

# POPULATION MOBILITY AND MALARIA



Review of International, Regional and National Policies and Legal Frameworks that Promote Migrants and Mobile Populations' Access to Health and Malaria Services in the Greater Mekong Subregion (Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam)



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**World Health  
Organization**



International Organization for Migration (IOM)  
The UN Migration Agency

Population mobility and malaria

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Cambodia. Phea Savy, 29, a mobile worker; holding a bednet while members of his family and co-workers are sitting near him in their temporary house in Prolien Village of Battambang Province. Credit:Vlad Sokhin. WHO 2016



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# LIST OF ACRONYMS

<b>ACT</b>	Artemisinin-based Combination Therapy
<b>ADB</b>	Asian Development Bank
<b>AEC</b>	ASEAN Economic Community
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>AIM</b>	Action and Investment to Defeat Malaria 2016–2030
<b>APMEN</b>	Asia-Pacific Malaria Elimination Network
<b>ART</b>	Anti-Retroviral Treatment
<b>ARV</b>	Anti-Retroviral
<b>ASCC</b>	ASEAN Socio-Cultural Community
<b>ASEAN</b>	Association of Southeast Asian Nations
<b>BCC</b>	Behaviour Change Communication
<b>CAP-Malaria</b>	Control and Prevention of Malaria Project
<b>CBHI</b>	Community-based Health Insurance
<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination Against Women
<b>CMHI</b>	Compulsory Migrant Health Insurance
<b>CNM</b>	National Centre for Parasitology, Entomology and Malaria Control
<b>CNMCP</b>	Cambodian National Malaria Control Programme
<b>CSO</b>	Civil Society Organisation
<b>DHO</b>	District Health Offices
<b>DHS</b>	Department of Hospital Services
<b>DOP</b>	Department of Population
<b>EIA</b>	Environmental Impact Assessment
<b>EII</b>	Employment Injury Insurance
<b>ERAR</b>	Emergency Response to Artemisinin Resistance
<b>EPs</b>	Equator Principles
<b>EU</b>	European Union
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>GMS</b>	Greater Mekong Subregion
<b>HEF</b>	Health Equity Fund
<b>HIA</b>	Health Impact Assessment
<b>HIV</b>	Human Immunodeficiency Virus
<b>IDP</b>	Internationally Displaced Persons
<b>IEC</b>	Information, Education and Communication
<b>IHR</b>	International Health Regulations (2005)
<b>ILO</b>	International Labour Organization
<b>IOM</b>	International Organization for Migration
<b>IRD</b>	International Relations Division
<b>ISSA</b>	International Social Security Association
<b>ITNS</b>	Insecticide treated bed nets
<b>JUNIMA</b>	Joint United Nations Initiative on Migration and Health in Asia
<b>LLINS</b>	Long-lasting Insecticide Treated Bed Nets
<b>MBDS</b>	Mekong Basin Disease Surveillance
<b>MCC</b>	Malaria Control in Cambodia Project
<b>MLSW</b>	Ministry of Labour and Social Welfare
<b>MMN</b>	Mekong Migration Network

<b>MMP</b>	Migrants and Mobile Populations
<b>MoH</b>	Ministry of Health
<b>Mol</b>	Ministry of Interior
<b>MoL</b>	Ministry of Labour
<b>MoLES</b>	Ministry of Labour, Employment and Social Security
<b>MoLISA</b>	Ministry of Labour, Invalids and Social Affairs
<b>MoLVT</b>	Ministry of Labour and Vocational Training
<b>MoP</b>	Ministry of Planning
<b>MoPH</b>	Ministry of Public Health
<b>MoU</b>	Memorandum of Understanding
<b>MRA<sub>s</sub></b>	Mutual Recognition Agreements
<b>NERI</b>	National Economic Research Institute
<b>NGO</b>	Non-governmental organization
<b>NIMPE</b>	National Institute of Malaria, Parasitology and Entomology
<b>NMCP</b>	National Malaria Control Programme
<b>NSSF</b>	National Social Security Fund
<b>NV</b>	Nationality verification
<b>OHS</b>	Occupational Health and Safety
<b>OSSC</b>	One Stop Service Centre
<b>PHO</b>	Provincial Health Offices
<b>PMI</b>	President Malaria Initiative
<b>RBM</b>	Roll Back Malaria Partnership
<b>RGC</b>	Royal Government of Cambodia
<b>SDC</b>	Swiss Agency for Development Cooperation
<b>SDH</b>	Social Determinants of Health
<b>SHI</b>	Social Health Insurance
<b>SSF</b>	Social Security Fund
<b>SSL</b>	Social Security Law
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>UHC</b>	Universal Health Coverage
<b>UN</b>	United Nations
<b>UNICEF</b>	United Nations Children's Fund
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDESA</b>	United Nations Department of Economic and Social Affairs
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>URC</b>	University Research Co LLC
<b>USAID</b>	U.S. Agency for International Development
<b>USDS</b>	U.S. Department of State
<b>WB</b>	World Bank
<b>WCF</b>	Workmen's Compensation Fund
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization





Lao People's Democratic Republic. Mobile and migrant populations in southern Laos. Credit: IOM



# INTRODUCTION

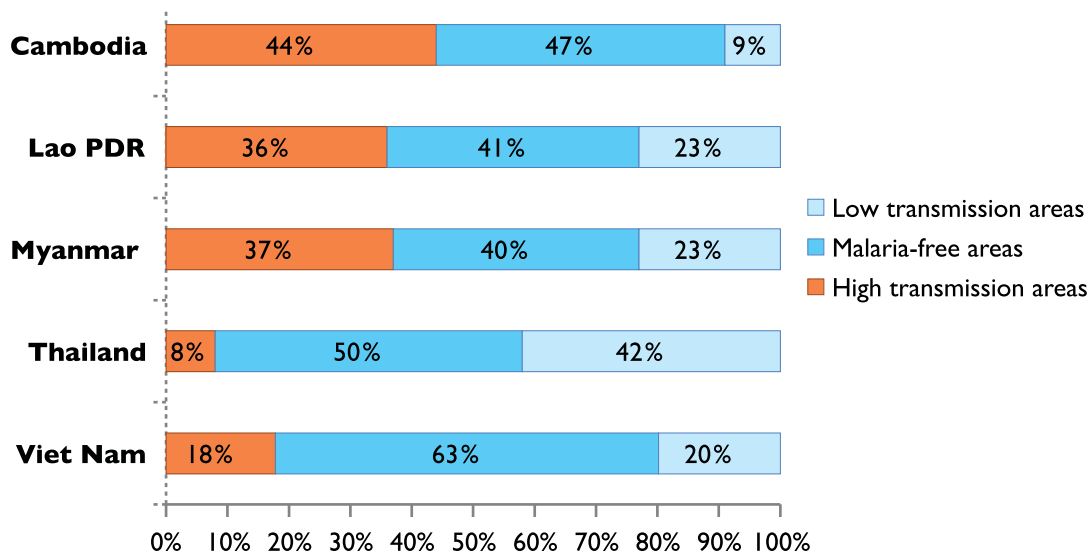
## 1.1 Background

Migration within and across the Greater Mekong Subregion (GMS) is a long-standing and common practice and is expected to increase as the region continues to develop, especially following the commencement of the ASEAN Economic Community (AEC) in 2015 (WHO SEARO, 2016). Well-managed migration can contribute to achieving eventual malaria elimination in the GMS. Enough evidence suggests that malaria may not be a forest-dependent disease, but may be influenced by population movements (Jitthai, 2013:1). While migration alone is not itself a risk factor for increased malaria transmissions, several factors may make migrants and the local populations vulnerable to malaria. This includes 'push and pull' factors that encourage people to enter into and out of malaria-endemic areas, such as infrastructure and rural development, deforestation for logging and economic farming, political movements and natural disasters (Jitthai, 2013:1).

The Region shows a primary clear pattern of migration characterized by population movements from Myanmar, Cambodia and Lao People's Democratic Republic to Thailand. Thus, Thailand is by far the main receiving country in the GMS hosting more than 3 million migrants (UNDESA, 2013). Also, secondary migration flows occur, including population movements from Myanmar, Lao People's Democratic Republic and Viet Nam to the border provinces of China PRC or cross-border mobility between Cambodia and Viet Nam. Malaria is endemic in five of the six GMS countries – Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam – with specific high-prevalence areas in the Myanmar-Thai border and in some provinces of Cambodia. Figure 1 below shows the percentage of total country's population living in high transmission and malaria-free areas for the five aforementioned countries. Specific information related to malaria mortality rates and other epidemiological indicators can be found in Annex 8.1.

**Figure 1. Distribution of total country's population living in high transmission, low transmission and malaria-free areas by GMS country.**

**Percentage of total country's population living in high transmission, low transmission and malaria free areas by GMS country**



World Malaria Report 2014, WHO (WHO, 2014a)

The elimination of malaria requires development of harmonized global, regional and national strategies based on a strong evidence base. The previously-implemented global programme to eliminate malaria and the trans-border disease control campaigns showed evidence that consideration of human movement is important to understand trends in disease transmission and where to target elimination efforts (Tatem and Smith, 2010:1). This highlights the need for further dialogue and sharing of effective practices to stress the importance of ensuring that migrants are fully integrated into their host communities and that their right to health is upheld, as this can have serious implications for overall health and social costs. This dialogue must take place at all levels and sectors of government, as addressing malaria among migrants throughout the migration process requires intra and inter country coordination for information sharing and ensuring good practices (IOM, 2013a:1).

Although regular migration channels are available, they are often unaffordable or inaccessible (WHO SEARO, 2016). Deterrents to the use of regular migration channels include the length and inconvenience of the process, and the associated costs, such as private recruitment agencies fees, training fees, passports, transportation, health examinations, visas and work-permits among others. As a result, migrants may engage in irregular migration<sup>1</sup> in order to work. This, as mentioned above, has implications for migrants to access prevention and health-care services in transit and destination countries.

<sup>1</sup> Irregular migration is understood here as: "Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries, it is entry, stay or work in a country without the necessary authorization or documents required under immigration regulations. From the perspective of the sending country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfil the administrative requirements for leaving the country. There is, however, a tendency to restrict the use of the term 'illegal migration' to cases of smuggling of migrants and trafficking in persons." (IOM Glossary).

Many development projects, such as transport infrastructure projects<sup>2</sup> within the GMS, are influencing regional trends in malaria transmission. Human movements can impact malaria transmission patterns and even introduce drug-resistant parasites (Dellacollete et al, 2009:677;WHO SEARO, 2016). Without access to health services, migrants are likely to self-medicate and there may be an increase in the use of substandard antimalarials and monotherapies. Furthermore, in circumstances of displacement, populations with low immunity and no protection against malaria may be forced into malaria endemic areas (WHO SEARO, 2016).

Therefore, addressing migrant health demands a paradigm shift, from the traditional migrant-exclusive approach based on security reasons, disease control and overall national priority, to a multidimensional, migrant-inclusive approach that encourages integration and equality in access to health and social protection for migrants, and bilateral and multicountry, intersectoral policy development (WHO WPRO, 2014:3).

The GMS urgently needs a comprehensive strategy to address the issues of migrants and mobile populations (MMPs) within the framework of the goal of global malaria elimination in accordance with the 2008 World Health Assembly resolution WHA61.17 on the Health of Migrants and its operational frameworks, the WHA68.2 Resolution on Global Technical Strategy and Targets for Malaria 2016-2030 (WHO, 2015d), the Roll Back Malaria Partnership's Action and Investment to Defeat Malaria 2016-2030 (AIM) (RBM, 2015a) and the Strategy for Malaria Elimination in the Greater Mekong Subregion (2015–2030); with consideration of recommendations from global and regional partners.

In order to provide an evidence-base and guidance for malaria programme, managers at national level, the International Organization for Migration (IOM) and the World Health Organization (WHO) have collaborated on this document to provide up-to-date recommendations on the technical implementation and policy implications of addressing malaria for MMPs. A key part of this collaboration is the documentation and analysis of existing migration and health-related laws, policies and legal frameworks that impact on access to health and malaria services.

This report, therefore, reviews existing national laws, policies and legal frameworks in the five GMS countries of Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam as well as regional and international legal frameworks and policies as they relate to the access of migrants (internal, inbound and outbound) to health services, particularly those for malaria.

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2 The Cambodia Provincial Roads Improvement Project (ADB, 2012) or the Cambodia Railway Rehabilitation Project (AusAID and ADB, 2011) among others.

## 1.2 Scope and objective

This review aims to develop a guidance document on strategies to address malaria, artemisinin resistance and malaria elimination for migrant and mobile populations in five countries of the Greater Mekong Subregion (GMS), namely Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam. For the purpose of this report, the People's Republic of China (PRC, specifically Yunnan Province and Guangxi Zhuang Autonomous Region), which is also part of the Greater Mekong Subregion, is not covered in the study.

The study identifies and describes existing laws, policies and legal frameworks in both health and nonhealth sectors (such as labour and immigration) that impact on migrants and mobile populations' access to health services or ensure occupational health and safety of workers, in particular malaria interventions. The review of the existing laws and policies in the aforementioned five countries was conducted between April and June 2015; thus, this report outlines the situation as of June 2015.

## 1.3 Methodology

This report compiles findings from the five GMS countries, Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam. Each country review was conducted by in-country consultants or IOM country offices and further reviewed by the IOM Regional Office for Asia and the Pacific and the WHO Thailand Office (Emergency Response to Artemisinin Resistance (ERAR)-GMS). A regional consultant was responsible for gathering applicable regional data and integrating all country reports. Technical review of the report was conducted by the Migration Health Unit of the IOM Regional Office for Asia and the Pacific with inputs from the WHO ERAR focal person for Malaria and Border Health based at the Thailand Office of WHO.

The methods used for this research include (1) reviews of existing documentation, electronic database, publications among other sources, detailing how Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam have addressed the health of inbound, outbound and internal migrants and responded to the global and regional migration and/or health frameworks, such as ASEAN resolutions, Memoranda of Understanding (MoUs) and beyond; and (2) supplementary informal discussions with key actors, such as the International Relations Division (IRD) of the Ministry of Health and other ministries of Myanmar and Cambodia, the Ministry of Health and Ministry of Foreign Affairs of Lao People's Democratic Republic as well as other experts in the field of malaria in Thailand.

The report also makes reference to Universal Health Coverage, International Labour Organization (ILO) conventions on Occupational Health and Safety, the International Health Regulations (IHR), WHA61.17, WHA68.2, AIM 2016–2030 and others as benchmarks, and considers their application in the context of malaria elimination and artemisinin resistance. Furthermore, this report identifies existing gaps and opportunities affecting the implementation of health policies and laws. It utilises available data, reports, studies and publications to identify the trends and patterns of migration within and between countries and their implications on malaria in the Greater Mekong Subregion.



## 1.4 Limitations

The following were some of the challenges and limitations experienced by the country consultants who participated in the study:

### **Cambodia**

The main limitation was the direct accessibility and availability of information of the Cambodian legal framework and the policies specifically provided for migrants, thus informal discussions were required to form a basis from which arguments could be made.

### **Lao People's Democratic Republic**

Some of the limitations encountered relate to the availability of information as the Government Official Gazette does not contain a complete record of all legislation currently in force in Lao People's Democratic Republic, particularly those adopted before the Law on Making Legislation. Article 80 of this Law requires that all legislation (including laws, decrees, orders, decisions and instructions) is published in the Gazette and indicates that all legislation enters into force 15 days after its publication. Nevertheless, it was observed that in practice, regulatory and judicial authorities may apply laws and presidential decrees before they enter into force. The documentation used for the legal review dates from 1994 onward.

### **Myanmar**

Myanmar has recently begun a wide range of social and political reforms that consider expanded social protection concepts, following several decades of political isolation. Many existing laws related to migration are more than 60 years old and are very limited in scope. It was noted that the updated migration laws relate purely to labour migration channels. As of the time of this report, there are no specific policies or laws that solely directly address the health of migrants although migrants are considered in a number of more general health policies (such as HIV or malaria). The Ministry of Labour, Employment and Social Security (MoLES) is in the process of adopting the National Action Plan draft for the Management of International Labour Migration 2013–2017 that will address some gaps in rights protection. Additionally, the Government of the Republic of the Union of Myanmar has recently signed a MoU with the Royal Thai Government on Health Cooperation (2013) to better address cross-border health issues.

### **Thailand**

The country's review was done from a health rather than a legal perspective; thus, a judicial interpretation of laws and regulations was not made.

### **Viet Nam**

The Viet Nam review was done from a non-legal perspective, thus a judicial interpretation of laws and regulations was not made.

The findings of the country reviews are based solely on the adequacy of the administrative procedures and the specificity of rights and obligations created or purportedly created by the laws and regulations reviewed, and do not include information relating to their implementation. Therefore, administrative authorities or the courts may adopt an interpretation or application of laws, which is not in accordance with the findings detailed in this report.

## 1.5 Operational definitions of terminology

For the purposes of this report, the following terminology is used as defined below:

- **Artemisinin and artemisinin resistance:** Artemisinin and its derivatives are powerful medicines known for their ability to swiftly reduce the number of parasites in the blood of patients with malaria as they are potent blood schizontocide. Artemisinin-based combination therapies (ACTs) consist of artemisinin derivatives that reduce the parasite load in the first 3 days, and a partner drug that helps eliminating remaining parasites. ACTs are recommended by WHO as the first-line treatment for uncomplicated *P. falciparum* malaria. Artemisinin resistance is defined as delayed parasite clearance following treatment with an artesunate monotherapy, or after treatment with an artemisinin-based combination therapy (ACT). Such resistance represents partial resistance. Patients may still be cured using a longer treatment regimen, provided that they are treated with an ACT containing a partner drug effective in that geographical area (WHO, 2015g:1). As of February 2015, artemisinin resistance has been confirmed in five countries of the Greater Mekong Subregion (GMS): Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam (WHO, 2015b).
- **Internal migration:** refers to the movement of people from one area of a country to another area of the same country for the purpose or with the effect of establishing a new residence. This migration may be temporary or permanent. Internal migrants move but remain within their country of origin (for example rural to urban migration) (IOM, 2011:51).
- **Internationally displaced populations:** People who have been forced to leave their places of habitual residence and are now residing in the transit or destination country.
- **Inbound migrants:** Foreign immigrants regardless of their immigration status (e.g. regular/ documented or irregular/undocumented) and purpose (e.g. work or pleasure; temporary or permanent).
- **Labour migration:** Movement of persons from their home State to another State for the purpose of employment. Labour migration is addressed by most States in their migration laws. Additionally, some States take an active role in regulating outward labour migration and seeking opportunities for their nationals abroad (IOM, 2011:58).
- **Migrants and mobile populations (MMPs):** Either inbound, outbound or internal migrants regardless of (1) a person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is.
- **Migrant for employment:** A person who migrates from one country to another with a view to being employed otherwise than on his own account and includes any person regularly admitted

as a migrant for employment and precludes frontier workers, short-term entry of members of the liberal professions, artistes and seamen (ILO C97, Art. I 1.1).

- **Migration:** Process of moving, either across an international border, or within a State, away from one's habitual place of residence. It is a population movement, encompassing any kind of movement of people, whatever its length, composition, causes and people's legal status (IOM, 2011:62).
- **Outbound migrants:** Citizens of a country who are temporary or permanent emigrants that travel or travelled out of the country regardless of duration or residency status.
- **Policy:** Set of "general principles by which a government is guided in its management of public affairs, or the legislature in its measures. This term, as applied to a law, ordinance, or rule of law, denotes its general purpose or tendency considered as directed to the policy" (Black's Law Dictionary, 2015).
- **Ratification of a convention:** Defines one of the means whereby a State indicates its consent to be bound to a treaty and may involve a process of obtaining assent of the national legislatures. In the case of bilateral treaties, ratification is usually accomplished by exchanging the requisite instruments, while in the case of multilateral treaties the usual procedure is for the depositary to collect the ratifications of all States, keeping all parties informed of the situation (UN, 1969; Vienna Convention on the Law of Treaties, Arts. 2.1.b, 11, 14.1 and 16).
- **Signature of a convention:** One of the means by which a State can express consent to be bound by a treaty. It expresses such consent when the treaty provides for such an effect or when the parties have agreed upon such an effect. When such effect has not been provided for by the parties, the signature is a means of expressing the willingness of the signatory State to accept the treaty, subject to ratification, acceptance or approval. Even when the signature is not the mean by which a State agrees to be bound by a treaty, it creates an obligation to refrain, in good faith, from acts that would defeat the object and the purpose of the treaty (UN, 1969; Vienna Convention on the Law of Treaties, Arts. 10, 11, 12 and 18).
- **Social security systems:** Provide for basic income in cases of unemployment, illness and injury, old age and retirement, invalidity, family responsibilities, such as pregnancy and childcare, and loss of the family breadwinner (ILO, 2015a). It is an element of the ILO concept of social protection, which also includes (1) extending the coverage and effectiveness of social security schemes; (2) promoting labour protection, which comprises decent conditions of work, including occupational safety and health; and (3) working through dedicated programmes and activities to protect such vulnerable groups as migrant workers and their families; and workers in the informal economy (ILO, 2015b).
- **Universal Health Coverage:** Aims to ensure that all people obtain necessary health services without suffering financial hardship as a result of costs. For a community or country to achieve universal health coverage, several factors must be in place, including (1) a strong, efficient, well-run health system that meets priority health needs through people-centred integrated care (including services for HIV, TB, malaria, noncommunicable diseases, maternal and child health); (2) a system for financing health services so recipients do not suffer financial hardship when utilizing them; (3) access to essential medicines and technologies to diagnose and treat medical problems; and (4) a sufficient capacity of well-trained, motivated health workers to provide services that meet patients' needs based on the best available evidence (WHO, 2015e).



Lao People's Democratic Republic. A district malaria staff maps access, surveillance and and response measures among mobile populations. Credit: Bouasy Hongvanthong, 2016



## 2. INTERNATIONAL LEGAL FRAMEWORK AND POLICIES

This chapter offers an overview of the main international conventions and legal instruments as well as global policies guiding efforts for artemisinin resistance and malaria elimination or relating to the health and rights of migrants.

### 2.1 International human rights standards

The twenty-fifth article of the Universal Declaration of Human Rights (UDHR) sets out for the first time the fundamental human right for everyone to “a standard of living adequate for the health and well-being of himself and of his family, including [...] medical care and necessary social services, and the right to security in the event of [...] sickness” (UN, UDHR 1948, Art.25). Also, “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (ICESCR, 1966: Art.12.1) is embedded in Article 12.1 of the International Covenant on Economic, Social and Cultural Rights, which has been ratified by all GMS countries but Myanmar. Several international human rights treaties have been adopted since 1948 creating an international legal framework on human rights. Table 1 lists the most relevant ones with their ratification status in GMS countries, including those which grant migrants health rights. The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families emphasized migrants’ right to “receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned”. Unfortunately, Cambodia is the only GMS country who has signed the instrument and has yet to ratify it. The health of migrants was also featured in the World Migration Report 2013, published by IOM. It is the first report of its kind that focused on migrant well-being, placing migrants at the centre of migration discourse. Table 1 below shows the ratification of international treaties relevant to migrants on the health protection of migrants in GMS countries.

**Table 1. Status on the ratification of international treaties of relevance to migrant health by countries in the Greater Mekong Subregion**

Convention	CAMBODIA	LAO PDR	MYANMAR	THAILAND	VIET NAM
Universal Declaration of Human Rights, 1948	Universal Recognition	Universal Recognition	Universal Recognition	Universal Recognition	Universal Recognition
Convention relating to the Status of Refugees, 1951	Ratified in 1992	Not party	Not party	Not party	Not party
International Covenant on Economic, Social and Cultural Rights, 1966/1976	Ratified in 1992	Ratified in 2007	Not signed	Ratified in 1999	Ratified in 1982
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979	Ratified in 1992	Ratified in 1981	Ratified in 1997	Ratified in 1985	Ratified in 1982
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990	Signed in 2004; not ratified	Not signed	Not signed	Not signed	Not signed
Convention on the Rights of the Child, 1990	Ratified in 1992	Ratified in 1991	Ratified in 1991	Ratified in 1992	Ratified in 1990

Source: Based on the United Nations Treaty Collection.

Based on these international human rights instruments, in 2003, the UN adopted a Human Rights-Based Approach (HRBA) to development cooperation and programming<sup>3</sup>. Five underlying principles rule a HRBA – the PANEL principles – ensuring that an HRBA can be applied in practice.

### **Box 1. The PANEL principles**

**Participation:** People should be involved in decisions that affect their rights.

**Accountability:** There should be monitoring of how people's rights are being affected and remedies for breaches in human rights.

**Non-discrimination and equality:** Nobody should be treated unfairly because of their age, gender, ethnicity, disability, religion or belief, sexual orientation or gender identity.

**Empowerment:** Everyone should understand their rights, and be fully supported to take part in developing policy and practices, which affect their lives.

**Legality:** Approaches should be grounded in the legal rights that are set out in domestic and/or international law.

Source: Adapted from Scottish Human Rights Commission. [www.scottishhumanrights.com](http://www.scottishhumanrights.com)

## **2.2 World Health Assembly Resolutions**

WHO acts as the directing and coordinating authority on international health issues since its Constitution gives the Organization the mandate to address global health issues (art.2, WHO Constitution, 1946). The decision-making body of WHO, the World Health Assembly (WHA), determines the policies of the Organization itself, among other functions. International health policy frameworks and action plans are adopted and endorsed through WHA resolutions, which are binding to all Member States. Three resolutions are mentioned in this section due to their relevance to malaria and population mobility: resolution WHA58.3, resolution WHA68.2 and the resolution WHA61.17.

### **2.2.1 Resolution WHA58.3: International Health Regulations (IHR 2005)**

The IHR 2005 came into force in 2007, after their adoption at the fifty-eighth WHA (resolution WHA58.3), on 23 May 2005. This legal instrument represents the agreement between 196 countries and articulates the principles, activities and responsibilities of State parties and WHO to ensure global public health through prevention, protection, control and provision of a public health response to the spread of diseases. Ensuring global health can be achieved through inclusive health systems that address the health needs of migrants. Migrant inclusive health systems reduce long-term health and social costs, facilitate integration (therefore reducing stigmatization) and contribute to development of societies (Gushulak et al, 2010:9).

<sup>3</sup> UN Statement of Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming; UNDG, 2003.

To control the global spread of diseases, the IHR 2005 point out that any measure taken should respect whatever rights persons have under applicable international law. While States may request health information, basic examinations and vaccination documentation, they are required to “treat travellers with respect for their dignity, human rights and fundamental freedoms” (IHR 2005, Art.32); medical confidentiality must always be preserved (IHR 2005, Art.45.1).

### **2.2.2 Resolution WHA68.2: Global Technical Strategy and Targets for Malaria, 2016–2030**

The Global Technical Strategy and Targets for Malaria for 2016–2030 was endorsed on May 2015 at the Sixty-eighth World Health Assembly. Recorded as resolution WHA68.2, the global strategy sets the target to eliminate malaria in 35 new countries by 2030, reduce the global disease burden by 40% by 2020, and by at least 90% by 2030. Unlike its previous version, the post-2015 global strategy emphasises a multisectoral approach, equitable services access, universal coverage for all populations at risk, regional collaboration and improved surveillance across borders to accelerate efforts towards malaria elimination. The resolution recognizes the vulnerability of migrants and mobile populations, including cross-border populations, and the challenges posed by human mobility and migration in eliminating malaria. By doing this, the resolution has acknowledged the vulnerability to malaria of hard-to-reach populations, such as high-risk occupational groups, **migrants**, people in humanitarian crises and rural communities with poor access to health services.

The Millennium Development Goal (MDG) target of halting malaria spread by 2015 has been achieved<sup>4</sup>; but despite these positive developments, emerging parasite resistance to antimalarial treatment and mosquito resistance to insecticides are threatening progress. The Strategy underlines under its first pillar (see Table 2 below) the need to ensure universal coverage for vector control, chemoprevention, diagnostic testing and treatment. To accelerate efforts towards malaria elimination and attain a malaria free world (Pillar 2), it sets as a priority the elimination of *Plasmodium falciparum* malaria from the GMS. In this region, artemisinin resistance has emerged independently in several geographical locations, especially along the Cambodia-Thailand border, where *P. falciparum* has become resistant to almost all available antimalarial treatments.

In 2013, WHO launched an “Emergency response to artemisinin resistance (ERAR) in the Greater Mekong Subregion: regional framework for action 2013-2015”. WHO Malaria Policy Advisory Committee recommended in September 2014 to pursue the goal of eliminating *P. falciparum* in the GMS by 2030. Consequently, in May 2015, WHO launched a *Strategy for Malaria Elimination in the GMS 2015-2030* (See Section 3.1), which has been endorsed by all GMS countries (WHO, 2015g:4).

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4 The global malaria mortality rate has been reduced by 47% with 4.3 million deaths averted, and 55 countries have been identified as on-track to achieve the WHA target of reducing malaria burden by 75% by 2015 (WHO, 2015c:7).

