MEETING REPORT

MULTI-STAKEHOLDER DIALOGUE ON MIGRANTS’ HEALTH AND ACCESS TO HIV SERVICES IN THE ASEAN REGION

29-30 NOVEMBER 2011

AMARI WATERGATE HOTEL

BANGKOK, THAILAND
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EXECUTIVE SUMMARY

Every year millions of people within ASEAN Member States migrate within and across borders. The UNDP Global Human Development Report 2009 estimates that there are approximately 55.6 million migrants from Asia, representing 29.6 per cent of total global migrants\(^1\). In 2007, ASEAN and its Member States formally recognized migrant workers as a vulnerable group whose rights require protection, through their adoption of the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers.

Within the broader spectrum of migrant workers’ rights, ASEAN Member States have also committed to take action on migrant sensitive health policies and practices and promote the exchange of information and dialogue on health of migrants, by becoming signatories to the World Health Assembly’s Resolution on the Health of Migrants\(^2\) in 2008.

The key guiding documents for regional work on migrant health now include the ASEAN Strategic Framework on Health and Development (2009-2015)\(^3\) which fits under the broader theme of Social Welfare and Protection, Health and Development within the ASEAN Socio-cultural Blueprint (2009-2015). This framework calls for ‘increasing access for ASEAN citizens including migrants in the achievement of health-related Millennium Development Goals’. On the more specific issue of HIV/AIDS, the ASEAN Task Force on HIV/AIDS (ATFOA) provides the regional mechanism to address vulnerability and ill-health outcomes among migrants in the region. Frameworks for action in this area are the ASEAN Work Programme on HIV and AIDS and the ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths.

Drawing guidance from all of the above, UNDP Asia-Pacific Regional Centre and the ASEAN Secretariat jointly convened this 2011 Multi-Stakeholder Dialogue on Migrants’ Health and Access to HIV Services in the ASEAN Region, in order to address the challenges and opportunities for migrants’ access to health and HIV services within the region\(^4\). 41 government representatives from ministries of health, labour and foreign affairs from ASEAN’s 10 Member States (Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand and Vietnam) attended the event, along with civil society representatives from nine of the ten Member States. The meeting was facilitated by Jacqueline Weekers, Senior Migration Health Officer with IOM Headquarters in Geneva, facilitated the event and members of the Joint United Nations Initiative on Mobility and HIV in South East Asia (JUNIMA) provided key technical support.

Working sessions of the Dialogue were organized around the thematic areas of the Operational Framework for Migrant Health, as formulated during the 2010 Global Consultation on Migrant Health\(^5\). Guided by this framework participants shared country progress and challenges under four key ‘Pillars’, or priority areas: (i) monitoring migrants’ health; (ii) policies and legal frameworks affecting migrants’ health; (iii) migrant sensitive health systems; and, (iv) partnerships, networks & multicountry frameworks. The presence of representatives from across various government ministries, alongside key civil society representatives,

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\(^1\) UNDP HDR 2009. Overcoming Barriers: Human mobility and development. Page 30, Table 2.1


\(^3\) This Framework was endorsed by the 10\(^{th}\) ASEAN Health Ministers Meeting, Singapore, 2010 under the purview of the ASEAN Senior Officials Meeting on Health Development (SOMHD)

\(^4\) The conduct of this Dialogue was also recommended by participants of the first High Level Dialogue on HIV Prevention, Treatment, Care and Support for Migrants in the ASEAN Region in 2009

ensured that discussions covered a range of different perspectives, opportunities and challenges. Complete matrices of country responses under each of the priority areas are included in this report, in Sessions 3-6.

Beyond the obvious benefits of multi-sectoral and inter-country information exchange and dialogue, the key outcome of this Dialogue was a list of joint priorities for addressing migrants’ health and access to HIV services in the ASEAN region. These priorities were reached following in-country policy discussions, which also allowed for input from a number of different ASEAN working groups, such as the ASEAN Task Force on AIDS, the Senior Labour Officials Working Group on HIV in the Workplace and the ASEAN Committee on Migrant Workers.

Priorities addressed included: (i) increased involvement of migrant communities, civil society organizations and unions as active partners in Memoranda of Understanding, bilateral and multilateral agreements, advocacy and service delivery; (ii) enhanced collaboration on migrants’ health concerns with respect to ASEAN mechanisms, including the ASEAN Inter-governmental Commission on Human Rights (AICHR); (iii) development of standard migrant health indicators and disaggregated data, while ensuring confidentiality and privacy; (iv) further study on the costs and benefits of providing migrant sensitive health services to migrants; and, (v) further outreach to undocumented migrant populations to identify effective health interventions.

These joint priorities now provide a useful tool to assist participating government and civil society representatives from ASEAN Member States, as well as ASEAN sectoral working groups represented at the meeting, to better plan and coordinate with all stakeholders at the country level. Participants’ identification of key challenges and gaps in access and provision of health and HIV services for migrants in the region will also assist the ASEAN Secretariat and UNDP APRC, through JUNIMA, to identify priority areas for further collaboration.
Distinguished delegates
Ladies and gentlemen,

On behalf of the Ministry of Public Health, Thailand, it is my great honor to welcome you to the JUNIMA - ASEAN Regional multi-stakeholder dialogue on migrant workers’ health and access to HIV services.

First of all I would like to express my warmest welcome to all honorable delegates from ASEAN Member States, representatives from the civil society, and representatives from the United Nations agencies. The presence of all of you here shows how committed we all are. It gives us optimism that our joint efforts might further ensure that migrants in our region will be able to enjoy healthy lifestyles, be safe from HIV, and those that fall ill will be able to access treatment and care with the highest possible coverage.

Migrant health and access to HIV Services is a very important issue for Thailand. There are large numbers of people that cross the border from Myanmar, from Cambodia, from Lao PDR and also southern China in search of alternative livelihoods in our country. Around 700,000 migrant workers from Myanmar, Cambodia and Lao PDR are currently registered, while more than 2 million migrants are estimated to be in the country. In 2007, it was reported that HIV prevalence among pregnant migrant women and migrant fishermen were 1.4% and 2.49% respectively. To reduce new infections and their impact, the 2007-2011 National Plan for Strategic and Integrated HIV/AIDS prevention and alleviation recognized the need to focus on Most at Risk Populations, including migrant workers. Our National Plain now aims to enhance HIV prevention interventions, improve the accessibility to health care services and referring system, and develop co-operations among key stakeholders and migrants.

The Ministry of Public Health has developed a health care system for migrant workers in Thailand. Thanks to the hard work of various government departments and other stakeholders, registered migrants are now able to access national health care services. However we acknowledge that a gap in health care access remains for undocumented migrants. With regards to addressing this gap and the needs of unregistered migrants, I would like to thank international donors and NGOs for their strong support. Cross border migrants critically require our harmonized efforts, to ensure that they have equitable access to information, health promotion, prevention, treatment and care.

