Health of refugees and migrants

Practices in addressing the health needs of refugees and migrants

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COUNTRIES HIGHLIGHTED

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

BANGLADESH

Promoting occupational safety and gender equality and empowerment

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

PRACTICES:

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

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

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

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

Bangladesh-Jordan: Bilateral Agreements

Practices: The bilateral agreements have been signed between the governments of Bangladesh and Jordan, in effect enabling Bangladeshi women aged 25–46 years to be legally recruited as domestic workers for households in Jordan. The governments agreed that the Jordanian employers should pay the full cost of recruiting women from Bangladesh, including paying their visa fees and airfare. The agreement also stipulated that the employers should provide employees with private sleeping quarters and food, purchase a life insurance policy for the employee that covers the entire period of employment, and should open a bank account into which the domestic worker's salary should be deposited each month. These types of bilateral agreements overlay existing labour and migration legislation and compensate for the fact that certain sectors, most notably domestic work, are frequently not covered by national labour law. They also provide a framework for redress, both by individual workers and also by states. However, these agreements must be underpinned by consular resources and investment in outreach to foreign workers, along with effective monitoring and dispute resolution mechanisms[2].

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

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

INDIA

Intervention on HIV and AIDS by Trade Union

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

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

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

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

MALDIVES

Improving communication and counter xenophobia

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

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

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

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

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

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

MYANMAR

Promoting refugee and migrant health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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