**Table 2. Overview of the WHO Global Technical Strategy for Malaria 2016–2030**

Vision: A world free of malaria			
Goals	Milestones		Targets
	2020	2025	2030
1. Reduce malaria mortality rates globally (compared with 2015)	≥40%	≥75%	≥90%
2. Reduce malaria case incidence globally (compared with 2015)	≥40%	≥75%	≥90%
3. Eliminate malaria from countries in which malaria was transmitted (compared with 2015)	At least 10 countries	At least 20 countries	At least 35 countries
4. Prevent re-establishment of malaria in all countries that are malaria-free	Re-establishment prevented	Re-establishment prevented	Re-establishment prevented
<b>PRINCIPLES</b>			
<ul style="list-style-type: none"> <li>All countries can accelerate efforts towards elimination through combinations of interventions tailored to local contexts.</li> <li>Country ownership and leadership, with involvement and participation of communities, are essential to accelerate progress through a multisectoral approach.</li> <li>Improved surveillance, monitoring and evaluation as well as stratification by malaria disease burden are required to optimize the implementation of malaria interventions.</li> <li>Equity in access to services, especially for the most vulnerable and hard-to-reach populations, is essential.</li> <li>Innovation in tools and implementation approaches will enable countries to maximize their progression along the path to elimination.</li> </ul>			
<b>STRATEGIC FRAMEWORK</b> – comprising three major pillars, with two supporting elements: (1) innovation and research; and (2) a strong enabling environment.			
<b>Maximize impact of current life-saving tools</b>			
<ul style="list-style-type: none"> <li><b>Pillar 1.</b> Ensure universal access to malaria prevention, diagnosis and treatment</li> <li><b>Pillar 2.</b> Accelerate efforts towards elimination and attainment of malaria-free status</li> <li><b>Pillar 3.</b> Transform malaria surveillance into a core intervention</li> </ul>			
<b>Supporting element 1. Harnessing innovation and expanding research</b>			
<ul style="list-style-type: none"> <li>Basic research to foster innovation and the development of new and improved tools</li> <li>Implementation research to optimize impact and cost-effectiveness of existing tools and strategies</li> <li>Action to facilitate rapid uptake of new tools, interventions and strategies</li> </ul>			
<b>Supporting element 2. Strengthening the enabling environment</b>			
<ul style="list-style-type: none"> <li>Strong political and financial commitments</li> <li>Multisectoral approaches, and cross-border and regional collaborations</li> <li>Stewardship of entire health system, including the private sector, with strong regulatory support</li> <li>Capacity development for both effective programme management and research</li> </ul>			

Source: WHO. 2015. Malaria: draft global technical strategy; post 2015 (A68/28). Report of the Secretariat

### 2.2.3 Resolution WHA61.17 on the “Health of Migrants”

Adopted during the Sixty-first World Health Assembly in May 2008, the resolution on the Health of Migrants (WHA61.17) brings into international policy the involvement of the public health sector in addressing the health consequences and challenges of migration. It considers various UN and WHA resolutions on international migration, health and development to call upon countries to formulate and



implement policies and strategies that improve the health of migrants. It also asks WHO to collaborate with relevant international organizations in promoting and operationalizing the migrant health agenda at the national, regional and global level; encourage interregional and national cooperation; and promote exchange of information and dialogue among countries with particular attention to strengthening health systems.

The resolution was developed based on the *WHA Secretariat's Report on the Health of Migrants*. According to the Report, a large proportion of migrants who are moving through legal channels may not face as much the negative impact of migration but "some subgroups, namely vulnerable migrants, trafficked persons, refugees and smuggled migrants" are of particular concern because of their inability or "difficulty to access health care" (WHO, 2008a: 1). The Report addresses the public health implications of migration and the health needs of vulnerable migrants. Four principles are described that frame a public health approach for migrants' health: i) **avoiding disparities in the health status and access to health services** between migrants and the host population as a primary public health goal; ii) **ensuring migrants' health rights**, which entails "removing impediments to migrants" access to preventive and curative interventions; iii) **minimizing the negative impact of the migration process** on migrants' health outcomes; and iv) **reducing excess morbidity and mortality** among migrant populations in situations of forced migration that result from disasters or conflict (WHO, 2008a:2). The Report identified health needs and factors of vulnerability for migrants, such as limited and unequal access to social benefits, health services, employment and education. The WHA suggests interventions to reduce migrants' health risks and strengthen "migrant sensitive" programmes and services that take cultural, religious, linguistic and gender needs into consideration.

Based on the report, the resolution WHA61.17 calls upon Member States to, among others, promote migrant-sensitive health policies and equitable access to health care; establish health information systems to analyse trends in migrants' health; share information and best practices for meeting migrants' health needs in all countries involved in the migratory process; raise health professionals' cultural and gender sensitivity to migrants' health issues and train them on migrant health issues; and promote bilateral and multilateral cooperation on migrants' health among countries (WHO, 2008b).

### 2.3 The International Labour Organization Standards

ILO Conventions are effectively binding instruments for ILO Member States who ratify them<sup>5</sup>. Once a convention is ratified, "the country is subject to the ILO's regular supervisory system responsible for ensuring that the convention is applied" (ILO, 2016). Although key relevant ILO Conventions have been mentioned in this section, most of these specific Conventions have not being ratified by GMS countries and are therefore not binding for such countries. Table 3 below lists key ILO Conventions that are relevant to the health protection and rights of migrant workers together with their key obligations.

5 Ratification is a formal procedure whereby a state accepts the convention as a legally binding instrument. An adopted convention normally comes into force 12 months after being ratified by two Member States (ILO, 2016).

**Table 3. International treaties and their key obligations that are of relevance to the health protection and rights of migrant workers**

ILO Conventions	Key obligations stated in ILO Conventions
No. 97: Migration for Employment Convention (Revised), 1949	Ensure that migrants for employment and their families enjoy adequate medical attention at the time of departure, while in transit and upon arrival at the destination (Art. 5).
No. 102: Social Security (Minimum Standards) Convention, 1952	Ensure for persons the provision of benefits towards conditions requiring medical care of a preventive or curative nature (Article 7). Furthermore, Article 68.1 specifies that "Non-national residents shall have the same rights as national residents".
No. 143: Migrant Workers Convention, 1975	Calls on members to respect the basic human rights of all migrant workers and their families; to guarantee equality of treatment, including that regarding social security (Article 10).
No. 155: Occupational Health and Safety Convention, 1981	Ensure occupational health services of all migrant workers (Article 3) with adequate working facilities provided by the employer (Article 5).
No. 181: Convention on Private Employment Agencies, 1997	Calls on private employment agencies to ensure the protection of workers in relation to statutory social security benefits, occupational health and safety and compensation in case of occupational accidents or diseases (Article 11).
No. 188: Convention on Work in Fishing, 2007	Assigns responsibilities to different stakeholders (skippers, fishers, governments, etc.) regarding health and safety, medical examinations and certificates, on-board medical equipment and medical supplies, social security protection and more (Article 6.1).
No. 189: Domestic Workers Convention, 2011	Calls on the effective promotion and protection of the human rights of all domestic workers, including the right to a safe and healthy working environment (Article 13.1).

Only the Occupational Health and Safety Convention 1981 (No. 155) has been ratified in the GMS, by Viet Nam.

The Declaration of Philadelphia (1944), part of the ILO Constitution, imposes obligations on all ILO Members (including all GMS countries), such as extension of social security measures and comprehensive medical care; and adequate health protection of workers in all occupations (ILO, 1944 III f, g). The 1998 Declaration on Fundamental Principles and Rights at Work states that by joining ILO, Members have endorsed the principles and rights set out in its Constitution and the Declaration of Philadelphia. In addition to the aforementioned ILO Conventions, in 2005, ILO developed the *ILO Multilateral Framework on Labour Migration: Non-binding Principles and Guidelines for a Rights-Based Approach to Labour Migration*. The framework suggests adopting measures to ensure that i) national labour and social legislation cover male and female migrant workers, including domestic workers, particularly regarding OHS (occupational health and safety); ii) migrant workers and their families enjoy equal rights to access health care (at a minimum, access to emergency care), and that migrant workers benefit from equal treatment as national workers regarding OHS protection. The framework also suggests entering into bilateral, regional or multilateral agreements to provide social security coverage and benefits, and portability of social security entitlements to regular migrant workers (ILO, 2006: 17-18).

## 2.4 Related international commitments

This section presents the main international political commitments and global policies regarding health that GMS countries have committed to that are relevant to the health of migrants.

### 2.4.1 Sustainable Development Goals

The Sustainable Development Goals were adopted in September 2015 during the UN Summit 2015 for the adoption of the post-2015 development agenda, built upon the eight Millennium Development Goals (MDGs) adopted in 2000.

A total of 17 goals and 169 associated targets were agreed upon, to be achieved by 2030. Through these goals, States committed to a global partnership to eradicate poverty, including extreme poverty in its many dimensions – income poverty, hunger, disease, lack of adequate shelter and exclusion – and to achieve sustainable development in its three dimensions: economic, social and environmental. The new defined goals set up a key and updated global framework for development that goes far beyond the MDGs. Social, economic and environmental objectives have been included as well as guidance for implementation, all from an integrated and cross-cutting approach. Health matters have been included under Goal 3 – *Ensure healthy lives and promote well-being for all at all ages* includes ending the epidemic of malaria (among others) by 2030 and achieving universal health coverage and access to quality essential health-care services for all (UN, 2015:16). Migration issues have been included under Goal 10 – *Reduce inequality within and among countries* – setting a specific target on these issues: “Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies” (UN, 2015:21). Although not a legally binding instrument, countries and development agents are expected to comply, as was the case with the MDGs. In April 2016, WHO adopted resolution WHA69.15 on Health in the 2030 Agenda for Sustainable Development, which provides a framework with targets for Goal 3 on *Good health and well-being*.

### 2.4.2 The Rio Political Declaration on Social Determinants of Health

Gathered in Rio de Janeiro, Brazil in October 2011, ministers and government representatives expressed their “determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach”. It considers as essential the promotion of health equity to sustainable development and a better quality of life for all based upon resolution WHA62.14 “Reducing Health Inequities through Action on the Social Determinants of Health”, government representatives committed to develop and support policies, strategies, programmes and action plans to address social determinants of health (SDH) that encompass the following (WHO, 2011a).

- a) Adopting better governance for health and development by developing inclusive policies that consider the needs of the entire population, particularly those of vulnerable groups; collaborating with all sectors, especially the private sector; strengthening OHS and health protection; promoting universal access to social services and access to affordable, quality medicines.
- b) Promoting participation in policy-making and implementation, which includes enhancing inclusive and transparent decision-making, implementation and accountability for health governance at all levels; enhancing access to information, justice and public participation; empowering communities’ contribution to policy-making to address social determinants of health at the international level.

- c) Further reorient the health sector towards reducing health inequalities “acknowledging that accessibility, availability, acceptability, affordability and quality of health care (see box below) and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being”.

**Box 2. The four elements of the right to health (Health and human rights, WHO 2015, Fact sheet 323)**

**Accessibility:** Health facilities, goods and services accessible to everyone. Accessibility has four dimensions: non-discrimination; physical accessibility; economical accessibility (affordability); information accessibility.

**Availability:** A sufficient quantity of functioning public health and health-care facilities, goods and services as well as programmes.

**Acceptability:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.

**Quality:** Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

- d) Strengthening global governance and collaboration by supporting social protection floors to address specific needs of countries within the UN system and fostering South-South cooperation in building capacity and transferring technology for integrated action on health inequities.
- e) Monitoring progress and increasing accountability by establishing, strengthening and maintaining monitoring systems that provide disaggregated data to assess health inequities.

WHO, through resolution WHA65.8 on the Outcome of the World Conference on Social Determinants of Health (2012), urges countries to implement the Rio Declaration of Social Determinants of Health, among other actions. To implement policies and action on SDH, in 2013, experts from 122 countries proposed during the 8th Global Conference on Health Promotion (Helsinki, 2013) a ‘Health in All Policies’ approach that systematically takes into account the health implications of decisions and avoids harmful health impacts to improve population health and health equity (WHO, 2014b).

The **Global Operational Framework on Migrant Health** (see Annex II for outline) is an outline to guide governments and stakeholders in implementing the recommendations of the 2008 resolution WHA61.17 on the health of migrants. It is a synthesis of the recommendations of experts from governments, international organizations, civil societies, academia and other development partners agreed during the **Global Consultation on the Health of Migrants** (Madrid, 2010). The framework is divided into four thematic areas, with their corresponding actions to address migrants’ health issues.

The first area, **monitoring migrants’ health** highlights the importance of building the evidence for programmes and policies that facilitate interventions addressing the health of migrants. This encourages standardization and development of health information systems to cover marginalized population groups, such as migrants.

To improve migrant health, policies must span across sectors to reflect the interdisciplinary nature of the topic, and require harmonization among communities and countries (WHO, 2010a:43). Thus, the



second area for action is **policy and legal frameworks**. Such policy approaches to address challenges of modern migration are (a) disease control (also codified in the IHR 2005); (b) migration management and control (such as health certificates required from prospective migrants) (WHO, 2005:24); and (c) norms that ensure human rights are fundamental components in the design, implementation and evaluation of all health-related policies and programmes.

The third area, **migrant-sensitive health systems**, aims to consider the needs of migrants in accessing health services, from the initial planning of health services to its implementation and evaluation. It provides the following targeted interventions to help migrants access health services: (a) provision of interpreter services and adequate, language-appropriate written materials; (b) delivery of culturally sensitive health-care services; (c) development of health promotion, disease prevention and disease support programmes that are culturally tailored; and (d) availability of cultural support staff both in clinical settings and the community. Additionally, this approach highlights the need for efficient research and data collection to effectively monitor the health of migrants.

The fourth area focuses on building **partnerships, networks and multicountry frameworks**. Close cross-border collaboration and intersectoral cooperation for migrant health is required to ensure strengthening existing regional health networks, and supporting migration health dialogues.

### 2.4.3 The Action and Investment to Defeat Malaria 2016–2030 – for a malaria free world (AIM)

The *Action and Investment to Defeat Malaria 2016–2030 – for a malaria free world (AIM)* was developed by the Roll Back Malaria Partnership (RBM)<sup>6</sup>. This document complements WHO's Global Technical Strategy for Malaria 2016–2030 and describes a solid economic and humanitarian rationale for continued investment in the fight against malaria. Both documents provide directions towards the 2030 malaria goals and have been developed in coordination. The AIM considers mobile and migrant populations as a vulnerable group and therefore, several approaches are described to address their health needs with respect to malaria. Some examples of suggested best practices are summarized in the box below:

#### Box 3. Best practice examples for extending services to MMPs

- Gather data on migration patterns for interdisciplinary and cross-sectoral analysis.
- Develop implementations at possible points of interaction.
- Engage with employers of migrant workers in malaria prevention interventions.
- Make efforts to expand the network of migrant-friendly health services by training staff in health vulnerabilities of migrants and so on.
- Extend malaria services in border regions (malaria mobile clinics, laboratories and health promotion points)

<sup>6</sup> The RBM Partnership "is the global platform for coordinated action against malaria. [It] is comprised of more than 500 partners, including malaria endemic countries, their bilateral and multilateral development partners, the private sector, nongovernmental and community-based organizations, foundations, and research and academic institutions". [www.rollbackmalaria.org](http://www.rollbackmalaria.org). (Accessed on 3 November 2015) (RBM, 2015b).



Thailand. A Myanmar migrant worker holds a vaccination record card for hard-to-reach mobile and migrant children developed by Ministry of Public Health and WHO with financial support from the European Union. Credit: Thavinkaew A. WHO Thailand. 2016.

# 3. REGIONAL LEGAL FRAMEWORK AND POLICIES

As migration connects communities and countries or regions as well as different sectors in societies, the management of health, social and or economic issues pertaining to migration require close cooperation and collaboration among countries, sectors and related institutions. Migrant inclusive policies can be achieved by integrating health and social protection of migrants through various regional, interregional and global platforms and processes on migration and social or economic development. Regional and global policies, strategies and legal frameworks and joint recommendations and resolutions, while often informal and non-binding, are useful in providing the framework for policy-makers and development partners to address the health concerns related to migrants. Listed below are some of these active frameworks and policies that are relevant for policy advocacy on malaria programming for migrants and their host communities.

## 3.1 The Strategy for Malaria Elimination in the Greater Mekong Subregion (2015–2030)

Based on the WHO Global Technical Strategy for Malaria 2016–2030, the *Strategy for Malaria Elimination in the Greater Mekong Sub-region (2015–2030)* was launched in May 2015 by WHO. Several factors triggered the development of this strategy, including the magnitude of the global threat of drug resistance. Resistance of *Plasmodium falciparum* to artemisinin and other antimalarial drugs has reached alarming levels in some areas of the GMS (WHO, 2015a:X).

In 2013, WHO launched an “Emergency response to artemisinin resistance (ERAR) in the Greater Mekong Sub-region: regional framework for action 2013–2015”. Priority actions include firstly, **full coverage with high-quality interventions in priority areas** through increased service quality and coverage in both the private and public sector and engagement of health and nonhealth fields to reach high-risk populations. The second priority aims for **tighter coordination and management of field operations** through improved coordination of field activities and monitoring staff performance as well as integrating resistance containment in malaria elimination and control efforts. The framework also aims to **increase understanding of artemisinin resistance containment** through improved collection and use of data, fast-track priority research for containment and elimination, increased monitoring of antimalarial therapeutic efficacy and insecticide resistance, and strengthening therapeutic efficacy networks worldwide. Finally, a **regional oversight and support priority** calls for enhanced accountability and exchange of information; building political support at all levels; facilitating progress and regional cooperation on pharmaceutical regulation, production, export and marketing; creating a regional community of practice on approaches to high-risk and hard-to-reach populations; and supporting cross-border coordination (WHO, 2013:9).

In line with the ERAR strategy, the *Strategy for Malaria Elimination in the GMS* aims to eliminate *P. falciparum* by 2025 and malaria in all GMS countries by 2030. In malaria-free areas, the goal is to prevent reintroduction of malaria and maintain a malaria-free status. As shown in Table 4, this regional strategy outlines three key interventions and two supporting elements to achieve these goals, recognizing the need of service delivery for mobile and migrant populations to eliminate malaria. In this regard, the strategy proclaims equity in access to services as an essential principle, especially for the most vulnerable and hard-to-reach populations, emphasizing the necessity of providing full access to services for mobile and migrant populations in all areas of the GMS. "Elimination will not be achieved unless these population groups have access to malaria protection measures, early diagnosis and treatment." (WHO, 2015a:16)

**Table 4. Overview of the Strategy for Malaria Elimination in the Greater Mekong Subregion**

<b>Vision: A region free of malaria and the continual threat posed by antimalarial drug resistance</b>
<b>GOALS</b>
<ul style="list-style-type: none"> <li>Eliminate malaria by 2030 in all GMS countries, and considering the urgent action required against multidrug resistance in the GMS, to eliminate <i>P. falciparum</i> by 2025.</li> <li>Maintain malaria-free status and prevent reintroduction in areas where malaria transmission has been interrupted.</li> </ul>
<b>PRINCIPLES</b>
All countries can accelerate efforts towards elimination through combinations of interventions tailored to local contexts.
Country ownership and leadership, with involvement and participation of communities, are essential to accelerating progress through a multisectoral approach.
Improved malaria case and entomological surveillance, monitoring and evaluation, and stratification by malaria disease burden are required to optimize the implementation of malaria interventions.
Equity in access to services is essential, especially for the most vulnerable and hard-to-reach populations.
Innovation in tools and implementation approaches will enable countries to maximize their progression along the path to elimination.
<b>OBJECTIVES</b>
<ol style="list-style-type: none"> <li>To interrupt transmission of <i>P. falciparum</i> in areas of multidrug resistance, including ACT resistance, by no later than 2020, and in all areas of the GMS by 2025.</li> <li>To reduce malaria in all high-transmission areas to less than 1 case per 1000 population at risk and initiate elimination activities by 2020.</li> <li>To prevent reintroduction of malaria transmission in areas where it has been interrupted.</li> </ol>
<b>KEY INTERVENTIONS</b>
<ol style="list-style-type: none"> <li>Case detection and management.</li> <li>Disease prevention in transmission areas.</li> <li>Malaria case and entomological surveillance.</li> </ol>



## SUPPORTING ELEMENTS

1. Expanding research for innovation and improved delivery services
  - Development of novel tools and approaches to respond to existing and new challenges, such as outdoor vector exposure and varying patterns of population mobility.
  - Operational research to optimize impact and cost-effectiveness of existing and new tools, interventions and strategies.
  - Action to facilitate rapid uptake of new tools, interventions and strategies.
2. Strengthening the enabling environment
  - Strong political commitment and adequate financial support for malaria elimination.
  - Capacity development appropriate to the implementing strategy.
  - Health systems strengthening to facilitate malaria elimination.
  - Policies for delivery of services to meet the needs of mobile and migrant population.
  - Intersectoral collaboration and community involvement.
  - Advocacy to support collective action.
  - GMS regional functions.

Source: WHO. 2015. Strategy for malaria elimination in the Greater Mekong Subregion (2015–2030)

Improving migrants' access to health services is considered a multisectoral task under this strategy, as migrants can be reached both through employment channels or health or social public services. Different modalities should be considered, such as centres for migrants to provide information on malaria and distribute bednets; fixed-schedule mobile clinics or provincial-level malaria clinics with mobile teams for managing malaria in mobile and migrant populations. These teams should be authorized to work across borders and also with migrant recruitment agencies (WHO, 2015a:16). Additionally, systematic collection of information on migrants is essential to provide health services according to their needs.

The strategy considers community involvement a crucial element to achieve effective malaria prevention. Community participation, especially with the health sector in various social groups and minorities, could guarantee that malaria prevention strategies are compatible with their practices and beliefs.

To succeed, the GMS Malaria Elimination Strategy calls for effective national policies, strong political commitment and cross-border and regional collaboration that could lead to malaria elimination in the GMS as described.

### **3.2 The Dhaka Declaration of the Colombo Process' fourth ministerial consultation for Asian labour sending countries on migration with dignity, April 2011**

The Colombo Process<sup>7</sup> is a regional consultative process on the management of overseas employment and contractual labour for countries of origin in Asia that provides Member States and Observers, including international organizations and development partners “a non-binding and informal environment to engage in dialogues and cooperation on issues related to labour migration that are of common interest and concern” (IOM, undated:11). The informal and nonbinding dialogues and information exchanges that come out of the Ministerial Consultations that leads and governs the processes of this network evolved mainly within three thematic areas: 1) protection and provision of services to migrant workers; 2) optimizing benefits of organized labour migration; and 3) capacity-building, data collection and interstate cooperation. The Colombo Process is by far the only regional consultative process on labour migration in Asia and the Pacific that has opened up its ministerial consultations to include health and social issues of migrants with the participation of the civil society.

The 2010 Regional Multi-Stakeholder Dialogue on Addressing the Health Challenges of Asian Migrant Workers, which brought together for the first time health, foreign affairs, immigration and labour officials of the Colombo Process Countries to develop a common understanding on the main health challenges and priorities associated with labour migration in and from South and South-East Asia and particularly to the Arab States, was a key milestone. The Dialogue recommended specific activities to improve the health and well-being of migrant workers and their families throughout the migration cycle.

These recommendations later fed into the 2010 Asia-Pacific Preparatory Meeting for the Global Forum on Migration and Development where participants called for improved migrant health services, including the development of guidelines and minimum standards to facilitate provision of health services, such as health financial schemes, social protection in health and mandatory health insurance. Out of this preparatory meeting, representatives of States of the Asia-Pacific region came up with the Bangkok Statement on Migration and Development. The statement recommends that assistance to migrants in all aspect of their health should be increased, including making predeparture health assessments aligned to international health standards and enhancing access to information on health matters; special consideration should be given to those in vulnerable situations, such as women migrant workers, children or displaced persons. Also collecting disaggregated migration data on health and undertaking qualitative and quantitative studies to promote better policy formulation should be further improved (UNESCAP, 2010:12,44).

In April 2011, during the Fourth Ministerial Consultation for Asian Labour Sending Countries (also known as the Colombo Process), 11 countries adopted the Dhaka Declaration, which includes recommendations to promote migrant-inclusive health policies to ensure equitable access to health care and services as well as occupational safety and health for migrant workers.

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7 The Colombo Process is composed of 11 Member States, namely Afghanistan, Bangladesh, China, India, Indonesia, Nepal, Pakistan, Philippines, Sri Lanka, Thailand and Viet Nam; and eight observer countries, namely Bahrain, Italy, Kuwait, Malaysia, Qatar, Republic of Korea, Saudi Arabia and the United Arab Emirates. For more information, please consult: <http://www.colomboprocess.org>.

### 3.3 Legal framework and policies of the Association of Southeast Asian Nations (ASEAN)

With all GMS countries under the umbrella of the Association of Southeast Asian Nations (ASEAN), the ASEAN Charter sets out to enhance the well-being and livelihood of the people by providing them with equitable access to opportunities for human development and social welfare for the poor, vulnerable, underserved and disadvantaged groups affected by adverse impacts of integration process and globalization; and strengthening ASEAN cooperation in protecting female migrant workers (ASEAN, 2009:73). It also contains the strategic objective ensuring “access to adequate and affordable healthcare, medical services and medicine, and promote healthy lifestyles for the peoples of ASEAN” (ASEAN, 2009:74). However, the section on the protection and promotion of the rights of migrant workers does not make any mention of health or social security.

The ambition of the AEC is that it will “transform ASEAN into a region with free movement of goods, services, investment, skilled labour, and freer flow of capital.” (Huelser and Heal, 2014:1). However, labour mobility under the AEC is limited to skilled professionals. Mobility is further constrained in many sectors, due to the application of nationality restrictions even where Mutual Recognition Agreements (MRAs) have been concluded. As noted by Huelser and Heal, the majority of labour migrants in ASEAN are low-skilled and the AEC framework “does little to either: (i) open labour markets to low-skilled migrants; or (ii) provide co-operative mechanisms to better regulate existing patterns of migration and discourage irregular migration” (Huelser and Heal, 2014:7).

#### 3.3.1 The Declaration on the Protection and Promotion of the Rights of Migrant Workers (2007)

In 2007, Members of ASEAN signed two landmark declarations during the Twelfth ASEAN Summit: the Declaration on the Protection and Promotion of the Rights of Migrant Workers, which formally recognized migrant workers in this Region as a vulnerable group whose rights require protection and laid down the obligations of sending and receiving States in promoting the fundamental rights and dignity of migrant workers and their families; and the ASEAN Commitments on HIV and Acquired Immune Deficiency Syndrome (AIDS), which included a focus on migrants and mobile populations. Likewise, since 2006, the South Asian Association for Regional Cooperation has adopted regional strategies for HIV/AIDS and TB/HIV co-infection, both focusing on migrant-related issues. However, neither of the said regional instruments explicitly mentioned the migrants’ right to health or health-related obligations of ASEAN Member States towards migrant workers and other people on the move. An ASEAN Socio-Cultural Community (ASCC) Blueprint also identified protecting migrants’ rights as a strategic objective.

#### 3.3.2 The Declaration on Strengthening Social Protection (2013)

Most notably, in 2013, at the occasion of its 13<sup>th</sup> Summit, the ASEAN Member States adopted the Declaration on Strengthening Social Protection that potentially impacts health of migrants, which proclaims in its first principles that “Everyone, especially those who are poor, at risk, (...) children, migrant workers, and other vulnerable groups, are entitled to have equitable access to social protection

that is a basic human right and based on a rights-based/needs-based, life-cycle approach and covering essential services as needed [and that] extending coverage, availability, quality, equitability and sustainability of social protection should be gradually promoted to ensure optimal benefits to the beneficiaries" (ASEAN, 2013:2). It further preconizes to "advocate strategies that promote the coverage, availability, comprehensiveness, quality, equitability, affordability and sustainability of various social protection services, including the expansion of social insurance to the informal sector" (ASEAN, 2013:4) and to accelerate progress towards Universal Health Coverage (UHC) in all ASEAN Member States.

There are regional discussions on the drafting of a new ASEAN Agreement on the Protection and Promotion of the Rights of Migrant Workers for 2015 in response to the 2015 AEC integration.

Further, other related deliberations include the following:

- ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths, (2011)
- Declaration of the 8th ASEAN Health Ministers Meeting, "ASEAN Unity in Health Emergencies", (2006)
- Declaration of the 6th ASEAN Health Ministers Meeting on Healthy ASEAN Lifestyles Vientiane Declaration, (2002)
- Regional Action Plan on Healthy ASEAN Lifestyles, (2002)
- Declaration of the Fifth ASEAN Health Ministers Meeting on Healthy ASEAN 2020, (2000)

The 7th ASEAN Forum on Migrant Labour, "Towards the ASEAN Community by 2015 with enhanced measures to protect and promote the rights of migrant workers", was held in November 2014 in Myanmar and led to a set of recommendations among which figures capacitating recruitment agencies in securing better package of benefits for migrant workers. It also suggests setting up policies and procedures to strengthen cooperation between the countries of origin and destination in providing assistance to migrant workers with health concerns in order to ensure access to treatment and relevant social welfare services (ASEAN, 2014).

### **3.4 Other regional instruments**

#### **3.4.1 The GMS MoU on Joint Action to Reduce HIV Vulnerability Related to Population Movement (2011)**

The parties to the GMS have concluded MoUs relating to diseases other than malaria concerning population movement for joint actions, such as the Joint Action to Reduce HIV Vulnerability Related to Population Movement (2011) identified the following priority needs: improved understanding of the continuum of treatment and care across borders, including treatment compatibilities across borders; increased joint implementation prevention and care programmes at source and destination by community and civil society groups; and greater advocacy for migrants' inclusion in universal coverage schemes as the region moves towards one ASEAN community by 2015. The health system responses set up in these can also be leveraged for Malaria control in the Mekong region.

