legal and medical counselling to women migrant workers. It offers reintegration programmes with entrepreneurship training for return migrants and a Child Education Fund to support the children of exploited migrant workers. It has been active in lobbying for the rights and entitlements of women migrant workers both at home and abroad. *Pourakhi* developed a partnership with the Pravashi Nepali Coordination Committee, which maintains a large network among Nepali migrant workers across Gulf countries, to work with Nepalese embassies to provide support for the rescue and repatriation of Nepali women in abusive situations. It also operates an emergency shelter in Kathmandu.⁴

The NGO **Maiti Nepal** provided shelter and care to 448 repatriated sex trafficking survivors, most of them women and girls involved in forced sex trade and therefore with high prevalence of HIV. Maiti Nepal is a local NGO and is part of a larger network in South Asia and has been able to provide trafficking prevention and intervention services for individuals detained in brothels. Repatriated survivors have been protected from brothel owners and hosted in temporary shelters before moving to longer term rehabilitation facilities located in their region of origin. Legal assistance and required healthcare including HIV testing, which is undertaken after the provision of verbal consent with an average time of seven months after brothel servitude for the victim to recover first, is also provided. HIV test results are recorded by hospital-based laboratories and are retained within the medical record. Such approaches help returned trafficked victims to recover, acquire HIV prevention and care knowledge, and be protected from social stigma and patterns of ostracizing on the basis of an HIV-positive status.⁵

(Source: *Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action*; International Labour Office – Geneva: ILO, 2016)

⁴ UN Women. 2012. *Supporting women workers towards a safer migration journey*, in UN Women (website): <http://www.unwomen.org/en/news/stories/2012/12/supporting-women-workers-towards-a-safer-migration-journey>.

⁵ J. Silverman et al.: “HIV Prevalence and Predictors of Infection in Sex-Trafficked Nepalese Girls and Women” in *Journal of the American Medical Association* (2007, Vol. 298, No.5, August): 536-542.

SRI LANKA

Promoting refugee and migrant health

CONTEXT: Historically and currently, migration affects sociodemographic and economic development in Sri Lanka which is experiencing outbound, inbound, internal migration and also to a lesser degree migration of refugees. Sri Lanka is known as a country of origin as well as a destination country for labour migrants. 1.9 million Sri Lankans (10% of the population) work overseas and provide the highest revenue to the country (US\$ 7.2 billion in 2015, making up 8% of GDP). There were 1.8 million tourists in 2015 which was which was the third largest source of national revenues. Furthermore, 50,000 non-citizens apply for a resident visa to Sri Lanka annually and 60% of them are labour migrants. It is expected that the number will increase due to the proposed trade agreements with China and India. Inbound refugees have also increased recently. Sri Lanka is also concerned with health and social issues of families left behind.

Promoting the right to the enjoyment of the highest attainable standard of physical and mental health

National Immigration Law and International Health Regulations apply to all persons in Sri Lanka. Sri Lanka is not signatory to the 1951 Convention on the Status of Refugees. In 1996, Sri Lanka ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. In 2009, Sri Lanka launched the National Labour Migration Policy, setting non-binding principles and guidelines for a rights-based approach for labour migrants. With regard to health, however, it was limited to HIV and reproductive health. To better address health issues, the National Migration Health Policy was launched in 2013. This policy applies an inclusive approach, and health needs are not seen as a barrier to migration but used as an opportunity to extend health services for the greater public health good of the community. Migrant communities are free to mix with the host community. There are no restrictions that limit access to health.

Lessons learned: In the past, migrants who came to work in the plantation sector during British Colonial times faced some disparities when compared to the host community. This was created by employers who were largely private owners of large Plantation Estates. Feudalistic cultures were seen to be important to get work done and large disparities then occurred in shelters, education and access to health. Successive Governments of Sri Lanka over the past 3 decades have taken many positive steps to change the situation and the recent Demographic and Health Survey shows that inequities between Estates and other areas have significantly narrowed but still exist. Returning Sri Lankans who were refugees in South India are not considered refugees but as citizens and integrating them into the existing health services took place after the civil war.

Recommended future priority actions: Access to health in countries of destination should be included into bilateral agreements as well as in individual labour contracts. Measurements of UHC should include migrant populations in country of origin and destination. Sri Lanka will institute an inbound health assessment after entry for Resident visa applicants in order to detect and provide care, in particular for those with TB and HIV. They will be included into a National Health Protection Scheme that will enable access to primary and emergency health care.

Addressing the social determinants of health and health inequality for refugees and migrants. Inbound labour migrants' access to housing, water and sanitation are provided by the employer, or they are free to get their own housing. There are no detention camps for refugees unless they have violated the immigration law of the country.

Lessons learned and recommended future priority actions: The lack of availability of statistics of inbound labour migrants leads to lack of information to plan for other services, including health. There is no responsible/dedicated government agency to manage the issue. A revision to labour migration policy, inclusive of inbound non-citizens is needed. A responsible authority should be identified for compilation of statistics on inbound labour migrants and refugees.

