

Health of refugees and migrants

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

WHO South-East Asia Region
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ACRONYMS AND ABBREVIATIONS

ART	antiretroviral therapy
ASEAN	Association of Southeast Asian Nations
BCC	behaviour change communication
CMHI	Compulsory Migrant Health Insurance (Thailand)
EWARS	early warning alert and response system
GDP	gross domestic product
GMS	Greater Mekong Subregion
IDP	internally displaced person
IEC	information, education and communication
ILO	International Labour Organization
IOM	International Organization for Migration
JUNIMA	Joint United Nations Initiative on Mobility and HIV/AIDS
MBDS	Mekong Basin Disease Surveillance (Consortium)
MDR-TB	multidrug-resistant TB
MMPs	migrants and mobile populations
MoU	memorandum of understanding
MRCS	Myanmar Red Cross Society
NCD	noncommunicable disease
NGO	nongovernmental organization
OD	occupational disease
OHS	occupational health service
OOP	out of pocket
PCU	primary care unit
PHC	primary health care
SAARC	South Asian Association for Regional Cooperation
SDG	Sustainable Development Goal
SEA	South-East Asia
SSS	Social Security Scheme (Thailand)
STI	sexually transmitted infection
TB	tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNHCR	United Nations Refugee Agency
UNICEF	United Nations Children's Fund
WOREC	Women's Rehabilitation Centre (Nepal)

WHO South-East Asia Region

I. INTRODUCTION

Background

To achieve the vision of the 2030 Sustainable Development Goals (SDGs) – to leave no one behind – it is imperative that the health needs of refugees and migrants be adequately addressed. In its 140th session in January 2017, the Executive Board requested that its Secretariat develop a Framework of priorities and guiding principles to promote the health of refugees and migrants.¹ In May 2017, the World Health Assembly endorsed resolution WHA70.15 on “Promoting the health of refugees and migrants”.² The resolution urges Member States to strengthen international cooperation on the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants. It urges Member States to consider providing the necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants, as well as using the Framework of priorities and guiding principles at all levels. In addition, the resolution requests the Director-General to conduct a situation analysis, and identify best practices, experiences and lessons learnt in order to contribute to the development of a global action plan for the Seventy-second World Health Assembly in 2019.

In alignment with resolution WHA70.15, from August 2017 to January 2018, WHO conducted an online call for contributions on evidence-based information, best practices, experiences and lessons learnt in addressing the health needs of refugees and migrants. Thirteen inputs covering practices in six Member States in the South-East Asia (SEA) Region were received from Member States and partners such as the United Nations Refugee Agency (UNHCR), International Organization for Migration (IOM) and International Labour Organization (ILO). This includes valuable information on the current situation of refugees and migrants, health challenges associated with migration and forced displacement, past and ongoing practices, interventions to promote the health of refugees and migrants, legal frameworks in place for addressing the health needs of this population, lessons learnt and recommendations for the future.

Scope of the report and evidence synthesis

This report examines the contributions from WHO regional and country offices, Member States and partners in responding to a global call for contributions as well as from evidence available on current migration trends, legal frameworks, health challenges and outcomes, policies and public health interventions, and good practices to improve the health of refugees and migrants in the Region. The report will contribute to the development of a draft global action plan to promote the health of refugees and migrants to be considered at the Seventy-second World Health Assembly in 2019. The report also aims to provide information to Member States and partners in the WHO SEA Region of current public health interventions and good practices in promoting refugee and migrant health, including access to and outcomes of care. In addition, the report’s accompanying document highlights practices in the Region that include efforts to address the health needs of refugees and migrants. The information received from Member States and partners in response to the aforementioned WHO global call for contributions was examined and compiled in the accompanying document – practices in addressing the health of refugees and migrants in the Region.

¹ EB Decision 140(9) on promoting the health of refugees and migrants

² Resolution WHA70.15 on promoting the health of refugees and migrants

Methodology and type of evidence

A rapid scoping review of available technical reports, the peer-reviewed and grey literature in English as well as contributions from Member States and partners to the global call was conducted between August 2017 and 20 January 2018.

The synthesis questions

The objective of the review was to address the following questions:

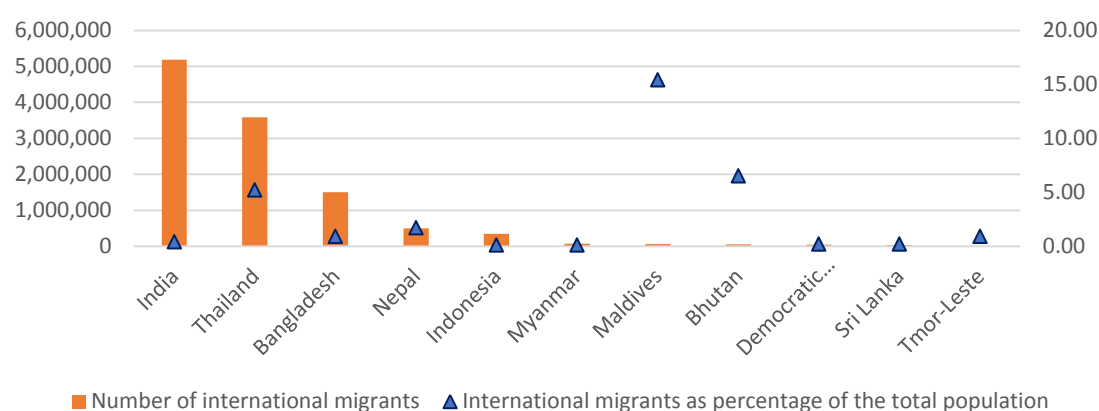
- What are the current migration and displacement trends in the Region?
- What are the relevant global and regional legal frameworks used in the Region to address the health of refugees and migrants?
- What are the current health challenges and outcomes of refugees and migrants in the Region?
- What are the current policies, interventions and practices, experiences and lessons learnt within the Region? Examples of good practices are presented in boxes.
- What are the ways forward and recommendations for addressing refugee and migrant health in the Region?

II. CURRENT SITUATION

The WHO SEA Region is one of the world's most dynamic regions, with a large number of migrant workers moving both within and between the Region and the rest of the world. The most predominant flows are those of temporary labour migrants. In addition to inter- and intraregional regular labour migration, other migration trends have been observed, such as irregular migration, including human trafficking, in particular, of women and children. There were an estimated 11.42 million international migrants in the WHO SEA Region in 2017. A significant observation is that countries in the Region can no longer be compartmentalized as either source or destination countries. To illustrate, India is among the top 10 countries of destination for migration within the WHO SEA Region but it is also one of the top 10 countries from where migrants originate in the same Region.

The WHO SEA Region is vulnerable to different types of emergencies and disasters resulting in population movements. Countries in this Region face a broad range of disasters such as floods, cyclones, earthquakes, tsunamis, landslides, volcanic eruptions, heat waves and droughts. Following the conflict in August 2017 in Myanmar, 898,300 people moved from Myanmar to Bangladesh.

Fig. 1. Number of migrants in the Region and the percentage of international migrants as a percentage of the total population (source: UNDESA 2017 (<https://www.un.org/development/desa/en/news/population/international-migration-report-2017.html>, accessed 28 April 2018))



III. KEY LEGAL FRAMEWORKS AND INSTRUMENTS

The ratification of the United Nations legal instruments related to international migrants and migration, while steadily increasing over time, remains uneven. The 1951 Refugee Convention and its 1967 Protocol has been ratified by Timor-Leste. The protocol to combat human trafficking has been ratified by India, Indonesia, Myanmar, Thailand and Timor-Leste. India, Indonesia, Myanmar and Timor-Leste have ratified the protocol seeking to stem migrant smuggling. Furthermore, Bangladesh, Indonesia, Sri Lanka and Timor-Leste have ratified the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. As of September 2017, of all the WHO SEA Member States, only Timor-Leste had ratified all five United Nations legal instruments related to international migration, while four Member States had ratified none of the relevant instruments.³

Increasing efforts are being made to prioritize migrants' rights in Asia, including a specific focus on their right to health. These include the 2007 Declaration on the Protection and Promotion of the Rights of Migrant Workers by the Association of Southeast Asian Nations (ASEAN); the 2011 Dhaka Declaration to promote migrant-inclusive health policies; the Colombo Statement from the High-level meeting of the Global Consultation on Migrant Health, Colombo, 23 February 2017, issued in February 2017; and The Delhi Call for Action to End TB in the WHO South-East Asia Region by 2030 (1). Other examples include the WHO Mekong Malaria Programme – population mobility and malaria; WHO Regional Strategy to Stop Tuberculosis in the Western Pacific; bilateral collaboration and memoranda of understanding (MoUs) between Thailand and the neighbouring Greater Mekong Subregion countries (GMS, which covers some Member States of both the South-East Asia and the Western Pacific Regions), which focus on migrant workers; and the WHO Regional Action Framework on Universal Health Coverage.