### 3.4.2 The Extension of Memorandum of Understanding among the Health Ministries of the Six Mekong Basin Countries on the Mekong Basin Disease Surveillance (MBDS)<sup>8</sup> Cooperation

The “Extension of Memorandum of Understanding among the Health Ministries of the Six Mekong Basin Countries on the Mekong Basin Disease Surveillance (MBDS) Cooperation”, agreed upon in 2008, aims to strengthen nation and subregional capabilities in disease surveillance of, and outbreak response to five priority diseases, which includes malaria. Cooperation includes the scope of health system development, institutional and laboratory capacity strengthening, human resources development, information technology development and exchange, cross-border activities and joint outbreak responses, and calls for the development of a 5-year action plan to be developed (MBDS, 2015).

Table 5 shows the status of the Greater Mekong Subregion countries commitment to the regional legal framework and policies that have been mentioned in this chapter:

**Table 5. Status of the Greater Mekong Subregion countries’ commitment to selected regional legal framework and policies in Asia Pacific**

Regional Legal Instruments	CAMBODIA	LAO PDR	MYANMAR	THAILAND	VIET NAM
Strategy for Malaria Elimination in the Greater Mekong Subregion (2015-2030)	Signatory	Signatory	Signatory	Signatory	Signatory
The Dhaka Declaration of the Colombo Process’ Fourth Ministerial Consultation for Asian Labour Sending Countries on Migration with Dignity, April 2011	Not part	Not part	Not part	Signatory	Signatory
ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers	Signatory	Signatory	Signatory	Signatory	Signatory
ASEAN Declaration on Strengthening Social Protection	Signatory	Signatory	Signatory	Signatory	Signatory
GMS MoU on Joint Action to Reduce HIV Vulnerability Related to Population Movement (2011)	Signatory	Signatory	Signatory	Signatory	Signatory
Extension of the MoU among the Health Ministries of the Six Mekong Basin Countries on the Mekong Basin Disease Surveillance (MBDS) Cooperation (2001)	Signatory	Signatory	Signatory	Signatory	Signatory
MoU on Cooperation against Trafficking in Persons in the GMS-region (2004)	Signatory	Signatory	Signatory	Signatory	Signatory

8 The Mekong Basin Disease Surveillance (MBDS) consortium comprises Cambodia, China (Yunnan and Guangxi Provinces), Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam and a growing number of development partners working together to reduce morbidity and mortality caused by outbreak-prone diseases in the subregion.





Myanmar: Reaching out to mobile and migrant workers in a rubber plantation. Credit: IOM

# 4. OVERVIEW OF POLICIES AND LEGAL FRAMEWORK IN THE GREATER MEKONG SUBREGION

## 4.1 Migration flows in the Greater Mekong Subregion

In the past decade, the Greater Mekong Subregion (GMS) has experienced consistent economic development primarily due to the implementation of the Greater Mekong Subregional Economic Cooperation Programme across the six countries. This programme and the ASEAN trade agreements<sup>9</sup> have contributed to developing transport infrastructure, such as roads and bridges, linking the subregion, opening borders which were previously closed, and creating employment opportunities. The region has a population of approximately 326 million (ADB, 2015), and this economic development and opportunity has consequently resulted in large volumes of intraregional migration in recent years. Data from 2013 estimated between 3 and 5 million migrant workers across the GMS (IOM & ADB, 2013:VII). However, because irregular migration is widespread in the Region, precise migration data are difficult to obtain.

Labour migration constitutes both the major push and pull factors for migration internally and intraregionally. Labour migration is mainly motivated by unequal social and economic development within the region and by the road infrastructure developed across these countries. Internal migration (rural to urban and rural to rural) is more prevalent than intraregional migration in the GMS countries. The majority of intraregional migrants work in low-skilled jobs (e.g. agriculture, fisheries and construction) and most of them are irregular workers. Furthermore, beyond internal and intraregional migration, a special form of migration – border mobility – has emerged. Border mobility occurs in border-towns along GMS economic corridors, whereby migrants engage in a pattern of daily or weekly migration for specific economic activities in border-areas (IOM & ADB, 2013:VII).

Migrants are distributed unequally throughout the GMS, which is mainly due to differences among country economies. Thailand, the PRC Provinces of Yunnan and Guangxi, and Viet Nam have stronger economies than Cambodia, Lao People's Democratic Republic and Myanmar. This has resulted in clear patterns of primary migration flows in the GMS, with Thailand hosting by far the greatest number of migrants mostly from Myanmar (around 50%), Lao People's Democratic Republic and Cambodia (UNDESA, 2013). Secondary migration flows also occur among GMS countries: the PRC provinces of Yunnan and Guangxi host migrants from Myanmar; Cambodia hosts permanent migrants from Viet Nam; Myanmar and Viet Nam host migrants from Yunnan Province; and Lao People's Democratic Republic hosts migrants predominantly from Viet Nam and Yunnan Province.

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<sup>9</sup> ASEAN trade agreement refers to the Common Effective Preferential Trade-ASEAN Free Trade Agreement (CEPT-AFTA) signed in 1992 and its posterior transformation into the ASEAN Trade in Goods Agreement signed in 2009 (entered into force in May 2010). Both agreements have aimed to further cooperate in the economic growth of the region by enhancing ASEAN trade and investment. ASEAN has also signed several free trade agreements with other Asian nations, such as People's Democratic Republic of China among others.

## 4.2 Social protection laws and policies enabling migrants' access to health services

This section analyses existing laws and policies that directly or indirectly relate to access to health services of inbound and outbound migrants, mobile populations and internal migrants as well as irregular migrants or migrants working in the informal sector.

### 4.2.1 Outbound migrants rights, health checks and pre-departure orientation

This section examines the instruments established by GMS countries that support well-managed internal and outbound migration of their nationals throughout the migration process.

For countries of origin, authorities work towards the protection of the rights of their citizens. A rights-based approach to labour migration, indicates that countries of origin must include the following four elements: a) access to formal migration mechanisms (including reducing the cost of passports) through the strengthening and implementation of formal bilateral migration mechanisms between States via Memoranda of Understanding (MoUs) in order to reduce migration occurring through illegal channels; b) bilateral, regional or multilateral agreements for the provision of social security coverage and benefits as well as portability of social security entitlements for regular migrant workers and, as appropriate, to migrant workers in irregular situations; c) "measures, [...] educational programmes and [...] other activities aimed at acquainting migrant workers as fully as possible with the policy, with their rights and obligations and with activities designed to give effective assistance to migrant workers in exercise[ing] their rights and for their protection" (ILO, 1975, Art.12.c); and d) comprehensive medical services to ascertain, at the time of departure, whether labour migrants and family members are in reasonable health and to ensure adequate medical attention at the time of departure, during transit and upon arrival in the territory of destination (ILO, 1949) in line with the International Health Regulations.

Among the four primary countries of origin within the GMS (i.e. Cambodia, Lao People's Democratic Republic, Myanmar, and Viet Nam), **Cambodia** has established a comprehensive legal framework (2011; 2013) tasking recruitment agencies that source Cambodians for employment outside of the country with providing pre-departure orientations that include information on employment rights, access to health and some occupational health and safety information. **Myanmar's** Overseas Employment Law (1999) aims to ensure that there is no loss of rights and privileges of migrant workers and that the rights they are entitled to are respected. The standard employment contract for Myanmar labour migrants to Thailand includes a stipulation that employers are to ensure that employees have access to medical treatment free of charge if illness or injury is incurred during work. **Viet Nam** requires that outbound migrants undergo medical assessments and provide health certificates, and contracts for outbound labour migrants are required to include provision of health care; however, there is no guaranteed access to health facilities and services. **Lao People's Democratic Republic** is still short of policies and legal frameworks that protect outbound migrant workers other than the MoU signed with Viet Nam on Labour Cooperation (2002). The MoU includes provision of health insurance and health services for Lao workers in Thailand and vice versa (art.7). Cambodia and Myanmar are the first two countries of the GMS to reflect their political commitment to protecting outbound labour migrants through extended legal frameworks, particularly for those migrants to Thailand; the legal framework

and policies of **Lao People's Democratic Republic and Viet Nam** lack measures to ensure the protection of their emigrants. This is particularly concerning in the case of Viet Nam as the country ranked among the top emigration countries in 2000–2010 (UNDESA, 2013b:13).

#### 4.2.2 Social security, occupational or employment insurance, workers' compensation, occupational health and safety

This section considers GMS countries' commitment to inbound migrants and mobile populations, examines legal instruments that address their social protection and occupational health and safety and highlights gaps in law and policy.

According to the conventions of the International Labour Organization (ILO), countries hosting inbound migrant workers – so-called countries of destination (COD) – must have measures to ensure that national labour legislation and social laws and regulations apply to all migrant workers, including domestic workers and other vulnerable groups, particularly with regard to occupational health and safety and other conditions of work. There must also be measures to ensure that migrant workers and accompanying members of their families are provided access to health care, with a minimum of access to emergency medical care. Furthermore, medical care provided to regular migrant workers and accompanying family members must be equal to that received by nationals. COD must also adopt measures to ensure that both, in law and practice, all migrant workers are afforded treatment equal to that provided to nationals regarding safety and health protection. This includes measures to address specific risks in certain occupations and sectors, particularly agriculture, construction, mining, hospitality and tourism, and domestic work; special priority must be made to address the specific risks faced by women and, where applicable, promote opportunities<sup>10</sup>.

With the exception of **Thailand**, the primary COD for all five other GMS countries, the treatment of migrant workers has yet to be made equal to that of nationals. For example, while all citizens of **Myanmar** are entitled to access health care according to the country's Constitution, there are no provisions in established laws describing access to services for noncitizens, irregular migrants, internationally or internally displaced persons or other categories of migrants. The Myanmar National Health Plan 2011–2016 does identify internal migration and aims to provide basic and essential health services for internal migrants. However, apart from the National Strategic Plan on HIV/AIDS and the Strategic Framework for Artemisinin Resistance Containment in Myanmar (MARC) 2011–2015, which explicitly mention prevention interventions targeting MMPs (most likely understood as internal migrants), there was at the time of review a lack of specific, dedicated strategies for addressing the health of migrants. The Ministry of Health is currently taking steps towards developing a comprehensive Migrant Health Policy and aims to include this as a strategic priority in the next National Health Plan (2016–2021). The recently updated Social Security Act (2012) does not mention inbound migrants and how they may be included.

<sup>10</sup> According to the Migrant Workers Convention No. 143 (1975) article 10, "equality of opportunity and treatment in respect of employment and occupation, of social security, of trade union and cultural rights and of individual and collective freedoms for persons who, as migrant workers or as members of their families, are lawfully within its territory" should be promoted.



Both **Cambodia and Lao People's Democratic Republic** provide inbound migrants with the protection of their labour laws, which outline different sections on social security protection, occupational health and safety, and occupational accidents and diseases. **Lao People's Democratic Republic's** Social Security Law (2013) also provides health coverage for employees registered and contributing to the Social Security Organisation (art.11-13), an obligation under the Labour law for inbound, regular workers. **Cambodia** limits the provision of 'employment cards' to its own citizens (art.4 Labour Law, 1997) and it is unclear how this affects access to health care for those who do not hold one. Furthermore, the country introduced a mandatory employment injury insurance (EII) for private sector employees to provide coverage for work-related accidents and illnesses for all persons working in Cambodia covered by the Labour Law (1997), regardless of nationality; however, this does not cover outbound or irregular migrants. Malaria is not specifically referred to in this Law although it could be argued that if an employee contracts malaria as a result of his or her work, subsequent medical care should be covered by this scheme.

**Thailand's** Labour Protection Act (2008) applies to all businesses and registered employees with the exception of domestic workers. Although labour protection for Thai nationals should apply to regular migrant workers this is not always the case, and most migrants are not covered by accident and compensation plans or pensions from their employers (Huguet et al., 2012). The Workmen's Compensation Fund (WCF) under the Workmen's Compensation Act (1994) is only relevant for Thai nationals and regular migrant workers in larger workplaces with 10 or more regular employees where regulations are complied with, and employers have paid contributions.

All GMS countries have minimum health and safety regulations, with only **Viet Nam** having ratified ILO Convention No. 155 on Occupational Health and Safety. The Royal **Thai** Government has yet to effectively respond to the need for improved occupational health and safety with the current response largely limited to providing medical care or financial compensation, while failing to consider prevention (WHO, 2011b:14). However, the Third National Master Plan on Occupational Safety, Health and Environment (2012-2016) aims to strengthen OSH networks, get all relevant sectors involved in OSH activities and develop OSH laws consistent with international levels (Ministry of Labour Thailand, 2012:17-18).

#### 4.2.3 Occupational malaria prevention interventions

This section examines which GMS countries have established malaria interventions targeting workers, including migrant workers, exposed to malaria as a result of their work, such as forestry or agricultural workers in endemic areas. The section specifically considers those instruments pertaining to occupational safety as well as health law, policy and malaria elimination strategies.

Findings from the review indicate that **Cambodia** has the best targeted initiative in terms of occupational malaria prevention. The *Strategy to Address Migrant and Mobile Populations for Malaria Elimination in Cambodia* (2013) noted that many migrants – a large portion of which are irregular – were seasonal, worked in construction, mining, forestry, as security personnel or were visitors or cross-border travellers and therefore, more often exposed to malaria because of the areas they worked or travelled in. Under this elimination strategy, USAID is working closely with the Cambodian National Malaria Control Programme (CNMCP) to provide labourers in endemic areas malaria information in buses and taxis



using short video clips as well as discussions with bus and taxi drivers who have received malaria training (USAID, 2014). Although CNMCP does not provide nets to short-term, seasonal migrant workers travelling in and out of malaria endemic areas, USAID funds a bed net lending programme under the U.S. President's Malaria Initiative (PMI) aimed at seasonal farmers working on agricultural plantations. Under this scheme farm owners loan bed nets to migrant workers and collect them when the workers leave.

In **Myanmar**, migrants and mobile populations are recognized as a key population by the National Malaria Control Programme National Strategic Plan and are explicitly referenced (Guidelines on The Prevention and Control of Malaria for Migrants in Myanmar, 2012, NMCP Myanmar, draft) in areas of prevention and vector control, especially those involved in forestry. The Plan includes the following objectives: i) establish malaria clinics in strategic and hard-to-reach areas where there are large numbers of migrant workers; ii) provide migrant targeted information, education and communication (IEC) materials; and iii) appoint dedicated malaria volunteers catering to the needs of migrant populations.

In **Viet Nam**, seasonal workers, such as cashew and cassava farm labourers, are specifically targeted as a most-difficult-to-reach migrant and mobile population and receive assistance, such as provision of repellents, LLINs and/or insecticide-treated hammock nets, instructions on how to use protective products, health promotion material and rapid diagnostic tests by special outreach units, such as the malaria posts<sup>11</sup>. These measures have targeted people living in malaria endemic areas, MMPs, cross-border population and poor families. In 2011, the Prime Minister approved the *National Strategy to malaria prevention and elimination in Viet Nam for the period 2011 to 2020 and orientations to 2030* (Decision No. 1920/QĐ-TTĐ October 27, 2011), which aims to reduce malaria prevalence under 0.15 per 1000 population and malaria mortality rate to below 0.02 per 100 000 population by 2020. Also, the Strategy sets targets to achieve different malaria elimination phases<sup>12</sup> in Viet Nam's provinces aiming to reach, by 2020, no provinces in the phase of malaria control, 40 provinces in the pre-elimination phase, 15 provinces in the elimination phase and 8 provinces in the phase of prevention of reintroduction.

**Thailand** highlights in its National Strategic Plan for Malaria Control and Elimination 2011-2016 the need for cross-border collaboration to provide cross-border screening and treatment to migrant workers (MOPH Thailand, undated). Migrant and seasonal workers in **Lao People's Democratic Republic** are considered as a risk group in Lao People's Democratic Republic National Strategy for Malaria Control and Elimination 2011-2015. The Strategy mentions prevention measures for migrant workers, such as development of specific IEC/BBC materials.

Although malaria is not specifically mentioned as a health and safety concern in existing labour laws or health and safety regulations, there are work situations with a foreseeable risk of contracting malaria; it could thus be argued that specifications pertaining to malaria should be included under these laws.

11 Through the WHO and Global Fund Project for malaria support, Viet Nam has implemented "malaria posts" for MMPs to contribute to the control of malaria in malaria hyper-endemic areas.

12 "The path towards malaria-free status is characterized by four distinct programme phases: control, pre-elimination, elimination and prevention of reintroduction. Each phase is defined by a set of specific programme interventions needed for prevention, treatment, surveillance, monitoring and evaluation and health systems strengthening." ([www.who.int/malaria/areas/elimination/overview/en](http://www.who.int/malaria/areas/elimination/overview/en); accessed on 5 Jan 2016.).

### 4.3 Health law and policy framework enabling migrants' access to health care to fight malaria

This section analyses existing laws and policies that directly relate to enabling inbound and outbound migrants and mobile populations, internal migrants as well as irregular migrants or migrants working in the informal sector to receive prevention, diagnosis and treatment for malaria. Key national legal support for migrants on access to health services, migration flows and artemisinin resistance tiers in the Greater Mekong Subregion are summarized in Figure 2.

#### 4.3.1 Universal Health Coverage and non-occupational health scheme

Universal Health Coverage (UHC) aims to ensure that all people obtain the health services they require without suffering financial hardship as a result of service costs. This section, therefore, aims to identify how far GMS countries are from achieving UHC and whether migrants are afforded equal treatment as nationals.

The only GMS country with a UHC law that includes inbound and irregular migrants is **Thailand**; this has become a model of best-practice since its inception in 2002. As of 2007 estimates, the Universal Coverage Scheme covers 74.6% of the population. Financed from general taxation, Universal Coverage Scheme offers a comprehensive package of both preventive and curative care, whereby public hospitals are the primary care providers. Gaps remain in the coverage and availability of many public health services, particularly for poorer Thai populations, as well as migrant and mobile populations. Relevant legislation directed at migrant populations to date consists of the Ministry of Public Health (MoPH) Announcement on Health Examinations and Insurance for Migrant Workers from Myanmar, Lao People's Democratic Republic and Cambodia, (2009; revised in 2013) and the Migrant Health Insurance Scheme of Thailand's Universal Coverage Scheme (2002). Under this Scheme, registered migrant workers should be privy to the same services as nationals. Thailand also has a comprehensive social security system under the Social Security Act (1999) and the Social Security Fund (SSF) has been now extended to the informal sector. Registered migrants in the formal sector are now being transferred to the SSF from the Migrant Health Insurance Scheme. Irregular migrants may purchase insurance for periods as short as 3 or 6 months. Payment of the 2200 Thai Baht (approx. US\$ 68) annual registration fee permits registered migrants access to Thailand's universal health-care system (Guinto, 2015) and patients pay a further 30 Thai Baht at each visit. This '30 Baht Health Scheme' applies only to Thai nationals and regular migrants under the Migrant Health Insurance Scheme. As a result, irregular migrants cannot be granted access to the public health system.

In Cambodia, the Strategic Framework for Health Financing (2008–2015) and the draft of a Social Health Protection Master Plan are intended to further develop and expand universal coverage of social services – aimed at Cambodian nationals only – using a combination of different approaches, to improve the quality of public and private health services and overall access to them, especially for poor and disadvantaged groups. In Myanmar, commitment has been made to attain UHC by 2030. While migrants have been mentioned in initial planning meetings, as of this report there are no formal legislative or legal policy frameworks to ensure the inclusion of migrants in UHC activities. Lao People's Democratic Republic has no such health-care laws that include foreigners and Viet Nam has committed to attaining UHC to at least 80% of its population by 2020 (WB, 2014).

### 4.3.2 Access to prevention, control and treatment of malaria

This section reviews gains made by GMS countries towards achieving Millennium Development Goal 6, to “halt and begin to reverse, by 2015, the incidence of malaria and other major diseases” and the extent of implementation of the World Health Organization’s diverse strategies to eliminate malaria and respond to artemisinin resistance, taking into account the particular vulnerabilities of MMPs. As of 2015, all GMS countries had adopted national strategies for the elimination of malaria in accordance with WHO malaria frameworks, and all of them specifically recognize MMPs as particularly vulnerable.

Notably, **Cambodia** has designed the Strategy to Address Migrant and Mobile Populations for Malaria Elimination in Cambodia (2013). It recognizes the characteristics of MMPs in Cambodia and includes inbound seasonal migrants, visitors and cross-border travellers, which encompasses a large proportion of irregular migrant workers in the country. The Royal Government of Cambodia is working in partnership with civil society organizations and donors<sup>13</sup> to achieve the Strategy’s aims.

Both **Myanmar** and **Thailand** have established ‘malaria clinics’ along border-areas where there are large congregations of migrants, in areas of high malaria transmission and inadequate access to health services as well as in remote endemic villages. Inbound migrants can receive diagnosis, appropriate treatment and counselling on malaria free of charge at malaria clinics (Khamsiriwatchara et al., 2011:2) (DoH Myanmar, 2012:70). There are also Behaviour Change Communication (BCC) efforts through educational and communication tools adapted for target groups, such as migrant workers. Furthermore, populations from neighbouring villages converge to create vector-borne disease committees for community involvement and accountability.

As previously mentioned, **Viet Nam** provides special outreach units, such as the malaria posts to provide assistance (provision of repellents, LLINs and/or insecticide-treated hammock nets, instruction on how to use protective products, health promotion materials and rapid diagnostic tests), which is then expanded to those most-difficult-to-reach MMPs, especially seasonal workers, such as cashew and cassava workers.

<sup>13</sup> For example, the USAID/PMI Control and Prevention of Malaria Project (CAP-Malaria), is a multipronged approach that provides malaria information and services at multiple points in the GMS most frequented by migrants travelling from or returning to their country of origin. The approach targets migrants from Thailand, Cambodia and Myanmar for vector control via: increased use and availability of insecticide-treated bed nets in hotspots for highly vulnerable populations; early diagnosis and treatment through community-based service provision; capacity-building of malaria staff at all levels (from improved support supervision to increased laboratory capacity); strategic information, such as surveillance of drug resistance; and entomological studies. Other initiatives under this programme include continuous service delivery by long-term migrants (called migrant malaria workers under the programme) who educate other migrants about malaria and the local health services available; outreach by mobile clinics in isolated and remote villages and by border malaria posts in high-traffic areas; and engaging local malaria officials to build relationships with the more urban centres on either side of the malaria affected borders (USAID, 2012). The Cambodian National Malaria Control Programme (CNMCP) runs a community-based control and prevention project called Malaria Control in Cambodia Project (MCC) with University Research Co LLC (URC). The project uses a multilevel approach, working from the ground-level right through to the management-level of the CNMCP. It brings the subnational public and private sector together to reduce the impact of malaria by improving the quality of malaria service delivery and supporting the promotion of improved health-seeking behaviours.

#### 4.4 Constitutional provisions in GMS countries

This section considers whether the GMS countries' Constitutions or fundamental norms, such as a Declaration of Human Rights, implicitly or explicitly ensure migrants the right to access health services.

**Viet Nam's** Constitution states that "everyone has the right to health protection and care, and to equality in the use of medical services"; this could be interpreted as a universal right to health. The Constitution of **Lao People's Democratic Republic** indicates that "the State and society shall attend to building and improving disease prevention systems and providing healthcare to 'all people', creating conditions to ensure that all people have access to health care". The current Constitution in **Thailand** guarantees equal rights between men and women; and **Cambodia's** and **Myanmar's** Constitutions specify rights for "citizens."

#### 4.5 Bilateral Cooperation and Memoranda of Understanding between GMS countries (including the Yunnan province of the People's Republic of China) – regarding health of migrants, including malaria

An MoU between the governments of **Myanmar** and **Thailand** was signed in June 2016 (MoU on Labour Cooperation; see Table 6 below), together with a pursuant Agreement on the Employment of Workers, which includes a mention of health in pre-departure and destination scenarios, including provisions to ensure that authorities coordinate to ensure that workers are provided health insurance or health access. In practice, Thailand has the Migrant Health Insurance Scheme, which covers regular migrant workers and occasionally opens to include irregular migrants; Myanmar, which does not yet have public health insurance schemes, is thus not yet able to provide such a reciprocal system for migrants to Myanmar.

A report published by the World Health Organization (WHO SEARO, 2013) highlights that **Lao People's Democratic Republic** has been cooperating with **Viet Nam** via a joint survey and programmatic review conducted in 2010 for the purposes of improving malaria control methods between the two countries. This study involved data collection in villages within 5 kilometres of the Lao-Viet border. The research demonstrated that malaria prevalence was higher in Lao People's Democratic Republic (5.2%) compared to Viet Nam (1.8%). One of the reasons for this difference was that both countries were managing access to health care and government-led initiatives to control malaria differently. A real need for improved cooperation was observed as inhabitants of the areas studied were authorized to travel freely between both countries. The WHO report concluded that this study facilitated "an improved cross-border collaborative effort" between Lao People's Democratic Republic and Viet Nam, the establishment of "an agreement to have regular exchanges of malaria surveillance data", and standardization of "malaria control efforts such as indoor residual spraying" (WHO SEARO, 2013:22).

#### Box 4. Government and Asian regional networks and partnerships on the health of migrants

- There has been regular government attendance and involvement in regional networks, partnerships and multicountry frameworks on mobility, labour migration, human trafficking and HIV.
- However, despite good initiatives and commitments, the health of migrants is often not addressed sufficiently in global, regional or national health policy debates, such as Social Determinants of Health (SDH), Noncommunicable Diseases (NCDs), national disease control programmes or globally, such as in the Global Forum on Migration and Development (GFMD), Global Health Security Agenda, Health in All Policies, Global Health and Foreign Policy, among others.
- There continues to be a need to have greater multisectoral policy coherence and collaboration between health and nonhealth sectors.
- Many of these networks, such as the Colombo Process, Abu Dhabi Dialogue and the Bali Process are designed for the purpose of information sharing and may not necessarily result in binding declarations requiring national-government involvement.

#### 4.6 Role of political systems on the legal frameworks

This section analyses how policies and legal frameworks of GMS countries may be influenced by political agendas and motivation.

**Thailand's** policies and legislation regarding migrants have been influenced predominantly by national security concerns rather than by pragmatic responses to market and labour needs, while in **Cambodia** the government relies heavily on civil society and NGOs. In Cambodia, civil society and NGOs play a core role in the malaria response with more than 30 community organizations in the Migration NGO Network targeting migration issues. Realistically, social protection programmes are still under development for nationals, and at this stage such support does not extend to inbound migrant workers.

**Myanmar** has engaged in broad and systematic political and social reform with leadership at the highest levels, including a commitment of the president to strive towards Universal Health Coverage. Recognizing the importance of migration health, the International Relations Division (IRD), in collaboration with disease specific programming and IOM, successfully advocated for the creation of a Migrant Health Desk in the MoH, tasked with promoting the health of migrants in line with resolution WHA61.17 and liaising with counterparts in other relevant ministries as well as with regional and international counterparts. IOM has been promoting a migrant health agenda in Myanmar and implementing migration health programming, including for malaria, since 2006.

In **Lao People's Democratic Republic**, the Ministry of Public Health provides leadership and plays a central role as a technical advisor to the Provincial Health Offices (PHO) and the District Health Offices (DHO). The DHOs are key actors for the implementation of activities at health facilities and at the community level. The public sector is the primary provider of health services in the country, although it is underutilized, especially in rural areas. The private sector remains relatively small with the majority of private health services being pharmacies.



In **Viet Nam**, the Ministry of Health (MoH) is in charge of the agenda for health and health care; malaria issues are assigned to the National Malaria Control Project (NMCP); the management and implementation of malaria programmes are assigned by vertical model from MoH to National Institutes of Malaria, Parasitology and Entomology (NIMPEs) in three regions of Viet Nam and the local health system. The MoH has a strong network of partnerships with various international and national organizations. Since 2009, two of the One UN Programme Coordination Groups have partnered directly with MoH to address various health issues, such as HIV. Additionally, migration issues have also been raised with MOLISA, the Ministry of Foreign Affairs and the Ministry of Planning and Investment.