Provision of equitable access to universal health coverage, including access to quality essential health services, medicines and vaccines, and health care financing for refugees and migrants: As per the communiqués, the use of government health facilities is for citizens and there is a payment to be made by non-citizens accessing health in government institutions. This is a very minimal payment and collection of such payment is not currently regulated. There are no barriers to access the free health system in the country, despite the communiqué. Currently treatment is not denied and often payment mechanisms do not exist in government institutions. There is no active screening of inbound non-citizen migrant communities to provide them access to government health programs. They do have the liberty to present themselves to any government screening program. Outbound / pre-departure screening is done at the request / requirement of the destination country.

Lessons learned: An assessment of pre-departure health assessment services has been carried out in Sri Lanka and in collaboration with 3 other countries as part of a multi-country study. Sri Lanka having drafted the National Guidelines also conducted an international Consultation on pre-departure health assessments and the draft National guideline, its development and rationale was used as a case study in this consultation.

Recommended future priority actions: To establish inbound health assessment for resident visa applicants to Sri Lanka, with access to primary health care and to institutionalize national pre-departure assessment guidelines, improving health access to migrants before migration, and to ensure through bilateral agreement, access to primary health and emergency care in destination countries.

Promoting people- centred, gender-, refugee- and migrant -sensitive health policies and health systems and programme intervention: The National Health Policy includes access to primary health care. Primary health care is provided through a network of facilities available throughout the country. Primary health care policies are currently reviewed to improve scope and quality to be better people-centred. Sri Lanka health services are non-gender discriminating, and regulations that directly affect their access to health services do not exist.

Lessons learned: The publicly funded health system can be overburdened. At the same time, the health system understands that access to affordable health care is an important step in addressing public health problems.

Recommended future priority actions: Payment schedules should be revised for accessing government health services. A package of services to be provided through a National health protection fee is in consideration.

Provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants: All community health services provided free to Sri Lankans are also extended and are inclusive of migrants, refugees including health services such as immunizations, antenatal care and emergency care which are provided free of charge.

Lessons learned: It is better to be inclusive to expand coverage of important communicable diseases. There are a significant number of migrants and refugees coming from countries where disease prevalence is much higher than Sri Lanka and can even affect diseases that have been eliminated.

Recommended future priority actions: Revisit local public health programs and strengthen activities/capacities to identify and extend services to migrants and refugees, educate migrants and refugees about the national health system, support national interests of controlling national public health threats. The operationalizing of Inbound Health assessment and the National Pre-Departure Health assessment guidelines will have an effect on strengthening public health programs for TB, HIV and keeping Sri Lanka free of malaria and filariasis and will also give health access to migrants.

Promoting continuity and quality of care for refugees and migrants: Care provided is similar to non-citizens. Only some destination countries provide access to quality and continuity of care for Sri Lankan migrants but care is provided to non-citizens at the cost of the Government of Sri Lanka and negotiating for access to health care with destination countries is a challenge.

Recommended future priority actions: As it is difficult for a single country to put forward demands for access to health care, it is best to negotiate regionally or collectively with other countries of origin.

Prevention and control of communicable and non-communicable diseases, including mental health for refugees and migrants: The national health system provides free access to health care and the government communiqué to charge non-citizens is rarely practiced.

Lessons learned: The burden on the national health system has not been objectively ascertained, but the public health significance in terms of providing free access to care for communicable diseases is seen as a public health good.

Recommended future priority actions: A national health protection system for migrants and refugees (non- citizens) to access continuing health care (primary care) is recommended.

Improving the health and well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee and migrant women and girls: Sri Lankan health system does not discriminate between gender and provides for all ages. The same would apply to migrant / refugee women and girls.

Addressing the health of migrant workers, occupational health safety measures, including improving working conditions; addressing health workforce shortages: The National policy on Occupational Safety & Health, refers to the working population within the country and does not specifically refer to non-citizens. The

Code of Practice for international recruitment of health personnel is applicable. Sri Lankan Migrant workers registered with the Sri Lanka Foreign Employment Bureau are paid compensation for death and disability incurred overseas. Inbound migrant and occupational health and safety are not monitored adequately.

Recommended future priority actions: Strengthening of occupational health and safety information systems to provide disaggregated statistics that capture the situation of labour migrants is needed.

Partnerships and cooperation, inter-sectoral, intercountry, in-country and interagency coordination and collaboration mechanisms: The national health policy encourages multi-sectoral engagement and the internal policy process includes consensus and has adopted a multi-stakeholder and evidence-based approach, involving thirteen key government ministries in developing the National Migration Health Policy, launched in 2013. In line with WHA61.17, Sri Lanka initiated the policy process and reported on progress in 2010-2012.