³ <https://esa.un.org/MigGMGProfiles/indicators/indicators.HTM#europe>

IV. HEALTH CHALLENGES AND HEALTH OUTCOMES ASSOCIATED WITH MIGRATION AND FORCED DISPLACEMENT IN THE REGION

Access to health services and determinants of health

Mobile populations pose additional challenges to countries that are often already struggling to cope with day-to-day demands on their health-care systems. Migrants also encounter obstacles to accessing quality health care, as provision of health services is contingent on their legal and administrative status. Pockets of unreached non-resident population groups have contributed to failure in eliminating vaccine-preventable and other communicable diseases. Targeted health services designed for migrants and innovative financing of revenues generated by migrants have not been meaningfully deployed with flexible regulations. As a result, productive migrant populations have been perceived as a burden to the country rather than an asset to the prevailing health services.

The inability of policies and strategies to be adaptive to the global migratory context is one of the key challenges with regard to access. Furthermore, there is a lack of comprehensive national health policies and strategies for migrants in many South-East Asian countries. While migration policies exist in some countries, there is no focus on internal migrants (e.g. in Thailand and India).

Lack of disaggregated data in health information systems is a challenge in the region. Except for a few countries in the Region, data that permit analysis of the main health issues are not available either for refugees and migrants or those directly related to migration and displacement. Lack of disaggregated data hampers efforts to fully understand the extent of their health challenges and develop evidence-informed health policies.

There is great variability in the capacity of health-care systems in the Region to address migrant health (2). Thailand has demonstrated good capacity in this regard and has signed an MoU with Cambodia, Myanmar and Lao People's Democratic Republic, providing support for health service access to migrants. Legal labour migrants working in Thailand are covered by the Social Security Scheme (SSS). There is also the Compulsory Migrant Health Insurance (CMHI) Scheme, which enrolls migrant workers at the time of pre-employment health screening and deducts premiums from the workers' wages. Under this Scheme, the migrant has access only to services at the registered hospital, and not all services available to Thai citizens are made available to them. Additionally, irregular migrants are allowed to enrol into the CMHI scheme (3). Universal Health Coverage (UHC) remains weak in the GMS, with the exception of Thailand.¹⁰ Consequently, migrant workers, especially irregular migrants, are affected by these systems and remain uncovered, often facing extortionate out-of-pocket (OOP) expenses. Migrant workers overall have limited access to health services, and even when certain services are made available to them, lack of awareness of the services among migrant populations remains a challenge.

Social determinants of health relate to factors such as the migration process, reasons for migrating, mode of travel, length of stay, migrants' language skills, and social and legal status of migrants in the destination countries. Migrants, and consequently societies at large, may be more vulnerable to ill-health and disease. Some migrants (e.g. victims of trafficking and low-skilled irregular migrants) are vulnerable to violence and exploitation, including sexual exploitation, which can lead to physical, mental, sexual and behavioural health consequences, including injury, depression, sexually transmitted infections (STIs), and harmful alcohol and substance use (3).

The poorest, least protected, least informed and least trained people are the most affected. Women, children, disabled workers, migrant workers and ethnic minorities often fall within this category (5). Studies have indicated that migrants are at a higher risk of occupational injury, financial burden and physical disability. In Bangladesh, most internal migrants live in poor environments, such as slums and temporary housing, with inadequate access to basic needs. They thus have poorer health

profiles and are more vulnerable than general urban populations. The estimated morbidity rate for slum dwellers is 52%, while 42% of female migrant workers in the garment and textile industry are at a higher risk of occupational injury. In addition, approximately one fifth of female garment factory workers who have migrated from rural to urban areas suffer from STIs.

Disease burden

Communicable diseases

Communicable diseases such as malaria, tuberculosis (TB) and HIV/AIDS are both an epidemiological as well as a public health concern. Migrating peoples often do not have access to proper health check-ups. Irregular migration of people in border areas also leaves them susceptible to abuse and exploitation. Cross-border movements also increase the vulnerability of migrants to communicable diseases.

Malaria

Migration on its own is not a risk factor for increased malaria transmission (6). However, movement into malaria-endemic regions, as a result of infrastructure and rural development, deforestation for logging and economic farming, political movements and natural disasters can make migrant populations more vulnerable to malaria. Malaria is endemic in five of the six GMS countries (Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam). The Thai–Myanmar border and some provinces in Cambodia are the areas with the highest prevalence of malaria. In the WHO SEA Region, other than the two countries that have already eliminated malaria (Maldives and Sri Lanka), the remaining nine countries are endemic for malaria. The Region, the second most heavily malaria-affected after sub-Saharan Africa, has several countries that are rapidly progressing towards elimination – including Bhutan, Nepal and Timor-Leste – and have the potential to eliminate local malaria transmission by 2020. Imported malaria through migration from neighbouring high-burden countries is increasingly a challenge for them as well as for the two countries that have eliminated malaria to prevent reintroduction.

HIV/AIDS

Migrants may acquire HIV in their country of destination or while in transit and face specific vulnerability to HIV related to their status as a migrant. In South-East Asia, HIV prevalence among migrants to Thailand from Cambodia, Myanmar, southern China and Viet Nam is up to four times the HIV prevalence among the general population (7). The highest prevalence among migrants in Thailand was found in the fishing industry, with rates of 2% among fishermen and 2.3% among fishery workers, as compared to an HIV prevalence of 1.1% and 0.74% among factory workers and farm workers, respectively (8). Internal migrants and their families are also vulnerable. In some countries, the vast majority of sex workers are migrants from villages, who use the income from sex work to support families. Studies indicate that women who have been internationally trafficked and forced into sexual exploitation also have a significantly higher HIV prevalence as well as an increased vulnerability and exposure to violence (9). In Mumbai, India, almost a quarter (22.9%) of sex-trafficked women and girls are HIV-positive (10). HIV prevalence is 38% among sex-trafficked women and girls returning from India to Nepal (11). In Indonesia, one in five women trafficked internationally was HIV-positive in 2011 (12). In India, HIV prevalence among people who have migrated from rural to urban areas is estimated at 0.9%, almost four times the national prevalence of 0.27% (13).

Knowledge of ART and how one can benefit from treatment tends to be low among migrant populations, further highlighting the need to increase outreach activities. One study found that only 10% of Nepalese migrants in India were aware of the availability of treatment for HIV (14). These low rates of ART knowledge were found across the Region; 14% of spouses in Nepal had heard of ART,

while only 20% of respondents had heard of antiretroviral drugs in Bangladesh. These rates are much lower than those found among other key populations at risk of HIV exposure (15).

Stigma, discrimination and social exclusion have made it more difficult to provide health services to migrants. Case studies illustrate the difficulties that undocumented migrants may face in accessing treatment due to stigma and discrimination directed at them from health-care workers and employers (16). These barriers exist despite protective legislation that guarantees the right to basic health care for migrants. Without a multifaceted, rights-based approach to addressing the HIV and health needs of migrant populations within their specific contexts, interventions run the risk of missing key groups of this mobile population.

Tuberculosis

TB is a disease of significant public health concern. Six of the 11 WHO SEA Member States⁴ are on the list of the top 30 high-burden countries identified for TB, multidrug-resistant TB (MDR-TB) and TB/HIV for the period 2016–2020 (17). Migration itself can impact the epidemiology of TB, especially in countries with a low TB incidence. Furthermore, migrants can face an increased risk of TB infection, TB disease and poor treatment outcomes, as well as drug resistance, wherein risk factors such as poor living and working conditions, uncertain legal status, poor access to services or discrimination can all play a part (18). The large international migrant “sending” countries include several of the 30 highest TB burden countries. Bangladesh and India are among the top five countries contributing to international migrants living abroad (19). Both are among the highest TB burden countries. Challenges associated with a lack of continuity of care along the migration pathway can increase vulnerability to TB. Cross-border migration between mid- and high-TB burden countries can also contribute to challenges with prevention and management of MDR-TB due to such factors as delayed diagnosis, interrupted or poor quality of treatment, and unavailability of appropriate drug regimens at various stages of migration. With delayed diagnosis and interrupted or substandard treatment, the emergence of MDR-TB can be of concern in conflict situations with forced displacement (20).

Noncommunicable diseases

Noncommunicable diseases (NCDs) are the leading cause of mortality worldwide; almost half of the deaths due to NCDs are premature and affect people under 70 years of age, especially in low- and middle-income countries. Migrants, whether internal or international, who have been subjected to stressful living and working conditions, and adverse environmental, behavioural and health factors are highly vulnerable to NCDs and its risk factors.

Migration from rural to urban areas is becoming increasingly frequent; studies have found that rural-to-urban migration in India is associated with rapid increases in obesity and diabetes compared to urban non-migrant populations and original rural communities (21). According to WHO, migrant populations have heightened risks of malnutrition, substance abuse, and maternal and neonatal mortality. A study in Sri Lanka showed that female migrant workers had a higher prevalence of nutritional deficiencies such as underweight and anaemia, risky sexual behaviours and psychological depression than their non-migrant colleagues (22).

Migrant workers in the Region are mostly employed in the fishing, farming, construction, textile and service industries, with women more likely than men to engage in domestic work. Many migrants in the Region are working in what are known as 3-D jobs – dirty, dangerous and demanding. They work for longer hours and in worse conditions than non-migrants and are less inclined to complain about unsafe conditions. Commercial fishing is one of the most dangerous occupations in the Region,

⁴ Bangladesh, Democratic People's Republic of Korea, India, Indonesia, Myanmar, Thailand

having among the highest incidences of occupational injuries and fatalities. Work-related hazards and violence are common experiences faced by undocumented migrants (23).