Cambodia. Border crossing, Poipet, 2016. Credit: IOM

**Table 6. Overview of national legal frameworks and policies for the health of migrants**

	CAMBODIA		LAO PDR		MYANMAR		THAILAND		VIET NAM	
	Internal- Outbound <sup>a</sup>	Inbound	Internal- Outbound	Inbound	Internal- Outbound	Inbound	Internal- Outbound	Inbound	Internal- Outbound	Inbound
<b>Social Protection and Health Laws or Policies</b>										
Universal Health Coverage	x	x	x	x	•	•	•	•	•	•
Social Security	✓	✓	✓	✓	•	•	•	•	•	•
Occupational Health and Safety <sup>b</sup>	✓	✓	✓	✓	•	•	•	•	•	•
Occupational Malaria Prevention Interventions	✓	✓	✓	✓	✓	✓	•	•	•	•
Migrant Health Examinations	✓	✓	•	•	✓	✓	✓	✓	✓	✓
Pre-departure Orientation for Migrants	✓	NA	•	NA	•	•	•	•	•	•
Migrant Health Insurance	•	•	•	•	•	•	•	•	•	•
National Malaria Strategy <sup>c</sup>	✓	NS	✓	NS	✓	NS	✓	NS	✓	NS
<b>Labour Laws</b>										
Worker's compensation	✓	✓	•	•	•	•	•	•	•	•
Employment and job seekers protection regulations	✓	NA	•	NA	✓	NA	✓	NA	✓	NA

**Sources:**

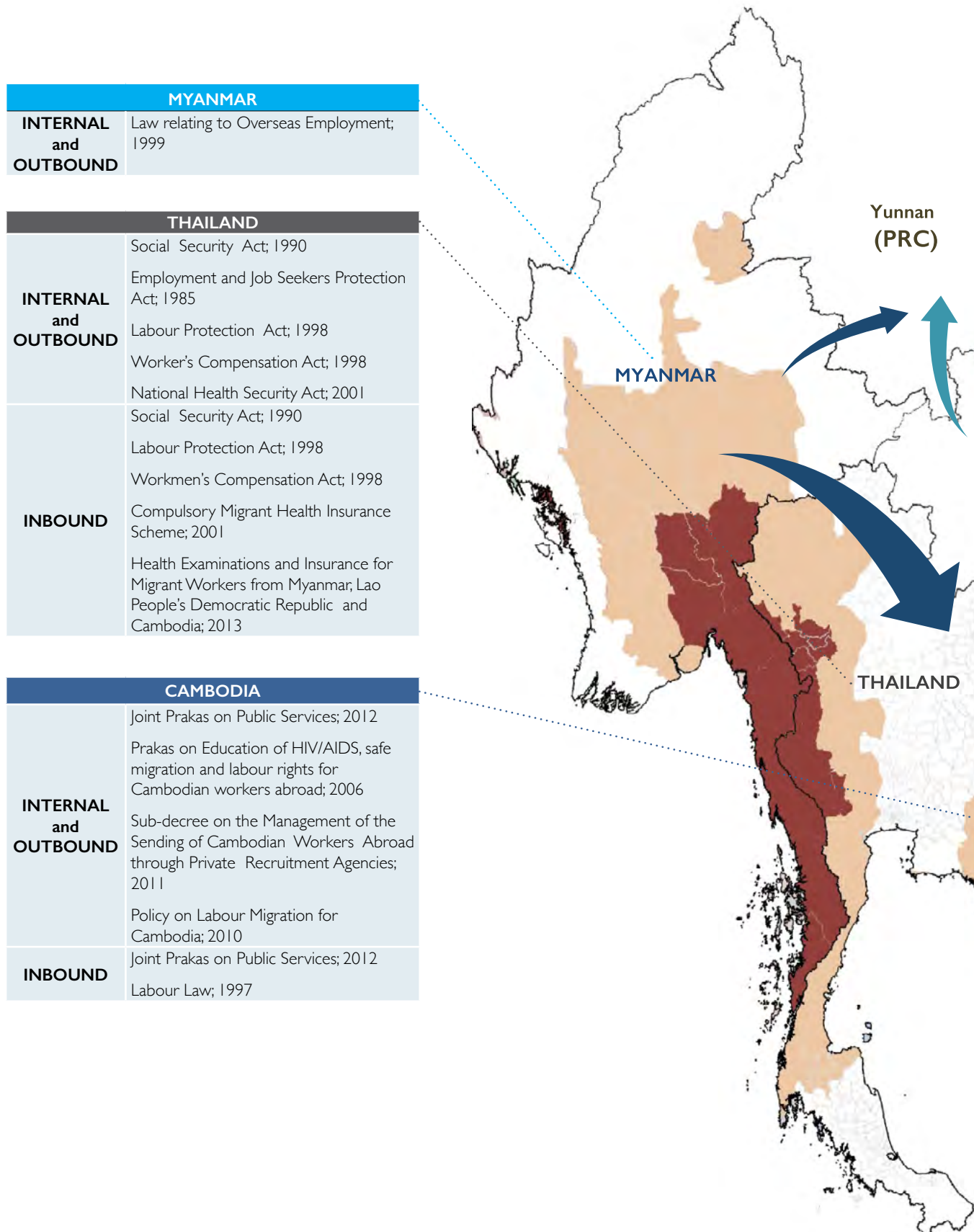
- Cambodia: Law on Social Security Schemes (2002); Labour Law (1997); Strategy to address MMPs in Cambodia (2013); Prakas No. 046/13 on Recruitment Process and Pre-departure Orientation Training (2013); Joint Prakas on Public Services Provided by MLVT (2012); Sub-decree 190 on the Agreement of the Sending of Cambodia Workers through Private Recruitment Agencies (2011).
- Lao People's Democratic Republic: Labour Law (2006, amended 2013); Social Security Law (2013); National Strategy for Malaria Control and Elimination 2011-2015 (2010).
- Myanmar: National Strategic Plan for Malaria Prevention and Control (2009); Law relating to Overseas Employment (1999); National Plan of Action for the Management of International Labour Migration in Myanmar 2013-2017 (2013).
- Thailand: National Health Security Act (2001); Compulsory Migrant Health Insurance Scheme (2001); Social Security Act B.E. 2533 (1980, amended 1990); Labour Protection Act (1998); Workmen's Compensation Act (1998); Announcement on Health Examinations and Insurance for Migrant Workers from Myanmar, Lao People's Democratic Republic and Cambodia (2009); Employment Agencies and Job Seekers Protection Act B.E. 2528 (1985).
- Viet Nam: Law on Vietnamese Guest Workers (2006); Decree 44/ 2013 on Labour Contract (2013); Decision on the Promulgation of the Action Plan to Prevent Artemisinin Resistant Malaria 2015-2017 (2014); Decree on Regulation and Guidance on the Law of Overseas Workers (2007); Circular No.14/2013/TT-BYT guiding medical examination (2013); Social Insurance Law No. 71/2006/QH11 (2006).

**Notes:**

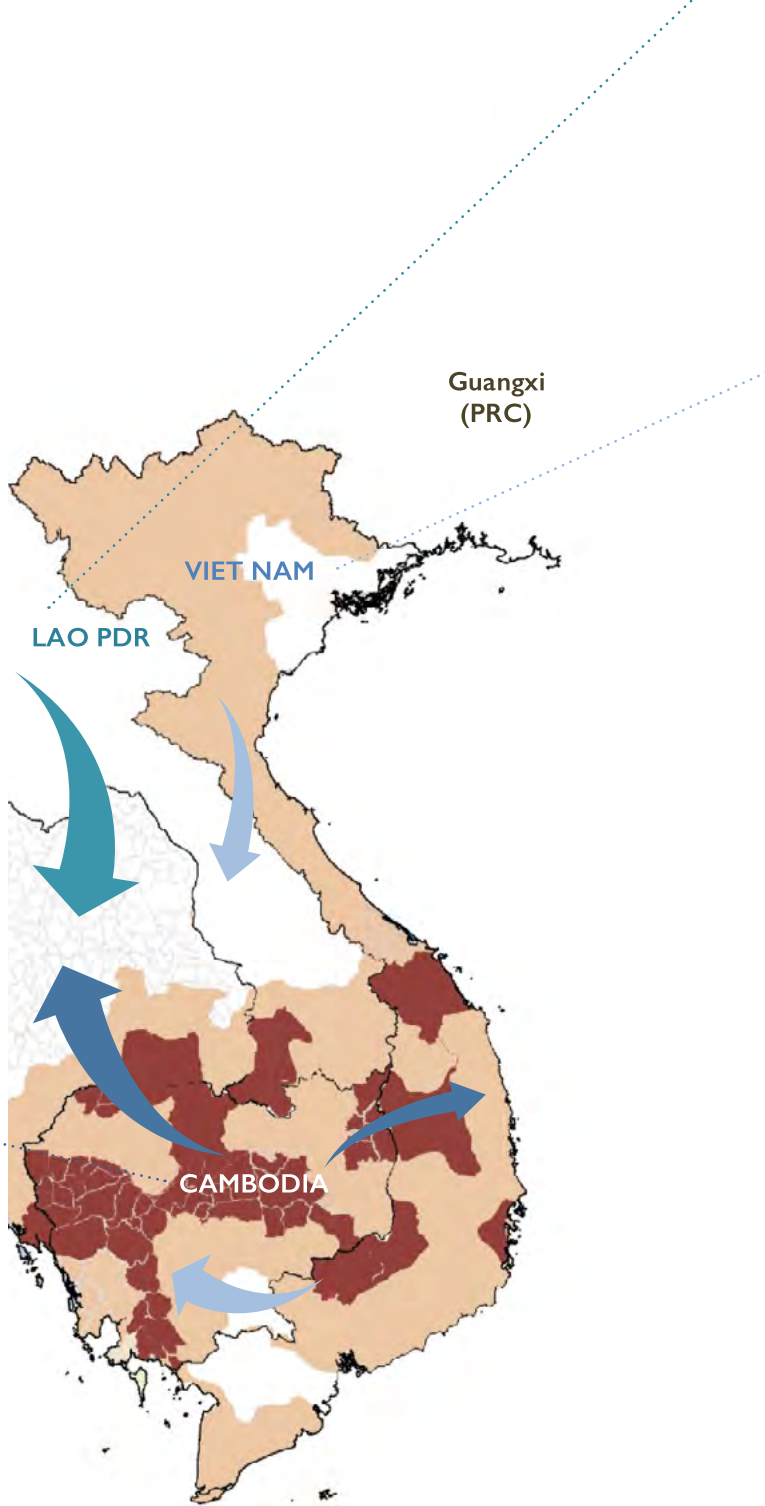
- Internal and outbound migrants have been grouped together as they are both nationals of the same country. However, in this table and for the remaining figures and tables in this report, rights have been considered when applicable to either internal or outbound but not necessarily to both.
- While all countries do have minimum standards of occupational health and safety, this is not necessarily indicative of the quality of these services in practice.
- Although inbound migrants are not specifically mentioned in the strategies, it could be considered that the term "migrant" used in the national strategies could be applicable to the three groups of migrants.

**NA:** Not Applicable; **NS:** Not Specified

**Figure 2. Key national legal support for migrants on access to health services, migration flows and artemisinin resistance tiers (February 2015) in the Greater Mekong Subregion**







LAO PDR	
<b>INTERNAL and OUTBOUND</b>	Social Security Law; 2013
	Social Welfare Decree; 2013
	Law on Healthcare; 2005
	Policy on Primary Healthcare; 2000
	National Health Insurance Decree, 2012
<b>INBOUND</b>	Labour Law; 2013
	Social Security Law; 2013
	National Health Insurance Decree; 2012
	Labour Law; 2013

VIET NAM	
<b>INTERNAL and OUTBOUND</b>	Law on Vietnamese Guest Workers; 2011
	Law on Health Insurance; 2009
	Decree on Regulation and Guidance on the Law for Overseas Workers; 2007
	Decision on the promulgation of the Guideline for Malaria Diagnosis and Treatment (Ref. number: 4605/QĐ-BYT); 2009
<b>INBOUND</b>	Decree on Labour Contract; 2013
	Decision on the promulgation of the Guideline for Malaria Diagnosis and Treatment (Ref. number: 4605/QĐ-BYT); 2009

**Artemisinin resistance tiers as of February 2015\***

- Tier 1:** areas for which there is credible evidence of artemisinin resistance where an immediate response is recommended to contain or eliminate resistant parasites as quickly as possible.
  
- Tier 2:** areas with significant inflows of mobile and migrant populations from tier 1 areas or shared borders with tier 1 areas, with intensified malaria control to reduce transmission and/or limit the risk of emergence or spread of resistant parasites.
  
- Tier 3:** *P. falciparum* endemic areas, which have no evidence of artemisinin resistance, where prevention should focus on increasing coverage with diagnostic testing, ACTs and vector control.



Thailand. Supervised malaria treatment among mobile and migrant populations. Credit: IOM.



# 5. GAPS AND OPPORTUNITIES ON LEGISLATION AND POLICY FRAMEWORK RELATED TO HEALTH AND PROVISION OF MALARIA SERVICES FOR MIGRANTS

The following section aims to illustrate the observed gaps and opportunities of GMS country legislation and policies related to access to health services for migrants, with particular emphasis on malaria. Both gaps and opportunities have been deducted from the review of country policies and legal frameworks and are presented with regard to their content as follows:

- 1) gaps and opportunities on health laws and policies for migrants;
- 2) gaps and opportunities on labour laws and policies for migrants; and
- 3) gaps and opportunities on access to malaria services for migrants.

## 5.1 Gaps and opportunities on health laws and policies

- **Lack of health policies or laws targeting all types of migrants.** With the exception of Thailand, GMS countries' legal and policy frameworks related to the health of inbound and outbound migrants are very limited (see Table 7 for country specific gaps). There is a clear lack of migrant-inclusive laws and policies. Furthermore, there is ambiguity in the use of the term "migrant" as to whether it refers to inbound, outbound or internal migrants. Additionally, there is a lack of data on health problems, patterns of movement and health-seeking behaviour of migrants in the GMS, as was stated in the *Joint Assessment of the Response to Artemisinin Resistance (ERAR) in the GMS Report (2012)*: "not enough is known about the patterns of movement, living, employment and healthcare seeking behaviour of migrants across the GMS despite their potential importance to the emergence of artemisinin resistance" albeit since that Report, significant work has been achieved and ongoing through the WHO ERAR project<sup>14</sup>. Internal migration also remains widely under documented. This lack of data together with the ambiguous use of the term "migrant" and other related terms hinders development of an appropriate approach to develop specific health policies for all migrants.
- **Lack of legislation related to migrant-friendly health systems.** In some specific health programmes, such as that for malaria and HIV, migrants are considered a key population, and the importance of migrant-sensitive and friendly health systems in most GMS countries is acknowledged. Despite this, in broader health policies, this issue is not adequately addressed in the current legal framework and/or is not specifically articulated, documented and implemented. In some countries, this may be a result of their status as a primarily migrant sending country with little internal requirement or need to address inbound migrant health issues. In Thailand, while the MoPH has the capacity to introduce more migrant-friendly services to many remote and mountainous areas, national security, employer concerns, market interests,<sup>15</sup>

14 Activities and report available on [http://www.who.int/malaria/areas/greater\\_mekong/technical-reports/en/](http://www.who.int/malaria/areas/greater_mekong/technical-reports/en/).

15 For example, industrial factories were established in Mae Sot, Tak Province along the border to Myanmar; in the early 1990s where they profited from special tax exemptions, and were located exactly where the factories would have access to

and political and scientific discourses have taken precedence, restricting the provision of services predominantly to migrants and Thai populations in need.

There is, however, growing acknowledgement among GMS governments of the importance of improving the health protection mechanisms offered to outbound migrant workers abroad, especially access to health care and prevention services. Current initiatives in some GMS countries such as Myanmar to revise labour and immigration laws present opportunities for inclusion of migrants in health-service provision and social security systems that would help the region achieve Universal Health Coverage.

- **Lack of legislation regarding the access to health care.** With regard to Universal Health Coverage, in most GMS countries, the State should have the responsibility to facilitate access to healthcare services. However, it has been observed that in some of the GMS countries, such as Thailand, this responsibility has been left up to employers resulting in inconsistent compliance and a relatively low proportion of migrant workers with access to health care throughout the region. Existing policies and legal frameworks are not conducive to inclusive approaches and do not advocate for removing barriers in order for migrants and mobile populations to access quality health services. Therefore, this lack of legislation leaves migrants at high risk of social exclusion, making them a vulnerable and underserved segment of society. As stated in international UHC resolutions<sup>16</sup> and in line with the elements of the right to health, efforts should be made by governments to ensure non-discriminatory access to health services for vulnerable groups.

Additionally, too many migrants face language, cultural and socioeconomic barriers to health services, as there is no specific legislation considering these issues in order to better facilitate access to health services for migrants. Thailand, however, utilizes migrant health translators within some health facilities to address the issues of language barriers. GMS countries are a long way from achieving a Universal Health Coverage that would ensure that citizens or immigrants, regular or irregular migrants and migrant workers in both the formal or informal sector can access health services without suffering financial hardship. Therefore, economical and non-discriminatory access to health services needs to be improved in GMS countries.

- **Lack of policies or plans on procedures to inform migrants of their health rights.** In most GMS countries it was reported that many migrant populations, including irregular migrants, were not informed of their rights, health policies or services in place available to them. Furthermore, huge numbers of migrants work in the agricultural sector where working conditions and health status of employees are rarely monitored. Most countries do not have systematic pre-departure orientation mechanisms in place for outbound migrants or any post-arrival procedures for returning migrants who may need health-care services. Information accessibility constitutes one of the elements of the right to health; however, this review has shown that this element is absent in most GMS countries.

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cheap labour. While this special tax exemption policy followed market needs, there were no real policy formulations in the early 1990s to manage migrant workers.

16 UN Resolution A67/L36 (2012); WHA64/9 (2011) on Sustainable health financing structures and universal coverage.

- **Restrictive laws regarding access to health services for migrants.** In Viet Nam, the Law on Residency and the Law on Health Insurance can restrict internal migrants from utilizing services if they do not return to the community in which they were registered; this stands in contrast to provisions for registered Vietnamese citizens who are entitled to unrestricted health services under these laws. For many migrants, returning to the place of registration to access health services implies high costs, long travel times and risk to their employment.

## 5.2 Gaps and opportunities on labour laws and policies

- **Lack of adequate policy regarding pre-departure training for migrants.** A general lack of legislation and policy protecting migrants in GMS countries has been observed, as migrants have no access to pre-departure training in their countries of origin or receive information on labour rights in the country of destination.

Cambodia, however, has presented a model of pre-departure training for migrant workers (see Annex 8.2 Section A.2, *Prakas on Recruitment Process and Pre-departure Orientation Training No. 046/13*). This offers an opportunity to include malaria prevention training and information on access to health services in destination countries, especially for vulnerable migrants who will be working in the malaria endemic areas. This measure could be adopted and reproduced in other GMS countries.

- **Social protection legislation and policies exclude undocumented migrants.** With the exception of Thailand, irregular migrants are excluded from all social protection legislation and policies, resulting in difficulties in accessing services at hospitals or clinics.

Through the existing corporate social responsibility concept, the inclusion of migrants in social protection mechanisms could be promoted. Because there are formal migration mechanisms in place (such as reducing the cost of passports), the strengthening of formal, bilateral migration mechanisms between GMS countries could help reduce the number of irregular migrants, thereby avoiding social protection exclusion.

The implementation of the 2030 Transformative Agenda for Sustainable Development Goals specifically Goals 3, 8 and 10; Targets 3.3, 8.8 and 10.7 respectively, presents an opportunity for countries to ensure the development of migrant-inclusive social protection legislation and policies.

- **Inadequate implementation of laws regarding provision of health care for migrant workers.** While some MoUs or laws include the provision of health care for outbound workers in Thailand, Myanmar or Lao People's Democratic Republic, there appears to be a widespread gap in the implementation of such regulations<sup>17</sup>. Although required by law

<sup>17</sup> Key regulations providing rights to health insurance for regular migrant workers in Thailand, Myanmar and Lao People's Democratic Republic refer to: 1) MoU between Thailand and Myanmar on Cooperation in the Employment of Workers; 2) MoU between Lao People's Democratic Republic and Thailand on Labour Cooperation; and 3) national laws in Thailand regarding health insurance for migrants under the Compulsory Migrant Health Insurance Scheme and the Social Security Scheme.

or MoUs, migrant workers end up without health-care provision included in work contracts. Additionally, no complaint mechanism exists to enforce these laws. In Thailand for example, gains “have been largely employer-driven, with migrants dependent on their employers for effective implementation of the process and access to their rights upon gaining a regularized status” (Natalie et al, 2014).

- **Limited occupational health and safety regulations.** There is a lack of occupational health and safety (OHS) regulations in the GMS. Only Viet Nam has signed the ILO Convention on Occupational Health and Safety No.155 (1981) (it effectively entered into force 16 May 2015). However, as some procedures on OHS regulations do exist, this provides an opportunity to include malaria interventions in them, mainly for those industries where exposure to malaria is likely due to workplace geography, such as that of logging, mining, rubber plantations and several types of agriculture, or as a result of work-related mobility, such as that of truck drivers, road construction crews and the groups who serve them.
- **Low ratification of relevant international conventions.** As Table I illustrates, ratification of relevant international conventions in the GMS is poor; in particular the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which has not been ratified by any country in the GMS and only signed by Cambodia. Relevant International Labour Organization Conventions (Table I) have not been ratified either. However, this does not mean GMS countries are exempt of any commitments as ILO State membership obliges governments to respect requirements set by the ILO Constitution and imposes all ILO members “to achieve the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care” and “adequate protection for the life and health of workers in all occupations” (ILO, 1944; Section III f, g).

### 5.3 Gaps and opportunities on malaria policies

- **Inbound migrants not specifically included in national strategies for malaria.** Although all GMS countries have adopted national malaria strategies in accordance with the different WHO resolutions, all, with the exception of Thailand, refer to migrants or migrants and mobile populations as internal and do not specify inbound migrants.

The national malaria strategies and operational plans of Lao People’s Democratic Republic, Myanmar and Thailand remain effective until the end of 2015. Updates of the strategies for 2016–2030 are under development following recommendations of the *WHO Global Technical Strategy for Malaria 2016-2030* and the *WHO Strategy for Malaria Elimination in the Greater Mekong Sub-region 2015-2030*. This is an opportunity to ensure that specific consideration of inbound migrants will be included in the updated national plans, and that migrants’ rights to access quality diagnosis and treatment free of charge will be guaranteed.

- **Difficulties in implementing malaria programmes in migrant populations.<sup>18</sup>**

The implementation of national malaria programmes has faced several challenges in the region, such as inadequate number and distribution of health educators with appropriate language skills and services to reach MMPs; lack of adequate coordination between partners and funding agencies providing malaria services; lack of funding to provide long-lasting insecticidal bed nets (LLINs) or appropriate protective measures to migrants; access to and availability of quality-assured diagnosis and treatment; distance to the nearest health-care facility; high mobility of MMPs and the lack of action enforcement to reduce counterfeit and substandard antimalarials available in the informal private sector. Self-medication and availability of counterfeit and substandard antimalarial medication in the GMS make it difficult to ensure access to proper treatment, undermine public confidence in malaria treatment regimens and increase the likelihood of drug resistance. Legal problems, such as inability of civil servants to enforce law relating to the sale of counterfeit medication and the presence of illegal pharmacies and clinics create difficulties in adequate implementation of malaria prevention and treatment strategies as described in national programmes.

There have been several communication campaigns<sup>19</sup> using strategic behavioural and interpersonal communication tools in the region that have been well received by MMPs and should be further implemented. Upscaling the use of mobile health clinics,<sup>20</sup> especially fixed schedule mobile clinics,<sup>21</sup> to reach remote communities, could also be introduced. Malaria outreach services through mobile services and clinics, especially during peak transmission period, epidemics, in inaccessible areas have shown to be one of the most cost-effective case detection methods for malaria control as a supplement to Passive Case Detection through health facilities. Additionally, informal providers are often the first point of contact for those seeking health services in remote rural areas; providing them with training could improve the treatment of malaria in the region.

It is necessary in this section to highlight that there is a significant opportunity to contribute to malaria elimination by incorporating malaria evaluations in Health Impact Assessments (HIA). HIA refers to “a suite of methods ranging from participatory planning to economic analysis to evaluate the health impacts of policies, plans and projects” (WHO SEARO, 2013:14) and they have already been adopted in some projects in the GMS. HIA aims to enhance the use of data and participatory approaches to improve quality and transparency of decision-making for investment purposes. The need to consider health equity when formulating public policies to achieve improved population health has been globally recognized in the 2009 WHA Resolution on Reducing Health Inequities through action on the social determinants of health (WHA62.14) and, later, on the 2011 Rio Political Declaration on Social

18 Although this report does not aim to comment on how all policies and laws mentioned in it have been implemented, exceptionally, it has been considered relevant to highlight the difficulties related to the implementation of malaria programmes in the region with the aim of providing guidance for malaria programme managers (as initially mentioned in Section 1.1) towards malaria elimination.

19 “Caution mosquito” campaign, Pallin, Cambodia 2012; Malaria Behaviour Change Communication campaign, IOM, Thailand 2014.

20 Jungle health clinics for Internally Displaced, Thai- Burma Project. Global Angels.

21 Workshop to Consolidate Lessons Learned on BCC and Mobile/Migrant Populations in the Strategy to Contain Artemisinin Resistant Malaria Meeting Report Santi Resort & Spa Luang Prabang, Lao People’s Democratic Republic 5–7 July 2011; Malaria Consortium, World Health Organization.



Determinants of Health (art.7), endorsed in the 2011 resolution WHA65.8. Beyond advocating for the adoption of the “Health in all policies” (HiAP) approach (WHA65.8, section 5.2; WHA62.14, section 3.3, section 4.6), these resolutions also call for increased dialogue and cooperation between health and nonhealth sectors (WHA65.8, section 3.2; WHA62.14, section 3.4) to incorporate health issues in policy development. For instance, the construction of dams, irrigation channels and watercourses may provide increased breeding sites of disease vectors, thus the malaria impact assessment of these projects should be considered.

An example of HIA implementation in the GMS is a hydroelectric project in Lao People’s Democratic Republic.<sup>22</sup> An assessment of health risks was conducted covering up to 11 health topics, such as vector- and waterborne diseases, health services, social determinants and cultural practices, among others. The assessment led to developing “public health plans to mitigate risks for each of the impact areas”, including “provision of health infrastructure, human resource development, health education, service delivery and surveillance and monitoring” (McLeod, 2013:5). The 2009 Chiang Mai Declaration on HIA highlighted the role of the equator principles<sup>23</sup> in promoting HIA in Asia (McLeod, 2013:6).