There are many reasons why we believe it is very important to address migrant’s access to health care services. Please allow me to highlight a few issues that we, at the ministry of health have been taking very seriously for a number of years, and that I believe you will be touching upon those coming two days:

- First, well-managed health services for migrants, including public health, promote the well-being of everyone and facilitate the integration of migrants within communities. Proper migration health policy is essential in moving from exclusion to inclusion. Hence it is important that we continue to find mechanisms to ensure that migrants remain within the scope of our work and our reach.
• Second, Migration is a challenge for the 21st century. It will continue to prevail in our societies as a result of economic, political and social dynamics. The way we address it will dictate the kind of world we build for the future generations. Migration cannot be dealt with in isolation or by one country alone. We must engage with partners we would not normally deal with, like our colleagues in Labor, or in Immigration. We need to partner with CSOs and we also have to engage in cross border dialogue if we want to make a difference.

As you will be hearing a few times in the next 2 days, at the 61st World Health Assembly resolution in 2008 on the Health of Migrants, the World Health Organization called upon all Member States’ attention to take action and promote bilateral and multilateral cooperation on migrants’ health. This call is in line with the Declaration on the Protection and promotion of the rights of Migrant Workers from 2007, and the latest ASEAN Commitments on HIV/AIDS endorsed last week by the ASEAN leaders in Bali.

Ladies and gentlemen, therefore, I would like to urge us all in this meeting to utilize this and other opportunities to enhance cooperation among stakeholders, at all levels, in South-East Asia Region to make our goals a reality. I salute you all for your dedication and commitment on migrants’ health.

Allow me to take this opportunity to extend my sincere gratitude to UNDP Regional Bureau for Asia and the Pacific, ASEAN Secretariat, and the JUNIMA partners for your assistance and support to make this meeting happen.

I wish you all success in your deliberations. Thank you.

DR MANDEEP DALIHWAL, CLUSTER LEADER, HIV, HEALTH, HUMAN RIGHTS AND GOVERNANCE, UNDP BDP

Distinguished Guests,
Ladies and Gentlemen,

I am honoured to welcome you to today’s conference, both on behalf of JUNIMA (the Joint United Nations initiative on Mobility and HIV/AIDS in South East Asia) and UNDP.

There are currently around 20 million migrants in South East Asia alone. Without counting the large population of Indonesia, this represents roughly 5-6 per cent of the total population of the region, and a much larger percentage of the region’s total workforce. These figures are the result of economic and social inequalities prevalent in South East Asia.

Unsafe migration puts migrants at risk (including increasing their vulnerability to HIV infection), for example:

On HIV: While it is very difficult to estimate how many people have contracted HIV due to migration, because of mandatory HIV testing we know that large percentage of registered HIV cases in countries like Lao PDR, the Philippines, but also Nepal and Bangladesh in Southern Asia are migrant workers. We also know that in Thailand, from the various studies that have been conducted of migrant groups engaging in high risk behaviour (like fishermen or sex workers in border areas), there is a much higher prevalence rate of

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6 includes documented and undocumented
7 This 20 million only includes 12.6 million migrants leaving Cambodia, Lao PDR, Indonesia, Philippines, Myanmar and Vietnam, and 7.6 million migrants working in Malaysia, Thailand, Singapore and Brunei Darussalam. The 20 million figure does not include Thais and Malaysians going abroad.
HIV than in the local population. However, having presented you with these facts and figures, I also want to emphasize something that is central to today’s meeting: migration is not a risk factor for HIV. It is the conditions in which migrants find themselves or move from one place to another that can put them at greater risk or make them vulnerable to HIV infection.

On reproductive health: There is increasing concern about the reproductive health of migrant women who have less access to reproductive health information and services compared to non-migrants. The barriers that they experience in accessing these services are related to lack of knowledge and information about how the services are organized and delivered. Moreover, in some cases there may be institutional, cultural, language and financial barriers to accessing services, and in some others women may be deported if they are found to be pregnant.

In terms of coverage, migrants and mobile populations are beyond the reach of their home programmes (as they are already abroad) and most of the time not accounted for in the host country programmes.

When it comes to health and welfare services, Governments give priority to their citizens, and usually reject on each other the responsibility of who takes care of migrants. Because of this, many national governments lack clear and convincing policies on migrant populations. This is also compounded by the lack of detailed data on migration. Basically, migrants fall between the cracks. There is lack of money to address their needs, and it is not clear of who is in charge.

Effective migration – health policies would benefit everyone. The principle is simple: migrants themselves would be able to earn better incomes than they would back home; their countries of origin would enjoy these remittances; and destination countries would benefit from their cheaper labor.

However, migration can only contribute to human and economic development if the rights of migrants are protected, including their right to life, right to health, privacy and non-discrimination. For this to happen, all migrants must be treated with the same dignity and respect afforded to others.

Migrants should also enjoy the right to HIV care, support and treatment. This means that states have to ensure means to HIV prevention, confidentiality, counseling and non discrimination; and for those still imposing restrictions on entry, stay and residence consider lifting them like China, South Korea and Fiji have done recently.

Countries should share their positive experiences with migration in the region. There are many good examples to learn from. In the Philippines for example, various government departments in partnership with CSOs have developed comprehensive pre-departure and reintegration programmes for migrants. Thailand is also scaling up its efforts to provide migrants with access to health care, including HIV treatment for those who need it.

The underlying commitments upon which today’s conference has been planned and convened are three:

- One, the Recommendations endorsed in February 2009 at the first High Level Multi-Stakeholder Dialogue on migrant’s health and HIV;
- Two, the 2011 ASEAN Commitments on HIV and AIDS; and
- Three, The 61 World Health Assembly resolution from 2008 and the Operational framework on migrant health that unfolded

As policy makers and development practitioners, it is our duty to follow up on these promises and make sure that they are translated into firm policies and practices.
ASEAN leaders recognize migrant and mobile populations as a vulnerable group to HIV infection and other diseases and have ratified the ASEAN declaration on the protection and promotion of the rights of migrant workers.

Against this background I firmly believe that we need to start thinking about health in the context of human rights and social cohesion.

What we need to get out of this dialogue are clear plans that will indicate to all of us - governments, civil society, and the UN family - how best we can work together to address migrants’ access to health including HIV services on an individual country level, country-to-country but also regional level.

The agenda of this conference has been set so that you can have in-depth discussions on the various challenges you are all facing, and the opportunities we all have at hand, especially if we work together.

In conclusion, let me take the opportunity to express our thanks to the ASEAN Secretariat for co-organizing this meeting. Without their support this meeting would simply not have been possible. I also want to thank the members of JUNIMA for their continuous commitment and support.

I wish this meeting great success and look forward to hearing about its outcomes.