As a result of intense and daily exposure to toxic nail products, migrant Asian nail workers, predominantly female, commonly suffer from asthma, cancer and reproductive health complications. The consequences of occupational exposure are worsened by limited safety information, small or poorly ventilated workspaces and long hours of exposure to the toxic air or through skin contact (24).

Mental health problems are also common among migrants as a result of the demands of unfamiliar and difficult living and working environments. In a study conducted in Nepal among migrants and returnees, 29–30% of all migrants reported experiencing occupational hazards and mental health problems. In the same study, 40% of all migrants had used drugs in the past 12 months with greater reported drug use among men than women (25).

Policy approaches have not kept pace with the growing challenge associated with the volume, diversity and disparity of modern migration and do not sufficiently address the existing health irregularities, gaps and need for social protection. Addressing NCDs needs a robust response from the health system of the host country for comprehensive delivery of services on a long-term basis, and behaviour change communication (BCC) and counselling for risk factor reduction, such as tobacco, alcohol, unhealthy diet and physical inactivity. Hence, policy coherence that goes beyond traditional approaches needs to be in place to address this global issue.

Maternal and child health, immunization

The increase in demand for workers in highly feminized sectors such as health care, domestic work, entertainment, manufacturing and textiles results in a large number of migrant women workers. At least 30% of migrant workers in Malaysia and Thailand are girls between 15 and 24 years of age (26). Migrant women face multiple challenges in accessing sexual and reproductive health services and are at a higher risk of discrimination and maternal mortality (27). The gap in reproductive health education and family planning is more pronounced among adolescents. In a study conducted among displaced populations in Myanmar and migrant areas in Thailand, it was shown that while structural issues create significant barriers for the provision of reproductive health care for forcibly displaced persons and migrants, adolescents face additional difficulties in gaining access to services (28).

One of the consequences of migration is the impact on family members that stay behind. Long absences of the parents with a lack of clarity on when reunion will be possible are likely to negatively impact the children. In a study conducted in South-East Asia, higher odds of common mental disorders were found for mothers whose husbands were working overseas (29).

Refugees and migrants, especially children, are generally vulnerable and at higher risk of vaccine-preventable diseases as they have been found to be undervaccinated compared to the resident population. The low immunization coverage of refugees and migrants may also undermine efforts at controlling and eradicating vaccine-preventable diseases. In India, surveillance data demonstrated that there was an overrepresentation of polio cases among migrants. Genetic sequencing of the poliovirus showed that viruses were moving from one part of the country to another through population movements.

V. EXAMPLES OF CURRENT PUBLIC HEALTH INTERVENTIONS AND PRACTICES

Based on the contributions and in line with the Framework of priorities and guiding principles to promote the health of refugees and migrants, the following are the priorities along with examples of interventions/practices in place in Member States of the WHO SEA Region.

1. Promoting, advocating and mainstreaming the right to health, and mainstreaming refugee and migrant health in global, regional and national policies, planning and implementation

Several Member States in the WHO SEA Region have taken an active role in the Colombo Process, such as Bangladesh, India, Indonesia, Nepal and Thailand (30). Member States of the Colombo Process strongly recommend “...promoting the implementation of migrant-inclusive health policies to ensure equitable access to health care and services as well as occupational safety and health for migrant workers”. The Colombo Statement (31) was issued in February 2017, calling for international collaboration to achieve equitable and non-discriminatory health services for all, including migrants and refugees. The 2011 Dhaka Declaration also calls for action to promote migrant-inclusive health policies (32).

Bangladesh: Migration health and related issues are a national priority in Bangladesh, with the Minister of Health and Family Welfare designated as the focal point for migration and health. This reiterates the importance of formulating migrant-inclusive health policies and strengthening regional partnerships and bilateral agreements to protect the human rights of migrants.

Maldives: The Government of Maldives is working with the Government of Bangladesh to implement a pre-departure health screening system for potential migrant workers from Bangladesh to Maldives. This system has been developed with support from IOM.

Thailand: The second Border Health Development Master Plan 2012–2016 is a framework for public health work in border areas to improve the quality of life of the border population. Migrant health is one of the six priorities of the WHO Country Cooperation Strategy Thailand 2017–2021.

Sri Lanka: Second Global Consultation on Migration and Health in Colombo

Context. The 2010 first Global Consultation on Migrant Health in Madrid, co-organized by IOM, WHO and the Government of Spain, developed an Operational Framework for the implementation of World Health Assembly Resolution WHA61.17 on the Health of Migrants. Furthermore, following recommendations from the Executive Board of WHO, 12 priorities for promoting migrants’ health were developed by WHO. In February 2017, **Sri Lanka** together with WHO and IOM co-organized the Second Global Consultation on Migration and Health in Colombo in order to further engage with migrants’ health (33).

Practice. The Second Global Consultation on Migration and Health in Colombo has offered Member States and partners a platform to share best practices and research on the health of migrants, identify gaps, opportunities and new challenges, reach consensus on key policy strategies and benchmarks with the aim of creating a unified agenda on the health of migrants and refugees, and engage multisectoral partners to enable a policy environment for change.

Results. The Global Consultation on Migration and Health has relaunched awareness of the crucial importance of including migrants in health systems and national health strategies, provided guidance to countries, international agencies and global dialogues on how to take concrete actions

to advance the health of migrants (34). Consultation outcomes included recommendations at the national, regional and global levels, and the endorsement of the Colombo Declaration by participating Member States. By creating this important platform, Sri Lanka has pushed towards promoting migrants' health within the WHO SEA Region.

On a **global level**, the need for partnerships was raised as well as the need to ensure a dedicated space for health and migration issues within Global Compacts. Furthermore, it was recommended to mainstream migrants across sectors and within the scope of implementation of the SDGs. The need for political leadership, partnerships and mobilization of resources was raised, as well as the importance of multiagency regional and global platforms for collaborative learning and sharing of lessons learnt.

On a **regional level**, it was agreed to enhance cross-border cooperation, including communication between the country of origin and destination, partnerships to harmonize policies and practices, ensure continuity of care, and mainstream migration and health issues in labour or foreign policy. Recommendations at a regional level included maintaining commitments and advocating goals and targets globally.

2. Promoting and implementing 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

Bhutan is currently drafting a comprehensive health legislation, which gives the opportunity to address the need for migrant-sensitive health legislation and policies.

Indonesia has a Ministry of Manpower and Trans-migration, which is responsible for deploying and protecting migrant workers and has also ratified the Migrant Workers' Convention. Furthermore, Indonesia has passed legislation to protect migrant workers from Indonesia (National Law on the Placement and Protection of Migrant Workers Overseas). The Government has included migrants into the national health insurance system and entered into MoUs with destination countries to cover the health of migrants. In addition, Consul Generals – as an example – provide support to Indonesian migrants. The Government of Indonesia has also launched a national health scheme for those who have worked in Indonesia for at least 6 months.

The Ministry of Health and Sports of **Myanmar** has identified migrant health as an important issue and has developed a "Migrant Health Policy Framework" in 2016 to ensure effective strategies for migration and health. It has proposed four pillars: (i) adopting and implementing relevant international standards on the right to health and protection of migrants regardless of legal status; (ii) having useful data in place for decision-making and monitoring of policies, migrant health status and programmes on migrant health, and promoting the inclusion of migration variables in the existing census, national statistics, targeted surveys and routine health information systems; (iii) adopting migrant-inclusive health services and programmes, and developing frameworks for the implementation and monitoring of health systems delivering migrant-sensitive services; (iv) developing resource mobilization plans from well-resourced countries, and a legal policy framework to create policy and legal documents for migrant health. The Health Care Management Working Committee has been established under the National Disaster Management Committee. It has 19 main functions to promote the right to enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants. In addition, the Disaster and Public Health Emergency Response Unit has been established as a focal point to manage the health aspect of disasters, including social disaster and internally displaced person (IDP) camps.

In **Nepal**, the recently developed National Health Sector Strategy (NHSS) 2015–2020 mentions the issue of migrants.

In **Sri Lanka**, the National Health Policy includes access to primary health care, which is provided through a network of facilities available throughout the country. Primary health-care policies are currently being reviewed to improve their scope and quality and be more people-centred. Sri Lankan health services are non-gender discriminating, and regulations that directly affect access to health services do not exist.

Timor-Leste is in the preliminary stage of addressing migration and health, especially the framework for health of the migrants, which specifically covers (i) evidence-based inclusive migrant-sensitive health policies and legal options; (ii) disaggregated health information with robust epidemiological data on migration; and (iii) transformation of health systems sensitive to the needs of migrants.