PRACTICE: Sri Lanka has been active in taking the migration health agenda forward regionally through the Colombo Process resulting in the inclusion of Migration Health in the agenda of the SEA Regional Committee meeting 2016. In September 2016, at the UN General Assembly, Sri Lanka co-hosted the side event on "Health in the context of migration and forced displacements" together with Italy, IOM, WHO and UNHCR. They were able to conduct the GC2 with the collaboration of the IOM and WHO in February 2017. The Consultation brought together over 100 participants from 30 countries. An important feature making a difference from the first global Consultation held in 2010 in Madrid, Spain was that it added a political dimension with national high-level officials making the 'Colombo Declaration'. Sri Lanka has also taken the lead to draft and read a regional one-voice statement on Health of Migrants and Refugees at the WHA 2017. Sri Lanka has also brought up the issue of health of labour migrants at the SAARC Health Ministers' meeting held this year in Colombo. There was acceptance to include it into the agenda of future SAARC meetings. At the Regional Committee meeting of WHO SEARO this year on agenda item 'Bending the Curve for TB', Sri Lanka responded with policy and technical interventions linking migration health, highlighting the importance of migration health assessments which should be linked with national TB control programs, and offering treatment and follow up. Sri Lanka also hosted the international consultation on pre-departure health assessments in September 2017, which will further have promoted global discussion on the topic linking such health assessments to UHC.

Lessons learned: Continued political and high-level commitment is required for such an engagement of activities that have taken place. National focal point is relevant. During in-country development activities it was noted that development partners too need to acknowledge working together even though there are certain boundaries that they would like to maintain. These boundaries can have an effect of creating further boundaries in local context.

Recommended future priority actions: National focal points and action programs with dedicated staff should be identified within Ministries of Health to address health issues of migrants and refugees. Coordinated programs would be relevant even within ministries of health. Multi-sectoral engagement can be difficult and hence high-level monitoring mechanisms should be sustained with financial commitment.

(Source: Ministry of Health, Nutrition & Indigenous Medicine, Sri Lanka)

THAILAND

Promoting refugee and migrant health

CONTEXT: Thailand receives a large number of migrants, mostly from its neighbouring countries. There are around 3-4 million migrants in the country of whom about 1.5 million crossed the border without legitimate documents. They are then registered with the government under the One Stop Service Policy. In addition, there are 100,000 refugees from Myanmar, who fled the political conflicts from their home around 20 years ago. Currently 200,000-300,000 migrant workers with work permits are registered under the Social Security Scheme and they also have private health insurance. For 1.5-2 million migrant workers with legal documents and dependents mostly, from Cambodia, Laos and Myanmar, they are required to purchase a health card from the Ministry of Public Health (MOPH). There is an unknown number of undocumented migrant workers who either purchase health cards voluntarily, do not purchase health cards but make out-of-pocket payments for health services, or alternatively not pay at all. In addition, there are 700,000-800,000 registered stateless people who are covered by MOPH systems but those without registration have no health rights (unknown figure). There are 100,000 refugees who are currently supported by UNHCR.

Promoting refugee- and migrant-sensitive health policies, and legal and social protection

PRACTICE: The Ministry of Public Health (MOPH) launched the Border Health Development Master Plan with aims to promote migrant-sensitive policies such as encouraging the facilities to hire migrants as translators, providing the Health Insurance Card Scheme (HICS) for cross border ex-undocumented migrants working in the informal sector and the Social Security Scheme for migrant workers in the formal sector with comprehensive benefits packages for those schemes, including high-cost care and anti-retroviral treatment (ART). The Border Plan encourages all public facilities to hire migrants as translators as part of the migrant-sensitive policies. Some facilities face financial constraints in hiring migrants as translators, as migrants cannot enrol in civil servant positions or public officials and they can only be hired as temporary employees. As a result, the facilities cannot be reimbursed the salary for these migrants from the central authorities. Accordingly, they mobilised external financial resources, such as using support from donors or their own funds. Translators are listed as 'high skill' workers and those who join this work must be legal migrants only. Ex-undocumented registered migrants are not officially allowed to work as health translator, as the policy allows them to work only in some occupations, that is, housemaid and labourer.

Recommended future priority actions: Some facilities sought NGOs' support to address the issue. Without supporting mechanisms/regulations, migrant-sensitive policies cannot be effectively implemented. Employment rules/regulations on migrants need to be reviewed. The government should provide financial support to health facilities in need of hiring migrants and accordingly revise employment laws.

Addressing the social determinants of health and health inequality for refugees and migrants

PRACTICE: Low-skilled migrants are allowed to engage in certain work such as housemaid and manual labour including those in construction. Refugees in camps are provided housing and sanitation with support from NGOs. Some migrants are self-employed, which is not allowed by the employment laws. Support from NGOs is limited.

Recommended future priority actions: Obsolete employment laws should be revised. Thailand is not a part of the 1951 Refugee Convention. The country should reconsider its position in this regard. There should be a long-term plan set out by the government on how refugees in the camps are, and will be, treated and how the government can help them resettle in either Thailand or a third country.

Accelerate progress towards achieving the Sustainable Development Goals including universal health coverage: Undocumented migrants are allowed to buy the health insurance once registered with the government under the One Stop Service Policy. The Health Insurance Card Scheme for cross border ex-undocumented migrants in low-skill occupations is available.