Thank you very much.
SESSION 1: OVERVIEW OF EXISTING FRAMEWORKS AND COMMITMENTS

OVERVIEW OF LABOUR MIGRATION, ACCESS TO HEALTH AND HIV IN SOUTHEAST ASIA

Presenter Ms Marta Vallejo Mestres, HIV/AIDS Programme Specialist, UNDP Asia-Pacific Regional Centre

Presentation Outline

- Characteristics of Migration in Asia
- Migration, Health and HIV
- From the High Level Multi-Stakeholder Dialogue in 2009 to today

Characteristics of Migration in Asia

Main Countries of Origin

Main Host Countries

Complex movement of people in the region
Large Proportion of Migrant Workers in Host Countries

![Bar chart showing the proportion of migrant workers in host countries](chart1.png)

**Foreign Workers in Key Receiving Countries (% of LF)**

Large Increase of Remittances to Developing Asia (USD Bn)

![Bar chart showing the increase of remittances](chart2.png)

**Source:** World Bank

### Summarizing – Migration in Asia

- Very large number of people are moving, and patterns of movement are very diverse
- Some important factors pushing migration include economic and development disparities and improved infrastructure, transportation and communications systems
- The economic gains generated by migrant workers to countries of origin through remittances are considerable
- Migrants in destination countries mainly engage in 3D jobs, which locals either don’t want to do or would charge much larger amounts to do

### Migration, Health and HIV – Health risks and vulnerabilities of migrants

**Poor Access to services by migrants (at home and abroad)**

- Limited preparedness and poor access to information and services render migrants vulnerable
- Agents charge large sums of money which pushes migrant workers into further debt
- High cost of migration is not matched with sufficient wages
- Abusive and exploitative working conditions and lack of redress mechanisms trap migrants in a vicious cycle of poverty
HIV and Migration

- Migration is not a risk factor for HIV, but the conditions under which people migrate increases the vulnerability for HIV infection
- Migrants face discriminatory policies (especially on HIV) facing restrictions on entry, stay, and residence
- Most common reasons cited for these restrictions:
  - to protect public health
  - to avoid possible costs associated with care, support and treatment of PLHIV

HIV specific conditions for migrants throughout the migration cycle

- HIV testing in both countries of origin and host countries is not migrant friendly (no counseling nor support), even though this is an opportunity to inform migrants of HIV risks
- Policies and laws related to HIV specific restrictions on entry, stay and residence of migrant workers either ban PLHIV to enter or restrict their stay
- Globally, 49 countries, territories and areas (including 13 in Asia Pacific) impose some form of restriction on the entry, stay and residence of people living with HIV, based on their HIV status

From the High Level Multi-Stakeholder Dialogue in 2009 to today

High Level Multi-Stakeholder Dialogue on HIV Prevention, Treatment Care and Support, February 2009

- Jointly organized by former UN Regional Task Force/ASEAN Secretary and CARAM Asia
- Produced a very progressive set of recommendations, used as an advocacy tool in the region
- Ministers and Ministries of Health used it during the World Health Assembly of 2009
- First submission to ASEAN Intergovernmental Commission on Human Rights (AICHR)
- Development of an easy to use scorecard

Presentation Summary

- **Large number of people are moving**: Around 44 million are international migrants, and a large percentage are undocumented
- **Unsafe migration puts migrants at risk**: Abusive and exploitative working conditions and lack of redress mechanisms trap migrants in a vicious cycle of poverty
- **HIV Restrictions on entry, stay and residence**: HIV testing, deportation of HIV positive migrants and lack of reintegration perpetuate distressful migration conditions
- **Migrants are beyond reach of programmes**: Migrants are not reached by home programmes and usually not accounted for in host country programmes
- **Governments pass on the responsibility to each other**: When it comes to health and welfare services, governments give priority to their citizens.
- **General lack of comprehensive policies for migrants**: exacerbated by the lack of detailed data on migration and health

Migrants fall between the cracks, lack of money to address their needs, and not clear who is in charge
ASEAN BLUEPRINT 2010-2015, HEALTH AND DEVELOPMENT FRAMEWORK AND COMMITMENTS ON HIV/AIDS

Presenters
Dr Ferdinal M. Fernando, Assistant Director, Health and Communicable Diseases Division, ASEAN Secretariat
Mr Joel Atienza, Associate Senior Officer, Health and Communicable Diseases Division, ASEAN Secretariat

Presentation Outline

- ASEAN Community Overview
- ASEAN Blueprint/Roadmap
- ASEAN Socio-Cultural Blueprint
- Migrants’ Health under ASCC Blueprint
- ASEAN Health Development Framework
- ASEAN Declaration of Commitment on Getting to Zero New HIV Infections, Zero Discrimination and Zero AIDS Related Deaths

ASEAN Community Overview

Transformation of ASEAN

- The ASEAN Charter (2008) and the Road Map for the ASEAN Community (2009) are the two guide posts for ASEAN. The Road Map outlines objectives and strategic activities in areas of the community building process: the ASEAN Political Security Community (APSC), ASEAN Economic Community (AEC) and the ASEAN Socio-Cultural Community (APSCC)

- Central to the achievement of the ASEAN Community is the implementation, monitoring and assessment of outcomes at every stage of the Roadmap, to assess the achievement of goals/outcomes/targets.
- Each of the three pillars of the ASEAN Community (AEC, APSC and ASCC) has a blueprint, which sets out a scorecard and monitoring system (Health and development are highlighted under the ASCC).
ASEAN Socio-Cultural Community (ASCC) Blueprint (2009-2015)

- The goal of the ASCC is to contribute to realising an ASEAN Community that is people-centred and socially responsible with a view to achieving enduring solidarity and unity among the nations and peoples of ASEAN by forging a common identity and building a caring and sharing society which is inclusive and harmonious where the well-being, livelihood, and welfare of the peoples are enhanced.
- Migrant’s are referred to specifically in action lines which sit under Sections A, B and C, as noted in bold below.

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ASEAN Bodies on Migrant Health

ASEAN Socio-Cultural Community

ASEAN Labour Ministers Meeting & Senior Labour Officials Meeting
ASEAN Health Ministers Meeting & Senior Officials Meeting on Health Development
SLOM WG on HIV
ASEAN Committee on Migrant Workers
Lead Countries on Migrants Health
ASEAN Task Force on AIDS

ASEAN Committee on the Implementation of the Declaration on the Protection and Promotion of the Rights of Migrant Workers (AMCW)

- The ACMW was established in 2008, following the adoption of the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers in 2007.
- It is as a subsidiary body of the ASEAN Senior Labour Officials Meeting (SLOM).
- The ACMW has convened a series of meetings and workshops to discuss and develop an ASEAN instrument on the protection and promotion of the rights of migrant workers.
- At the SLOM Meeting in May 2011, the decision was made to take a phased approach in the development of the instrument. They would first focus on issues which are comfortable to all ASEAN Member States in line with the existing national laws and/or policies, and in accordance with the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers.
- Further updates on progress will be provided at the ASEAN Summit in 2012.