**Table 7. Gaps on legislation and policy framework related to health of migrants and malaria services by GMS countries**

COUNTRY	INTERNAL & OUTBOUND MIGRANTS	INBOUND MIGRANTS	ALL MIGRANTS
<b>CAMBODIA</b>	<ul style="list-style-type: none"> <li>• Need for legislation and policy to protect irregular outbound migrants.</li> <li>• No specific minimum health-care entitlements or health insurance strategies for regular Cambodian workers who migrate to other GMS countries.</li> </ul>	<ul style="list-style-type: none"> <li>• Unclear/inconsistent definition of migrants and mobile populations (including inbound migrants).</li> </ul>	<ul style="list-style-type: none"> <li>• No ratification of ILO Conventions.</li> <li>• Legal challenges, such as: a) inability of civil servants to enforce law regarding sale of counterfeit medicines; or b) illegal pharmacies and clinics.</li> <li>• Need for migrant-inclusive policies and legal frameworks that advocate for MMPs’ access to quality health services.</li> <li>• Health Equity Fund (HEF) and community-based insurance (CBHI) still need external funding support although both are increasingly being funded using domestic resources.</li> </ul>

22 Nam Theun 2 (NT2) Hydropower Project, Lao People’s Democratic Republic.

23 The Equator Principles is a risk management framework, adopted by financial institutions, for determining, assessing and managing environmental and social risk in projects and is primarily intended to provide a minimum standard for due diligence to support responsible risk decision-making. (<http://www.equator-principles.com>)

COUNTRY	INTERNAL & OUTBOUND MIGRANTS	INBOUND MIGRANTS	ALL MIGRANTS
<b>LAO PDR</b>	<ul style="list-style-type: none"> <li>• Need for legislation and policy to protect irregular outbound migrants.</li> <li>• Need for Pre-departure orientation programmes for outbound migrants.</li> <li>• No specific minimum health-care entitlements or health insurance strategies for documented Lao workers who migrate to other GMS countries.</li> </ul>	<ul style="list-style-type: none"> <li>• Ambiguous laws (not clear if inbound migrants are included).</li> <li>• Inadequate administrative procedures may limit or restrict effective implementation.</li> </ul>	<ul style="list-style-type: none"> <li>• No ratification of international instruments.</li> <li>• Need for migrant-inclusive policies and legal frameworks that advocate for MMPs' access to quality health services.</li> <li>• Need for updated information about health-seeking behaviour and attitudes of migrants to develop adequate approaches.</li> <li>• Need for regulations facilitating inbound, internal and outbound migrants access to migrant health examinations.</li> <li>• Need for increased workers' protection, such as provision of compensation in the event of work-related injuries or illnesses.</li> </ul>
<b>MYANMAR</b>	<ul style="list-style-type: none"> <li>• Need for better implementation of laws and MoUs regarding outbound migrant workers' contracts.</li> <li>• Lack of official policy documentation specifically regarding internal migration.</li> <li>• Need for interministerial collaboration and cooperation between development partners to establish integrated pre-departure orientation and health examination programmes for outbound migrants (regular and irregular).</li> <li>• Need for better enforcement of Overseas Employment Law regarding health status examination of outbound migrants.</li> </ul>	<ul style="list-style-type: none"> <li>• Need for specific strategies and targets for addressing the health of migrants.</li> <li>• Need for a clear definition of MMPs in laws or policy documents (do not seem to include inbound migrants).</li> </ul>	<ul style="list-style-type: none"> <li>• No ratification of international instruments.</li> <li>• Need for migrant-inclusive policies and legal frameworks that advocate for MMPs' access to quality health services.</li> <li>• Need for information about health-seeking behaviour and attitudes of migrants making it difficult to develop an adequate approach.</li> <li>• Need for data collected on implementation of malaria strategies.</li> <li>• Need for inclusion of migrants in the updated Social Security Law (as of July 2015 yet to be enacted).</li> <li>• Need for OHS regulations.</li> <li>• Need for increased workers' protection, such as provision of compensation in the event of work-related injuries or illnesses.</li> </ul>

COUNTRY	INTERNAL & OUTBOUND MIGRANTS	INBOUND MIGRANTS	ALL MIGRANTS
THAILAND	<ul style="list-style-type: none"> <li>• Need for pre-departure orientation programmes for outbound migrants.</li> </ul>	<ul style="list-style-type: none"> <li>• National security and market interests take precedence<sup>1</sup> over MoPH capacity to develop policies on migrant-friendly health services for migrants in remote and mountainous areas. Government policy development has been predominantly driven by these issues and by political and scientific discourses.</li> <li>• Need for adequate implementation of the Labour Protection Act: <ul style="list-style-type: none"> <li>-Most regular migrants are not covered by accident and compensation from their employers (under this law they should have equal rights as Thai nationals)</li> <li>-Many employers do not comply with the law, resulting in a relatively low proportion of migrants transferred to the Social Security Fund from the Migrant Health Insurance Scheme.</li> </ul> </li> <li>• MoPH does not provide provincial hospitals with a budget for migrant populations, which exhausts subsidies for Thai patients in order to cover migrants.</li> <li>• Inflexibility of the Migrant Health Insurance Scheme - linked to the hospital where migrants were originally registered.</li> <li>• Many migrant populations (regular migrants included) are not informed of their health and labour rights and health services available to them. Most irregular migrants are referred to NGOs and private clinics that are usually overburdened.</li> <li>• Need for monitoring health status and working conditions of migrant workers in the agricultural sector.</li> <li>• MoU process complexity and levels of bureaucracy exceed the capacities of the governments involved to deal with them efficiently.</li> <li>• Laws and legislation are typically interpreted as only applying to Thai nationals as there exist no specific provisions pertaining to the establishment or implementation of recruitment protections for inbound labour migrants.</li> </ul>	<ul style="list-style-type: none"> <li>• Substantial gaps remain in UHC coverage and availability of many public health services, particularly for MMPs.</li> <li>• Government has not yet addressed the need for improved OHS regulations.</li> <li>• The Labour Protection Act (1998) does not apply to domestic workers.</li> <li>• The Workmen's Compensation Fund (WCF) under the Workmen's Compensation Act, (1994) is only relevant for Thai nationals and regular migrant workers, but only if they work for large companies (must comply with regulations and pay contributions). Despite the achievements of the National Social Security Scheme, the majority of the more than 3 million foreign workers still wait for secured access to quality health services (Huguet, 2014a:39).</li> </ul>

COUNTRY	INTERNAL & OUTBOUND MIGRANTS	INBOUND MIGRANTS	ALL MIGRANTS
<b>VIET NAM</b>	<ul style="list-style-type: none"> <li>• Law on Residence (2006) and Law on Health Insurance (2009) tend to be more restrictive than protective as access to health services is based on residence location.</li> <li>• Need for public, migrant-friendly health services; no adequate distribution and timetable.</li> <li>• The Law on Residence restricts internal migrants from accessing health services in the place of destination.</li> <li>• Need for provision of health insurance to irregular migrant workers.</li> <li>• Labour migrants returning to Viet Nam are not provided with specialized services targeting returnees.</li> <li>• Need for Pre-departure orientation programmes for outbound migrants.</li> </ul>	<ul style="list-style-type: none"> <li>• National policies do not specifically support or include migrants and, in some cases, restrict access to health services.</li> <li>• Health facilities and providers have not been developed to ensure nonjudgmental, supportive services.</li> <li>• Although contracts for labour migrants are required to include provision of health care, international migrants do not have a guarantee to health facilities and services.</li> <li>• 2015-2017 Artemisinin-Resistant Malaria Action Plan, while targeting migrants, does not specify which types of migrants.</li> <li>• Ambiguous use of the term migrant in laws; not clear if inbound migrants are included.</li> </ul>	<ul style="list-style-type: none"> <li>• Few laws and policies on health specifically include or identify migrants, particularly internal migrants.</li> <li>• Need for ratification of international instruments.</li> <li>• Need for migrant-inclusive policies and legal frameworks that advocate for MMPs' access to quality health services.</li> <li>• Need for information about health-seeking behaviour and attitudes of migrants to develop adequate approaches.</li> <li>• Need for increased workers' protection, such as provision of compensations in the event of work-related injuries or illnesses.</li> </ul>



Lao People's Democratic Republic. Insecticide treated bed net use in a temporary shelter by mobile forest goers.  
Credit: Iwagami Moritoshi. 2015





Lao People's Democratic Republic. Mobile workers en route to the forest. Credit: Bouasy Hongvanthong. 2015



# 6. CONCLUSIONS AND RECOMMENDATIONS

## 6.1 Summary of analysis

The Greater Mekong Subregion (GMS) has experienced consistent economic development in the last decade coupled with the opening of borders and economic corridors, emergence of mega-cities, ease and speed of travel, accessibility to digital information and thus resulting in exponential increase in intraregional migration. Labour migration constitutes the primary motivation for migration for both international and internal migrants, as a result of unequal social and economic development within the region. In border-towns along LMS economic corridors, border mobility has emerged creating a new pattern of daily or weekly migration for economic opportunities in the border-areas. Internal migration, however, also remains prevalent. The majority of intraregional migrants work in low-skilled jobs (e.g. agriculture, fisheries and construction) and most of them are irregular workers. Thailand hosts by far the highest number of migrants, accounting for more than 3 million.

As of 2015, all GMS countries have adopted national strategies for the elimination of malaria in line with the WHO Global Technical Strategy for Malaria and WHA68.2 for 2016–2030, which specifically recognize migrants and mobile populations as a vulnerable group. **Cambodia** has designed a strategy for malaria elimination, which specifically addresses migrants and mobile populations (MMP) with targeted malaria interventions for MMPs and acknowledges foreign, seasonal, visitors or cross-border workers, a large proportion of which are irregular and particularly hard-to-reach. **Myanmar** and **Thailand** both have set up malaria outreach facilities, such as malaria clinics or malaria posts along the border where large congregations of migrant labourers can receive immediate diagnosis, appropriate treatment and counselling on malaria as well as Behaviour Change Communication through educational and communication tools adapted for migrant groups. **Viet Nam** has introduced special outreach units, such as the malaria posts to provide LLINs, hammock nets and repellent products, instruction on how to use products, health promotion material, rapid diagnostic tests and the like, which has been expanded to most-difficult-to-reach MMPs.

The use of the term 'migrant and mobile populations' appears to have been interpreted in National Malaria Strategies as exclusively including internal migrants or citizens, but specific reference to inbound migrants is not made. In **Viet Nam**, access to health services for migrants is restricted through regulations where access to free of charge services is possible to those hospitals where migrants' maintain their household registration (internal migrants). This means many migrants have to risk their employment and invest the time and money to return to their registered place of residence to receive health services.

Legal and policy framework related to the health of inbound migrants is very limited in GMS countries that are predominantly countries of origin, with the exception of Thailand, which is a main country of destination. However, even in **Thailand**, complete equality of treatment of inbound migrant workers with that of national workers has yet to be achieved. Although labour protection for Thai nationals should apply to regular migrant workers, the Workmen's Compensation Fund (WCF) under the

Workmen's Compensation Act (1994) is only relevant for Thai nationals and regular migrant workers in large workplaces where regulations are complied with and employers have paid contributions. **Myanmar** has no provisions in established laws, including the recently updated Social Security Act (2012) that describes access to services for noncitizens.

A significant need for data collection tools or indicators on the health of migrants within national health surveillance systems coupled with a need for specific strategies and targets for addressing the health of migrants may hinder any strategy for improvement. Very little of the data collected is disaggregated by nationality or immigration status. This lack of concrete, reliable and adequate evidence or documentation of migrants in GMS countries limits the understanding of the gaps and opportunities, and it impedes efforts to address any health challenges faced by migrants. There is also, in parallel, a real need for a regional agreement to have regular exchange of malaria surveillance data and effective mechanisms to respond, especially with regards to cross border issues.

**All GMS countries are signatories of, among others, WHO Global Technical Strategy for malaria 2016-2030, the Strategy for Malaria Elimination in the Greater Mekong Subregion (2015-2030) launched in May 2015, the two Extensions of the MoU among the Health Ministries of the Six Mekong Basin Countries on the Mekong Basin Disease Surveillance (MBDS) Cooperation (2001 and 2007) as well as the ASEAN Declaration on Strengthening Social Protection. All have also entered into bilateral agreements with one another regarding migration or trafficking in persons, which include cooperation on health matters, such as focal points for health services at border crossings;<sup>24</sup> health-care assistance;<sup>25</sup> health insurance;<sup>26</sup> occupational health and safety;<sup>27</sup> and even a Trilateral Cooperation for Health between Myanmar, Thailand and the United States Cross-Border Partnership,<sup>28</sup> which provides a platform for cities along the border to synchronize malaria control activities.**

**Thailand** has become a model of best-practice since the inception of UHC in 2002, which includes inbound and irregular migrants, and offers a comprehensive package of both preventive and curative care. Thailand also has a comprehensive social security system under the Social Security Act now extended to the informal sector; irregular migrants may purchase insurance for short periods and regular migrants can access UHC through the '30 Baht Health Scheme' under the Migrant Health Insurance Scheme.

24 Memorandum of Understanding (MoU) between the Royal Government of Cambodia and the Royal Thai Government on Cooperation in the Employment of Workers (May 2003).

25 MoU on Cooperation against Trafficking in Persons in the Greater Mekong Sub-Region (October 2004); MoU between the Government of Lao People's Democratic Republic and Thailand on Cooperation to Combat Trafficking in Persons, Especially Women and Children (13 July 2005); Agreement between Lao People's Democratic Republic and Viet Nam on Cooperation in Preventing and Combating Trafficking in Persons and Protection of Victims of Trafficking (3 November 2010).

26 MoU between the Government of Lao People's Democratic Republic and the Royal Thai Government on Labour Cooperation (10 October 2002).

27 MoU between the Trade Unions in Cambodia and the Trade Unions in Thailand on Protection of Migrant Worker's Rights (2013).

28 Trilateral Cooperation for Health: Burma, Thailand and United States Cross-Border Partnership (Regional Development Mission for Asia and the Control and Prevention (CAP) Malaria Programme), (2013).

Regarding occupational malaria prevention intervention, **Cambodia** is leading the most interesting initiative through its *Strategy to Address Migrant and Mobile Populations for Malaria Elimination in Cambodia* noting that migrants who are seasonal or work in construction, mines or forests are more often exposed to malaria. In **Myanmar**, the national strategic plan includes the establishment of malaria post in strategic and hard-to-reach areas and malaria screening sites where there are large congregations of migrant workers to provide migrant-specific information, education and communication (IEC) materials and dedicated malaria volunteers catering to the needs of migrant populations.

All GMS countries have minimum occupational health and safety regulations. Although malaria is not specifically mentioned as a health and safety concern in labour laws or health and safety regulations, in some work situations, one could argue malaria should fall under these laws where there is a foreseeable risk of contracting malaria in a work setting. Another opportunity could rise from adding malaria to health impact assessments of policies, plans and projects. For example, the construction of dams, irrigation channels and watercourses that may provide increased breeding sites for vectors should require a health risks assessment to be conducted for areas with vector-borne diseases as well as for health services and social determinants, such as migration and cultural practices, with the aim of developing a public health plan to mitigate the risks in each of the impact areas. This should include the provision of health infrastructure, human resources development, health education, service delivery, among others, in order to minimize the negative effects that development projects may have on local communities and their work forces. **Cambodia, Lao People's Democratic Republic, Thailand** and **Viet Nam** have already adopted regulations imposing HIA for some infrastructure developments but various issues remain in some countries regarding the criteria where these regulations are applied, the speed in which recommendations are adopted and their enforcement.



Thailand. Employer of a construction company providing transportation for migrant workers attending a government child immunization program. Credit: Sansiri. 2016.

## 6.2 Regional policy recommendations according to type of migrants

Governments of GMS countries, with the support from international agencies, could adopt the measures described in Table 8 below. These recommendations are not based entirely on legal covenants and WHA resolutions, but are critical areas that could help improve migrants' access to health care — in this context, malaria services. A more complete review should be undertaken to examine current efforts of countries on these fronts, whilst examining how these are guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10), and WHA61.17 Resolution on Health of Migrants — particularly regarding key operational frameworks.

**Table 8. Policy recommendations for addressing the health of migrants at the regional level**

TYPE OF MIGRANTS	SHORT-TERM RECOMMENDATIONS	LONG-TERM RECOMMENDATIONS
<b>INTERNAL MIGRANTS</b>	<ul style="list-style-type: none"> <li>Amend laws restricting access to health services that are based on hospital or residence registration.</li> <li>Ensure that strategies promoting health-service delivery consider specific factors affecting sustainability of health-service uptake in both the public and private sectors.</li> <li>Ensure inclusive social protection mechanisms and universal health coverage.</li> </ul>	<ul style="list-style-type: none"> <li>Develop national plans to build health infrastructure that can deliver services to remote, hard-to-reach populations.</li> <li>Ensure inclusive social protection mechanisms and universal health coverage.</li> <li>Disaggregate health information to enable analysis and policy refinement to improve access by migrant populations to needed services.</li> </ul>
<b>INBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>Develop policies that support establishing "One-stop service centres" for migrants to receive information on malaria diagnosis and treatment and LLINs or other protective measures.</li> <li>Modify laws, which restrict access to health services that are based on hospital or residence registration.</li> </ul> <p>Engage the private sector; employers of both large and small enterprises employing labour migrants should provide migrants with health and labour rights information in appropriate languages.</p> <ul style="list-style-type: none"> <li>Establish national health information systems, which include migrant health indicators by increasing cross-border screening and disaggregated data collection.</li> <li>Agree on a definition of MMPs that includes inbound migrants to be consistently used throughout the policy framework of each country.</li> <li>Conduct periodic reviews of migration, labour and health policies at the national level to ensure policy coherence and adequate distribution of government budgets for health programmes.</li> <li>Ensure inclusive social protection mechanisms and universal health coverage.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that both health and labour laws include inbound migrants and are implemented without discrimination.</li> <li>Facilitate the portability of social security benefits across the ASEAN (Guinto, 2015).</li> </ul> <p>Develop GMS guidelines on minimum standards for social protection schemes, such as mandatory health insurance for migrants.</p> <ul style="list-style-type: none"> <li>Ensure "Health in All Policies" (HiAP), in particular in immigration and labour policies<sup>2</sup>.</li> </ul>

TYPE OF MIGRANTS	SHORT-TERM RECOMMENDATIONS	LONG-TERM RECOMMENDATIONS
<b>OUTBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Improve implementation of the strategy for malaria elimination in the GMS 2015–2030 (WHO), especially regarding availability of either malaria posts and/or mobile malaria teams in migrant-heavy areas, including key transit points.</li> <li>• Strengthen cross-border dialogue and collaborations.</li> <li>• Harmonization of malaria treatment protocols at points of transit, at destination and origin.</li> <li>• Ensure inclusive social protection mechanisms and universal health coverage.</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate the portability of social security benefits across ASEAN.</li> <li>• Amend labour laws to include compulsory, pre-departure trainings that provide information on access to health services in destination countries and malaria prevention measures.</li> <li>• Develop national coordinated strategies to reach those intending to migrate through irregular channels (transit points, border areas, work places, media) in order to ensure that they receive the pre-departure trainings provided to regular migrants at least related to health services, malaria, social security, among others.</li> <li>• Strengthen and implement formal bilateral migration between GMS countries to improve access to formal migration mechanisms.</li> </ul>
<b>ALL MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Improve implementation of the 2015–2030 strategy for malaria elimination in the GMS (WHO) regarding the availability of mobile malaria teams wherever migrants congregate, including key transit points.</li> <li>• Promote and strengthen multisectoral and interministerial collaboration to develop interdisciplinary educational programmes for migrants.</li> <li>• Increase collaboration of regional financial institutions and multilateral development banks</li> <li>• Improve monitoring and surveillance of migrants' health by establishing systems to collect regional health migration data that include migrant health indicators and malaria trends.</li> <li>• Conduct periodical mapping of malaria trends (including for internal and irregular migrants).</li> <li>• Conduct malaria risk assessments particularly for migrants involved in logging, mining, rubber plantations, agriculture, transportation and road construction sectors.</li> <li>• Develop a model similar to that proposed by JUNIMA<sup>3</sup> to document the situation of access to treatment for migrants, such as scorecards, in order to follow up on GMS countries' commitment towards Malaria eradication.</li> <li>• Integrate migrants' perspective when formulating upcoming health and labour policies by improving active participation of migrant communities in policy development.</li> <li>• Be guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10).</li> <li>• Be guided by the WHA61.17 Resolution on Health of Migrants particularly on its key operational frameworks.</li> </ul>	<ul style="list-style-type: none"> <li>• Include all migrant workers in social security schemes,<sup>4</sup> in social protection mechanisms and in Corporate Social Responsibility.</li> <li>• Establish a welfare fund or special insurance scheme for migrant workers to cope with contingencies.</li> <li>• Develop policies towards UHC considering three channels of service delivery to achieve it: public, private and community based (WHO, 2015a:15).</li> <li>• Develop pharmaceutical regulations to ensure high-quality drugs.</li> <li>• Advocate inclusion of all types of migrants in the post-2015 development agenda.</li> <li>• Inclusion of the health of all migrants, displaced populations and refugees in post-2015 development agenda.</li> <li>• Advocacy for increased ratification of international instruments, in particular ILO Conventions No. 97, No 102, No 143, No 155, No 181, No 188 and No 189; the Refugee Convention; and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.</li> <li>• Be guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10).</li> <li>• Be guided by WHA61.17 Resolution on Health of Migrants particularly on its key operational frameworks.</li> </ul>



### 6.3 Country specific policy suggestions on migration and malaria according to type of migrants<sup>29</sup>

Governments of each GMS country could consider the following suggestions for action listed in the table 9 below:

**Table 9. Specific policy suggestions on migration and malaria according to type of migrants**

TYPE OF MIGRANTS	CAMBODIA: SPECIFIC RECOMMENDATIONS
<b>INTERNAL &amp; OUTBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Enact legislations and policies protecting irregular Cambodian migrants.</li> <li>• Establish minimum health-care entitlements or health insurance strategies for regular migrant workers who migrate to other countries in the GMS.</li> <li>• Strengthen and implement MoUs with neighbouring countries to ensure Cambodian migrant workers' access to national health insurance schemes in other GMS countries.</li> </ul>
<b>INBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Expand health coverage to noncitizens, independently of their legal status, as a key underserved group within the context of the national universal health coverage agenda.</li> </ul>
<b>ALL MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Ratify ILO Conventions and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990).</li> <li>• Review existing pre-departure national health, labour and migration policies to provide an optimum package of malaria prevention and treatment services for all migrants regardless of legal status or gender.</li> <li>• Ensure a definition of MMPs that includes inbound and outbound migrants used consistently in policy and legal documents.</li> <li>• Be guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10).</li> </ul>

TYPE OF MIGRANTS	LAO PEOPLE'S DEMOCRATIC REPUBLIC: SPECIFIC RECOMMENDATIONS
<b>INTERNAL &amp; OUTBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Establish minimum health-care entitlements or health insurance strategies for regular migrant workers who migrate to other countries in the GMS.</li> <li>• Enact legislations and policies protecting irregular migrants.</li> <li>• Further develop and implement bi- and multilateral cooperation agreements, mainly with destination countries of Lao migrants (Thailand and the PRC province of Yunnan), to protect the rights of migrants and facilitate access to health services.</li> </ul>
<b>INBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Review health, social, labour and immigration legislation to expressly provide rights to inbound migrants (including irregular migrants) to access health care, as migrants constitute a key underserved group within the context of the national universal health coverage agenda.</li> <li>• Include health-care entitlements in labour migrant contracts.</li> <li>• Review the "Decree on subsidy for delivery and health care for children under five (No.273/GOV on 19 August 2014)" to benefit migrant children and comply with the United Nations Convention on the Rights of the Child (1990).</li> </ul>

<sup>29</sup> The recommendations provided here target the following groups of migrants: internal (citizens of the country who temporarily or permanently resettle to another area of the country), outbound (citizens of a country who travelled out of the country for the purpose of work or pleasure regardless of duration or immigration status) and inbound (temporary or permanent immigrants born abroad but living in the country regardless of their immigration status). As internal and outbound migrants are citizens from the same country, they have been grouped here because they are entitled to the same rights under the laws of their country of origin. This approach has been taken throughout the whole document.

TYPE OF MIGRANTS	LAO PEOPLE'S DEMOCRATIC REPUBLIC: SPECIFIC RECOMMENDATIONS
<b>ALL MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Ratify ILO Conventions.</li> <li>• Conduct a legislative and regulatory reform to provide more effective government administrative procedures and to include comprehensive definitions. This may help to provide a clearer institutional basis for implementation of health and social laws and serve as a source of enforceable rights and obligations for all citizens, migrants and the state. Implementation should not be subject to broad discretionary powers of relevant officials and it should be monitored and evaluated by complaint mechanisms among others.</li> <li>• Develop specific strategies to gather data on health-seeking behaviour and attitudes of migrants in order to formulate policies that include a migrant perspective.</li> <li>• Enact laws or policies that provide access to malaria prevention measures for all workers, including all types of migrants in malaria endemic areas.</li> <li>• Include a malaria perspective in Decree 54/MP on the Declaration of use and Implementation of National Policy on HIA (this Decree imposes the HIA approach in infrastructure projects).</li> <li>• Be guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10).</li> </ul>

TYPE OF MIGRANTS	MYANMAR: SPECIFIC RECOMMENDATIONS
<b>INTERNAL &amp; OUTBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Strive for greater bi-national and regional cooperation to ensure that migrants across the region have access to health services. Existing country cooperation in the health sector, such as the MoU on Health Cooperation between Thailand and Myanmar, should be further capitalized upon.</li> <li>• Conduct further research on the scale, nature and potential impact of internal migration (both positive and negative) to inform policy-makers.</li> <li>• More efficiently implement the Law relating to Overseas Employment, No. 3/99 to ensure no loss of outbound migrant workers' rights (for instance, according to this law "[a worker] has the right to claim through the Service Agent full compensation to damages to which he is entitled for injury sustained at a foreign worksite"). Also, revision of this law should be considered to include provision of pre-departure information on malaria prevention and migrants' rights, such as access to health services and social security.</li> </ul>
<b>INBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Develop specific strategies and targets for addressing and monitoring the health of migrants.</li> <li>• Enact the newly updated Social Security Law (2012) considering a previous amendment to include migrants. This act outlines provisions for employment injury insurance and outlines steps to establish a Social Security Fund supported by the contributions of employers, workers and the Government.</li> <li>• Expand health coverage to non-citizens, independently of their legal status, as a key underserved group within the context of the national universal health coverage agenda.</li> </ul>

TYPE OF MIGRANTS	MYANMAR: SPECIFIC RECOMMENDATIONS
<b>ALL MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Ratify ILO Conventions.</li> <li>• Ensure that health policies and legal frameworks facilitate access of migrants to health services, explicitly including all types of migrants – internal, inbound and outbound regardless of their legal status and residence registration.</li> <li>• Develop a data collection system to monitor the implementation of policies and impact of interventions.</li> <li>• Conduct operational research on malaria control and develop strategies to protect migrant forest workers due to the current low ITNs/LLINs coverage among this at-risk population.</li> <li>• Develop specific strategies to gather data on health-seeking behaviour and attitudes of migrants in order to formulate policies that include a migrant perspective.</li> <li>• Include migrants in the initial legal reform plan to achieve UHC. Migrant-sensitive and migrant-friendly health systems need to be promoted and the current legal and policy framework need to address adequately how this will be articulated and implemented.</li> <li>• Include voluntary malaria testing as part of the Migrant Worker Medical Assessment required under the Law on Overseas Employment (2009).</li> <li>• Be guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10).</li> </ul>
TYPE OF MIGRANTS	THAILAND: SPECIFIC RECOMMENDATIONS
<b>INBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Increase cooperation between the MoPH and the Mol to develop effective health policies that include national security concerns but also adequate migration management policies and fiscal concerns. This would simplify the existing complex migration policies for both inbound migrants and stateless populations.</li> <li>• Facilitate the access of undocumented migrants to health care in all hospitals throughout the country. Provision of health services specifically for migrants, such as mobile clinics in hard-to-reach areas or along Thailand's long and porous border, should be considered.</li> <li>• Facilitate the migration process through MoUs channels reducing the complexity and bureaucracy level of the MoU process.</li> <li>• Modify the Migrant Health Insurance Scheme to eliminate restrictions in access to health services based on hospitals.</li> </ul>

TYPE OF MIGRANTS	THAILAND: SPECIFIC RECOMMENDATIONS
<b>ALL MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Effectively respond to the need for improved occupational health and safety (OHS).</li> <li>• Include domestic workers in the definition of “employee” provided by the Labour Protection Act and the Social Security Act.</li> <li>• Tackle unregulated practices that overlook workplace inspections.</li> <li>• Better implement the Workmen’s Compensation Act (1994) to guarantee that all regular migrants are covered in the event of work-related injury or illness. This Act should be amended to impose all businesses, regardless of the number of employees, to provide this coverage.</li> <li>• Amend and better implement the Social Security Act (1990) to impose all businesses, regardless of the number of employees, to provide accident and compensation plans for employees; all types of migrants should be considered under this Act. Efficient implementation of this Act should be achieved to avoid inconsistent compliance of employers’ contribution payments and submission of workers insurance paperwork. Transferring the responsibility of submitting insurance paperwork from employers to migrant workers should be considered, providing assistance for that task in migrant resource centres.</li> <li>• Adopt “Health-in-All Policies”.</li> <li>• Conduct further research on outdoor transmission and vector dynamics in forests and mountainous areas to support the development of malaria surveillance systems for improved case detection.</li> <li>• Address the remaining gaps in the coverage and availability of public health services for MMPs.</li> <li>• Be guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10).</li> </ul>

TYPE OF MIGRANTS	VIET NAM: SPECIFIC RECOMMENDATIONS
<b>INTERNAL &amp; OUTBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Review the Law on Residence (2006) and the Health Insurance Law (2009) to guarantee access to health care to all migrants at least for malaria interventions regardless of the place of registered residence. The price of insurance premiums should be made affordable for all migrants working in the informal sector in order for them to be insured throughout their employment.</li> </ul>
<b>INBOUND MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Include inbound migrants in all national health policies, as a key underserved group within the context of the national universal health coverage agenda.</li> <li>• Perceived stigma and discrimination must be tackled to prevent migrants from accessing poorly trained private doctors or self-medicating.</li> </ul>
<b>ALL MIGRANTS</b>	<ul style="list-style-type: none"> <li>• Ratify ILO Conventions.</li> <li>• Review the Law on Vietnamese Guest Workers (developed and approved by the National Assembly in 2006) to include pre-departure information trainings on health services, malaria prevention measures and labour rights.</li> <li>• Better enforce the Law on Health Insurance (2009) to ensure compliance of enterprises regarding provision of social, health or accident insurance for workers.</li> <li>• Develop specific strategies to gather data on health-seeking behaviour and attitudes of migrants in order to formulate policies that include a migrant perspective.</li> <li>• Include a malaria perspective in regulations that impose the HiA approach in infrastructure projects (Law on Environmental Protection and Decree NO.29/2011/ND-CP) .</li> <li>• Be guided by the 2030 Transformative Agenda for Sustainable Development Goals (Goals 3, 8 and 10).</li> </ul>





Thailand. Residential construction site in Phuket. Migrant workers mainly from Cambodia and Myanmar attending an immunization program organized jointly by the project developer, Ministry of Public Health, UNICEF and WHO. Credit: WHO Thailand. 2016.



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Thailand. WHO staff interviews a migrant mother from Myanmar working in a construction camp on her migration history and access to vaccination services in Thailand. Credit: Thavinkaew A. WHO Thailand, 2016.

# 8. ANNEXES:

## 8.1 Malaria epidemiological profile of GMS countries

Malaria Indicators (2013) <sup>5</sup>	CAMBODIA	LAO PDR	MYANMAR	THAILAND	VIET NAM
Population at high risk	6 660 000	2 440 000	19 700 000	5 360 000	16 100 000
Population at low risk	1 360 000	1 560 000	12 200 000	28 100 000	18 300 000
Population living in malaria-free areas	7 110 000	2 780 000	21 300 000	33 500 000	57 300 000
Reported confirmed cases	21 309	38 131	333 871	33 302	17 128
Reported deaths	12	28	236	37	6
Major <i>Plasmodium</i> species	<i>P. Falciparum</i> (55%) <i>P. Vivax</i> (45%)	<i>P. Falciparum</i> (73%) <i>P. Vivax</i> (27%)	<i>P. Falciparum</i> (74%) <i>P. Vivax</i> (26%)	<i>P. Falciparum</i> (44%) <i>P. Vivax</i> (47%)	<i>P. Falciparum</i> (60%) <i>P. Vivax</i> (40%)
<i>Plasmodium Falciparum</i> resistant to artemisinin	YES	YES	YES	YES	YES

## 8.2 National policies and legal frameworks

### A. Cambodia

#### I. Migration flows

Cambodia predominantly has internal and outbound migrants. Trends of internal and outbound migration of Cambodia's relatively young population are typically for the purposes of better employment opportunities or to obtain a higher level of education (MoP, 2012:90). The increased availability of jobs in factories around Phnom Penh and the booming tourist industry have been significant pull factors attracting rural Cambodians into urban centres. These migrants tend not to return to rural areas, which has resulted in significant urbanization of Cambodia in recent years.

Cambodian migration spills over international boundaries with approximately 30% of all Cambodian migrants leaving the country (MoP, 2012:71, 90). The primary country of destination for migrant workers is Thailand; 9% of Thailand's regular migrants are Cambodian (MoLVT & ILO, 2014); however, a much larger proportion of Cambodians working in Thailand are irregular and this number has increased over the last 2 decades (Manning, C and Bhatnagar, 2004). Lao People's Democratic Republic, Viet Nam, China and Myanmar are also common destinations among Cambodian migrants.