PRACTICE: Migrants are allowed to access care in public hospitals free of charge if they obtain the insurance card. The uninsured are still able to enjoy health services but there will be costs incurred. A number of migrants were registered. Some hospitals refuse to sell the insurance card to migrants, especially the unhealthy ones. Some migrants refuse to buy the insurance card due to economic reasons. In order to be eligible for the insurance, undocumented migrants need to register with the government first. This process is often intervened by brokers or private intermediaries, making the cost of registration rise up dramatically.

Recommended future priority actions: As long as the insurance still depends on 'selling/purchasing', it is difficult to make the insurance 'compulsory' to all migrants in practice. Innovative financing is needed, for example, enrolling all registered migrants to the Universal Coverage Scheme, which is the main scheme available for Thai nationals. But this approach needs further studies on political feasibility. There should be a clear policy message that requires 'all' migrants to be insured of their health. There should be policies that provide a safety net for migrants who do not purchase the card. Additionally, there should be mechanisms that prevent the intervening of the registration system by brokers.

Provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrant: Policies to reduce mortality and morbidity of migrants vary. Vaccination is a good example, with insured migrants eligible to free basic vaccinations, while uninsured migrants must pay. However, some providers provide free basic vaccinations to uninsured migrants by using the stockpile of vaccines assigned for Thai children.

Recommended future priority actions: Vaccination and humanitarian rescue should be provided free of charge to all persons regardless of status. The Government should earmark additional budgets to supply vaccination to 'all migrants' and should communicate that vaccination is provided to everybody free of charge.

Promoting continuity and quality of care for refugees and migrants

PRACTICE: There is no specific law on quality of care to migrants, as it is part of the services available to Thai patients already. Some hospitals provide migrant friendly initiatives, such as creating bilingual leaflets or hiring migrants as translators.

Recommended future priority actions: Migrant-friendly services should be promoted. There is a need to revise currently existing laws, for example, the obsolete employment law should be revised in order to allow ex-undocumented migrants to lawfully work as translators in public facilities.

Prevention and control of communicable and non-communicable diseases, including mental health for refugees and migrants.

PRACTICE: Treatment for psychosis is not yet included in the HICS benefit packages. Migrants with severe tuberculosis (TB)⁶ are not eligible to be insured by the HICS. Some providers do not comply to the above regulations. They still allow migrants with severe TB to be insured. However, some providers do the opposite.

Lessons learned: The regulation does not cover health insurance for migrants with severe TB, which may create negative consequence on the health system as a whole.

Recommended future priority actions: Treatment for psychosis should be included in the HICS benefit packages. The regulation that prohibits migrants with TB to the HICS should be terminated.

Improving the health and well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee and migrant women and girls

PRACTICE: Migrant children are eligible to free basic education. Some undocumented migrants tend not to take their children to be registered with the government due to fear of deportation. Places for migrant children in public schools are not always available in practice.

Recommended future priority actions: The government should work closely with civil society groups that are more flexible in accessing vulnerable populations, especially undocumented migrant children.

Addressing the health of migrant workers, occupational health safety measures

PRACTICE: There is no financial compensation for occupational injuries for migrant workers under the HICS. This is a stark contrast to the benefit for beneficiaries under the Social Security Scheme. Some employers refuse to take their migrant employees to register with the government in order to avoid the registration cost.

Recommended future priority actions: The HICS should include compensation benefits for occupational injuries. The HICS regulation should be made clear from the outset, that is, who between migrants and employers must defray the cost of the insurance card.

Health monitoring and health information systems for refugees and migrants: There are many authorities responsible for recording stock and flow of migrant workers such as the MOPH, the Ministry of Interior, and the Bureau of Police.

⁶ TB in an highly infectious stage

PRACTICE: Different authorities use different criteria for recording. Without a robust and reliable recording system, long-term planning on migrant policies will face many hindrances.

Recommended future priority actions: All relevant stakeholders should harmonize and synchronize their functions on migrant recording.

Communication and countering xenophobia: All patients are protected by the Health Professional Laws, stipulating that all providers cannot deny the treatment of patients in emergency conditions due to discrimination based on the nationality of a patient or his/her ability to pay. Xenophobia is still prevalent in the society.

Recommended future priority actions: Revising the education curriculum in the way that aims to reduce xenophobia and discriminatory attitudes is vital.

Partnerships and cooperation, inter-sectoral, intercountry, in-country and interagency coordination and collaboration mechanisms: Thailand is a party of many international conventions such as the International Covenant on Civil and Political Rights (ICCPR), the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), but not the 1951 Refugee Convention. Most agreements in the Association of Southeast Asian Nations (ASEAN) to protect the health of migrants are not legally binding. Policies to protect migrant health in ASEAN vary across countries.

Recommended future priority actions: There should be legal agreements between countries, particularly in ASEAN, such as providing vaccinations to all migrant children, free-of-charge, regardless of their status. WHO should recommend a set of benefits that should be included in the insurance benefits package for migrants and list health screening items for all migrants. WHO should also act as intermediaries between countries in conflict or in some contentious issues that may affect health and well-being of migrants. For instance, WHO should help facilitate the nationality verification process on migrants whose citizenship status is in doubt.