Institutionalization of ASEAN Health Development

ASEAN Health Ministers Meeting (AHMM)
Senior Officials on Health Development (SOMHD)

6 ASEAN Working Groups
4 Ad-hoc Task Forces
Networks and Initiatives

- The Health and Communicable Diseases Division of the ASEAN Secretariat coordinates 6 ASEAN Working Groups and 4 task forces, including the AEGD, AEGFS, AWGPD and ATFOA.
ASEAN Task force on AIDS (ATFOA)

Goal
- To prevent further transmission of HIV and mitigate the impacts of HIV and AIDS in ASEAN, by improving regional responses and enhancing Member Countries’ development of people-centred initiatives.

Strategic Objectives
- To promote regional cooperation and partnership in combating HIV and AIDS;
- To strengthen regional capability and capacity in responding to HIV and AIDS;
- To strengthen ASEAN partnership with regional and international partner organizations, civil society organizations and the private sector

Three Strategic Thrusts of ATFOA Annual Work Plan 4 (AWP 4)
1. Policy Advocacy to Promote ASEAN’s (ATFOA) Agenda at International and Regional Platforms Utilizing Evidence-Based Epidemiological Data and Research Findings towards Achieving its Goal;
2. Strengthening Capacity to Plan, Implement and Monitor and Evaluate through Knowledge Sharing among ASEAN Member States;
3. Leveraging for Increased Access to Affordable HIV-Related Care and Treatment.

Major Accomplishments in 2011
- Development of Advocacy Agenda
- ASEAN Regional Report on HIV and AIDS

HIV in ASEAN

ASEAN HIV Prevalence

![HIV Prevalence Map](image)
Characteristics of ASEAN HIV Epidemics

- Higher prevalence of risk behaviours with successful prevention response (SW):  
  *Thailand, Cambodia, and Myanmar: declining HIV prevalence*
- Moderate risk (IDU) with varying response success:  
  *Malaysia: good IDU response, concern for MSM transmission*
  *Indonesia, Viet Nam: expanding epidemic IDU to SW and MSM*
- Currently low prevalence of risk behaviour but evidence/potential for increasing spread  
  *Philippines: recent rapid expansion in certain sites – mixed IDU and MSM*
  *Lao PDR: increasing IDU transmission in border crossing sites*
- Low prevalence of risk behaviour, important migrant population  
  *Singapore and Brunei*

**ASEAN Declaration of Commitment: Getting to Zero New Infections, Zero Discrimination, Zero AIDS-Related Deaths**

**Addressing new HIV Infections:**

- National prevention strategies comprehensively target populations at higher risk, such as people who use drugs, sex workers, and men having sex with men, including transgender people.
- Accelerate efforts to virtually eliminate parent-to-child transmission of HIV and preventing new paediatric HIV infections and eliminate congenital syphilis by 2015.
- Expand and promote access to HIV testing, including provider-initiated HIV testing that is voluntary, confidential and rights-based

**Addressing AIDS-related deaths:**

- Accelerate efforts to achieve the goal of universal access to antiretroviral treatment by 2015, with the target of 80 percent coverage of people living with HIV who are eligible;
- Improve treatment coverage, equity, effectiveness and efficiency
- Expand efforts to combat HIV co-morbidities such as tuberculosis and hepatitis

**Addressing AIDS-related discrimination**

- Promote the health, dignity and human rights of people living with HIV and key affected populations;
- Pledge to eliminate gender inequalities and gender-based abuse and violence

**Sustainability, Ownership and Leadership**

- Develop, update and implement evidence-based, comprehensive, country-led national strategic plans
- Mobilise a greater proportion of domestic resources for the AIDS response in line with national priorities,
- Strengthen the mechanisms of South-South collaboration
- Strengthen the role of ASEAN bodies
- Implement the Fourth ASEAN Work Programme on HIV
- Partnership and collaboration

**How can this all be achieved?**

- National efforts
- Complementary Regional efforts
- Partnership
WORLD HEALTH ASSEMBLY RESOLUTION AND OPERATIONAL FRAMEWORK ON MIGRANT HEALTH

Presenter Ms Jacqueline Weekers, Senior Migration Health Officer, International Organization for Migration (IOM)

Presentation Outline

2008: 61st WHA Resolution on ‘the health of migrants’
- Migrant-sensitive health policies and equitable access to services;
- Capacity building of health service providers and professionals;
- Bi- and multi-lateral cooperation, intersectoral action

2010: Global Consultation on Migrant Health
- Take stock of actions by MS & Stakeholders
- Reach consensus on priority areas and strategies
- Initiate an operational framework to assist MS and stakeholders

Global Consultation on Migrant Health, Madrid, Spain, 3-5 March 2010
- Organized by WHO, in collaboration with the International Organization for Migration and the Government of Spain
- The consultation helped set up priorities in four major cross-cutting areas: monitoring migrant health policy and legal frameworks affecting migrant health; migrant sensitive health systems; and, partnerships, networks and multi country frameworks

Operational Framework: Priorities

Monitoring migrant health
- To identify key indicators useable across countries
- To ensure the standardization and comparability of data on migrant health
- To map good practices in monitoring migrant health, policy models, health system models [...] 

Policy and legal frameworks
- To implement international standards that protect migrants' right to health
- To develop and implement policies that promote equal access to health services for all migrants
- To extend social protection in health and improve social security for all migrants and family members [...] 

Migrant sensitive health systems
- To ensure continuity and quality of care in all settings
- To enhance the capacity of the health workforce to address the health issues associated with migration
- To ensure health services are culturally, linguistically and epidemiologically appropriate [...] 

Partnerships, networks and multi-country frameworks
- To establish and support migration/ health dialogues and cooperation across sectors and countries of origin, transit and destination
- To address migrant health in global and regional processes (e.g. GMG, GFMD)
- To develop an information-clearing house of good practices [...]
Risk Factors for Migrant Health

- Most migrants are healthy, young people - the ‘Healthy Migrant Effect’ - but conditions surrounding the migration process can increase vulnerability to ill health.
- Migrants in an irregular situation are at greatest disadvantage when addressing health risks, because they are not even able to exercise the few rights that they have.
- Limiting access to migrant to health care and leaving migrant health to be managed at the level of emergency care only will have a negative impact on the health of migrants, and also runs counter to public health principles.
- Lack of access to health services ultimately fuels marginalization and reduces productivity. An uneven distribution of MDGs can be witnessed not only between countries but also between population groups within a city or community.
- Marginalized status will fuel risk factors to health and creates a vicious circle.