## 2. Policies and legal framework

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>SOCIAL PROTECTION AND HEALTH LAWS</b>			
Law on Social Security Schemes for persons defined by the provisions of the Labour Law; 2002 (KHM-2002-L-71910 adopted on 25/09/2002)	Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation	The law poses the guiding principles of a mandatory social security system for private sector employees as defined by the Labour Law consisting of three pillars: Employment Injury Insurance, Health Insurance Scheme and Pension Scheme. The law tasks a technical council to issue a <i>prakas</i> (proclamation) to identify a list of occupational diseases, including those related to employment performed in insalubrious conditions or areas that may cause diseases (art.13.1). This list shall be revised periodically (art.13.2). The above-mentioned mandatory Employment Injury Insurance (EII) was implemented in 2008 and provides coverage for work-related accidents and illnesses to all persons working in Cambodia covered under the Labour Law, regardless of nationality. This includes private and public sector workers, apprentices and temporary workers. The EII scheme is financed by employer contributions and State subsidies, and is designed to provide health-care coverage for occupational risks, including accidents that occur during working hours, regardless of the cause; accidents that occur during a worker's direct commute to or from work; and occupational diseases or illnesses that develop as a result of work. Malaria is not specifically referred to, but it is open to make the argument that were an employee to contract malaria as a result of his or her work, the resulting medical care should be covered by this scheme. Workers requiring medical treatment for occupational risk can obtain free of charge care at NSSF-recognized hospitals, or claim reimbursement of transport and authorized expenses for treatment provided at other facilities.	Social Security Healthcare
Sub-Decree No. 16 concerning the Establishment of National Social Security Fund; 2007	Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation, Ministry of Economy and Finance	The sub-decree defines the objectives and administration of the National Security Fund.	Social Security
Prakas No. 022/08 on Determination of the Phases and Coverage of the Implementation of the Occupational Risk Scheme; 2008	Ministry of Labour and Vocational Training	This prakas details the implementation of the Occupational Risk Scheme (ORS) in 2008 and regulation of the Health Insurance, Pension and other Social Security Schemes to occur following implementation of the ORS.  Article 2 indicates that the ORS will initially be applied to businesses with eight employees or more.	Social Security



LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
National Social Protection Strategy for the Poor and Vulnerable; 2011	Royal Government of Cambodia	The strategy seeks to expand coverage of social services and emergency responses and acknowledges the Royal Government of Cambodia's duty to provide essential services to ensure the development and enhancement of human capital through health, nutrition, education and livelihoods to reduce the vulnerabilities of the poor. It aims to provide the poor and vulnerable effective access to affordable quality health care and financial protection in the case of illness. Internal and returning outbound Cambodian migrants who are financially poor can access affordable health care and financial protection in the case of illness through social safety net projects and programmes, such as the Health Equity Fund (HEF) and community-based insurance (CBH). However, like most social safety net programmes, they are ad hoc and dependent on donor funding.	Social Security Healthcare
Cambodia Health Strategic Plan 2008-2015; 2008	Ministry of Health	The plan aims to further develop and expand universal coverage of social services using a combination of different approaches, to improve quality of public and private health services and access to them, especially for poor and disadvantaged groups.	Social Security Healthcare
Joint Prakas No. 1009 on Public Services; 2012	Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation; Ministry of Economy and Finance	This prakas allows the MOLVT to collect revenue from public services, including for medical examinations and physical examinations of Cambodian workers, inbound migrant workers and outbound Cambodian migrants.	Migration Management
Prakas No. 1911 on Fees for Work ID Cards, Work Books and Health Check Services; 2006	Ministry of Economy and Finances	There is an annual fee payable by employers of foreigners who require Work ID Cards and Work Books to work in Cambodia for a specified period, or who are over 18 years and wish to reside permanently in Cambodia, or who already have their Work ID Cards and Work Books and require an annual extension/authorization.	Migration Management
Prakas No. 108 on Education of HIV/AIDS, Safe Migration, and Labour Rights for Cambodian Workers Abroad; 2006	Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation	This prakas details: <ul style="list-style-type: none"> <li>(a) Provision of pre-departure training: potential migrant workers are required to pass through pre-departure orientation on HIV/AIDS, safe migration and labour rights.</li> <li>(b) Collaboration: recruiting agencies are required to collaborate with non-governmental organizations and concerned institutions and give favourable conditions in provision of pre-departure orientation to potential migrant workers.</li> <li>(c) Inspection: Inspection Officers are required to conduct inspection at recruiting agencies/destination countries at least once per year.</li> <li>(d) Letter of contract: The contract is made between recruiting agencies and the Ministry of Labour and Vocational Training.</li> <li>(e) Provision of training, report, data and related documents: recruiting agencies are required to provide information of migrant workers before departure, upon arrival and after return</li> </ul>	Migration Management

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
The National Strategic Plan for Elimination of Malaria in Kingdom of Cambodia 2011-2025; 2011	Ministry of Health	This plan outlines a number of strategic objectives, including prevention of artemisinin-resistant malaria parasite transmission among target populations via vector control, personal protection and environmental management; universal access to early malaria diagnosis and treatment services; detecting all malaria cases, including among mobile and migrant populations (MMPs); ensuring effective malaria treatment; removing malaria as a major cause of mortality; and removing malaria as a barrier to social and economic development and growth in Cambodia. It aims to provide all Cambodian citizens' universal access to malaria prevention as well as treatment. The definition of a Cambodian citizen under the law precludes inbound migrants to Cambodia, but would cover internal migrants, and outbound migrants who return to Cambodia following a period of migration requiring malaria treatment.	Malaria
Strategy to Address Migrant and Mobile Populations for Malaria Elimination in Cambodia; 2013	National malaria control programme Cambodia	The strategy is the first government-led working strategy for malaria elimination in Cambodia. It was developed to better target malaria interventions for MMPs and acknowledges this group as a hard-to-reach population. It recognizes the characteristics of MMPs in Cambodia; identifies the different activities and risks particular to MMPs, such as the risk of exposure in forested areas and other work locations; and the types of intervention strategies needed to appropriately target this risk group in Cambodia. This strategy noted that many migrants in this group were seasonal, or worked in construction, mining, forestry or as security personnel, or were visitors or cross-border travellers and were therefore more often exposed to malaria because of the areas they work in. A large proportion of this group are also irregular, which makes them more vulnerable. The strategy defines migrant population as "resident in the area for more than 6 months and less than 1 year".	Malaria
Law on Immigration; 1994	Royal Government of Cambodia	Article 2 of the law defines anyone who is not a Cambodian national as an alien for the purposes of this law. Immigrants are defined in Art. 10 as those who come to Cambodia to work, and that they require employment, a medical certificate and an employment contract. Definitions for nonimmigrants are foreigners living along the borders of Cambodian provinces who are permitted regular border crossing.	Migration Management
Sub-decree on Procedure for Recognition as a Refugee or Providing Asylum Rights to Foreigners in the Kingdom of Cambodia (No. 224); 1994	Ministry of Interior	This sub-decree defines the procedure for refugee status determination and grants refugees the same rights and obligations as a legal immigrant.	Migration Management

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>LABOUR LAWS</b>			
Labour Law; 1997	Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation	<p>All employment relationships for work performed in Cambodia are governed by the Cambodian Labour Law, regardless of where the contract is entered into, what the nationality of the parties is, or where they reside. The Labour Law's wide scope means that both Cambodian and inbound, regular migrants are afforded protection under this law. The Labour Law covers all workers, providing comprehensive coverage for apprentices, artisans, labourers and workers, including seasonal workers in a wide range of industries. However, Article 4 states that employment cards may only be provided to Cambodian citizens. While there is no prima facie link between employment cards and access to health care, it does provide workers with a legitimate form of identification and so it is likely that they are of some benefit in accessing health-care services when considering the system as a whole. The Labour Law outlines minimum standards for employment, but acknowledges that employers are able to give greater rights than that afforded by law.</p> <p>There are a number of requirements employers must comply with pursuant to the Labour Law when establishing a business, which are important for health-care purposes as the MOLVT requires all employees to undergo a health assessment, which consists of a blood test for unspecified 'contagious diseases' at MOLVT for a fee of US\$ 25. Employers who employ more than eight employees must have internal regulations that cover, among other things, health and safety procedures (Article 22). Malaria is not specifically mentioned as a health and safety concern in the Labour Law or its accompanying materials, but there is a foreseeable risk of contracting malaria in some work settings and therefore, this could arguably fall under this law. A contract for labour can be suspended under Article 71 of the Labour Law if a worker is absent due to an illness certified by a doctor; and the employee's job is protected (Articles 71, 72, 82 and 86). The protections afforded by the Labour Law cover inbound, regular migrants, but does not cover outbound or irregular migrants, leaving these groups vulnerable.</p> <p>The Law governs the employment relationship between employers and employees in Cambodia, regardless of where the contract was entered into; it requires all employers to send their employees to MOLVT for a health assessment; it contemplates the employees' right to suspend the contract if ill; and it requires employers with more than eight workers to have internal regulations that cover among other things, occupational health and safety.</p> <p>Article 261 provides that inbound migrant workers must possess a valid work permit and employment card issued by the Ministry in Charge of Labour (currently, the Ministry of Labour and Vocational Training). They must also have a legal Cambodian work permit, have legally entered Cambodia and must possess a valid passport and residency permit. It also requires them to be fit to work and have no communicable diseases.</p>	Migrant Management

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Policy on Labour Migration for Cambodia; 2010	Ministry of Labour and Vocational Training	The policy includes protection and empowerment of migrant workers through supervision of recruitment and placement as well as establishing standards and providing support services. It outlines three strategic priorities of better governance of labour migration through a stronger legal, regulatory and institutional framework for migration; protection and empowerment of migrant workers through the supervision of recruitment and placement, standards setting and provision of support services; and harnessing the potential of labour migration for development by maximizing remittances and investments, and providing greater assistance in the return and reintegration of migrant workers.	Migration Management
Sub-decree 190 on The Management of Sending Cambodian Workers Abroad Through Private Recruitment Agencies; 2011	Royal Government of Cambodia	The sub-decree regulates private agencies that recruit Cambodians for roles outside of Cambodia, as supported by a number of prakas that clarify recruitment agencies' roles and responsibilities. MOLVT is currently formulating new prakas to outline more specific criteria including training-of-trainers for pre-departure orientations. The primary objective is to require agencies to be in a position to adequately prepare migrants to work abroad, ensuring that they have a basic level of knowledge in key areas, such as employment rights and appropriate services to ensure that workers return to Cambodia safely. The sub-decree also provides guidance for drafting contracts and lists and imposes obligations of Cambodian recruiting agencies, including educating Cambodian migrant workers prior to departure and repatriation of workers in case of death.  Furthermore, the sub-decree strengthens the regulatory framework for managing labour migration and protecting migrant workers, and also acknowledges the potential impact of migration on poverty reduction and human resource development.	Migration Management
Prakas No. 046/13 on the Recruitment Process and Pre-departure Orientation Training; 2013	Ministry of Labour and Vocational Training	This prakas sets national standards for pre-departure orientation materials, training for migrant workers on their rights at work and workplace practices, culture and tradition information in destination countries, financial literacy, health awareness and how to access their rights both at home and abroad.	Migration Management
Prakas No. 251 on penalty and reward to the private recruitment agency; 2013	Ministry of Labour and Vocational Training	The prakas insists that trainers from recruitment agencies must be certified, and that migrant workers receive a pre-departure orientation certificate as proof of completion and a pre-requisite to migration.	Migration Management

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Sub-decree 52 on the Organization and Functioning of the Ministry of Labour and Vocational Training; 2005; and MoVLT's Declaration No. 062/07; 2007	Royal Government of Cambodia, Ministry of Labour and Vocational Training	The sub-decree outlines the responsibilities of the Department of Labour and Manpower towards migrants. They include: managing and issuing work permits, work books and provide working visas to Cambodian workers in-country and abroad, and for migrants working in Cambodia; set up Employment Offices in Provincial/ Municipal Departments of Labour and Vocational Training; develop statistics on employment and manpower in-country and abroad for all levels of economic activities; prepare regulations on the management of migrants working in the Kingdom of Cambodia and on the management of Cambodian labour and workers who migrate to work abroad.	Migration Management
Sub-decree No. 159 on provision of normal passport to migrant workers going for employment abroad through legal channels; 2008	Royal Government of Cambodia	Sub-decree No. 159 stipulates the conditions for the provision of normal passports to Cambodian migrant workers seeking employment abroad. Normal passports are provided only to migrant workers going abroad for employment through legal channels and migrant trainees going abroad for employment and study. It also provides for the effective enforcement of this sub decree through government line ministries.	Migration Management

### 3. Role of the political system on policy and legal framework

The Royal Government of Cambodia (RGC) has established some social protection instruments, but realistically social protection programmes in Cambodia are still under development, and at this stage support does not extend to inbound migrant workers in Cambodia. The RGC relies on civil societies and NGOs, which play an important role in the malaria response in Cambodia, with more than 30 community organizations in the Migration NGO Network working on migration issues. These groups have made a number of gains in the area, such as the Joint Assessment of the Response to Artemisinin Resistance in the GMS by a group of international development partners in collaboration with WHO. Another example is the Cambodian Rural Urban Migration Project (CRUMP), a collaborative effort between the RGC (represented by the Ministry of Planning), UNFPA and an academic institution represented by a consultant from the University of California San Francisco. The project postulated that migration is inevitable and should be embraced, that as sound policy development requires evidence-based information, and survey data that allow examination of the characteristics of migrants and investigation into the linkages between migration and the welfare of individuals, families and communities are needed. It found that Cambodia's rural/urban migration and subsequent doubling of the population of Phnom Penh is a result of historical characteristics, young population and the increase in investment creating more jobs in urban areas. Internal migrants tend to be from rural areas, are young, generally in good health and pulled to urban areas to seek work so that they can remit funds back to their families in provincial Cambodia (MoP, 2012:91).

The development of successful programmes to obtain the greatest benefit from the current migration situation in Cambodia as well as social programmes for migrants and migrant households will require collaboration across government ministries and agencies, including the MOLVT, Ministry of Health,



Ministry of Foreign Affairs and Ministry of Interior as there are numerous areas of overlap between migrants' rights to work and health care whether they are internal or outbound migrants. Ministries need to work in close partnership with each other so that strong migration-related policy can be advanced and receive support (MoP, 2012:96).

#### **4. Constitution**

The Constitution of the Kingdom of Cambodia states that “the health of the people shall be guaranteed. The state shall give full consideration to disease prevention and medical care. People living in poverty shall receive free medical consultations in medical hospitals, infirmaries, and maternities” (Article 72).

### **B. Lao People's Democratic Republic**

#### **I. Migration flows**

Lao People's Democratic Republic is primarily a source of migrants, and to a lesser extent, a transit and destination country. The current economic development situation of Lao People's Democratic Republic, compared to neighbouring Thailand, has created pull factors for migration in search of better economic opportunities. With its abundant natural resources, Lao People's Democratic Republic also draws migrants from neighbouring countries to work in construction (including hydropower stations), forestry as well as agriculture. The Immigration Department in Viet Nam has recorded high numbers of Vietnamese crossing the Lao-Viet Nam border on a daily basis for trade and day employment.

Outbound seasonal migration occurs according to the agricultural cycle, with Lao workers migrating to Thailand during rice paddy planting and harvesting seasons. University students also work in Thailand between semesters and academic years. Approximately 300 000 Lao are currently registered as working in Thailand; this does not include those who cross for day work. There is also a steady flow of Vietnamese through Lao People's Democratic Republic to Thailand and the Swiss Agency for Development Cooperation (SDC) estimates that 50 000 Vietnamese are living in eastern Thailand. Substantial Vietnamese migrant populations also live in the eastern districts of Lao's southern provinces.

Internally, urban drift is slowly diminishing the rural population.

In 2014, it was estimated by the National Economic Research Institute (NERI) of Lao People's Democratic Republic that (Leebouapao, L; 2014:5).

- Approximately 200 000 Lao workers had migrated to ASEAN countries (of whom 190 000 went to Thailand).
- Approximately 110 000 workers from ASEAN countries had migrated to Lao People's Democratic Republic (of whom 100 000 people were from Viet Nam, 5 000 people from Thailand, and around 5 000 people from other ASEAN countries).
- The majority of immigrants in Lao People's Democratic Republic were employed in the construction industry, agriculture, trade and holesale-retail sectors.

The ILO and Asian Development Bank (ADB) have projected that Lao People's Democratic Republic will experience only limited labour force changes prior to 2025 as a result of the AEC, with the next

generation of an additional 141 000 jobs (El Achkar Hilal, 2014:9). This is significantly less than other countries in the region (ILO & ADB, 2014:40). Furthermore, the impact of the AEC will be distributed unevenly across different parts of the Lao economy. El Achkar Hilal (2014:29) predicts that this will continue to result in a significant skills mismatch in Lao People's Democratic Republic until at least 2025 as semi-skilled occupations account for the largest segment of total labour demand, but unskilled workers account for the largest share of the labour force. The most significant increase in employment would be for unskilled and semi-skilled agriculture workers. It is likely that the current migration patterns outlined by NERI (Leebouapao, L; 2014) will continue until 2025, which will result in some increased regular or irregular migration from Viet Nam to fill Lao People Democratic Republic's skills mismatch.

## 2. Policies and legal framework

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>SOCIAL PROTECTION AND HEALTH LAWS</b>			
Social Security Law (No. 34/NA, 26 July 2013); 2013	National Assembly	<p>This law provides for social security for public and private sector workers. Note that it applies to employers, employees, family members of the employee, self-employed persons and voluntarily insured persons in Lao People's Democratic Republic (Art. 7). Contribution to the National Social Security Fund is compulsory for each employer, employee, self-employed person and voluntarily insured person (Art. 6).</p> <p>Article 13 provides that medical care benefits for health-care services or treatment of infectious disease rendered overseas are to be provided under a specific regulation.</p> <p>The Social Security Law and its implementing instructions provide health coverage for employees registered and contributing to the Social Security Organisation (SSO). It does not clearly mention whether inbound migrants can contribute to or benefit under the fund if one of their family members is employed and covered by the Social Security Scheme outside of Lao People's Democratic Republic.</p> <p>Given the provisions of the Labour Law, which suggest that regular migrants are afforded protection and access to health care, and are under an obligation to register with the SSO, it may be inferred that they too are required to register under Article 7 of the Social Security Law; however, this is not expressly provided for. By the same inference, irregular migrants who are employed in Lao People's Democratic Republic may not be covered by the Social Security Law.</p>	Social Security
Social Welfare Decree (No. 169/ Govt, 19 June 2013); 2013	Government of the Lao People's Democratic Republic	<p>The decree provides measures to implement social welfare. Persons entitled to receive social welfare are children under the age of 18 with no parent or legal guardian, disabled persons, persons over 60 years of age from poor families, victims of human trafficking who are poor and dangerously ill, victims and the families of victims of disaster.</p> <p>This decree provides a broad right to access health care, including treatment and prevention.</p>	Social Security Healthcare

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Social Security Instructions (No. 2434/MLSW, 29 July 2014); 2014	Ministry of Labour and Social Welfare	<p>These instructions were adopted to implement the Social Security Law (SSL). They mention aspects of health-care benefits not covered by the Social Security Fund, such as:</p> <ul style="list-style-type: none"> <li>• Disease prevention and treatment under the Government's responsibility, such as tuberculosis and leprosy among others;</li> <li>• Cardiac surgery;</li> <li>• More than five rounds of dialysis in the event of kidney issues;</li> <li>• Thalassemia treatment;</li> <li>• Radiotherapy;</li> <li>• Eye glass or contact lenses, except in the case of employment injury or occupational disease;</li> <li>• Artificial teeth or orthodontia, except in case of employment injury or occupational disease;</li> <li>• HIV/AIDS treatment;</li> <li>• Yearly medical examination;</li> <li>• Unnecessary treatment (e.g. plastic surgery) (Section 2.1.2; Art. 13).</li> </ul> <p>This means, for example, that the SSL does not cover HIV/AIDS treatment under the health-care benefit.</p> <p>Additionally, an insured person may receive health care in a while abroad in case of emergency while performing short-term official activities or if the insured person receives authorization from the hospital in charge of health care in Lao People's Democratic Republic to be treated abroad for medical reasons. In these cases, health-care treatment shall be paid by the insured person and must be reimbursed by the hospital selected by the insured (Section 2.1.2; Art. 13).</p>	Social Security Healthcare

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<p>Law on Healthcare (No. 09/NA, 9 November 2005); 2005,</p> <p>Law on Healthcare, amended (24 December 2014); 2014</p>	National Assembly	<p>This law provides that all citizens, regardless of ethnic origin or race are entitled to receive health care when ill. It focuses on the health-care system in Lao People's Democratic Republic, but does not specifically regulate malaria treatment.</p> <p>The law provides for the possibility of free and paid health care in accordance with regulations (Art. 5) that are yet to be published. Article 3 defines free health care as medical treatment provided for low-income patients or poor patients, who are not able to pay for health care themselves, and who have been certified in accordance with the regulations of the relevant organization.</p> <p>However, according to Art. 51, any person who is not a member of a health insurance fund referred to in the Health-care Law shall bear the cost of medical consultation and treatment.</p> <p>Five different types of health insurance funds are provided under the Health-care Law: community health insurance; enterprise health insurance; civil servant health insurance; private health insurance; and public welfare insurance (Art. 45).</p> <p>Community health insurance funds are derived from the contributions of the people, including monks, novices, members of religious orders and students (Art. 46). The civil-servants health insurance fund is financed by government contributions and the contributions of civil servants, employees and staff, including retirees, veterans, [and] the disabled and persons who are no longer able to work for the Party organizations, State organizations, the Lao Front for National Reconstruction and mass organizations (Art. 47).</p> <p>Enterprise health insurance funds are financed by contributions from enterprise employees and employers (Art. 48). Private health insurance funds are financed by contributions from individuals who are not members of any health insurance fund listed above, including entrepreneurs, merchants and self-employed professionals (Art. 49).</p> <p>Public welfare health insurance funds at each level are established by the State to assist the poor and people with low incomes who are unable to pay their membership contributions in any other health insurance fund (Art. 50).</p>	Healthcare
Policy on Primary Health care; 2000	Ministry of Health	<p>The policy aims to develop quality access and management of health care, and prevention of disease in Lao People's Democratic Republic. Primary health care is a vehicle for reaching the target of "Health for All".</p> <p>Primary health care is defined as a strategy to provide basic health services with a scientific basis to the entire population and all ethnic groups, which is appropriate for actual needs and acceptable to all the people (Glossary of Terms).</p> <p>One of the approaches to primary health care is to generate equitable access to health services for all people in society (Section 3.0;2).</p>	Healthcare

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Law on Hygiene, Disease Prevention and Health Promotion (No. 08/NA, 21 December 2011); 2011	National Assembly	<p>The law applies to national and foreign individuals, legal entities and organizations located in Lao People's Democratic Republic (Art. 7). In terms of Art. 7, this law applies to foreign individuals but insofar as rights to health care are concerned, these are limited to Lao citizens.</p> <p>Article 6 provides that every citizen has the right to receive health care and disease prevention services.</p> <p>It regulates and defines access to disease prevention, but does not specifically mention rights to access vector control measures or chemoprevention for malaria.</p>	Healthcare
National Health Insurance Decree (No. 470/GO, 17 October 2012); 2012	Government of the Lao People's Democratic Republic	<p>Article 1 of this decree provides for access to health services of insured individuals, including all ethnic groups. Article 6 provides that this decree shall apply to individuals and legal entities as holders of health insurance for civil servants, enterprises, community-based health insurance and health equity funds.</p> <p>Article 16 mentions that registration for membership must be done at the registration unit of the Health Insurance Scheme that the member belongs to. These registrations are consolidated at the National Health Insurance Bureau. Members of National Health Insurance shall receive a health insurance card as defined in specific regulations.</p> <p>The decree includes a conflict resolution process for disputes. Article 40 provides that members of the National Health Insurance who find that they did not receive health services have the right to submit a proposal to the conflict resolution authority at the respective level within 10 days of the conflict.</p>	Healthcare
Decree on subsidy for delivery and healthcare for children under five (No. 273/GOV, 19 August 2014); 2014	Government of the Lao People's Democratic Republic	<p>Article 1 provides for the implementation of a policy to subsidize the delivery of health care for children under five so that pregnant women can deliver at public facilities countrywide, and children under five have access to health care when ill, especially those in remote, rural areas.</p> <p>Article 4 provides that this decree is applicable to pregnant women and children under five of Lao nationality in possession of Lao citizenship documents (such as Identity Card, family book, and certificates from village authorities).</p>	Healthcare
Regulation on Health Equity Fund Management and Implementation for Health Services Improvement Project (October 2007); 2007	Ministry of Health	<p>The Health Equity Fund ("HEF") is a form of social health promotion targeted at those who are unable to cover the cost of health services at public facilities or afford health insurance premiums of any kind (Art. 1). Article 2 determines the objective of the HEF, which is to provide a social safety net for poor populations.</p> <p>HEF beneficiaries are those listed in a family book and who received an HEF card. They can receive free health-care benefits from the HEF (Art. 9).</p> <p>HEF beneficiaries are entitled to medical care, such as consultation, diagnosis, medication or prevention and health promotion through the MoH vertical programmes, which include malaria (Art. 10).</p> <p>Article 15 provides for medical care, which is not covered by the HEF, such as diagnosis and treatment abroad and all services that are not available in a public hospital in Lao.</p>	Social Security Healthcare



LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
National Strategy for Malaria Control and Prevention 2011–2015; 2010	Ministry of Health	<p>The goal of the Malaria Prevention Strategy is to “Intensify malaria control efforts, targeting remaining endemic communities and key risk groups, and progressively roll out malaria elimination in selected provinces”.</p> <p>The Malaria Prevention Strategy (MPS) has eight objectives:</p> <ol style="list-style-type: none"> <li>1. Optimize the functionality of national malaria control and elimination efforts by strengthening programme management;</li> <li>2. Maximize access to effective vector control and personal protection measures;</li> <li>3. Improve access to early, effective diagnosis for malaria;</li> <li>4. Support routine case management for malaria in all public sector health facilities, at community level in Stratum 3 villages and in selected private sector health facilities in more endemic districts;</li> <li>5. Strengthen routine Malaria Information System;</li> <li>6. Maintain malaria epidemic preparedness and response capabilities;</li> <li>7. Progressively roll out malaria elimination in selected provinces; and</li> <li>8. Maximize utilization of malaria services through IEC/BCC and strengthen community mobilization efforts, especially in elimination provinces.</li> </ol> <p>Objective 3 of the MPS is to improve access to early, effective diagnosis for malaria through the following activities:</p> <ul style="list-style-type: none"> <li>• Maintain and strengthen the public sector microscopy network;</li> <li>• Develop and implement robust Quality Insurance for microscopy;</li> <li>• Provide combination Rapid Diagnostic Test based diagnosis at all Stratum 3 villages through the Village Malaria Worker network;</li> <li>• Provide combination Rapid Diagnostic Tests based diagnosis at all public sector health facilities for emergencies, post-treatment diagnosis and when microscopy services are unavailable;</li> <li>• Support parasite based diagnosis at selected Public Private Mix registered private sector pharmacies and clinics</li> <li>• Gradually roll out G6PD testing; and</li> <li>• Develop and maintain a high throughput Polymerase Chain Reaction based diagnostic facility to maximize case detection and support malaria elimination.</li> </ul> <p>Migrants and seasonal workers are considered as a risk group to be taken into consideration within the framework of the Strategy.</p> <p>Objective 8 of the MPS seeks to maximize utilization of malaria services through Information Education Communication (“IEC”)/Behaviour Change Communication (“BCC”) and by strengthening community mobilization efforts (especially in elimination provinces). The MPS does not specify IEC/BCC materials and methodologies but seeks that they should be developed and then made available in target areas. It suggests that IEC/BCC products are likely to include roadside billboards targeting border crossers and migrant workers. Its objectives include vector control and personal protections measures; improved access to early case detection, and effective diagnosis and treatment for malaria provided free of charge. Migrants and seasonal workers are considered a risk group to be taken into consideration within the framework of the Strategy.</p>	Malaria

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Revised Technical Guideline on Compensation and Resettlement of people affected by the Development Projects; 2010	Ministry of Natural Resources and Environment	<p>The guidelines provide specific objectives for project owners of development projects in planning and implementing resettlement plans for persons in Lao People's Democratic Republic. They provide that, depending on the scale of resettlement public health facilities should be established (Section 10.4.3).</p> <p>Health issues of relocated communities must be evaluated during the preparation of resettlement plans and through social assessments (Art. 10.4.4).</p>	<p>Migration Management</p> <p>Healthcare</p>
Law on the Protection of Rights and Benefits of Children (No. 05/NA, 27 December 2006); 2007	National Assembly	<p>Article 1 provides that the objective of this law is to protect the rights and interests of children of ethnic groups. Article 3 provides that children have the right to receive health care, including treatment and health rehabilitation. Articles 13 to 18 determine rights to receive health care of children.</p> <p>Article 14 also mentions that pregnant women have access to pre-natal and post-natal health care in accordance with regulations, including regular examinations, proper risk monitoring and birth assistance.</p>	Healthcare
Decree regarding the Entry to and Exit from Lao People's Democratic Republic and Foreigner Control (No. 136/PM, 25 May 2009); 2009	Prime Minister of the Lao People's Democratic Republic	<p>This decree is the main immigration legislation in Lao People's Democratic Republic. Under this decree, individuals infected with a "communicable disease, serious chronic disease", "listed in the International Health Regulations ("IHR")" or "notification of authorities", are not authorized to enter Lao People's Democratic Republic (Art. 6). This decree requires the submission of health certificates when applying for stay permits for certain types of visas, which do not include tourist visas or short-term business visas (Art. 17).</p> <p>Note that the Ministry of Public Security and Ministry of Foreign Affairs have the right and duty to study and unanimously decide whether a foreign person is prohibited from entering the country (Art. 22.5).</p> <p>Inadequate administrative procedures may limit or restrict effective implementation of this decree. The decree does not provide any clear requirements or processes to check the health of people entering into Lao People's Democratic Republic under Article 6. Broad discretionary powers are in place, which may serve to restrict the movement of cross-border migration. The parameters of these discretionary powers are not limited.</p>	Migration Management

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>LABOUR LAWS</b>			
Labour Law (No. 43/NA, 24 December 2013); 2013	Social Security Office	<p>The Labour Law applies to registered and unregistered employees (i.e. individuals working outside of a registered entity, such as freelancers), Lao workers working in foreign organizations and inbound migrants working within Lao People's Democratic Republic (Art. 6).</p> <p>The Labour Law includes a section on "Migrant Labour" (Art. 130.) Migrants are divided into three groups:</p> <ul style="list-style-type: none"> <li>• domestic migrant labour</li> <li>• migrant labour leaving the country</li> <li>• migrant labour entering the country.</li> </ul> <p>Migrant labourers who leave or enter the country are entitled to benefit from conditions where the employee and his/her family members have access to health care and social insurance (Art. 134).</p> <p>This law provides that measures contained in relevant laws and regulations must be implemented for irregular migrants (Art. 135; however, interpretation of this article is unclear.</p> <p>In terms of health-care access for employees (whether or not they are migrants), an employer must arrange a medical examination at least once a year. Workers who work in dangerous areas or work at night must undergo medical examinations at least twice a year (Art. 126). The law also requires employees working in Lao People's Democratic Republic to contribute to the Social Security Fund.</p> <p>Employers are required to ensure health and safety at the workplace. In the event of an occupational disease the employer or Social Security Organisation is responsible to assist the employee through different types of payment or allowances (Art. 127 to 129).</p> <p>Health-care access must be provided at workplaces. Workplaces with 100 or less employees must appoint a person responsible for the safety and health of employees; workplaces with more than 100 employees must establish a health and safety unit or committee (Art. 123). Remote workplaces with at least 50 employees must hire one medical staff; for less than 50 employees, the workplace must provide a first aid kit and have a person trained in first aid on site (Art. 124).</p> <p>According to Article 119 of the Labour Law, the employer has the obligation to hold trainings for employees on basic occupational health and safety knowledge, protection from diseases, such as HIV, at least once a year. Additionally, an employer is prohibited from obstructing employment or using direct or indirect force against a worker to resign due to HIV infection (Art. 143).</p>	

### **3. Role of the political system on policies and legal framework**

The Ministry of Health (MoH) is the main provider of health, particularly in remote, rural areas. Its three declared priorities are maternal, neonatal and child health-service delivery; health financing; and human resources for health strengthening. The MoH provides leadership and plays a central role as a technical advisor to the Provincial Health Offices (PHO) and the District Health Offices (DHO). The DHOs are the key actors for activities' implementation at health facilities and community level. The public sector is the primary provider of health services in the country, although it is underutilized, especially in rural areas. The private sector remains relatively small with the majority of private sector health-service access points being pharmacies. The health system is further divided into three branches: health-care; prevention, promotion and disease control; and health management and administration.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has, since 2003, been the driving funder in support of malaria programmes in the country. GFATM has to date committed nearly US\$ 55 million to malaria programmes in Lao People's Democratic Republic. Other major health sector development partners and donors include WHO, ADB, the World Bank, and the governments of Japan, Luxembourg and France. Nongovernmental actors include Lao Women's Union, the Lao Red Cross, the Clinton Foundation, and Health Poverty Action/ Health Unlimited.