(Source: International Health Policy Foundation, Thailand)

Promoting occupational health safety and services for migrant workers, Thailand

CONTEXT: Currently, more than 3 million migrants are estimated to be working in Thailand but only 1,955,487 migrant workers are registered in the system. Among the low-skilled migrant flows into the country, workers from Myanmar are estimated to constitute at least 80% of the total foreign labour population. Data from the Ministry of Labour (MoL) in 2017 identifies the top three sectors in which registered migrant workers have been granted work permits: construction, agriculture and livestock, and services. The types of work migrants undertake on a daily basis are characteristically dirty, dangerous and difficult. This has contributed to poor working conditions and raised the incidence of work-related injuries and fatalities.

Accelerate progress towards achieving the Sustainable Development Goals including universal health coverage

PRACTICES: Registered migrant workers could access health services through either a health insurance scheme or a social security scheme. Firstly, health screening (costing 500 baht in 2016) includes a chest X-ray for tuberculosis, and tests for syphilis, microfilaria, malaria and leprosy, for which a full course of treatment is offered. The health insurance scheme (costing 3,200 baht in 2016) covers comprehensive curative services and a range of prevention and health promotion services, similar to the Thai universal health coverage scheme. Secondly, migrants who have work permits are fully covered by the Thai social security scheme. Thai nationals and migrants who contribute to the social security system have equal rights of access to social security benefits, including health services.

Develop, reinforce and implement occupational health safety measures: The Bureau of Occupational and Environmental Diseases (BOED) is under the Department of Disease Control within the Ministry of Public Health and plays an important role in occupational safety and health in all sectors through its technical unit and health care network system.

PRACTICES: Occupational Health Services (OHSs) have been developed in health care providers throughout the country to provide such services to all groups of workers. However, most providers only offer general services addressing communicable diseases, such as tuberculosis and sexually transmitted infections. Only a few hospitals located in the border areas or industrial areas could provide occupational health services for migrant workers.

During 2016-2017, BOED has conducted a meeting to introduce the OHSs project and train provincial hospital staff where there is a large number of migrants, especially the hospitals located in 10 special economic zone

provinces. Six building blocks plus was carried out among stakeholders by brain storming to identify the issues that will help or hinder the plan to deliver the OHSs for migrant workers. As a result of this analysis, the challenges for migrant workers were identified and included: 1) one stop service to provide only general services, 2) limited data sharing among related agencies, 3) lack of compliance among employers to employ registered migrant workers, 4) language barriers, and 5) ineffective occupational disease surveillance data systems. BOED has recommended that participants conduct the plan to provide OHSs.

Presently, some provincial hospitals could perform OHSs, both passive and pro-active OHSs. Such hospitals provide health examinations, occupational disease (OD) screening and diagnosis, health education, return to work management and record keeping. An interpreter was employed to facilitate during the performance of OHSs activities. Moreover, the migrant health volunteers have been trained to advise other migrant workers regarding health issues. Health education has been provided to employers and employees to promote safe work and increase the number of registered workers. Because of the language barrier, occupational and safety media including in English, and languages of Myanmar, Cambodia and Lao PDR have been produced and distributed to the workplaces. Meanwhile, BOED has collaborated with the Health Data Centre (HDC) of the Ministry of Public Health to add the 14 common OD and injuries for migrant workers in the data system, therefore everyone could access the OD and injuries data that occurs among such workers.

Lessons learned and ways forward: Currently, only a few hospitals could provide entire OHSs for migrant workers, therefore the future development of OHSs delivery should be addressed through six issues, as follows: 1) policy-maker support for operational resources and personnel, 2) training to enhance hospital staff's competency for effective OHSs delivery, 3) improvement of data quality for recording and reporting OD cases or other OHSs interventions, 4) collaboration among related agencies, especially the Ministry of Labour to share related data, and 5) strengthen the hospitals to develop comparatively good systems to promote and achieve workplace occupational health and safety, specifically for migrants.

(Source: Department of Occupational Safety, MOPH, Thailand)

Prevention of HIV/AIDS in Migrant Workers in Thailand (PHAMIT) – Thailand

CONTEXT: Migrant workers from Cambodia, Laos and Myanmar are a major source of labour for Thailand, especially in the fishing industry. In 2003, HIV prevalence among migrant fishermen was as high as 5 per cent in some provinces. The main mode of transmission is unprotected sex, as more than 50% of migrant workers in the fishing industry did not use condoms during sex with casual partners. Furthermore, numerous barriers to HIV prevention and care for migrant workers exist, among which are lack of health insurance, budgetary constraints, and HIV-related discrimination and stigma.