Working towards a Paradigm Shift

- Traditional approaches to manage the health consequences of migration, have been directed at security of the nation: control of disease, quarantine, and protection of national public health.
- Governments are slowly recognising that in order to reach an approach that addresses diverse societies and realities, we need a paradigm shift, a movement from exclusive to inclusive and multi-dimensional approaches to public health.
- In recent years, we are witnessing an interest in the reduction of health inequities, social protection in health for migrants, the health determinants of migrants health and their vulnerabilities, and moreover NCDs, not just infectious problems.
- Multi-country and multi-sectoral approaches are also becoming more common.

Health as Part of the Global Migration and Development Debates, 2010

- The Global Migration Group is an Inter agency group formed to promote the development and application of international and regional instruments related to migration and encourage better coordinated approaches to international migration
- The Global Forum on Migration and Development is an intergovernmental-, non binding, government-lead process handling global migration and development questions and trends.

Observations from the Global Dialogues

- Migrants tend to be perceived as ‘workers’ who contribute to economic development. There is much less mention about the health dimensions of internationally agreed development goals
- Migration can be both ‘good’ for health and ‘bad’ for health
- The discussion is about costs. The only health related GFMD outcome was : ‘finding cost effective ways to address the health of migrants’

Role of Remittances

Remittance flows to developing countries 2011: 347 USD bn

<table>
<thead>
<tr>
<th>Country</th>
<th>Remittances (USD bn)</th>
<th>% of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>21.3</td>
<td>11.7%</td>
</tr>
<tr>
<td>Vietnam</td>
<td>7.2</td>
<td>7%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>7.1</td>
<td>1.3%</td>
</tr>
<tr>
<td>Thailand</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>Cambodia</td>
<td>0.4</td>
<td>3%</td>
</tr>
<tr>
<td>Myanmar</td>
<td>0.2</td>
<td></td>
</tr>
</tbody>
</table>
'Transnational Family Life’, how healthy is it?

- Household surveys show that remittances reduce poverty and make positive contributions to household welfare, nutrition health and living conditions in their places of origin but contemporary migration also comes with a high emotional cost.
- Costs include: family members living apart; psychological impact on left behind children and heavy burden on elderly grandparents and older siblings; gender roles, identities & inter generational relations change; ‘Global Care Chain’: special issue for women migrants; family disintegration, high divorce rates

**Models to enhance migrant health**

- Numerous national and international agencies, including non governmental agencies are engaged in finding ways to improve aspects of health and access to health services for migrants.
- Approaches are often fragmented and costly, operate in parallel to national health systems and are dependent on external funding and lack sustainability (UN or donor funds).
- Innovative approaches for contributory social security schemes, universal access schemes, compulsory health insurance schemes or employer based health insurances for migrants.

**Countries of Migrant Origin**

- Models include pre-departure orientation, overseas health insurance or insurance for family back home, reintegration assistance. However these initiatives have many limitations. For example: some countries that heavily rely on remittances, such as Sri Lanka and the Philippines put in place insurance schemes for their departing migrant workers, most of whom work in Arab States. Some 18 percent of the Sri Lanka workforce and 10 % of the Philippines workforce work abroad.
- However there are many limitations to each of these models:
  - many migrants go through informal channels without compulsory insurance
  - pre departure training is focused more on screening for visa purposes, counselling too limited (just STIs and HIV)
  - in the host country, a migrants’ health card can be taken away by employer, leaving migrant with no ability to seek health services, no PHC access (emergency care), no attention to NCDs
  - employers don’t pay attention to safety, lack of bilateral agreements
  - families left behind have limited benefits or none
  - on return, migrants report of abuse, preventable deaths
  - Lack of awareness about entitlements: low rate of claims

**Destination countries**

- Wide range of social protection in health models, from equal access to barring access
- Migrants’ legal status determines eligibility, undocumented migrants being most vulnerable
- Portability of benefits is rare
- Great lack of awareness about entitlements on the side of migrants and health service providers

**Multi-lateral arrangements**

- These are rare, but one promising model is the ‘Ibero American multilateral agreement on social security’

**Recommended approaches**

- Mitigate the burden of out-of-pocket health spending
- Develop/strengthen bilateral and multilateral social protection agreements that include health
- Explore the role of employers and private sector partners in health security schemes
- Raise awareness among migrants of their entitlements
- Research economic impact of current social protection in health schemes
DISCUSSION

Following is a summary of the key points that were addressed during discussion following the three Session 1 presentations.

1) **Note on the existence of WHO biennium country workplans in each of the 10 ASEAN countries**
   - WHO country workplans propose country actions and contributions that WHO as an agency can make.
   - They are developed in close cooperation with countries and are open to change.
   - One way delegates at this Dialogue might advocate for the rights of migrant workers in their home countries would be to look through your WHO biennium workplan and call on your WHO country office to insist that migrant health issues be reflected, and that proposed country interventions are devised based on assessment of the position of migrants and their access to health services.

2) **Note on the importance of civil society in improving migrant workers’ access to health services**
   - Although governments have very good overarching plans and frameworks, access to communities is essential in developing these plans and ensuring these plans come to fruition.
   - Civil society is a key partner in this regard, as such it is very important that the government and civil society work together.

3) **Questions as to where women/gender issues taken up in these frameworks**
   - Within ASEAN, the Division of Social Welfare, Women and Migrant Workers coordinates on women’s issues relating to labour and migrants. However in this region, it is very much country-specific how well women migrants’ access to health is addressed.
   - The ASEAN declaration on rights of migrant workers is a very broad policy that doesn’t address particular obligations for addressing issues related to women migrant workers’ rights. Nevertheless there are some provisions which deal with womens’ rights, for example encouraging, for returning migrants, the provision of access to an alternative livelihood in the country of origin.
   - The SOM working group on HIV Prevention and Control in the workplace endorsed its first workplan which includes certain activities that address women’s rights.
   - Point was noted that there has been an increased interest in capturing data on women. For example: UNFPA are about to publish a desk review on the ‘Socio-cultural influences on the sexual and reproductive health of female migrant workers in four Mekong region countries: Cambodia, Laos, Thailand and Vietnam’.
   - CARAM Asia has also worked on the issue of labour migration and reproductive health and HIV/AIDS.
   - One of the thematic interests for AICHR for 2011/12 is migration and they are particularly interested in migrant women.

4) **Question as to where young people are addressed in these frameworks**
   - Although an important issue, little work has been done so far within frameworks discussed, although it was noted that until mid 2011, UNICEF was the Global Migration Group Chair and produced relevant materials on the topic (www.globalmigrationgroup.org).
   - It is important to note that young people can be addressed in two ways: young people who are migrants, or young people who are left behind by migrants.