India: Health support to internal and international migrants

The National Commission for Scheduled Tribes (NCST) has developed a policy framework to address tribal migration, based on a pilot migration support program for tribal migrants in the state of Maharashtra during 2013–2016, which was jointly implemented by Tribal Development Department, Maharashtra and NGO Disha Foundation. NCST has recommended Government of India to extend this programme to other states of India. The National Urban Health Mission of 2013 has identified migrants as a vulnerable population in need of special interventions for health services. Suggestions have included the mapping of vulnerable groups, e.g. migrant workers, and setting up dedicated drug distribution centres in areas with concentrations of migrants and other vulnerable groups to provide over-the-counter (OTC) drugs and contraceptives, as well as outreach to vulnerable populations. The National Health Insurance Programme (*Rashtriya Swasthya Bima Yojana*) (36), a public–private partnership (PPP), is available for families below the poverty line (BPL). A biometric smart card is made available to such families to receive care. There are approximately 800 000 Indians who migrate to the Gulf Cooperation Council (GCC) countries every year under the Emigration Clearance Required (ECR) category. These migrant workers are provided various support structures and insurance schemes. These include: the MADAD Portal – addresses grievances pertaining to Consular Services offered by Indian Missions/Posts abroad and other worker-related grievances; Indian Workers Resource Centres (IWRC), 24*7 toll-free helpline, Overseas Workers Resource Centres (OWRC), enable Indian Missions abroad to meet the contingency expenditure for carrying out welfare activities for distressed overseas Indian citizens, and insurance schemes such as the Pravasi Bharatiya Bhima Yojana (PBBY) and the Mahatma Gandhi Pravasi Surakha Yojana (MGPSY). Ministry of Labor, Government of Odisha State of India has initiated state level action plan to address our migration from the state – both internal and international, which will be focussed on building structured migrant health program including pre-departure and on-arrival health screening of migrants, special support for livelihood, skill building and legal aid support.

Sri Lanka: Addressing migrants' health

Context. Sri Lanka is a major labour-sending country within the Region and per year over 250 000 Sri Lankans leave the country to work abroad. Remittances contribute significantly to the country's development. Sri Lanka also attracted over 40 000 international migrants in 2017, many of them labour migrants. Understanding the complex migration flows and their impacts on health has increasingly been a focus, and a National Migration Health and Development Programme was launched in 2010. Subsequently in 2013, a National Migration Health Policy was developed by the Ministry of Health using a multistakeholder approach, involving thirteen key government ministries. The National Migration Health Policy recommends a comprehensive series of strategies to promote the health of outbound and inbound migrants, as well as internal migrants, and the

families left behind by outbound migrants.

Practices⁵

Ensuring and expanding access to health care for migrant populations, including non-citizens, and strengthening maternal and child health services for migrants. The 2009 National Labour Law follows a rights-based approach to labour migrants. For health, it was limited to addressing HIV and reproductive health. Furthermore, to address other health issues of the migrant population, the National Migration Health Policy was launched in 2013. This Policy follows an inclusive approach and health concerns are taken as an opportunity to extend health services for the greater public health good of the communities.

Results. The programme on National Migration Health Policy has enabled Sri Lankan refugees who return from South India direct access to the primary health-care system upon their arrival. Health screening facilities are provided and early treatment for malaria, HIV and TB are available, as well as maternal and child health services and immunization. A coordinated Child Health Protection Plan has been developed and implemented, targeting vulnerable children of migrant workers, with a special emphasis placed on identifying psychological and mental health needs of migrant populations and providing access to services.

Strengthening monitoring, assessment and surveillance systems for all outbound and inbound migrants (including health assessments for long-term visa holders). With the help of partners, the country has gathered empirical evidence and implemented evidence-informed policies to address differing health challenges within the migration cycle for inbound and outbound migration, including left-behind family members.

Lessons learnt. There is a need to further increase monitoring and data collection for inbound labour migration in order to understand health needs and plan services accordingly.

Entering into bilateral agreements with countries to ensure health protection of Sri Lankan migrant workers through bilateral agreements and MoUs such as the one with Qatar and Republic of Korea to ensure that Sri Lankan workers have access to health care and social security benefits. The Sri Lanka Bureau of Foreign Employment has also established an Overseas Workers Welfare Fund to provide a comprehensive system for migrants' welfare (37).

Results and lessons learnt. The implementation of health assessments for incoming labour migrants, especially in the construction sector, remains a challenge. A proposed health assessment for resident visa applicants to Sri Lanka has been approved by the Sri Lankan Parliament and is in the process of implementation by the Ministry of Health in coordination with the Department of Immigration and Emigration. A hallmark of the process is planned focus on non-discrimination of incoming migrants by health status and ensuring quality care and treatment.⁶

3. Enhancing capacity to address the social determinants of health

Bangladesh–Jordan: Bilateral agreements

Context. Bangladesh is a major country of origin with approximately 7.2 million Bangladeshis living abroad in 2017 (38), many of whom are employed in the Gulf States in the domestic sector and are working and living in poor conditions. Steps have been taken to promote outgoing migrants' health.

⁵ Information collected from the country online submission in response to a WHO global call from August 2017 – January 2018

⁶ Information from the submission by the International Organization for Migration in response to a WHO global call from August 2017 – January 2018

Practices. 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 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.

Lessons learnt. These types of bilateral agreements overlie existing labour and migration legislation and compensate for the fact that certain sectors, most notably domestic work, are frequently not covered by national labour laws. They also provide a framework for redress, both by individual workers and by the states. However, these agreements must be underpinned by consular resources and investment in outreach to foreign workers, along with effective monitoring and dispute resolution mechanisms (38).

Addressing social determinants along the Thailand–Myanmar border

Context. As of February 2017, 102 412 people remained in refugee camps on the border with Thailand (39), following decades of conflict between the Myanmar military and armed ethnic groups in the south-east of Myanmar. Throughout the conflict, an additional 400 000 people were reportedly displaced internally (8767 are currently living in IDP camps) in the south-east of the country and there are an estimated 4 million undocumented Myanmar migrants living abroad (mainly in Thailand and Malaysia) (40), many of whom come from the south-east border regions of Myanmar. Communities in the south-east of Myanmar are not only socially and economically marginalized but also often suffer poor access to basic services, particularly health and education.

Practices. Significant steps have been taken to address the social determinants of health for migrants and refugees at the Thailand–Myanmar border. For over 13 years, the Myanmar Red Cross Society (MRCS) has partnered with UNHCR to raise the health and education status of vulnerable communities in the south-east. Furthermore, MRCS and their partner, the Australian Red Cross (including funding from the Swedish Red Cross) have aimed to build “resilient communities” in 28 locations in the south-east of Myanmar, which are expected to see large numbers of returning refugees and IDPs. Improving access to health, education and nutrition as well as creating livelihoods are key concerns.

Results. The initiative has reached over 16 000 people and helped to strengthen resilience in rural communities in Kayin State. One hundred and fifty-two vulnerable community members in the same return location were also provided with this assistance regarding to strengthen resilience as well as solar lamps. Specifically, since 2004, MRCS has worked in over 1000 villages to build 79 rural health subcentres, and trained over 45 000 people in life skills, health, and water, sanitation and hygiene (WASH) practices. Furthermore, access to education has been increased through the construction of 93 primary schools in remote locations. Two hundred and twelve latrines have been constructed in schools and 250 mine risk education (MRE) sessions conducted. This has led to an increase in health-seeking behaviour in participating communities and, through the formation of community-based organizations (CBOs), has also increased community self-management, local ownership and sustainability.⁷

⁷ Submission by Myanmar Red Cross Society. Addressing migration and displacement issues along the Thailand–Myanmar border in response to a WHO global call from August 2017 – January 2018

4. Enhancing and strengthening health monitoring and health information systems

In 2010, **Thailand** lifted its reservation to Article 7 of the Convention on the Rights of the Child. As part of the country's new Civil Registration Act, the Government committed to registering the birth of all children within its jurisdiction. Under the revised law, children born in Thailand are entitled to be registered at birth even when their parents are not Thai nationals. The law was an important step towards preventing statelessness among a new generation of refugees. Birth registration does not confer nationality on refugee children. But by establishing a legal record of their parents and their place of birth, a birth certificate can be used to prove the right to acquire nationality if a child returns to the parents' country of origin. The law came into effect in 2010 and in the years since, Thai civil registration authorities have worked with partners to address the backlog of registration for children born in refugee camps.

Maldives has recognized the critical importance of having added data and information on migration and health and taken steps to implement this. It also recognizes that the large number of migrants entering the country pose a risk to diseases that have been eliminated from Maldives. In the case of malaria, all cases are notified centrally and treatment is provided free of charge through the program. Epidemiological surveillance, prevention of vector-borne diseases attempted through cross-border health and international travel health regulations. An effective health-care system that has ensured primary care, prevention and treatment covering almost the entire population, and integrated vector surveillance and control has resulted in certification of elimination of malaria and Lymphatic filariasis in the country in 2015 and 2016, respectively.

In addition, under the requirements for certification of measles elimination in the country, Maldives is planning to introduce MR vaccination to migrants from high risk countries. Maldives has been certified as a measles free country in 2017.

The Government of **Myanmar** has prioritized the need for establishing a health information system, a migrant-sensitive surveillance system, and data-sharing among Member States for the management and control of major communicable diseases, including HIV, TB, malaria, vaccine-preventable diseases and emerging communicable diseases.

The Mekong Basin Disease Surveillance (MBDS) Consortium

Context. The flow of the Mekong river is a source of revenue but also poses health challenges for people living in its basin, such as cholera, multidrug-resistant malaria, dengue, STIs such as HIV, and TB (41). Improving investigation of and joint response to cross-border infectious disease outbreaks, developing expertise in epidemiological surveillance across countries and enhancing communication between countries will greatly improve the ability of individual countries to identify, confirm and respond to outbreaks.