PRACTICES: The *Prevention of HIV/AIDS Among Migrant Workers in Thailand* programme (PHAMIT) (2003-2008) was launched with the purpose of reducing the number of new HIV infections among migrant workers in Thailand and in the neighbouring countries. It focused on nineteen coastal and three non-coastal provinces bordering Myanmar – reaching migrants working in fishing and seafood processing, as well as those in sectors such as industry, construction and agriculture. The programme was implemented through a partnership between eight NGOs and the Ministry of Public Health and was operationalized due to funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The work with NGOs has helped enhance service delivery and strengthen advocacy, as well as the partnership with government departments to put in place “migrant-friendly services”. The focus on migrant communities through the innovative concept of “migrant health assistants” – registered migrants selected, recruited and trained to support fellow migrants in assessing public health services – contributed to the reach of the programme.

RESULTS: The programme reached over 460,000 beneficiaries with HIV-prevention information. There was an increase in condom-use by programme beneficiaries and in the number of HIV-positive migrants receiving home-based care and treatment for opportunistic infections. In policy terms, this effort was translated in migrants being recognized as a target population by the Thai Government in the 2007-2011 Thai National AIDS Strategic Plan. Through this, the government would subsidize ARV treatment for HIV-positive migrant workers in Thailand.⁷

(Source: Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action; International Labour Office – Geneva: ILO, 2016)

⁷ UNDP. 2010. *HIV, Health and Development - Innovative approaches: Raks Thai /PHAMIT Programme*. United Nations Development Programme Asia-Pacific Regional Centre. http://www.junima.org/resources/pdf/RaksThai_FINAL_web.pdf [accessed 25 September 2017].

REGIONAL INITIATIVES, COLLABORATION AND PARTNERSHIPS

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 condition, and lack 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 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 multi-sectoral 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 healthcare throughout the migration process and to live healthy, productive lives. **JUNIMA's mission** is to support multi-sectoral partners to share strategic information on migration and health, advocate for 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, policymaking and programming across the region to improve the health of migrants; (2) To strengthen multi-sector 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 ADB-funded Memorandum of Understanding (MOU) for HIV Vulnerability Reduction for Mobile Populations in the GMS. Following the signing of the 5-year MOU by all six governments in December 2011, a Joint Action Programme (JAP) to operationalize the MOU was developed in 2012.

Lessons learned 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. There is a need for and keen interest from partners and governments in regional coordination mechanisms for Migrant Health, however, there is limited support from donors for such initiatives. This lack of resources significantly hampers ability to mobilize action and produce concrete outputs. Without funding for specific actions, including necessary consultations, face-to-face meetings (especially for civil society representatives) and technology solutions, outputs can be lacking. In 2015, the JUNIMA membership decided to expand beyond South East Asia and include other countries within the broader Asia region. Whilst welcome, this has also diluted focus on sub-regional specific challenges.

Recommendations: 1) Regional mechanisms for migrant health advocacy, coordination and partnership should be replicated and include government, civil society and development partners, 2) Dedicated resources from donors are required to support these regional mechanisms to ensure participation, and 3) Regional coordination mechanisms should be focused on known migration-linked countries and pathways to promote relevant action at a national level.

(Source: International Organization for Migration)

CAMBODIA, LAO PEOPLE'S REPUBLIC, MYANMAR, THAILAND, VIET NAM

Population Mobility and Malaria: Review of International, Regional and National Policies and Legal Frameworks that Promote Migrants and Mobile Populations Access to Health and Malaria Services in the Greater Mekong Sub-Region

CONTEXT: The Greater Mekong Sub region (GMS) 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, accessibility to digital information and thus resulting in an exponential increase in intraregional migration. The Region shows a primary clear pattern of migration characterized by population movements from Myanmar, Cambodia and Lao People's Democratic Republic to Thailand. Malaria is endemic in five of the six GMS countries – Cambodia, Lao PDR, Myanmar, Thailand and Viet Nam – with specifically high-prevalence areas in the Myanmar-Thai border and in some provinces of Cambodia.

PRACTICES: As part of a comprehensive strategy to address the issues of migrants and mobile populations (MMPs), within the framework of the goal of global malaria elimination in accordance with the 2008 World Health Assembly resolution WHA61.17 on the Health of Migrants and its operational frameworks, the WHA68.2 Resolution on Global Technical Strategy and Targets for Malaria 2016-2030 (WHO, 2015d), the Roll Back Malaria Partnership's Action and Investment to Defeat Malaria 2016-2030 (AIM) (RBM, 2015a) and the Strategy for Malaria Elimination in the GMS (2015–2030); and in order to provide an evidence-base and guidance for malaria programme, managers at national level, the International Organization for Migration (IOM) and the World Health Organization (WHO) collaborated on the review of a legal framework 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 GMS countries of Cambodia, 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.

Results: The use of the term 'migrant and mobile populations' appears to have been interpreted in National Malaria Strategies by 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 GMS 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 been 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 of a 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 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. Lao People's Democratic Republic has no such health-care laws that include foreigners and Viet Nam has committed to attaining UHC to at least 80% of its population by 2020. However, as of 2015 all GMS 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 learned and ways forward: The joint approach of IOM and WHO working together on this activity was considered a significant success and examples of close cooperation between the agencies. IOM's expertise in migration and multi-sectoral engagement was capitalized on, and WHO's expertise in malaria and health policy was harnessed. It is important that the GMS 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, whilst examining how these are guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10), and WHA61.17 Resolution on Health of Migrants — particularly regarding key operational frameworks.