### **4. Constitution**

Consideration has been given to whether any rights to accessing health services is embedded in the Constitution of Lao People's Democratic Republic, or via any fundamental mechanism (such as the Declaration of Human Rights) and, if so, whether any rights they entail apply to migrants.

The Constitution of Lao People's Democratic Republic (2003) provides that the State and society shall attend to building and improving disease prevention systems and providing health care to "all people"; creating conditions to ensure that all people have access to health care, especially women and children, poor people and persons in remote, rural areas, to ensure good health of the population (Art. 25). A constitutional article added in 2004 obligates the government to improve and extend the health network; improve disease prevention; create conditions so all people receive health care, especially mothers, children and the poor; and legalize private investment in health services. Additionally, this provision does not provide a right to have access to health care but rather promotes development of health services in the country. Furthermore, the Constitution provides working persons the right to rest, receive medical treatment in times of illness and receive assistance in case of incapacity, disability and in old age as well as other cases as detailed by other laws. These rights are granted to Lao citizens to work and be engaged in legal occupations (Art. 39). To the extent that rights to health care can be granted by Article 25, the obligation to provide health care is jointly imposed on the State and "society". It is unclear how a person would or could enforce its rights against a society and where the obligations of the State end and the obligations of the "society" begin. Therefore, the Constitution only provides the right to access health care for current or former employees. It is uncertain whether "working people" also includes migrants (regular or otherwise) in Lao People's Democratic Republic.

## C. Myanmar

### I. Migration flows

Migration flows in Myanmar are significant, complex, long-standing and influenced by a range of different factors. Myanmar is the largest source country for migrants to Thailand, most of which migrate through informal channels. There is limited data on internal migration within the country.

Myanmar has experienced large volumes of most, if not all, types of migration within and beyond its borders. In a study conducted in 2003, many participants reported to have undergone several periods of migration, with some of them reporting more than 1000 migration episodes (Skidmore and Wilson, 2007:58; Bosson, 2007). In addition to economic reasons, national development activities are the predominant pull factors for migration of people from Myanmar today. Migration pathways in Myanmar are not only uni- or bi-directional and are often cyclical in nature, involving different phases and conditions of migration that can be categorized in different ways at different times for individuals and groups of mobile populations. Due to land development and strong establishment of border trade with Thailand, a large number of people, mainly from the central dry zones of Myanmar, migrate for work and remain in the south-eastern regions of Myanmar. There are large numbers of migrants and mobile populations on plantations in areas where artemisinin resistance has been confirmed. Findings from a 2013 study on internal migration by the Ministry of Immigration and Population (MoIP & UNFPA, 2013) showed that internal migration in Myanmar has increased during the last few decades and that the patterns of migration have changed overtime.

It is estimated that up to 10% (approximately 6 million) of Myanmar's population is abroad (Regional Thematic Working Group on International Migration, including Human Trafficking, 2008:69), but these statistics cannot be confirmed as most migration from Myanmar takes place through irregular channels. According to statistics from the Ministry of Labour, since 1999 only 130 000 workers from Myanmar have been recruited and departed to work abroad through formal channels (Huguet, 2014b). The key destinations for Myanmar migrant workers include Thailand, Malaysia, Singapore, United Arab Emirates, Korea and Japan. Almost 90% of all registered migrant workers in Thailand are from Myanmar (approximately 2 million); this flow is forecasted to continue to increase. Nevertheless, few activities have focused on this population mainly due to a lack of information regarding their characteristics and associated risks to malaria. Myanmar migrants abroad typically work in skilled, semi-skilled and low-skilled occupations.

As a result of decades of ongoing conflict in Myanmar, hundreds of thousands of people have been displaced internally and across international borders into Thailand. Displacement into malaria areas puts these populations at significant risk of disease.



## 2. Policies and legal framework

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>SOCIAL PROTECTION AND HEALTH LAWS</b>			
Social Security Law; 2012  (repealing the Social Security Act of 1954)	Ministry of Labour	The law outlines provisions for employment injury insurance and a right to access medical care and other benefits, including temporary and permanent disability benefits, and provides protections for injured employees against termination. It also outlines steps for establishing a Social Security Fund, which includes support for non-occupational health costs by the contributions of employers, workers and the government. This law is yet to be enacted. There is no mention of migrants within this law and no provisions on how they may be included.	Social Security
Myanmar Health Vision 2030; 2014	Myanmar's President U Thein Sein, the Minister of Health	Myanmar's President and Minister of Health have committed to attaining Universal Health Coverage (UHC) by 2030, and planning is currently underway to initiate the necessary reforms required to achieve UHC. Migrants have been mentioned in initial planning meetings, however, as of this report there are no formal legislative or legal policy frameworks to ensure the inclusion of migrants in UHC activities.	Healthcare
National Health Plan 2011-2016; 2011	Ministry of Health	<p>The plan recognizes the importance of migration and its impact on communicable disease, health security, public health and social determinants of health. It includes some indicators on reaching migrant populations (HIV), and improving health status in border areas; there is no mention of access to health or prevention specifically for migrants included.</p> <p>It does mention internal migration and its aims to provide basic and essential health services for migrants:</p> <p><i>“With changing economic policy and certain extent of industrial development, rural to urban migration for job-seeking and economic opportunities is another phenomenon raising health issues, particularly in the peri-urban areas. Having no better choice, these migrants have to live in sub-standard dwellings in places, which are overcrowded with poor environmental situations. In addition to the need for expanding health services coverage for the rural population and for those in the border area, the health sector is now facing another challenge to provide equitable access to health care for the entire population. The current cycle of the National Health Plan will have to take into consideration provision of basic and essential health services for the peri-urban population.”</i></p>	Healthcare

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Prevention and Control of Communicable Diseases Law; 1995; revised 2011.	Ministry of Health	<p>This law describes functions and responsibilities of health personnel and citizens in relation to prevention and control of communicable diseases. It describes the measures to be taken for environmental sanitation, reporting and control of outbreaks and epidemics of Principal Epidemic Diseases (PED), quarantine and penalties for those failing to comply. The law also authorizes the Ministry of Health to issue rules and procedures when necessary with approval of the government. PED includes specifically cholera, plague, dengue haemorrhagic fever and AIDS.</p> <p>Chapter VII – Quarantine Article 14</p> <p>An organization or an officer upon whom power is conferred by the Ministry of Health may issue a prohibitive order or a restrictive order in respect of the following matters:</p> <ul style="list-style-type: none"> <li>• right of the person suffering from Principal Epidemic Disease to leave and return to his/her house;</li> <li>• right of people living in the house, ward, village or township infected by Principal Epidemic Disease to leave and return thereto;</li> <li>• right of people from outside to enter the house, ward, village or township infected by Principal Epidemic Disease;</li> <li>• if there is a person suffering from Principal Epidemic Disease among those people arriving by train, motor vehicle, aircraft, vessel or any other vehicle, right of such person put under quarantine up to a period necessary for medical examination, to leave and return thereto; and</li> <li>• when an outbreak of Principal Epidemic Disease occurs during the time of fair and festival, right of the public to visit the site and right to continue the festival.</li> </ul>	Healthcare
National Strategic Plan Malaria Prevention and Control 2010-2015; 2009	Ministry of Health	<p>The plan recognizes migrants as a key population and prioritizes for interventions in prevention, behaviour change communication, research and access to diagnosis and treatment free of charge for Myanmar citizens.</p> <p>It states, “[t]here is need for operational research into innovative vector control methods and strategies to protect migrant and forest related workers in view of the current low ITNs/LLINs coverage level among this at risk population”. The plan also promotes a “population-centred public health approach, prioritizing the most vulnerable populations and adapting strategies to their characteristics”. This includes an objective to establish malaria clinics in strategic and hard-to-reach areas where there are large congregations of migrant workers, migrant specific information, education and communication (IEC) materials and dedicated malaria volunteers catering to the needs of migrant populations.</p>	Malaria

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
		<p>It specifically recognizes migrants and mobile populations as particularly vulnerable. The plan identifies migrants as particularly at risk as a result of social and economic factors as well as environmental factors relating to their movement into malaria-prone areas, such as forested areas, plantations, mines and rural construction projects.</p> <p>Migrants and mobile populations are recognized as a key population by the National Malaria Control Programme's (NMCP) National Strategic Plan and explicitly referenced in the areas of:</p> <p><b>(a) Prevention and vector control:</b></p> <p><b>(i)</b> <i>"There is need for operational research into innovative vector control methods and strategies to protect migrant and forest related workers in view of the current low ITNs/ LLINs coverage level among this at-risk population."</i></p> <p><b>(ii)</b> <i>"For all populations at risk in artemisinin resistance affected areas: distribution of LLINs or retreatment of nets with long lasting insecticide retreatment kits and aim for 100% population coverage. Priority is given to migrant populations."</i></p> <p><b>(iii)</b> <i>Behaviour Change Communication: "educational and communication tools will be adapted for specific target groups, for example... migrant workers."</i></p> <p><b>(b) Accessible and quality diagnosis and treatment:</b></p> <p><b>(iv)</b> <i>"Where there are large congregations of migrant labourers, transmission of malaria and inadequate access to health services, and in remote endemic villages where populations from neighbouring villages converge, vector borne disease committee and/or partners will establish 'malaria clinics' to provide immediate diagnosis, appropriate treatment and counselling on malaria [free of charge]."</i></p> <p><b>(v)</b> <i>"Operational research on 'standby treatment' will be done for forest-related workers and other mobile groups."</i></p> <p>Importantly, the NMCP's National Strategic Plan recognizes that migration contributes to social and economic determinants of vulnerability to malaria:</p> <p><i>"The other major risk group is migrants, who are often induced by economic opportunities such as logging or mining in forested areas or road or dam construction and maintenance. Displacement caused by dam construction may also lead to exposure. These population movements may be organised, in which case it is relatively easy to organise prevention and curative services. However, often the migrant groups are small, spontaneous and even clandestine and illegal, and this makes it difficult to protect them."</i></p>	

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>LABOUR LAWS</b>			
<p>Law Relating to Overseas Employment, No 3/99, 9 July 1999; 1999</p>	<p>State Peace and Development Council</p>	<p>The law aims to ensure that there is no loss of the rights and privileges of workers and that they receive the rights they are entitled to.</p> <p>Although Chapter 2 of the law refers to rights and privileges, there is no reference in the law to any relevant legislation that ensures such rights and the scope of the rights and privileges is not defined.</p> <p>Chapter 8 describes the duties and rights of workers, which include, to undergo a medical assessment and obtain a health certificate. There are no specifications or associated guidelines for the assessment; no provisions on compulsory testing or travel restrictions.</p> <p>Chapter 8 The Duties and Rights of Workers</p> <p>A worker, before going abroad:</p> <p>(a) shall undergo a medical assessment as directed by the Supervisory Committee, and obtain a health certificate.</p> <p>Although paragraph 24(a) of the law states that a worker “has the right to claim through the Service Agent full compensation to damages to which he is entitled for injury sustained at a foreign worksite”, this provision is often omitted from the standard agreement that migrant workers sign with their recruitment agency.</p> <p>Furthermore, the law mandates the training and recruitment of outbound migrants from Myanmar. Outbound migrant workers must pass a medical assessment in Myanmar before being issued a labour card; however, there is no stipulation about what this assessment should include and there is no requirement for malaria testing and treatment. In the case of regular outbound labour migration to Thailand, a second medical assessment is performed in Thailand (Mae Sot, day border crossing) before final clearance for employment and signing of agreement with recruitment agency is permitted. This assessment is part of the migrant health insurance scheme of the Royal Government of Thailand. The standard employment contract for labour migrants (to Thailand) does include a stipulation that employers are to ensure that employees have access to medical treatment free of charge if illness or injury is incurred during work. Article 24(a) describes the right to claim full compensation for any work-related injury through the Service Agent (licensed, private labour migration broker) – “[a worker] has the right to claim through the Service Agent full compensation to damages to which he is entitled for injury sustained at a foreign worksite”. In practice, this provision is usually omitted from the standard agreement that migrant workers sign with their recruitment agency.</p>	<p>Migration Management</p>

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Five-year National Plan of Action for the Management of International Labour Migration in Myanmar 2013-2017; 2013	Ministry of Labour, Employment and Social Security	The main strategic objective of the plan is to increase the protection and empowerment of outbound migrant workers from Myanmar. Again, there is no specific mention of health issues within this National Plan of Action. It should be noted that the Department of Labour is currently leading an internal process of drafting a new law to be submitted to the Myanmar parliament.	Migration Management

### 3. Role of the political system on policies and legal framework

Following decades of isolation and lack of reforms within the health sector, Myanmar has now begun to engage in broad and systematic political and social reform with leadership at the highest levels, including a commitment of the President to strive towards Universal Health Coverage by 2030. Recognizing the importance of migration health, the International Relations Division (IRD), in collaboration with disease specific programmes and IOM, has been advocating for the creation of a Migrant Health Desk in the MoH tasked with promoting the health of migrants in line with resolution WHA61.17 and liaising with counterparts in other relevant ministries as well as regional and international counterparts. IOM has been promoting a migrant health agenda, and has also been implementing migration health programming, including for malaria in Myanmar since 2006. IOM provides technical support, conducts research, mobilizes resources, supports international and regional partnerships and is also engaged with other ministries (MOLES, Ministry of Relief, Resettlement and Social Welfare, Ministry of Immigration and the like).

### 4. Constitution

The Constitution of the Republic of the Union of Myanmar states that “[e]very citizen shall, in accord with the health policy laid down by the Union, have the right to healthcare.” There is no specific mention of the right to health care of migrants or those without citizenship status.

## D. Thailand

### I. Migration flows

Thailand is the most economically advanced country within the Greater Mekong Subregion (GMS) and thus attracts many low-skilled workers from Myanmar, Lao People’s Democratic Republic and Cambodia, and seeks migrants from countries further afield. Most migrants perform labour-intensive work, and comprise up to 8% of the Thai labour force (Huguet, 2014a:3). Many workers are in low-tech factories, construction, agriculture and fisheries, with much of the remainder in the informal sector, including domestic work.

Since the 1990s migration in Thailand has become increasingly complex at the border areas; not only have there been refugees in nine camps along the border to Myanmar, but also many living outside of camps have remained in Thailand as economic migrants and or displaced persons for over 20 years. Additionally, there are various ethnic minorities along the Myanmar border who have lived in Thailand for long periods, many without citizenship. Also, there are migrants commuting across the borders daily as well as those seeking health services not available in Myanmar; many of them are internally displaced



persons from Myanmar. Ongoing conflict in Myanmar continues to be a push-factor for migrants to enter Thailand, blurring the line between economic migrants and displaced persons.

Economic migrants may work in Thailand on a daily or seasonal basis, or for longer periods. The registration process to access work permits has undergone many reforms and is plagued with confusion and complexity. Under the original registration system, migrants were initially granted work permits for 2 years. It was later declared that migrants could remain in the country for 4 years but would then have to return to their country of origin for a total period of 3 years. This regulation has since been abandoned and migrants may now stay for 180 days, after which they must apply for a new work visa (Huguet, 2014a:19).

Thailand has made efforts to manage the influx of migrant workers from surrounding countries since the early registration system began in selected provinces in 1992. Between 1992 and 2002, numbers of migrants in Thailand reached up to 3 million. It was not until the Thaksin Government (2001), however, when the registration process for migrant workers was expanded. In 2003, Thailand established MoUs with Lao People's Democratic Republic and Cambodia, and later with Myanmar, to recruit migrant workers outside the country to Thailand with passports and registration papers. In 2004 the first national registration took place and 1.28 million migrants underwent the registration process (Huguet, 2014a:XIV). As a follow-up to this, a National Verification system (NV) was incorporated to capture those already residing in Thailand, verify their documents and provide passports and registration. Subsequent registrations occurred after 2004 with more than 1 million migrants seeking work permits (Lyttleton, 2015). As of December 2012, 1 million Myanmar migrants and 150 000 migrants from Lao People's Democratic Republic and Cambodia had completed NV and held temporary passports and valid work permits (Huguet, 2014a:XIV). Despite cooperation across ministries and departments, and expansion of one-stop-service centres (OSSC) for migrant registration, more than half of the estimated 3.5 million migrant workers in Thailand are not registered (Jitthai, 2012).



Myanmar workers from a garment factory in BanTha Ard, Mae Sot, Thailand, returning home across the border after work. Credit: Thavinkaew A. WHO Thailand. 2013

## 2. Policies and legal framework

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>SOCIAL PROTECTION ANF HEALTH LAWS</b>			
Social Security Act B.E. 2533 (1980); 1990	Royal Thai Government, Social Security Office	The act affirms that registered employees receive protection in the event of illness or accident; physical disability; death not related to performance of work; child delivery; old age; child assistance; and unemployment. Initially, tentative protection coverage is provided to businesses with more than 20 employees. In 1993, this was extended to include those businesses with more than 10 employees with the following provisions: illness, disability and death not resulting from work performance and to child delivery on tentative basis. The employer, employee and the Government make contributions at an equal rate.	Social Security
National Health Security Act B.E. 2545 (30 Baht Scheme); 2001	Ministry of Public Health, National Health Security Office	<p>The act came into force in 2002 and has since been one of the most important social tools for health system reform in Thailand. The Universal Coverage Scheme (UCS), which combined the previous Medical Welfare Scheme and the Voluntary Health Card Scheme, is not influenced by private health insurance organizations but rather remains a supplemental option for high-income groups. Since its implementation in October 2001, the UCS has expanded coverage to an additional 18 million people.</p> <p>As of 2007 estimates, the UCS covers 74.6% (50 million) of the population. It offers a comprehensive package of both preventive and curative care. It is financed from general taxation. Public hospitals are the primary care providers (&gt;95% of those insured). About 60 private hospitals joined the system and serve approximately 4% of beneficiaries.</p> <p>The 30 Baht co-payment was abolished by the Thaksin Government in November 2006, but later reinstated. In October 2003, efforts were made to provide universal access to antiretroviral drugs (ARVs) for people living with HIV/ AIDS.</p> <p>The target population for the scheme is largely in the informal, agricultural sector and does not have access to consistent cash income for any kind of regular premium payment, therefore making premium collection difficult.</p>	Social Security Healthcare
Compulsory Migrant Health Insurance Scheme; 2001	Ministry of Public Health	The scheme aims to provide health screening, curative care, health promotion, and disease surveillance and prevention services to regular migrants in Thailand.	Healthcare
National Malaria Programme, 2011-2016; 2011	Royal Thai Government, MoPH	The programme provides the guidelines for malaria prevention, management and eradication. The 2011–2016 plan includes provision of services for migrant and mobile populations. The strategic framework mentions vulnerable populations and partners working with poor and marginalized population groups. The programme is closely entwined with regional action plans and guided largely by the Global Fund, the World Bank and other key players.	Malaria

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Announcement on Health Examinations and Insurance for Migrant Workers from Myanmar, Lao People's Democratic Republic and Cambodia; 2009, revised in 2013	Royal Thai Government Ministry of Employment	This policy was released by the MoPH detailing health examinations and insurance for migrants, including the accompanying fees.	Migration Management
<b>LABOUR LAWS</b>			
Employment Agencies and Job Seekers Protection Act; B.E. 2528; 1985	Royal Thai Government, Ministry of Employment	<p>The act is subject to rendering of domestic employment and employment abroad. It prohibits foreign employers from recruiting Thai workers directly and sets conditions for obtaining a licence for the purposes of domestic and foreign employment. Recruitment for work abroad is possible only by companies managed by a Thai national. There is a minimum security deposit of 500 000 Thai Baht<sup>13</sup>. Employment contracts for work abroad must be subject to approval by the Director-General of the Labour Department. Job seekers may be required to undergo prescribed physical examinations in addition to selection and proficiency tests. Recruited employees are entitled to training about the legal and cultural traditions of the country of destination. Sending and repatriation expenses are (implicitly) the responsibility of the employer. The employment agency is responsible for the repatriation expenses in situations, such as incongruent conditions, as per the employment contract. Under certain circumstances, these expenses are redeemable from the Fund to Assist Workers Abroad established by the act. Repatriation responsibilities cease if the employee does not return to the Kingdom of Thailand within 30 days of the expiry of the employment contract. The act provides for measures to control its functioning and criminally sanctions violations against it.</p> <p>It constitutes the primary legislation for protecting outbound Thai migrant workers during the recruitment process</p>	Migration Management
Labour Protection Act; B.E. 2541, 1998; amended 2008 (Labour Protection Act, B.E. 2551)	Ministry of Labour, Department of Labour Protection and Welfare	This act is the key legislation regarding workers' employment conditions, as provided by the employer, including maintenance of employment records, set working hours and leave, termination of employment, severance and employee welfare fund. The act applies to all businesses, and all registered employees with the exception of domestic workers who do not fall under the act's definition of an employee (MoL 2004).	Migration Management

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
Workmen's Compensation Act; B.E. 2537; 1994	Royal Thai Government, Social Security Office	<p>This act requires employers to make annual contributions at the rate of 0.2–1% of wage as per risk levels of any given business to the Workmen's Compensation Fund, which is established in the Social Security Office (section 3 of the Act). The fund provides benefits to employees who are injured, sick, disabled or die as a result or in the performance of their work. This contribution offers protection in the event of work-related injury, illness, loss of organs, invalidity, death and loss to employees who are insured persons. All insured are eligible to receive compensation for medical and/or rehabilitation expenses (depending on the seriousness of injuries), lost income and/or funeral allowance.</p> <p>This is only relevant for Thai nationals and regular migrant workers in larger workplaces where regulations are complied with, and employers have paid contributions.</p>	Migration Management

### 3. Role of the political system on policies and legal framework

Migration policies and legal measures in Thailand have been influenced predominantly by national security concerns rather than by pragmatic responses to market and labour needs. For example, industrial factories were established in Mae Sot, Tak Province, along the border with Myanmar in the early 1990s where they profited from special tax exemptions, and were located exactly where the factories would have access to cheap labour. These advantages continue to drive economic development, despite the implementation of many new regulations, including for minimum wage. While this special tax exemption policy followed market needs, there were no real policy formulations in the early 1990s to manage migrant workers and more than two decades later, a preoccupation with national security leaves the government overwhelmed by the consequences. Challenges persist despite international support and increased cooperation across ministries. The MoPH, maintains migrant health relatively high on its agenda, however, it is constrained by orders of the Ministry of Interior (MoI) with complex migration policies for both inbound migrants and stateless populations. Constraints on producing effective health policy include, national security concerns, but also inadequate migration management policies and fiscal concerns.

### 4. Constitution

The 2007 Constitution guarantees equal rights between men and women and prohibits discrimination on grounds of race and sex (Huguet, 2014a: 126). However, few laws and legislation addressing the rights in Thailand include migrants. As stated, most migrants are not covered by accident and compensation plans or pensions from their employers, and there are no protections afforded during the employee recruitment process. Conditions, such as the minimum wage, do apply but are poorly enforced.

## E. Viet Nam

### I. Migration flows

With an estimated 2.6 million Vietnamese living abroad, Viet Nam falls just behind Myanmar in terms of the number of emigrants reported worldwide. The two countries, however, show very different migration profiles (UNDESA, 2013a). Almost 80% of Vietnamese migrants live in the United States, Europe, Australia and New Zealand. There is almost an equal division between the number of Vietnamese migrants going to GMS countries or Malaysia and other countries in East Asia (excluding GMS countries and Malaysia). The profile of the Vietnamese migrants and the nature of migration vary greatly depending on the intended destination. There are about 500 000 Vietnamese in more than 40 countries, working in at least 30 different occupations that range from low to high-skill.

Relatively few Vietnamese migrate formally within Asia. About half of those that do migrate within Asia go to destinations in East Asia; the other half travel to other GMS countries or Malaysia. In mid-2013, there were about 172 000 Vietnamese migrants in East Asia, 70% of which were in South Korea (UNDESA, 2013a). Except for Malaysia, migration to other GMS countries is reported to be nominal. However, there is likely to be a significant underreported irregular migration taking place from Viet Nam to other GMS countries, particularly through cross-border movements to Lao People's Democratic Republic and Cambodia (MMN, 2013:152). Some estimates suggest that there may be up to 20 000 Vietnamese migrants in Lao People's Democratic Republic, mostly from rural areas of Central and Northern Viet Nam working as market traders in Vientiane and engaged in the largely illegal logging industry along the Lao-Viet Nam border (UNDESA, 2013a; USDS, 2014; ADB & ILO, 2014). This number is likely to increase in the coming years considering the recently concluded bilateral labour agreement between the Government of Lao People's Democratic Republic and the Government of the Socialist Republic of Viet Nam to expand labour coordination (MMN, 2013:154). The population of Vietnamese migrants in Cambodia is estimated at 37 000 (UNDESA, 2013c), comprising the largest migrant population in Cambodia, but there may also be large, unaccounted Vietnamese populations living in Cambodia along the Cambodia-Viet Nam border. Vietnamese migrants in Cambodia are largely involved in the agriculture, fishing and construction industries (MMN, 2013:152). There are also a number of Vietnamese women engaged in sex work, some of whom may be victims of trafficking (VOT) (MMN, 2013:153). Vietnamese migrants also transit through Cambodia to Thailand's north-eastern regions in order to work informally in restaurants, local markets, the service sector and garment workshops (MMN, 2013; Nguyen & Walsh, 2014:78). In some cases, migrants rely on the large ethnic Vietnamese community that has lived in Thailand for generations for employment and support. Improved infrastructure and road networks within the GMS allow Vietnamese migrants to travel to Thailand within a day, making Thailand an increasingly attractive destination. The Royal Thai Government estimated 100 000 Vietnamese migrants working in Thailand, 40% of which are estimated to be irregular migrants. According to recent estimates from border statistics, Vietnamese migration to Thailand is increasing rapidly due to a proposed regularization of migrants in 2015 and ongoing negotiations on labour agreements between the two governments (IOM, 2015).