Practice. The ministries of health of Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam signed an MoU in 2001, establishing one of the longest standing subregional disease surveillance networks to date. The MBDS (42) is a self-organized and subregional cooperation spearheaded by the health ministries of participating countries to collaborate on infectious disease surveillance and control. In May 2007 and May 2015, extensions of MoUs were signed by the six MBDS health ministers during the World Health Assembly for an indefinite period. The Consortium operates within an agreed governance structure and process. Over time, the MBDS has evolved to reflect different phases of its development, developing capacity and strengthening preparedness, regionally and nationally, setting up multiple cross-border projects, regional simulation exercises and focusing on seven core strategies (each led by one country). The seven strategies include enhancing cross-border communication and information exchange, improving the human-animal sector interface, strengthening community

surveillance, developing human resources and epidemiological capacity, reinforcing laboratory capacity, strengthening risk communication, and conducting and applying policy research.

Results. The Consortium has implemented joint outbreak investigations such as for H5N1 cases by Lao People's Democratic Republic and Thailand, supported the response to Cyclone Nargis, conducted field epidemiological training for Member States, reviewed human resource capacity of each member, continued to share information among the group, and supported members of the network (43).

Lessons learnt. The MBDS Consortium is a long-term trust-based collaboration. Member States have shown continuous engagement, and the trust established is a strong platform for sustaining collaboration and allows countries to share experiences and practices. Data-sharing among MBDS Member States is exemplary and is a successful model for regional disease surveillance.

Malaria: Operational research and migrant mapping in South-East Asia

Context. Over the past decade, national estimates of malaria morbidity and mortality in the GMS have 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 has identified migrants and mobile populations (MMPs) as key risk groups vulnerable to malaria, with limited evidence-based interventions being employed by national programmes to reach these populations.

Practices. In the Myanmar mapping project, the lack of clarity on the definition of migrants, limited information on migration patterns and flow, malaria knowledge, and prevention among the targeted MMPs 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 greatest possible extent.

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 Programme and partners and have been used in planning for improved service coverage in these populations. The results were utilized by the National Malaria Programme to improve targeting of MMPs with appropriate interventions.

Lessons learnt and recommendations. This study in Myanmar informed the future design and implementation of the mapping study and programmatic response. The summarized study recommendations are as follows: (i) protocols and tools should clearly define targeted MMPs; (ii) 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); (iii) qualitative methods should be integrated; (iv) higher-risk groups should be identified; (v) the national malaria campaign and safe migration promoted; (vi) targeted interventions conducted in key source communities; and (vii) routine reporting of population movement conducted at the village level.

5. Providing universal health coverage and equitable access to quality essential health services, financial support and protection, and access to safe, effective, quality and affordable essential medicines and vaccines for refugees and migrants

Thailand: Providing Universal Health Coverage for migrants

Context. Thailand is one of the few developing countries in the world to have implemented UHC. In 2015, an estimated 3.9 million migrants were living and working in Thailand. True UHC cannot be achieved without the inclusion of migrants. Thailand has sought to enhance migrant health coverage, including the development of migrant health policies/programmes, bilateral migrant worker agreements and migrant health insurance schemes. Currently, Thailand is perhaps one of the very few countries in the world that extends health coverage to undocumented migrant workers.

Practices. Regular migrants (labour migrants in Thailand) are covered by the national Social Security Scheme (SSS). Thailand has also introduced a Compulsory Migrant Health Insurance Scheme (CMHI) for documented and undocumented migrants and their dependents who are working in the informal sector. The Ministry of Public Health is responsible for this scheme. The benefits package of CMHI is similar to that of the UHC scheme for Thai people. This scheme enrolls regular migrant workers following pre-employment health screening, and annual premiums are deducted from the migrant's wage; health services are available only at the hospital where the migrant was registered, and some services available to Thai citizens are not accessible to migrants. Thailand has also established specific policies/programmes to address migrant health, including the Migrant Health Programme. They focus on, but are not limited to, international labour migrants and seek to strengthen the migrant sensitivity of existing health services and develop migrant health services (44).

Results. In 2014, approximately 1.6 million MHI cards had been issued. Thailand has established policies and good practices that relate to health services for some irregular migrants. From August 2013, irregular migrants were allowed to register for the MHI with annual fees attached (1500 Baht plus 500 Baht health check – or approximately US\$ 56 – as of 2014) (45).

Lessons learnt. The local health budget is allocated based on the number of patients registered. Although all migrant workers have the right to access health services, 60% of migrant workers are not registered but avail of the services of primary care units (PCUs), even as the budget does not take their presence into account. This results in the shortage of funding to provide all the services required for the PCUs (46). Other barriers include the scheme's uptake, including annual fees, lack of awareness of the scheme among irregular migrants, and reluctance of some hospitals to promote and implement the policy.

Indonesia: Access to health services

Indonesia allows migrants to enrol in its national health insurance programme (i.e. Jaminan Kesehatan Nasional) after 6 months of work. However, many are hesitant to join the programme as private health insurance is provided by their employers.¹¹

Maldives: In Maldives, all regular migrants are required to take health insurance as part of the requirements of obtaining work permit.

6. Providing humanitarian assistance and long-term public health interventions to reduce mortality and morbidity among refugees and migrants, including addressing communicable and noncommunicable diseases

The Regional Director of the WHO SEA Region has recognized NCDs as one of the four Flagship Priorities. This includes addressing NCDs in migrants within the broader framework of health system delivery. The Regional Committee resolution on strengthening primary health care (PHC) to address NCDs is clear evidence of taking this agenda forward. In addition, for special groups such as refugees and migrants in emergency situations, a guideline has been developed jointly by Department of Noncommunicable Diseases (NDE) and Department of WHO Emergency Programme (WHE) to provide comprehensive and quality NCD services to vulnerable populations, migrants in particular. In **Nepal**, there are more than 15 000 internally displaced persons living in temporary settings as a result of the earthquake in 2015, and 20 000 families are temporarily displaced due to recent floods and landslides in Nepal.⁸ In 2017, there were an estimated 30 651 refugees in Nepal, mainly from Bhutan and Tibet (47). Despite a lack of specific laws that addressing refugee and migrant health, refugees and migrants have access to free health services at government health facilities. Vaccines and medicines for TB treatment and health-care services, including psychosocial and mental health support, are provided to the Bhutanese and refugees from other countries.

Bangladesh: Provision of humanitarian health assistance for refugees from Myanmar

Context. Since August 2017, an estimated 898,300 (48) refugees from Myanmar have crossed the border into Cox's Bazar, Bangladesh, joining approximately 300 000 others who arrived in Cox's Bazar during the early waves of displacement. Cox's Bazar now has one of the densest refugee concentrations in the world, of which 1.2 million refugees and affected host populations are in need of humanitarian assistance. Key public health challenges are prevention and control of communicable diseases, injuries and burns, and maternal and child health as well as NCDs, including mental health. The overcrowding and lack of basic amenities have resulted in an increased risk of outbreaks of vaccine-preventable diseases and water- and vector-borne diseases.

Practices. The Government of Bangladesh has allocated 3000 acres for temporary settlement and engaged in road construction, expansion of electricity networks and installation of 50 public lights. It has also provided emergency food assistance to refugees through general food distribution, constructed 26 163 temporary latrines and installed 4821 water points. To complement general food distribution with the aim of increasing dietary diversity with fresh food items, cash-based transfers are also ongoing (49). The WHO-coordinated humanitarian health response included provision of communicable disease prevention, detection and control, and leadership and coordination for an effective health response. In addition, WHO provided access to essential health services, strengthened mental health and psychosocial support, and provided reproductive, maternal, newborn and child health services to both refugees and host communities. Furthermore, data collection has been improved and an early warning alert and response system (EWARS) has been established. WHO and the United Nations Children's Fund (UNICEF) have worked with the Ministry of Health and Family Welfare to vaccinate over 350 000 children in the refugee camps in order to step up efforts and respond to the diphtheria outbreaks in Cox's Bazar. Eighty-one vaccination teams will conduct 1000 vaccination sessions (50).

Results. Over 655 000 people have been provided with emergency shelter assistance, and partners are working to improve the living conditions of the refugees. More than 200 000 children have been

⁸ Ministry of Home Affairs, August 2017

vaccinated against diphtheria (51) and 700 000 people vaccinated against cholera (52).

7. Protecting and improving the health and well-being of women, children and adolescents living in refugee and migrant settings

Women and children living in refugee and migrant settings often face increased vulnerability. Trafficking of women and children for sex work and begging within the WHO SEA Region has been reported (53). In 2004, leaders of **all six GMS** nations signed an MoU on cooperation to address trafficking of people in the GMS, an agreement that led to the Coordinated Mekong Ministerial Initiative Against Trafficking (COMMIT). It commits to “providing all victims of trafficking with shelter, and appropriate physical, psychosocial, legal, educational and health-care assistance”. However, it is primarily nongovernmental organizations (NGOs) that work to meet the health and welfare needs of trafficked people in the GMS.

India has addressed child health and the Integrated Child Development Services (ICDS) provides health services to migrant women and adolescents in destination cities.

Protecting refugees and migrants from vaccine-preventable diseases

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

Practices

Bangladesh: A recent example of vaccination of migrants was 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 the 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 were administered between September and December 2017 to protect the migrant population from various vaccine-preventable diseases.