5) **Questions regarding discussion of migrant workers’ at November ATFOA summit, and within ASEAN**
   - While the ASEAN Declaration of Commitment on HIV/AIDS was adopted and is available for dissemination, there was no specific discussion of migrant workers.
At the Senior Officials Meeting on Health Development (SOMHD) in Myanmar in July 2011, migrant health was discussed, as part of the Strategic Framework on Health and Development.

There is currently no technical working group looking specifically at migrant health and access to health care. Instead the SOMHD designated three countries (Thailand, Indonesia and Philippines) to ‘lead’ on migrant health issues, coordinating activities such as the development of an advocacy tool on migrant health, and organizing workshops and seminars to share information on best practices and develop a regional cooperation framework. Outputs from these workshops and seminars would be tabled at the ASEAN Health Ministers Meeting, to be held in July 2012.
SESSION 2: SHARING OF EXPERIENCES ON INITIATIVES ON IMPROVING MIGRANT WORKERS’ HEALTH AND ACCESS TO HIV SERVICES

INDONESIA: HIV/AIDS NATIONAL ACTION PLAN FOR MIGRANT WORKERS

Presenter Dr Fonny Jacobus Silfanus, Deputy, National AIDS Commission

Presentation Structure

• HIV Epidemic in Indonesia
• National Action Plan for Migrant Workers
• Development Process

HIV Epidemic in Indonesia

Estimated number of PLWHIV in 2009: 186,257


Future trend of the HIV epidemic in Indonesia

Modelling estimate is 186,257 PLWHIV in 2010 and 813,720 PLWHIV in 2014.
HIV Prevalence among Indonesian Migrant Workers

- National HIV prevalence is 0.2%.
- HIV Prevalence among migrant workers around 0.11% (160 HIV positive out of 145,289 in 2005, and 174 positive out of 162,027 in 2009)
- Most migrant workers tested are women from rural areas
- Indonesia Migrant Workers around 6 million (legal and illegal)


Enactment Process
1. Recruitment of three persons as a core writing team, two NGO representatives and one National AIDS Commission representative
2. Defining the framework of document with the Migrant and Mobile Population Working Group (MMP)
3. Writing process & enrichment through consultation meeting with members of MMP Working Group.
4. Focus group discussion/in depth interviews
5. Review meeting with an expert panel, including representatives from the National Board on Placement & Protection of Indonesian Migrant Workers (BNP2TKI), the Ministry of Manpower, the Ministry of Health, the Ministry of Foreign Affairs, the Migrant Workers’ Labour Union (Sarikat Buruh Migrant Indonesia)
6. National workshop (October 2011)
7. Sub-national workshop in two provinces (November 2011)
8. Finalization of action plan (November - December 2011)

Targets (in line with SRAN HIV/AIDS 2010-2014)
- Program Coverage: 80% of migrant worker populations reached by effective prevention programs
- Program Effectiveness: 60% of migrant workers practice safe behaviours
- Program Sustainability: 70% budget covered by domestic funding

Strategic Priorities

Focus Area
- Prevention
- Care, support and treatment
- Mitigation of economic and social impact
- Establishment of conducive environment

Geographic Focus
- 10 Provinces and 107 districts & cities

The Action Plan

Prevention
- Scaling Up prevention programmes in sending areas and transit areas
- Increase quality of education in Migrant Workers’ Orientation Program (BLKLN)
- Increase quality of education in Pre-Departure Orientation (PAP)
- Provision of information access to migrant workers during employment.
- Scaling up community empowerment program
- Implementation of migrant-friendly testing and counseling
SESSION 2: SHARING OF INITIATIVES ON IMPROVING MIGRANT WORKERS’ HEALTH AND ACCESS TO HIV SERVICES

Care, Support & Treatment
- Scaling up counseling & HIV test for migrant workers in sending areas (before they enter transit areas)
- Development & implementation of proper referral system for HIV-positive migrant workers
- Increase collaboration with destination countries in regards to migrant workers’ health services & access
- Regular monitoring to ensure quality of local migrant workers’ medical agents

Mitigation of Social & Economic Impact
- Ensure all migrant workers receive national/local medical insurances and increase migrant workers’ access to other insurances.
- Socio-economic support for poor HIV-positive migrant workers.

Establishment of Conducive Environment
- Review the National Law on Placement & Protection of Indonesia Migrant Workers (UU 39/2004)
- Establishment of accurate and complete database system of migrant workers
- Enhance collaboration with destination countries and borders authorities (trafficking)
- Research on migrant workers’ biological & behavior status

Conclusion
- Migrant workers are vulnerable and at high risk for HIV infection
- Multi-sectoral coordination and collaboration to implement the Action plan at all levels, is very crucial.
- Collaboration among ASEAN countries is important to ensure success of action plan.

DISCUSSION

Following this presentation, the following points were clarified in discussion with delegates:

1) **Source of funding for HIV/AIDS National Action Plan for Migrant Workers**
   - Currently 40 per cent of funding comes from domestic budget and 60 per cent from donors. The aim is to decrease dependency on donors and increase domestic budget, with 70 per cent domestic funding being the target.

2) **Provision of information to departing migrant workers**
   - Information is given to migrant workers in their home town and also their transit point, that is, before they depart Jakarta.

3) **Use of health insurance by migrant workers**
   - Workers are supposed to pay part of their insurance before they depart and the remainder after they come home (approximately 4000 rupiah in total). The process of accessing insurance can be quite complicated.
   - In 2011, the Ministry of Labour passed a decree on insurance for migrant workers, however this insurance mechanism can only be used for opportunistic infections. Insurance will cover some illnesses, unpaid wage, death of migrants. HIV-related health services cannot be claimed, but other sexual and reproductive health issues might be covered.

4) **Mechanisms for collaboration with destination countries to provide access to health services**
   - Cooperation between Indonesia, as a sending country, and destination countries is very poor, as there is less incentive for destination countries to pay attention to migrant workers.
PHILIPPINES: INITIATIVES ON IMPROVING MIGRANTS’ HEALTH AND HIV/AIDS SERVICES

Presenter: M.A. Teresita Cucueco, Executive Director, Occupational Safety and Health Center (OSHC), Department of Labor and Employment

Outline of Presentation

- Philippines Statistics on HIV/AIDS
- Government and Civil Society initiatives on HIV and Migration
- Challenges in Implementation and Improving Migrant workers health and access to HIV

Philippines Statistics on HIV/AIDS


<table>
<thead>
<tr>
<th>Demographic Data</th>
<th>September 2011</th>
<th>Jan-Sept 2011</th>
<th>Cumulative Data 1984-2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Reported Cases</td>
<td>253</td>
<td>1,669</td>
<td>7,684</td>
</tr>
<tr>
<td>Asymptomatic Cases</td>
<td>248</td>
<td>1,598</td>
<td>6,748</td>
</tr>
<tr>
<td>AIDS Cases</td>
<td>5</td>
<td>71</td>
<td>936</td>
</tr>
<tr>
<td>Males</td>
<td>240</td>
<td>1,549</td>
<td>6,246*</td>
</tr>
<tr>
<td>Females</td>
<td>13</td>
<td>120</td>
<td>1,427*</td>
</tr>
<tr>
<td>Youth 15-24ye</td>
<td>82</td>
<td>495</td>
<td>1,799</td>
</tr>
<tr>
<td>Children &lt;15ye</td>
<td>0</td>
<td>3</td>
<td>58</td>
</tr>
<tr>
<td>Reported Deaths due to AIDS</td>
<td>2</td>
<td>15</td>
<td>339</td>
</tr>
</tbody>
</table>

*Note: No data available on sex for eleven (11) cases.