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

(Source: International Organization for Migration)

Migrant Mapping: Malaria in Migrants and Mobile Populations – Operational Research and Migrant Mapping in South East Asia

CONTEXT: Over the past decade, national estimates of malaria morbidity and mortality in the Greater Mekong Sub region (GMS) has fallen tremendously due to intensified malaria control efforts. However, GMS 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 Vietnam have identified migrants and mobile populations (MMPs) as key risk groups vulnerable to malaria, with limited evidence-based interventions being employed by national programs to reach these populations. In support of the 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 Programs and partners' strategies for how to provide migrant sensitive health services. In the South-Eastern region of Myanmar, IOM conducted a mapping study from 2011-2013. 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 Vietnam, 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 migrant and mobile populations 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, limited information on migration patterns and flow, on malaria knowledge, and prevention among the targeted migrant and mobile populations proved to be problematic. To mitigate this, several verifications and triangulations of available data from the mapping and other sources were conducted to ensure the accuracy of the data and its interpretation to the most possible extent. Similarly, in Vietnam, 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 the 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 Vietnam 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 migrants and mobile populations.

Lessons learned and recommendations: The mapping study in Myanmar informed the future design and implementation of the mapping study and programmatic response. The summarized study recommendations are: protocols and tools should clearly define targeted migrant and mobile populations, the full migration cycle process should be mapped (departure, transit, arrival and return), focusing more on the work environment instead of the occupational environment as it is more of a determinant of vulnerability, including relevant information relating to migration and malaria (e.g. forest coverage and behavioural data), integrate qualitative methods, identify higher risk groups, promote the national malaria campaign and safe migration, conduct targeted interventions in key source communities, and routine reporting of population movement conducted at village level.

The surveys in Vietnam 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 community level, formulate long-term malaria-control strategies targeting migrants and mobile populations 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, malaria vulnerability and occupation, as well as operational research to investigate specific vulnerability of traditional vector control methods that are found to be less effective.

(Source: International Organization for Migration)

Reference materials: <http://publications.iom.int/books/migration-mobility-and-malaria-study-migrants-vulnerability-malaria-and-epidemiology>

BANGLADESH, INDIA

Protecting Refugees and Migrants from Vaccine preventable diseases

CONTEXT: Migrants and refugees are generally vulnerable and at a higher risk of getting vaccine preventable diseases, as they have been usually found to be under-vaccinated, compared to the other population. Moreover, the Convention on the Rights of the Children (CRC) has identified that in large emergency settings, including that of migrants and refugee settlements, measles vaccination should be done to children based on the local epidemiology, including in very young age groups.

PRACTICES:

Bangladesh: A recent example of vaccination of the migrants has been seen in Cox's Bazar, Bangladesh. Since 25 August 2017, there has been a sudden influx of nearly 688,000 migrants into Bangladesh from Rakhine State in Myanmar. These individuals have joined the nearly 212,000 previously displaced people from Rakhine into Cox's Bazar taking the total number of migrants now living in Cox's Bazar to more than 900,000. The speed and scale of influx of migrants has led to a massive humanitarian crisis. WHO has supported the Government of Bangladesh, to coordinate the health response in Cox's Bazar. Multiple vaccination campaigns have been conducted with measles-rubella (MR) vaccine, bivalent oral polio vaccine (bOPV), oral cholera vaccine (OCV), pentavalent vaccine (DPT-HepB-Hib), Tetanus-diphtheria (Td) vaccine and pneumococcal vaccine (PCV). Almost two million vaccine doses have been administered between September and December 2017 to protect the migrant refugee population from various vaccine preventable diseases.

India: During the polio eradication initiative in India, surveillance data demonstrated that there was an over-representation of polio cases among migrants in India. Genetic sequencing of the polioviruses also showed that the poliovirus was moving from one part of the country to the other, through migrant populations. A targeted strategy was, therefore, put in place by the programme in India to identify, map and vaccinate the migrants. This initiative was among many others that contributed to the polio eradication in India and the SEA Region. The SEA Region has been polio free for last seven years but remains at a risk of importation from the currently polio- endemic countries outside of the Region through migrants and refugees.

Lessons learned and way forward: Migrants and refugees have not only been seen to be at higher risk of vaccine-preventable diseases, but low vaccination rates in the group may undermine control and eradication efforts. Furthermore, experience from countries like Bhutan and Maldives have shown that even after the elimination of Measles, the disease has been seen in migrants, tourists and imported labourers. This poses a risk of re-establishment of measles transmission in the country. It is, therefore, important to ensure that migrant communities are vaccinated, through a focused intervention, through routine and supplementary immunization activities as a part of vaccine preventable disease control strategies in countries and the Region. Surveillance of vaccine preventable diseases among migrants and refugees is also challenging, but critical to guide immunization strategies among these vulnerable populations.