India: During the polio eradication initiative in India, surveillance data demonstrated that there was an overrepresentation of polio cases among migrants in India. Genetic sequencing of the poliovirus showed that it was moving from one part of the country to another 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 polio eradication in India and the WHO SEA Region. The WHO SEA Region has been polio free for the past seven years but remains at risk of importation from currently polio-endemic countries outside of the Region through migrants and refugees.

Indonesia: Routine Immunization services are freely provided to all migrants / refugee children and no outbreaks of vaccine preventable disease have been reported from such populations. During the 2016 Polio National Immunization days, OPV was provided to all entire population of migrant’s families (all age groups vaccinated). Similarly in 2017 during Measles Rubella vaccination campaign MR vaccine was provided to all children 9 months to <15 years studying in refugee schools.

Lessons learnt and the way forward. Migrants and refugees are not only at a higher risk of vaccine-preventable diseases, but low vaccination rates in the group may undermine control and eradication efforts. Furthermore, experience from countries such as Bhutan have shown that to attain and sustain elimination of vaccine-preventable diseases such as measles, vaccination among migrants and imported labourers is essential. It is crucial to capture them during the surveillance process so that immediate action is rolled out when a case is reported and an outbreak does not occur in the community. Maldives is planning to begin vaccination of all expat health workers from high risk area with two doses of measles and Rubella vaccine to protect these high risk groups. In addition, relevant traveller's vaccine and prophylactic drugs prescription for citizens travelling out of Maldives has been beneficial to maintain low disease transmission in the country. This initiative minimizes the risk of re-establishment of disease transmission in the country. It is therefore important to ensure that migrant communities are vaccinated through a focused intervention and 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 challenging but critical to guide immunization strategies among these vulnerable populations.

Nepal: Addressing violence against women

Context. The returned migrant population in Nepal is estimated at half a million, many of whom have been in high HIV-incidence districts in India. Many of these returned women migrants have suffered sexual and other forms of abuse in other countries. Improving HIV prevention coverage and promoting behavioural change are priority areas for HIV prevention in Nepal. National policy developments have 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 an NGO established in 1991 with the purpose of fighting violence against women, and ensuring their economic, social and cultural well-being. Through its "Women Health Right Programme" and "Safe Migration Programme", 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 biointensive farming and political engagement. (Website: <http://www.worecnepal.org>).

8. Promoting continuity and quality of care for refugees and migrants, in particular, for persons with disabilities, people living with HIV/AIDS, tuberculosis, malaria, mental health and other chronic health conditions as well as those with physical trauma and injury

Cross-border coordination is key to an effective treatment strategy, which should include cooperation between the countries of destination, transit and origin to improve treatment adherence. For example, the governments of **Thailand** and **Cambodia** have collaborated on a scheme that allows Cambodian migrants living with HIV to return to their home country to obtain a three-month supply of antiretroviral medicines. Stigma, discrimination and social exclusion have made it more difficult to provide health services to migrants.

In **Bangladesh**, health promotion programmes for migrants have focused on HIV and communicable diseases through awareness-raising and community-based social mobilization activities for prospective migrants and their families. In **India**, global partnerships on HIV and mobile workers in the maritime sector (IOM, International Council on Social Welfare [ICSW], ILO, International Maritime Health Association [IMHA], Joint United Nations Programme on HIV/AIDS [UNAIDS]) have promoted changes in HIV-risk behaviour and provide access to health and HIV programmes and services (HIV testing and counselling).

In **Maldives**, all migrants entering Maldives are required to be certified as having good health before they are considered for employment in the Maldives. Currently, Maldives is working to implement pre-departure screening for migrants with one country with plans to extend to migrants from other countries. These include screening against diseases that are eliminated or have low transmission levels in Maldives. Examples of these diseases include malaria, filariasis, HIV/AIDS and TB. While these requirements are mandatory, the quality of testing at their respective countries cannot be assured. In addition, all migrants living in the country need to undergo medical examination as part of their work permit renewal. This process ensures identification of new infections and for priority diseases like tuberculosis, the treatment is provided for free of cost.

WHO has worked with the Ministry of Health in **Timor-Leste** to address the health needs of the population living along the border between Indonesia and Timor-Leste and the migrant population, focusing on communicable disease control, including the International Health Regulations (IHR) core capacity at the points of entry, tuberculosis, AIDS and neglected tropical diseases, particularly lymphatic filariasis, soil-transmitted helminthiasis, yaws and leprosy.

In Thailand, to prevent and control communicable diseases among migrant populations in cross-border areas, a **“healthy border programme”** has been established through an MoU between WHO and ASEAN with a focus on preventing and controlling TB, HIV and other prevalent communicable diseases in the Region. As part of this programme, a review of access to health and other related services by migrants in the Subregion is also forthcoming.

Human mobility and malaria in the Greater Mekong Subregion

Context. The GMS has experienced consistent economic development in the past decade coupled with the opening of borders and economic corridors, emergence of megacities, ease and speed of travel, and accessibility to digital information, thus resulting in an exponential increase in intraregional migration. The GMS 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 People’s Democratic Republic, Myanmar, Thailand and Viet Nam – with specifically high-prevalence areas on the Myanmar–Thai border and in some provinces of Cambodia.

Practices. In order to provide an evidence base and guidance for the malaria programme, managers at the national level, IOM and 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 among MMPs. This was part of a comprehensive strategy to address the issues of 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, resolution WHA68.2 on the Global Technical Strategy and Targets for Malaria 2016–2030, the Roll Back Malaria Partnership’s Action and Investment to Defeat Malaria 2016–2030 (AIM) and the Strategy for Malaria Elimination in the GMS (2015–2030). The report of the review of a legal framework to provide up to date recommendations on the technical implementation and policy implications of addressing malaria for Mobile and Migrant populations, 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 not 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 at the time of the review, there were 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 for 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 being particularly vulnerable.⁹

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

Bangladesh, India and Nepal: Enhancing mobile populations’ access to HIV services, information and support

Context. According to the 2011 serological surveillance in Bangladesh, HIV prevalence among people who use drugs, female and male sex workers, MSM and *hijras* (transgender community) was 0.7%. Although this HIV prevalence was below 1%, it was significantly higher than the 0.1% prevalence in the general population. EMPHASIS was a 5-year (2009–2014) HIV intervention programme led by CARE country offices in Bangladesh, India 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 the capacities of 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 had 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 was carefully crafted of static and drop-in service centres,

⁹ Information collected from the submission by the International Organization of Migration in response to a WHO global call from August 2017 – January 2018

community-led management committees, referral networks and cross-border reflection meetings. Migrants and their families were given greater access to health and HIV-related services due to the panoply of referral mechanisms for 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 the district level.

Results. The project reached 340 000 individuals in the Subregion 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 programmes (54).

9. Promoting workers’ health, including occupational health safety in workplaces where refugees and migrant workers are employed, in order to prevent work injuries and fatal accidents

In **Myanmar** (55), the Government has recognized the importance of migrant workers to Myanmar’s economy and development. A large number of migrants from Myanmar are in Thailand and the Government of Myanmar has been regularly conducting dialogue with the Thai Government to ensure the safety of its migrant workers.

All workers in **Maldives** with valid work permits can access any tier of the health-care system, irrespective of the country of origin, gender or religious background. The majority of drugs required for common illnesses are available in the local pharmacy. The central hospitals in Male (Indira Gandhi Memorial Hospital and ADK) also offer care to migrant workers. To protect the health of these vulnerable populations, appropriate policies on occupational health are being advocated for by WHO. In addition, WHO is also assisting the Health Protection Agency to develop, print and distribute information, education and communication (IEC) materials to migrant workers on occupational hazards and ways to mitigate potential injuries. All employers of the country are required to provide decent accommodation, three meals and cover the health costs of the migrant workers. While these facilities are better executed among skilled workers, resorts, industries and offices, the same cannot be assured for domestic and daily wage workers.

In **India**, in the preamble of the National Policy on Safety, Health and Environment at the Work Place (2009) issued by the Ministry of Labour and Employment, one of the resolutions states, “Particular attention needs to be paid to the hazardous operations and of employees in risk-prone conditions, such as migrant employees and various vulnerable groups of employees arising out of greater mobility in the workforce with more people working for a number of employers, either consecutively or simultaneously (56).”

In **Sri Lanka** (57), the National Labour Migration Policy (2008) aims to promote skilled migration. The Sri Lanka Bureau of Foreign Employment (SLBFE) provides predeparture training to domestic workers, including lectures on health (58). In addition, the SLBFE established an Overseas Workers Welfare Fund that offers a compulsory insurance scheme, coverage of the cost of repatriation, scholarships for children and schemes to cover some of the expenses incurred by migrants during the migration pathway.

Nepal: Health support for labour migrants through the establishment of welfare funds

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 (MoLE), every day, 1600 Nepalese leave Nepal for labour migration to various destination countries. 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).

Practice. All migration-related issues, including the health of foreign migrant workers, are covered by the MoLE under its existing Foreign Employment Act, 2007 and Foreign Employment Policy, 2012, which have some components on the 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 for anyone with health issues, monitoring of existing predeparture health assessment centres of Nepal and inclusion of a health component in the predeparture orientation training package. With regard to international migrants, Nepal is 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.