Number of New HIV/AIDS cases per month (2009- Sept 2011)

Number of HIV/AIDS cases reported by year
SESSION 2: SHARING OF INITIATIVES ON IMPROVING MIGRANT WORKERS’ HEALTH AND ACCESS TO HIV SERVICES

Comparison of Male/Female HIV/AIDS cases by age group

Reported Mode of HIV Transmission

<table>
<thead>
<tr>
<th>Mode of Transmission</th>
<th>Sept 2011 n=233</th>
<th>Jan–Sept 2011 n=1,889</th>
<th>Cumulative n=7,684</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Contact</td>
<td>226</td>
<td>1,997</td>
<td>7,013</td>
</tr>
<tr>
<td>Heterosexual contact</td>
<td>39(17%)</td>
<td>290(19%)</td>
<td>2,764(49%)</td>
</tr>
<tr>
<td>Homosexual contact</td>
<td>107(47%)</td>
<td>733(46%)</td>
<td>2,569(37%)</td>
</tr>
<tr>
<td>Bisexual contact</td>
<td>80(35%)</td>
<td>568(36%)</td>
<td>1,644(23%)</td>
</tr>
<tr>
<td>Blood/Blood Products</td>
<td>0</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Injecting Drug Use</td>
<td>27</td>
<td>63</td>
<td>218</td>
</tr>
<tr>
<td>Needle Prick Injury</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Mother-to-Child</td>
<td>0</td>
<td>3</td>
<td>55</td>
</tr>
<tr>
<td>No Data Available</td>
<td>0</td>
<td>5</td>
<td>375</td>
</tr>
</tbody>
</table>

Reported Mode of HIV Transmission among Overseas Foreign Workers (OFWs)

<table>
<thead>
<tr>
<th>Mode of Transmission</th>
<th>Sept 2011 n=16</th>
<th>Jan–Sept 2011 n=200</th>
<th>Cumulative n=1,729</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Transmission</td>
<td>16</td>
<td>206</td>
<td>1,667</td>
</tr>
<tr>
<td>Heterosexual contact</td>
<td>10(62%)</td>
<td>85(41%)</td>
<td>1,089(65%)</td>
</tr>
<tr>
<td>Homosexual contact</td>
<td>1(6%)</td>
<td>55(27%)</td>
<td>332(20%)</td>
</tr>
<tr>
<td>Bisexual contact</td>
<td>5(31%)</td>
<td>69(32%)</td>
<td>247(15%)</td>
</tr>
<tr>
<td>Blood/Blood Products</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Injecting Drug Use</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Needle Prick Injury</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>No Data Available</td>
<td>0</td>
<td>0</td>
<td>48</td>
</tr>
</tbody>
</table>

Number of OFWs compared to non-OFWs by year

*Data includes January to September 2011 only.*
Profile of HIV Positive OFWs

- 1,729 HIV-positive OFWs (1984-2011)
- 76% are male (1,317)
- Age range from 18 to 69 years (median 35 years)
- Predominant mode of transmission is sexual contact (96%)
- Asymptomatic cases: 84% (1,454)
- AIDS cases: 16% (275)

Government Initiatives on HIV and Migration

All government initiatives address three key documents

- Millennium Development Goals: MDG 6, Combat HIV and AIDS
- Republic Act 8504: Philippine AIDS Prevention and Control Act
- Republic Act 10022: Migrant Workers and Overseas Filipinos Act of 1995 as amended

Department of Health

- Has established AIDS Medium Term Plan, 2011-2016
- Provide Philhealth Package for Overseas Foreign Workers
- Department Order 01-04, s.2006 provides guidelines on the referral system of repatriated OFWs diagnosed with HIV abroad
- National demographic survey on key affected populations of OFWs
- Treatment services

Department of Foreign Affairs

- Integration of HIV in the pre-departure orientation seminar and training curriculum of all departing foreign service personnel and officers (since 2004)
- Development of a guidebook on Handling HIV cases among OFWs Onsite
- Conducting HIV awareness seminars for department personnel of Office of the Undersecretary for Migrant Workers’ Affairs (OUMWA), Office of Consular Affairs (OCA), Foreign Service Institute (FSI)

Department of Labor and Employment

- Labor offices in-charge of migration are the Philippine Overseas Employment Authority (POEA) and Overseas Workers Welfare Administration (OWWA)
- Education and Information Dissemination includes integration of HIV Modules into:
  - Pre-employment and Pre-Departure Orientation Seminar (PEOS and PDOS)
  - Capability Enhancement of Public Employment Service Office (PESO) Managers in Local Government Units
  - Continuing Education for Recruitment Agency Personnel and Applicants
  - Training of Overseas Labor Officers (POLOs) to provide needed services onsite

Department of Labor and Employment and Department of Foreign Affairs

- On-site assistance to nationals through Migrant Workers and Other Overseas Filipinos Resource Centres (24 hour information and assistance centre established in Phillipines Embassies and Consulates in locations with large numbers of OFWs)
- Assistance includes:
  - HIV/AIDS Counselling
  - IEC material dissemination
  - Legal and Consular Services (for OFWs with problems of deportation, arrest and dismissal from work)
  - Welfare Assistance (medical and hospitalization)
  - monitoring daily situation affecting migrant workers
Department of Labor and Employment and Partners

- 24 Hour information Centre (OWWA) facilitates communications of OFWs with their families
- Credit and livelihood training and related services (OWWA and NGOs/CSOs)
- Insurance (Social Security System)
- Health Care (OWWA and NGOs/CSOs)
- Return and Reintegration initiatives include:
  - Referral for Loans and Livelihood training from the National Reintegration Center for OFWs (NRCO)
  - Skills training and upgrading by TESDA (Technical Education and Skills Development Authority)

CSO Initiatives

- Conduct of pre-departure seminars on HIV and AIDS for OFWs (among seafarers, domestic workers, other land-based workers)
- Care and support (counselling, referrals) for HIV+ OFWs
- Community-based programmes for female spouses of seafarers
- Advocacy for recognition of migrant workers human rights, including right to health
- Action-researches to inform HIV and other health related programmes (sexual reproductive health and mental health) of migrant workers