Viet Nam is not considered a major destination country for migrants, however, with one of the strongest economies in the region and an annual growth rate of about 7%, Viet Nam may become a more significant destination country for GMS migrants in the future. The current inbound migrant population



in Viet Nam is estimated to be around 68 300 migrants (UNDESA, 2013c). Among GMS countries, only Lao People's Democratic Republic reports having a smaller amount of inbound migrant population (UNDESA, 2013a). Although small, Viet Nam's migrant population is relatively diverse, with migrants coming from across the globe. Migrants from other GMS countries and Malaysia account for 35% of the reported migrant population, with migrants from China and Myanmar comprising almost 80% of migrants from the GMS (UNDESA, 2013a). Most migrants from China are brought by Chinese companies to work on Chinese-led, large-scale construction projects. Cross-border migration is also common, with Chinese migrants frequently crossing into Viet Nam to rent farmland to produce cash crops for sale in China (Nguyen VC, 2013:22). Similarly, Cambodian and Lao migrants come into Viet Nam through border crossings, often staying for short-periods and remaining within the border area. In some cases, Cambodian street children are abducted or trafficked into Viet Nam to work as street beggars (MMN, 2013:96). Viet Nam also hosts about 11 000 stateless persons, most of which are ethnic Vietnamese from Cambodia (UNHCR, 2014). Many ethnic Vietnamese from Cambodia are not granted citizenship in either country and, subsequently their basic rights and entitlements are denied in both countries. Viet Nam also serves as a transit country for migrants from China traveling to Cambodia and Lao People's Democratic Republic (IOM and ADB, 2013:15).

The Government of the Socialist Republic of Viet Nam has a long history of implementing strategies to manage and control internal migration in the country. Since the 1960's, implemented internal migration programmes have aimed to redistribute the country's population to improve the management of resources; this led to mass movements from urban areas to rural areas (MMN, 2013:149; IOM, 2010). Government-sponsored internal migration continues in Viet Nam but has shifted to rural migration, facilitating the movement of agricultural workers from one worksite to another (IOM, 2013b). The Government also occasionally issues controversial decrees requiring the relocation of villages to planned residential areas, often to make way for development projects. Relocated villagers frequently have difficulties finding cultivatable land, forcing many to migrate further in search of alternative livelihoods. To control internal migration flows, Viet Nam maintains a household registration system that restricts changes in residency (IOM, 2013b; MMN, 2013:149). Despite these controls, unregulated internal migration continues to take place and as a consequence, there has been an annual growth in Viet Nam's urban centres of 3.5% (MMN, 2013). Most internal migrants are young, landless or land poor, and increasingly women are seeking employment in factories, construction or restaurants in urban areas or border provinces (MMN, 2013; Nguyen & Walsh, 2014:78).

In terms of overall numbers, Vietnamese outbound migration is dwarfed by internal migration. The 2009 census recorded around 6.6 million people that had migrated internally between 2004 and 2009 (UN Viet Nam, 2010:23). This was a substantial increase of 2.1 million in internal migrants compared to the 1999 census. In the 2014 mid-term census, four trends were observed: (i) the total population is characterized by increasing proportions of migrants; (ii) the proportion of female migrants is growing; (iii) the average age of migrants is decreasing; and (iv) the provinces with high monthly income per capita and urbanization are more likely to have higher rates of in-migration, namely around Ha Noi, Ho Chi Minh City and Da Nang (Anh, LTK et al, 2012:8).

## 2. Policies and legal framework

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>SOCIAL PROTECTION HEALTH LAWS</b>			
Law on Residence; 2006  Household Registration System Decree No. 51/1997/CP; 1997	Government of the Socialist Republic of Viet Nam	<p>The household registration system has a long history in Viet Nam and comprises four categories of registration statuses: migrants typically possess KT2, KT3 or KT4 registration status<sup>14</sup>, in contrast to those permanently registered in the district in which they reside (KT1). The KT2 to KT4 residents are limited with regard to receiving health services, schooling and other social services within their district of residence, and are unable to receive these services in the new residence district. Additionally, those with KT4 registration status are registered as individuals without a family (in contrast to the other three categories), and cannot own land titles.</p> <p>Government services, such as health care (including reproductive health), schooling, HIV care and treatment, and access to poverty reduction services depend on this registration system, which restricts or allows access to those permanently registered at any given place. Over the last two decades, the government has also introduced social insurance and health insurance into the country's social security system. The current legal structure, however, does not cover unregistered internal (spontaneous) migrants.</p> <p>In 2007, the new Law on Residence took effect, reducing the number of residence categories to just two – temporary and permanent – and easing conditions for obtaining permanent residency. Anecdotal evidence suggests that the law is being applied inconsistently by local authorities across the country due to a lack of guidance and differing interpretations of the law. This inconsistency has created confusion regarding what procedures people are required to complete when applying for different residency registration across Viet Nam.</p>	Social Security
National Law on Health Insurance No. 25/2008/QH12; 2009, amended in 2014 by Law No. 46/2014/QH11, enforced 2015.	Ministry of Labour, Invalids and Social Affairs	<p>Inbound migrant workers can participate in the national health insurance. Employers are requested by law to provide social insurance and health or accident insurance for workers. However, many enterprises ignore this regulation. Only one in ten migrants has accident insurance provided by employers.</p> <p>Viet Nam has been introducing social health insurance (SHI) since 1992. The country's health insurance law was promulgated in 2008, with the goal of universal coverage by 2014" (WHO, 2011c).</p>	Social Security  Healthcare
Law on Prevention of Infectious Diseases 03/2007/QH12; 2007	National Assembly	<p>Chapter 3. Health Inspection/quarantine at the border</p> <p>Article 35. Subject and location of health inspection</p> <p>(a) Subjects:</p> <ul style="list-style-type: none"> <li>(i) Humans entering, exiting, or transiting through Viet Nam</li> <li>(ii) Vehicles entering, exiting, or transiting through Viet Nam</li> <li>(iii) Goods entering, exiting, or transiting through Viet Nam</li> </ul>	Migration Management  Healthcare

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
		<p>(iv) Bodies, body parts, bio samples, cells, human tissue passing through a Vietnamese border.</p> <p>(b) Locations: at all border gates, checkpoints (land, sea, air).</p> <p>Article 36. Contents of border quarantine</p> <p>(a) Objects of border quarantine specified in Clause 1, Article 35 of this law are subject to medical declaration.</p> <p>(b) Medical inspection includes inspection of health-related papers and physical inspection. Physical inspection shall be conducted of objects originating from or going through epidemic zones or suspected of suffering from an infectious disease or carrying agents of infectious disease.</p> <p>(c) Medical disposal shall be conducted after medical inspection has been conducted and objects of border quarantine are detected to carry agents of a class-A<sup>15</sup> infectious disease. If receiving information reported by owners of means of transport or obtaining explicit evidences that a means of transport, a person or cargo carries agents of a class-A infectious disease, the means of transport, persons or cargo on board the means of transport must be isolated for medical inspection before it/they are allowed to carry out procedures for entering, leaving or transiting Vietnam; if it/they fails/fail to comply with the isolation request of the border quarantine body, an isolation measure shall be taken against it/them.</p> <p>(d) Infectious disease surveillance shall be conducted in border-gate areas under the provisions of Section 3, Chapter II of this Law”.</p>	
Decision on the approval of the National Strategy for the Control and Elimination of Malaria in Viet Nam, period 2011-2020 and Orientations towards 2030 (Ref. number: 1920/QD-BYT); 2011	Prime Minister of the Socialist Republic of Viet Nam	The strategy defines overall objectives, action plans, resources and competent authorities for the coordination and implementation of the action plan. This includes providing free of charge long lasting insecticide treated bed nets (LLINs) and treated hammock nets for those living in areas of medium and high malaria prevalence, including irregular migrants, border-crossing migrants and poor households as well as advocating use of treated nets in areas of low malaria prevalence.	Malaria
Decision on the promulgation of the Guideline for Malaria Diagnosis and Treatment (Ref. number: 3232/QD-BYT); 2013	Ministry of Health	The guideline details terminology, principles and instructions to undertake diagnosis and treatment for malaria cases. Only health workers from commune level and above shall be qualified to prescribe and provide self-medication to those who travel to highly malarious areas for longer than 1 week (tourists, forest/field workers, border-crossers, etc.). They should be given thorough guidance and instructions on self-diagnosis, self-treatment and self-monitoring upon return.	Malaria

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
National Strategy for Malaria Control and Elimination 2012-2015; 2012	Ministry of Health	The strategy identifies six specific objectives to be achieved for this period, which are a) ensure that all people have better access to early diagnosis, prompt and effective treatment of malaria at the public and private health facilities; b) ensure the coverage of all people at risk of malaria by appropriate malaria control measures; c) eliminate malaria in the provinces with low malaria endemicity, and reduce malaria incidence in the high and moderate malaria endemic provinces; d) improve epidemiological surveillance system and ensure sufficient capacity to malaria epidemic response; e) improve scientific research activities and apply results to malaria control and elimination activities; and f) improve the knowledge and behaviour change of regarding malaria control so that people may actively protect themselves.	Malaria
Decision on the promulgation of the Action Plan for the Prevention of Malaria period 2015-2020 (Ref. number: 4717/QD-BYT); 2014	Ministry of Health	<p>The action plan outlines the legal and scientific basis, objective and performance indicators, solutions, yearly work plan, budget, division of tasks and responsibilities, and coordination mechanisms between different government agencies at different levels for the purposes of preventing malaria.</p> <p>Concrete initiatives include ensuring prevention and protection measures, such as spraying chemicals, providing LLINs to malaria hotspots, such as forests or fields prior to the typical peak of malaria infection each year; expand the coverage of malaria prevention measures for all the population vulnerable to malaria infection; ensure access to early malaria diagnosis services and to safe, effective and timely treatment; ensure that malaria treatment is provided free of charge at private and public facilities.</p> <p>For areas where malaria is to be eradicated, the action plan indicates that the movement of migrants and malaria patients should be closely monitored; and active detection of malaria cases should be implemented.</p>	Malaria
Decision on the promulgation of the Action Plan to Prevent Artemisinin-Resistance Malaria for the period 2015-2017 (Ref. number: 4718/QD-BYT); 2014	Ministry of Health	<p>The action plan provides an overview of artemisinin resistance from 2010 to 2014 and includes a legal framework, target areas, objectives, performance indicators, yearly work plan, division of tasks and responsibilities and coordination mechanism between different government agencies at different levels. Initiatives include provision of LLINs free of charge to seasonal workers (one net per person); provide bed nets, hammock net and repellent products and instruction on how to use them, especially for seasonal workers, such as cashew and cassava workers; closely monitor MMP flow; and ensure provision of rapid-diagnostic tests and blood films at village level for timely and effective detection and treatment of MMP to avoid treatment failure.</p> <p>The action plan targets migrants as a risk group; however, the effectiveness of this plan remains to be seen as in the initial phase. The action plan does not specify if MMP also includes inbound migrants in Viet Nam.</p>	Malaria
Circular No 14/2013/TT-BYT guiding medical examination; 2013	Ministry of Health	This circular replaced the previous circular guiding health examination and certification for Vietnamese working overseas and applies to outbound Vietnamese migrants and inbound migrants living and working in Viet Nam.	Migration Management

LEGAL/POLICY DOCUMENT	AUTHORITY	SUMMARY OF CONTENT	RELEVANCE
<b>LABOUR LAWS</b>			
Law on Vietnamese Guest Workers (No: 72/2006/QH11); 2006	National Assembly	According to Article 17, I.e, II of the law, the labour contract must be in line with legislation of Viet Nam and of the receiving countries and include the following main contents: labour safety and protection, and health care.	
Law on Entry, Exit, Transit, and Residence for foreigners in Viet Nam (47/2014/QH13); 2015	National Assembly,	Inbound migrants intending to work in Viet Nam must first get a work permit before applying for a visa as per the 2014 Law on Entry, Exit, Transit and Residence for foreigners in Viet Nam (47/2014/QH13). A health assessment/certificate is not required in the visa application.	Migration Management
Circular Guiding The Granting Of Work Permits To Foreigners Working At Enterprises And Organizations In Vietnam (No 08/2000/LDTBXH-TT); 2000	Ministry of Labour, War Invalids, and Social Affairs	As per Article II, part I.a of this circular, to apply for a work permit, inbound migrants are required to submit a health certificate issued by at least a provincial hospital in Viet Nam. If the certificate is issued outside of Viet Nam, it must comply with the country's regulations. The health certificate must have at least 6-month validity from the day the work permit application is received.	Migration Management
Decree providing for the recruitment and management of foreigners working in Vietnam (34/2008/ND-CP); 2008; and  Decree on recruitment and management of foreign employees in Vietnam (46/2011/ND-CP); 2011	Government of the Socialist Republic of Viet Nam	These two decrees require that the MoH issues guidelines for agencies in charge of issuing health certificates for inbound migrants, and to clarify the validity of certificates.  To date, the MoH has not upheld these obligations.	Migration Management
Decree on Regulation and Guidance on the Law for Overseas Workers (126/2007/ND-CP); 2007	Government of the Socialist Republic of Viet Nam	According to Article 11 of the decree the responsibilities of the Ministry of Health include : <ul style="list-style-type: none"> <li>• Set requirements for clinics that can provide health examination and health certificates for (Vietnamese) workers who want to work abroad under contract; collaborate with the Ministry of Finance and MOLISA to set a fee for the health examinations;</li> <li>• Lead and coordinate with MOLISA to set the health requirements for Vietnamese who want to work abroad in accordance with each country's requirements;</li> <li>• Collaborate with MOLISA to carry out periodic health assessment of Vietnamese workers abroad; and</li> <li>• Supervise, inspect, and regulate clinics and resolve violations in health examination as prescribed by law.</li> </ul>	Migration Management
Decree 44/2013/ND-CP on Labour Contract (part of the Labour Law); 2013	Ministry of Labour, Invalids and Social Affairs	Chapter 2 of this decree mandates participation in health insurance, social welfare insurance and unemployment insurance for all employees with a labour contract (including inbound migrants in Viet Nam).	Migration Management



### 3. Role of the political system on policies and legal framework

In Viet Nam, the MoH is in charge of the agenda for health and health care. Issues pertaining to malaria are assigned to the National Institute of Malarology, Parasitology and Entomology (NIMPE) based in Hanoi and the two regional Institutes of Malariology, Parasitology and Entomology in Quy Nhon and Ho Chi Minh City. The 2011-2020 National Strategy for Malaria Control and Elimination received strong support from WHO. Within Viet Nam, the MoH has a strong network of partnerships with various international and national organizations. Since 2009, two of the One UN programme coordination groups have partnered directly with MoH to address various health issues. Additionally, migration issues have also been raised with MOLISA, the Ministry of Foreign Affairs and the Ministry of Planning and Investment. Migrants and migrant health have been included in assessments on human development and migration, research on trafficking and pilots on migrant resource centres and interventions with migrant drug users. One UN supported the Vietnamese Government in using census data to disaggregate migrant data, draft a series of monographs and develop a paper entitled, *"Internal Migration and Socio-economic Development in Viet Nam: A Call to Action"*.

Viet Nam has been an active participant of various regional and international networks and consultative processes. With the exception of the JUNIMA, none of these regional consultative processes, regional networks and regional frameworks specifically address the health of migrants. They do, however, provide a regular venue for discussion and dialogue and have been used to raise migrant health issues. Participants of these networks and collaborative partnerships from the National Assembly and the Ministries of Foreign Affairs, Labour, Health and Transport indicate that while most do not produce binding resolutions and declarations, they have greatly supported the development of policy and programming in Viet Nam.

### 4. Constitution

Viet Nam's Constitution seems to distinguish between the rights of all humans and the rights of citizens in its second chapter, which relates to the "human rights, fundamental rights and obligations of citizens". However, Article 38 reads: "[e]veryone has the right to health protection and care, and to equality in the use of medical services, and has the obligation to comply with regulations on the prevention of disease and medical examination or treatment; human rights and citizens' rights may not be limited unless prescribed by a law solely in case of necessity for reasons of national defence, national security, social order and safety, social morality and community well-being".

## 8.3 Outline for an operational framework on migrant health<sup>30</sup>

### Monitoring migrant health

<b>Priorities to address</b>	<ul style="list-style-type: none"> <li>• Ensure the standardization and comparability of data on migrant health.</li> <li>• Increase the better understanding of trends and outcomes through the appropriate disaggregation and analysis of migrant health information in ways that account for the diversity of migrant populations.</li> <li>• Improve the monitoring of migrants' health-seeking behaviours, access to and utilization of health services and increase the collection of data related to health status and outcomes for migrants.</li> <li>• Identify and map: 1) good practices in monitoring migrant health; 2) policy models that facilitate equitable access to health for migrants; and 3) migrant-inclusive health systems models and practices.</li> <li>• Develop useful data that can be linked to decision-making and the monitoring of the impact of policies and programmes.</li> </ul>
<b>Key Actions</b>	<ul style="list-style-type: none"> <li>• Identify key indicators that are acceptable and useable across countries.</li> <li>• Promote the inclusion of migration variables in existing census, national statistics, targeted health surveys and routine health information systems as well as in statistics from sectors, such as housing, education, labour and migration.</li> <li>• Use innovative approaches to collect data on migrants beyond traditional instruments, such as vital statistics and routine health information systems.</li> <li>• Clearly explain to migrants why health-related data are being collected and how this can benefit them, and have safeguards in place to prevent use of data in a discriminatory or harmful fashion.</li> <li>• Raise awareness about data collection methods, uses and data sharing related to migrant health among governments, civil society and international organizations.</li> <li>• Produce a global report on the status of migrants' health, including country-by-country progress reports.</li> </ul>

### Policy and legal frameworks

<b>Priorities to address</b>	<ul style="list-style-type: none"> <li>• Adopt and implement relevant international standards on the protection of migrants and the right to health in national law and practice.</li> <li>• Develop and implement national health policies that incorporate a public health approach to the health of migrants and promote equal access to health services for migrants, regardless of their status.</li> <li>• Monitor the implementation of relevant national policies, regulations and legislation responding to the health needs of migrants.</li> <li>• Promote coherence among policies of different sectors that may affect migrants' ability to access health services.</li> <li>• Extend social protection in health and improve social security for all migrants.</li> </ul>
<b>Key Actions</b>	<ul style="list-style-type: none"> <li>• Develop frameworks and indicators to monitor the success of policy implementation.</li> <li>• Promote and monitor the sufficient availability of resources for adequate policy development, formulation of strategies and programme implementation.</li> <li>• Conduct advocacy and public education efforts to build support among the public, government and other stakeholders for migrant-inclusive health policies and adoption of key international instruments.</li> <li>• Develop guidance, models and standards to assist countries, based on best practices.</li> <li>• Identify mechanisms for extending social protection in health and increasing social security coverage for migrants.</li> </ul>

<sup>30</sup> Health of Migrants: the way forward – report of a global consultation. Madrid, Spain 2010. WHO.

## Migrant sensitive health systems

<b>Priorities to address</b>	<ul style="list-style-type: none"> <li>• Ensure that health services are delivered to migrants in a culturally and linguistically appropriate way, and enforce laws and regulations that prohibit discrimination.</li> <li>• Adopt measures to improve the ability of health systems to deliver migrant inclusive services and programmes in a comprehensive, coordinated and financially sustainable way.</li> <li>• Enhance the continuity and quality of care received by migrants in all settings, including that received from NGO health services and alternative providers.</li> <li>• Develop the capacity of the health and relevant nonhealth workforce to understand and address the health and social issues associated with migration</li> </ul>
<b>Key Actions</b>	<ul style="list-style-type: none"> <li>• Establish focal points within governments for migrant health issues.</li> <li>• Develop standards for health-service delivery, organizational management and governance that address cultural and linguistic competence; epidemiological factors; and legal, administrative and financial challenges.</li> <li>• Develop frameworks for the implementation and monitoring of health systems' performance in delivering migrant sensitive health services.</li> <li>• Develop methods to analyse the costs of addressing or not addressing migrant health issues.</li> <li>• Include diaspora migrant health workers in the design, implementation and evaluation of migrant sensitive health services and educational programmes.</li> <li>• Include migrant health in the graduate, post-graduate and continuous professional education training of all health personnel, including support and managerial staff.</li> </ul>

## Partnerships, networks and multi country frameworks

<b>Priorities to address</b>	<ul style="list-style-type: none"> <li>• Establish and support ongoing migration health dialogues and cooperation across sectors and among key cities, regions and countries of origin, transit and destination.</li> <li>• Address migrant health matters in global and regional consultative migration, economic and development processes (e.g. Global Forum on Migration and Development, Global Migration Group, RCPs, United Nations High Level Dialogue on International Migration and Development).</li> <li>• Harness the capacity of existing networks to promote the migrant health agenda.</li> </ul>
<b>Key Actions</b>	<ul style="list-style-type: none"> <li>• Create a multi-stakeholder working group to further refine and implement the operational framework on migrant health and to develop a resource mobilization plan.</li> <li>• Develop an information clearinghouse of good practices in migrant health monitoring, policy development and service delivery.</li> <li>• Encourage local, regional and international migration dialogues and processes to assist governments in coordinating and harmonizing policies and regulations related to health and the determinants of health for migrants.</li> <li>• Promote the inclusion of migrant health needs in existing regional and global funding mechanisms.</li> </ul>

## 8.4 Memoranda of Understanding related to access to health services among migrants between GMS countries

Bilateral cooperation/MoU	MoU Period	Summary of content as it relates to migration/access to health services
MoU between the Royal Government of <b>Cambodia</b> and the Royal <b>Thai</b> Government on Cooperation on the <b>Employment of Workers</b> (May 2003)	2003- until written notification of termination by either Party	MoU between Cambodia and Thailand concerning cooperation in the employment of workers with provisions to support Cambodian and Thai migrants, such as <b>healthcare points</b> for more general <b>health services at border crossings</b> between Cambodia and Thailand, with a Cambodian Ministry of Labour office in Bangkok. Cambodia works with the Royal Thai Government on nationality verification to improve documentation for Cambodian migrants working in Thailand.
<b>Greater Mekong Subregion MoU</b> on Joint Action to Reduce HIV Vulnerability Related to Population Movement (2011)	2011–2016	The parties to the MoU identified the following priority needs: improved understanding of the continuum of treatment and care across borders, including continuum of care across borders; increased joint implementation prevention and care programmes at origin and destination by community and civil society groups; greater advocacy for migrants' inclusion in universal coverage schemes as the region moves towards one ASEAN community by 2015.
MoU on <b>Cooperation against Trafficking</b> in Persons in the <b>Greater Mekong SubRegion</b> (October 2004)	2004- until written notification of termination by the six Governments	Memorandum of understanding among Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam concerning cooperation against trafficking in persons in the GMS and provides that victims of trafficking should receive <b>healthcare assistance</b> (Art. 17).
MoU between the Government of <b>Lao People's Democratic Republic</b> and the Royal <b>Thai</b> Government on Labour Co-operation (18 October 2002)	2002- until written notification of termination by either Party	This MoU outlines reciprocal obligations between the two nations to migrant workers. This includes provision of <b>health insurance</b> (Art. 7). As of November 2014, approximately 21 000 migrants from Lao People's Democratic Republic have received a work permit under this agreement (ILO, 2015c:6) <sup>16</sup>
MoU between the Royal <b>Thai</b> Government and the Government of the Republic of the Union of <b>Myanmar</b> on <b>Health Cooperation</b> (2013)	2013–2018	The 5-year agreement outlines a framework in which both nations propose to cooperate on matters relating to health on the basis of reciprocity and mutual benefit for both countries. The agreement covering cooperation in information sharing, human resource development, co-research on native herbs, disease awareness, disease control in border areas and prevention of emerging and communicable diseases.

Bilateral cooperation/MOU	MoU Period	Summary of content as it relates to migration/access to health services
<p>Trilateral Cooperation for <b>Health: Myanmar, Thailand and United States Cross-Border Partnership</b> (Regional Development Mission for Asia and the Control and Prevention (CAP) Malaria Programme), (2013)</p>	2013–2017	<p>The partnership outlines specific cooperation and funding for a four year project on malaria in five 'twin-city' locations along the Thai-Myanmar border to provide a platform to synchronize malaria control activities in both countries. Activities include malaria surveillance, research, commodity distribution and prevention activities, as well as capacity-building to Myanmar's Malaria Control Programme staff on diagnosis, treatment, mosquito vector control and support for operational costs of delivering services in targeted areas.</p> <p>Specifically, malaria control will be strengthened through capacity-building of Myanmar's Malaria Control Programme staff on diagnosis, treatment, vector control and support for operational costs to deliver services in these five twin cities<sup>17</sup>:</p> <ul style="list-style-type: none"> <li>• Thachileik, Myanmar and Mae Sai, Thailand</li> <li>• Myawaddy, Myanmar and Tak (Mae Sot), Thailand</li> <li>• Phayathongzu, Myanmar and Kanchanaburi, Thailand</li> <li>• Dawei, Myanmar and Kanchanaburi, Thailand</li> <li>• Kawthaung, Myanmar and Ranong, Thailand</li> </ul>
<p>MoU between the Government of <b>Lao People's Democratic Republic</b> and the Royal <b>Thai</b> Government on Cooperation to Combat Trafficking in Persons, Especially Women and Children (13 July 2005)</p>	2005- indefinite until written notification of termination by either Party	<p>This MoU provides that victims of trafficking should receive <b>healthcare assistance</b>.</p>
<p>Agreement between <b>Lao People's Democratic Republic</b> and <b>Viet Nam</b> on Cooperation in Preventing and Combating Trafficking in Persons and Protection of Victims of Trafficking (3 November 2010)</p>	2010- indefinite, unless written notification of termination by either Party	<p>This MoU provides that victims of trafficking should receive <b>healthcare assistance</b>.</p>
<p>MoU between the Government of the Kingdom of <b>Thailand</b> and Government of the Republic of the Union of <b>Myanmar</b> on Labour Cooperation and pursuant Agreement on the Employment of Workers</p>	2016–2021	<p>An MoU and pursuant agreement was signed between the two nations in June 2016. Health related matters are mentioned in the Agreement on the Employment of Workers, such as:</p> <ul style="list-style-type: none"> <li>• Workers are required to pass recruitment process and medical check-up as agreed by parties</li> <li>• Workers who entered the territory of the receiving country shall be entitled to the same fair treatment as enjoyed by local workers ... [and] shall obtain protection, rights and benefits in accordance with the labour laws and regulations in the receiving country</li> <li>• In the event of an accident, serious illness or death, the employer shall be responsible to ensure the necessary medical care</li> <li>• Authorities to ensure that workers fulfilled requirements for health insurance or health services as required</li> </ul>



Bilateral cooperation/MoU	MoU Period	Summary of content as it relates to migration/access to health services
MoU between the Government of the Socialist Republic of <b>Viet Nam</b> and the Government of the Kingdom of <b>Thailand</b> on labour cooperation	Five years from date of signature in July 2015, renewable upon mutual consent	<p>The MoU and pursuant agreement on labour recruitment set out the following principles:</p> <ul style="list-style-type: none"> <li>• The sending authority will send to the receiving authority the list of workers who have successfully passed the recruitment requirements and health check in accordance with the agreement between the two parties;</li> <li>• The designated agencies will ensure that migrant workers fulfil the requirements of the receiving country in term of health insurance and health services;</li> <li>• In case of serious accident, injury or dead, the employer is responsible for fulfilling the necessary requirements and procedures related to compensation on behalf of the worker and repatriation in case of death;</li> <li>• The two countries shall work towards the encouragement of technical cooperation in the field of labour, including exchange of systems, programmes, studies, expertise, research, studies and information on, among others, occupational safety and health.</li> </ul>



Myanmar: Ei Ei Khin, 42, a volunteer of PCI malaria and TB program explaining to local women the importance of malaria treatment and blood testing in her house in Paik Kyee Wei Village, Hlegu Township, Yangon Region. Credit: Vlad Sokhin. WHO 2016



Migrants and mobile populations face many obstacles in accessing equitable essential health care services due to factors such as living and working conditions, education level, gender, irregular migration status, language and cultural barriers, anti-migrant sentiments, and lack of migrant-inclusive health policies among others. Despite significant progress having been made in the context of malaria control in the Greater Mekong Subregion (GMS), human movements can impact malaria transmission patterns and potentially introduce drug-resistant parasites. This legal framework review therefore serves as a guidance document on approaches to address malaria and malaria elimination for migrant and mobile populations (MMPs) in five countries of the GMS, namely Cambodia, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam.

In order to provide an evidence-base and guidance for malaria programme managers at national level, the International Organization for Migration (IOM) and the World Health Organization (WHO) collaborated on this document to provide recommendations on the technical implementation and policy implications of addressing malaria for MMPs. A key part of this collaboration is the documentation and analysis of migration and health related laws, policies and legal frameworks existing as of 2015 that impact upon access to health and malaria services, whilst identifying the gaps and further opportunities for paving the way to eventual malaria elimination in the GMS.