Lessons learnt and challenges. With increasing numbers of inbound and outbound migrants into and out of 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 the right of 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 predeparture health assessment guidelines and health components of the predeparture 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 many ministries and stakeholders should be established to work on migration and health.

Thailand: Developing occupational health service delivery for migrant workers

Context. Thailand is currently home to an estimated 3 million labour migrants, almost 1 million of whom are unregistered. Registered migrants work mainly in the construction and agriculture services. Migrants, especially those who are low-skilled, often work in dangerous, dirty and difficult working conditions. This contributes to poor working conditions and raises the incidence of work-related injuries and deaths. Registered workers can access health services on a health or social insurance scheme. Whereas health insurance needs to be purchased by the migrants themselves, covering a comprehensive range of services, migrants with contracts covered by the social security scheme can obtain all social services and have the right to access all health services as Thai citizens.

Practices. *Accelerate progress towards achieving the SDGs, including UHC:* registered migrant workers could access health services through either a health insurance scheme or the SSS. First, health screening (costing 500 Baht in 2016) includes a chest X-ray for TB, and tests for syphilis,

microfilaria, malaria and leprosy, for which a full course of treatment is offered. Then the health insurance (costing 3200 Baht in 2016) was applied. It covers comprehensive curative services and a range of prevention and health promotion services, similar to the Thai UHC scheme. Second, migrants who have work permits are fully covered by the Thai SSS. Thai nationals and migrants who contribute to the SSS 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. Occupational health services (OHSs) have been developed in health-care facilities throughout the country to provide such services to all groups of workers. However, most providers offer only general services addressing communicable diseases such as TB and STI. Only a few hospitals located in the border areas or industrial areas could provide OHSs for migrant workers.

Results. Presently, some provincial hospitals can provide both passive and proactive OHSs. Such hospitals provide health examination, occupational disease (OD) screening and diagnosis, health education, return to work management and record-keeping. An interpreter was employed to facilitate performance of the OHS activities. Moreover, 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. As a result of language barriers, occupational and safety media messages, including in English and the regional languages of Myanmar, Cambodia and Lao People's Democratic Republic have been produced and distributed to workplaces. Meanwhile, BOED has collaborated with the Health Data Center (HDC) of the Ministry of Public Health to add the 14 common ODs and injuries for migrant workers in the data system. Therefore, everyone can access the statistics of ODs and injuries that occur in such workers.

Lessons learnt. Currently, only a few hospitals provide the entire range of OHSs for migrant workers; therefore, the future development of OHS delivery should be addressed through six issues, as follows: (i) policy-maker support for operational resources and personnel; (ii) training to enhance the competency of hospital staff for effective OHS delivery; (iii) improvement of data quality for recording and reporting OD cases or other OHS interventions; (iv) collaboration among related agencies, especially the Ministry of Labour to share related data; and (v) strengthening of hospitals to develop comparatively good systems to promote and achieve workplace occupational health and safety, specifically for migrants.¹⁰

10. Promoting gender equality and empowering refugee and migrant women and girls

Nepal: Women's empowerment

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, decent

¹⁰ Information received from submission by Bureau of Occupational and Environmental Diseases (BOED) Department of Disease Control, Ministry of Public Health, Thailand in response to a WHO global call from August 2017 – January 2018

work and 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 predeparture to post-return support programmes.

Practices. Pourakhi runs a hotline providing psychosocial, legal and medical counselling to women migrant workers. It offers reintegration programmes with entrepreneurship training for returning 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.²⁹²

Bangladesh, Nepal and Sri Lanka: Support to domestic workers

There are serious gaps and anomalies in national and international policies for migrant domestic workers. Women domestic workers are around two fifths of the total outgoing Sri Lankan migrant workers annually, with nearly all going to Gulf Cooperation Council countries, Jordan or Lebanon. In recent years, Bangladesh has increased recruitment of female domestic workers to the Middle East. Over 80% of Bangladeshi migrant workers are employed in the Gulf countries, a significant percentage of which are women working in the domestic sector. In many of these countries, domestic work is performed outside the scope of national labour laws, which excludes domestic workers from national minimum wages, limited working hours, occupational safety measures and social security schemes (59).

In **Bangladesh**, the Government Bureau of Manpower, Employment and Training (BMET) has developed and implemented training programmes and predeparture briefing sessions to prepare intending migrants for employment abroad and inform them of their rights as well as specifically raise awareness on HIV risks and prevention. BMET provides training through thirty-eight technical training centres, of which six are exclusively for women workers. The course curriculum is developed according to the requirements outlined by foreign employers and its content covers languages, rights, information on the migration process and personal safety. Yearly 7000–8000 women are trained in different technical areas at these centres. In addition to the official programme, the Bangladeshi Ovhibashi Mohila Sramik Association (BOMSA) offers female migrant workers a two-day predeparture training programme that covers financial and personal management, and information on rights and health, including HIV/AIDS (60).

11. Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

In **Thailand**, the following activities have been undertaken: IEC activities targeted at migrant populations; ensuring accessible health services for migrants; outreach services for the reproductive health of migrants; involvement of diverse stakeholders in reaching migrants; and development of a health service networking system and an information system.

Maldives: Health for all – enhancing health information to migrants

Context. Migrants in Maldives comprise approximately a quarter of the country’s total workforce (61), with the majority originating from South Asian countries, such as Bangladesh (58%), India

(24%) and Sri Lanka (10%). Many migrant workers are engaged in low-skilled labour in the construction and tourism industries. Ordinary living conditions, inadequate regulatory frameworks and issues relating to human trafficking have further compounded concerns for the health and safety of migrant workers.

Practice.¹¹ The Ministry of Health, the Maldivian Red Crescent (MRC), some resident embassies and other partners aim to develop a regular service that can cater to the health needs of migrants in order to improve communication. Awareness-raising campaigns that target migrant populations in Male' are held on migrant rights, dissemination of information on communicable diseases, public health and human trafficking. A total of 12 public awareness campaigns have been conducted so far.¹²

Celebrate diversity event: in conjunction with International Migrants Day in Male', the event created an environment where migrants and the local population could meet and socialize. The event was attended by around one thousand people including of government agencies, foreign embassies and international organizations.

Community-based surveillance and awareness: the migrants volunteer network contributed to nationwide efforts to prevent and control the spread of the influenza outbreak in March 2017 after a national emergency was declared. Information materials were produced in nine languages commonly used by migrants and volunteers to actively disseminate the IEC materials produced. The Maldivian Red Crescent liaised with 98 private companies that employed migrants to assess their health status and conduct health promotion activities.

Results. A total of 1580 migrant workers were reached with information on dengue and HIV. More than 4500 migrants were contacted with information materials regarding influenza through outreach activities via the mobilization of more than 150 volunteers.

12. Enhancing partnerships, intersectoral, intercountry and interagency coordination and collaboration, better coordination between humanitarian and development health actors

Partnerships, networks and multi-country frameworks are essential in order to ensure cross-border cooperation and collaboration on migrant health. Regional and subregional initiatives that address migrant health include: the MBDS network; Joint United Nations Initiative on Mobility and HIV/AIDS (JUNIMA); WHO Mekong Malaria Programme; WHO Regional Strategy to Stop Tuberculosis in the Western Pacific; bilateral collaboration and MoUs that focus on migrant workers between Thailand and neighbouring GMS countries; and the WHO Regional Action Framework on Universal Health Coverage. These examples of bilateral and regional cooperation highlight the growing focus on migrant health and UHC. Attention to cross-border migrant health is likely to increase, given the linkages to the SDGs and other international, regional and national agendas. The ongoing move by countries towards integration under ASEAN, for example, will add momentum to extending health equity to their migrant populations (2).

Myanmar has been collaborating with neighbouring countries on migrant health in relation to malaria elimination and malaria multidrug resistance. In February 2016, five Member States of the WHO South-East Asia Region – Bangladesh, Bhutan, India, Myanmar and Nepal – came together to enhance cross-border collaboration on malaria elimination efforts (62).

¹¹ Maldivian Red Cross submission [in response to a WHO global call from August 2017 – January 2018]

¹² Seven in Male', one in Hulhumale, two in Villimale and two in Thilafusi

Thailand has been collaborating with neighbouring countries on migrant health in relation to malaria elimination, including malaria multidrug resistance, TB multidrug resistance and HIV among migrants through bilateral MoUs with neighbouring countries such as Myanmar, Lao People's Democratic Republic and Cambodia. Disease control in the Mekong Region with Thailand and CLMV countries (Cambodia, Lao People's Democratic Republic, Myanmar and Viet Nam) have been persuaded. In quarter 4/2017 and quarter 1/2 2018, these five Mekong Region countries are working to develop strategies to combat TB among migrants with financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Apart from government-to-government collaboration, the Royal Government of Thailand/Ministry of Public Health is also working closely with other line ministries, NGOs and UN partners to develop migrant health strategies contained in a strategic policy document and guide the work of its partners.

Nepal has taken a multisectoral, multiagency approach and with the help of IOM has conducted a pilot study on health-care services, mapping of cross-border migration in order to promote migrants' health and develop national guidelines on migration-sensitive health screening. Furthermore, the Nepalese Government, IOM and UNHCR, and partner organizations are working together closely in order to provide essential health-care services and protection. For transitioning the remaining Bhutanese refugees in the camps to the health services, a health task force has been established, which conducts assessments and collects data on the availability and quality of services. Based on the findings of the assessment, UNHCR and IOM are supporting capacity-building of nearby government health centres.