(Source: World Health Organization)

BANGLADESH, INDIA AND NEPAL

Enhancing Mobile Populations' Access to HIV Services, Information and Support (EMPHASIS) in Bangladesh, India and Nepal

CONTEXT: According to the Serological Surveillance in Bangladesh in 2011, HIV prevalence among people who use drugs, female and male sex workers, men who have sex with men, and Hijras (transgender community) was 0.7 per cent. Although this HIV prevalence was below 1 per cent, it was significantly higher than the 0.1 per cent prevalence in the general population. EMPHASIS was a 5-year (2009-14) HIV intervention programme led by CARE country offices in India, Bangladesh and Nepal, and funded by the BIG Lottery Group of the United Kingdom. The EMPHASIS initiative had three main objectives: improving access to social and health services across the mobility continuum; reinforcing capacities of the key stakeholders and populations concerned; and improving the policy environment on migration and mobility issues. It provided a diverse range of services focused on cross border migrants and their partners to decrease the vulnerability of mobile populations to HIV and AIDS, giving special attention to women, migrants and male migrants' wives.

PRACTICES: The project was composed of four interdependent focus areas: an information network; access to HIV and other-related services; safe mobility for migrants; and women's empowerment. Following the logic of migration, an information network of static and drop-in service centres, community-led management committees, referral networks and cross-border reflection meetings was carefully crafted. Migrants and their families were given greater access to health and HIV-related services due to the panoply of referral mechanisms for antiretroviral therapy (ART), health camps and mobile clinics. Two mobility corridors were identified to more closely monitor and address violence and harassment against women and to provide them with the tools to obtain economic empowerment. As well, 'creative spaces' were created as places for expression and exchange. The endeavour required participation and development of partnerships with private sector actors such as hoteliers, as well as transport unions, spouse groups, District AIDS Coordination Committees, and migrant workers at district level.

RESULTS: The project reached 340,000 individuals in the sub-region over its five-year time-frame. It worked closely with national networks of people living with HIV, and was seen to have facilitated access to testing, treatment and counselling services as well as enrolment in governmental targeted intervention programs.⁸

(Source: *Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action*; International Labour Office – Geneva: ILO, 2016)

SAARC Regional Strategy on HIV and AIDS

CONTEXT: At the end of 2005, out of the total of 8.3 million adults and children living with HIV in Asia, over 5 million were estimated to be within the area of the South Asia Association of Regional Cooperation (SAARC). Considering the higher prevalence of the epidemic in the region and the need for a coordinated response, SAARC formulated the *Regional Strategy on HIV and AIDS (2006-2010)*. This strategy envisaged: halting and reversing the spread and the impact of HIV and AIDS; encouraging national leaders to respond to HIV and AIDS; and providing people living with HIV with access to affordable treatment and care.

PRACTICES: Activities were divided into three main areas: policy and advocacy; prevention; and treatment and care. In the policy and advocacy area, the strategy called for and promoted greater regional dialogue on cross-border issues relevant to HIV and AIDS. Through ministerial meetings, program manager meetings and meetings of the Technical Committee on Women, Youth and Children, stakeholders discussed policies to better account for safe mobility and displacement, addressing also drug use and other related risks. The process benefited from collaboration with UN agencies, including UNHCR, UNODC and UNAIDS.⁹

(Source: *Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action*; International Labour Office – Geneva: ILO, 2016)

⁸ ILO: Leaving No One Behind: Reaching Key Populations through workplace action on HIV and AIDS (Geneva, ILO, 2014):60-62; D. Walker et al.: "Migration, Health and Dignity in South Asia Lessons from the EMPHASIS project on migration, women's empowerment and HIV in Bangladesh, India and Nepal" in EMPHASIS Learning Series: Towards safety, dignity and better health of migrants. Overseas Development Institute, Big Lottery Fund and Care, 2011.

⁹ F. Samuels and S. Wagle: *Population Mobility and HIV and AIDS review of laws, policies and treaties between Bangladesh, Nepal and India* Background note (Overseas Development Institute 2011). <http://www.junima.org/resources/pdf/>

ANNEX I

Framework of priorities and guiding principles to promote the health of refugees and migrants: priorities

1. Advocate mainstreaming refugee and migrant health in the global, regional and country agendas and contingency planning.
2. Promote refugee- and migrant-sensitive health policies, legal and social protection and programme interventions that incorporate a public health approach.
3. Enhance capacity to address the social determinants of health.
4. Strengthen health monitoring and health information systems.
5. Accelerate progress towards achieving the Sustainable Development Goals including universal health coverage.
6. Reduce mortality and morbidity among refugees and migrants through short- and long-term public health interventions.
7. Protect and improve the health and well-being of women, children and adolescents living in refugee and migrant settings.
8. Promote continuity and quality of care.
9. Develop, reinforce and implement occupational health safety measures.
10. Promote gender equality and empower refugee and migrant women and girls.
11. Support measures to improve communication and counter xenophobia.
12. Strengthen partnerships, inter-sectoral, intercountry and interagency coordination and collaboration mechanisms.