Sri Lanka: Intersectoral, in-country and intercountry collaboration

Context. Sri Lanka is known as a country of origin as well as a destination country for labour migrants. About 10% of the population (1.9 million Sri Lankans) work overseas and provide the highest revenue to the country (US\$ 7.2 billion in 2015, making up 8% of the GDP). There were 1.8 million tourists in 2015, which was the third largest source of national revenue. Furthermore, 50 000 non-citizens apply for a resident visa to Sri Lanka annually and 60% of them are labour migrants. The national health policy encourages multisectoral engagement, and the internal policy process includes consensus and has adopted a multi-stakeholder and evidence-based approach. Thirteen key government ministries were involved in developing the National Migration Health Policy launched in 2013. In line with resolution 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 WHO 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 second Global Consultation on Health of Migrants with the collaboration of IOM and WHO in February 2017. The Consultation brought together over 100 participants from 30 countries. An important feature that was different from the first Global Consultation held in 2010 in Madrid, Spain was that it added a political dimension with national high-level officials adopting the Colombo Declaration. Sri Lanka has also taken the lead in drafting and reading a regional one-voice statement on the "Health of Migrants and Refugees" at the World Health Assembly in 2017. Sri Lanka has also brought up the issue of the health of labour migrants at the South Asian Association for Regional Cooperation (SAARC) Health Ministers' meeting held in 2017 in Colombo. Its inclusion was accepted in the agenda of future SAARC meetings. Sri Lanka also hosted an international consultation on predeparture health assessments in September 2017, which will further promote global discussion on the topic, linking such health assessments to UHC.

Lessons learnt. Continued political and high-level commitment is required for such an engagement

of activities. A 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 the effect of creating further boundaries in the local context.

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

The Joint UN Initiative on Migration and Health in Asia (JUNIMA)

Context. The key drivers of migration are linked to the security, social and economic disparities between countries. Increasing numbers of migrants from Asia have been filling critical labour gaps and providing essential contributions to national economies. However, despite their value, migrants are often exploited, marginalized, experience violations of their basic human rights in terms of pay, working conditions and lack 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, making them particularly vulnerable to communicable diseases such as HIV, TB and malaria. 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 an evidence base for policy and programme development; lack of strong regional and bilateral coordination and collaboration on international migration and health issues; lack in mainstreaming migrants into national health systems and health security strategies and programmes; lack of multisectoral coordination and cooperation on health issues related to international migration; and lack of harmonization of national disease strategies, protocols and programmes.

JUNIMA's vision is for all migrants and their families to have equal access to health care throughout the migration process and to live healthy, productive lives. **JUNIMA's mission** is to support multisectoral partners in sharing 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 comprises 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: (i) to ensure that strategic information informs decision-making, policy-making and programming across the Region to improve the health of migrants; (ii) to strengthen multisectoral and multi-stakeholder partnerships to link and operationalize regional and national strategies and action plans on access to health for migrants; and (iii) to facilitate and advocate for 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 were the development and implementation of an Asian Development Bank (ADB)-funded 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 to operationalize the MoU was developed in 2012.

Lessons learnt and the 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 in regional coordination mechanisms for migrant health from partners and governments; however, there is limited support from donors for such initiatives. This lack of resources significantly hampers the 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, JUNIMA decided to expand membership beyond South-East Asia and include other countries within the broader Asia region. While welcome, this has also diluted the focus on subregional-specific challenges.

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

VI. PROGRESS, RECOMMENDED POLICY OPTIONS AND WAYS FORWARD

1. *Provision of disease prevention measures and public health interventions should be made available to refugees and migrants regardless of migration status.*
2. All countries in the Region need to make greater efforts towards understanding the health status of migrants in their countries, through assessment of migrant health in the Region and ***gathering data and evidence on the status of migrant health.***
3. Countries need to ***develop an inclusive migrant health policy and legal framework, and a national strategy and action plan*** where such policies do not already exist. In an adoptive refugee- and migrant-sensitive health system, a framework for short-, intermediate- and long-term action on promoting refugee and migrant health needs to be developed. It should include: *evidence-based, inclusive migrant-sensitive health policies and legal options, disaggregated health information with robust epidemiological data on migration and transformation of migrant-sensitive health systems.*
4. Country offices will need to support countries to ***implement and monitor progress on migrant health policies and national action plans.***
5. Countries will need to improve their ***monitoring of migrant health through the use of health information systems***, identifying indicators for migrant health, conducting periodic surveys to assess migrant health and migrant health issues, and integrating migrant health data into existing data collection systems. The threats must be addressed of newly emerging communicable diseases or dangerous pathogens with epidemic and pandemic potential across borders. Furthermore, outbreak surveillance measures and guidelines for early detection of emerging pandemic diseases such as avian influenza as well as monitoring antimicrobial resistance levels among migrants should be made available to countries sharing migrant populations.

6. The Regional Office will ***lead regional meetings on migration and health to promote coordination and partnership between countries***, raise the profile of migration health in countries, assist in ensuring that adequate resources are devoted to health for neglected and vulnerable migrant populations, and monitor progress on migrant health as part of achieving UHC targets.
7. **Partnerships between different UN agencies** and other partners, and division of labour among them, with clear articulation of the role of WHO as the Health Cluster Lead, is key. Such partnerships are necessary for coordination, information-sharing and stewardship, based on the typology of migration and other thematic areas. Along with UN agencies, intergovernmental stakeholders must also be invited to play a role in migration and health.
8. Targeted programmes are needed for the **elimination of communicable diseases such as malaria, TB and HIV/AIDS, and specific cross-border management of infections towards facilitating their elimination**. In addition, robust surveillance should be maintained of last-mile programmes and zero transmission cases.
9. There is a **need for evidence-based** scenarios for planning and advocacy backed up and supplemented by systematic data collection in support of securing the health of migrants. It is imperative to conduct periodic reviews of existing situations and future scenarios for better planning and preparedness based on modelling and forecasting the impact of health and disease, with or without effective interventions in place.
10. **Good experiences and best practices** from countries that have health policies in place for migrants must be documented and shared.

VII. STRENGTHS AND LIMITATIONS OF THE REPORT

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

- Studies assessing refugee and migrant health used inconsistent terminology and methodologies. There is a lack of a shared definition of migrants at the international level and it was challenging to stratify data by migrant legal status (documented versus undocumented, and refugees).
- Although migration and forced displacement are increasing, the number of studies in the Region are limited; most of these were carried out in western countries, and none used clinical or social outcome measures for evaluating the impacts of defined practices.
- There is also relatively little information about the health status of, and health policies for, refugees and migrants, in particular, undocumented migrants. Moreover, the information available often does not distinguish between documented and undocumented migrants.
- Since the implementation of policies takes place at the local level with the involvement of different actors and ministries (e.g. health, labour, foreign affairs, NGOs), it was not possible to ensure that all existing information had been collected, or to claim completeness of the report.
- The findings may also highlight the lack of available research in the Region on the subject. Although there has been some success in addressing refugee and migrant health, more research is needed to support the development of good practices in this area.

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Annex 1: International migrants in the WHO South-East Asia Region

South-East Asia Region								
Major area, region or country of destination	Number of international migrants (thousands)		International migrants as percentage of total population		Females among international migrants (percentage)		Median age of international migrants (years)	
	2000	2017	2000	2017	2000	2017	2000	2017
Bangladesh	988	1501	0.8	0.9	46.2	47.3	30.4	31.7
Bhutan	32	52	5.6	6.5	18.5	18.9	31.8	35.5
Democratic People's Republic of Korea	36	49	0.2	0.2	51	50.2	36.3	36.3
India	6411	5189	0.6	0.4	48.5	48.8	50.7	45.6
Indonesia	292	346	0.1	0.1	47.6	41.8	25.5	29.8
Maldives	27	67	9.7	15.4	45	12.3	33	32.4
Myanmar	98	75	0.2	0.1	46.8	45.2	31.7	36.9
Nepal	718	503	3	1.7	66.3	69.4	32.5	40.7
Sri Lanka	40	40	0.2	0.2	45.3	47.8	55.2	25.3
Thailand	1258	3589	2	5.2	48.5	49.8	26.1	33.5
Tmor-Leste	11	12	1.2	0.9	51.9	49.4	29.7	37.1
South-East Asia Region	9911	11 423	0.6	0.6	49.4	49.2	34.8	35.0

Source: United Nations, Department of Economic and Social Affairs. Population Division (2017). Trends in international migrant stock.

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Annex 2: Contributions from Member States and partners (WHO SEA Region)

Country	Contributor	Type
Bangladesh	ILO	Partner
India	ILO	Partner
Maldives	Red Crescent	Partner
Myanmar	Ministry of Health and Sports, IOM, Red Crescent	Member State, Partner (2)
Nepal	Ministry of Health, IOM, ILO	Member State, Partner (2)
Sri Lanka	Ministry of Health	Member State
Thailand	Ministry of Public Health, International Health Policy Foundation, ILO	Member State, Partner (2)
Regional	IOM (3), ILO, SAARC	Partner