Flow Chart for Overseas Welfare Officers in Managing HIV-positive OFWs

Flow Chart for Management of Repatriated HIV (+) OFW Cases
SESSION 2: SHARING OF INITIATIVES ON IMPROVING MIGRANT WORKERS’ HEALTH AND ACCESS TO HIV SERVICES

Issues and Challenges on Assistance to OFWs and other Filipino Nationals

- Reports from Philippines Overseas Labor Officers (POLOs)
  - Fear of Stigma
  - Fear of Disclosure of Disease by Embassy POLO staff
  - Lack of Trust and Confidence on Foreign service personnel
- Recommendation: Enhance and strengthen capacities of Philippine Embassy staff, DFA consular officers, Philippines Overseas Labor Officers and OWWA Representatives
  - Training on Counseling
  - Strengthen referral systems

DISCUSSION

Following this presentation, the following points were clarified in discussions with delegates:

1) Pre-departure Orientation

- One of the challenges in this area is monitoring delivery. While Philippines AIDS law contains a provision which requires all overseas foreign workers and overseas personnel to undergo HIV education, there are different entities accredited to deliver the actual orientation seminars. The majority of those accredited are private recruitment agencies and while these entities are all provided with a standard module for delivery, it is difficult to monitor which exact messages are delivered to participants.
- Given that recent data suggests that many of the returning workers with HIV are MSM, it is important to note that we do strongly integrate issues of stigma into pre-departure orientation. In addition, when we talk about protection we do not censure information, rather, information on all measures for prevention and protection is provided. For many condoms would be the first line of defense against HIV and information regarding condoms is given freely.

2) Post-arrival on site trainings

- Post-arrival on site orientations do continue to be given, however there is no data available on how frequently these occur. Generally CSOs work together with government officers on site to delivery post-arrival trainings. In areas where particular concerns are identified, on-site seminars will be delivered to overseas foreign workers as required.

3) Insurance Protections

- Insurance protections discussed in this presentation are available for family members and dependents who remain in the origin country.
- Insurance covers all illnesses, including HIV, which might affect overseas foreign workers and families.
- There is a clear gap in insurance provision for undocumented migrant workers. Unless they register and pay fees there are not covered, and it is not clear if collection agencies will continue collecting insurance fees for those workers that were originally documented workers. This is an important area to investigate.
THAILAND: SHARING OF INITIATIVES ON IMPROVING MIGRANT WORKERS’ HEALTH AND ACCESS TO HIV SERVICES

Presenter  Mr. Promboon Panitchpakdi, Raks Thai

Prevention of HIV Among Migrant Workers in Thailand

- Funded by GFATM
- PHAMIT 1 (2003-2007) round 2
- PHAMIT 2 (2008-2014) round 8
- RCC for ARV, care and support 2008-2014
- TB 2009-2014
- Organizations involved include: Raks Thai, World Vision, Pattanarak, Foundation for AIDS Rights, Stella Maris, Map Foundation, SDA, and Ministry of Public Health

Various types of documented migrants
1,335,155 migrants documented in 2010. Of this number,
- 932,255 with Tor Roh 38/1 (temporary permit)
- 228,411 with passport and visa (National Verification)
- 40,032 MOU passport and visa
- 70,449 other types of migrants
- 23,340 minority groups
- 23,245 special investment promotion
- 14,423 allow permanent migration

Health Insurance Coverage
- **Group A, passport and visa holders:** Employee and employer pays 5% of salary and government contributes 3% (employee now reduced to 3%). This is around 3,600 baht per year (Baht 30 = 1 USD) or 2,160 based on 3%.
- **Group B, Toh Roh 38/1 (temporary permit):** Compulsory health insurance administered by Ministry of Public Health requires migrant to pay 1,300 baht per year and an additional 600 Baht for health examination.

Undocumented workers
- Unknown number, includes children in various years (some allowed to be documented with parents)
- Policy – arrest and deportation
- No health insurance but can pay for medical treatment at government or private hospital
- On special conditions, decided by service provider, undocumented workers can benefit from “free treatment”

Health Promotion
- For holders of temporary residence (Toh Roh 38/1), from health insurance payment of 1,300 baht, 206 baht is for health promotion (932,255 x 206 = $6.4 million a year). 964 baht is for treatment or curative services and the remaining 130 baht is for administration. This managed by MOPH and participating hospitals.
- Under the Social Security system the insurance covers mainly treatment and is managed by the Social Security Office attached to the Ministry of Labour.
SESSION 2: SHARING OF INITIATIVES ON IMPROVING MIGRANT WORKERS’ HEALTH AND ACCESS TO HIV SERVICES

**What are the HIV relevant costs?**

**Prevention**
- Cost of BCC translation and modification to meet specific population groups
- Cost of production and dissemination
- Cost of outreach workers and volunteers (*regular cost) plus appropriate media channels
- Referral system and VCT and STI
- Condoms and other related materials
- Reproductive health and GBV

**Treatment**
- Cost of monitoring for treatment
- Cost of opportunistic diseases treatment and monitoring
- Cost of ART and monitoring
- Outreach psychosocial programs
- Programs to reduce discrimination and promote social integration
- Cross-country treatment

**What the prevention program includes**
- Migrant Health Assistants hired by hospitals or by civil society organizations
- Outreach volunteers that are trained and motivated to provide information and condoms to peers
- Tailored documents in various languages including Burmese, Mon, ethnic languages, Lao and Cambodian
- Cross-country prevention
- Working with employers and coordinating with labor offices
- Working on gender based violence
- Promoting safe migration including registration and national verification
- Policy development and advocacy toward health insurance for all migrants including dependents.
- Children’s learning centers

**What happens without international funding**
- Would remain a hospital based program with out and outreach activities.
- Condom availability would be reduced
- Information and education would be extremely limited.
- Hard to reach would not be reached – migrant sex workers, workers in fisheries, undocumented workers.
- Treatment (ART) would not be available.

**What should be done?**

**Thailand**
- Health insurance for all that includes minimum package on health promotion.
- Strengthen collaboration between civil society and government on outreach programs on long term basis.
- Develop mechanisms that can include all migrants and dependents.
- Revise laws that restrict Thai government budget being spent on migrant health, welfare and protection.
ASEAN

- Agreement in ASEAN of minimum health package (insurance) for all ASEAN citizens (or persons) wherever they are, with added health investment depending on the size of the population and the added value that this population creates for the country they are staying in. This minimum package is paid by cost sharing between respective members including the private sector/employers.

Migrants are people - citizens, sisters, brothers, friends and their children.

DISCUSSION

Following this presentation, the following points were clarified in discussions with delegates:

1) **Importance of culturally and linguistically appropriate information provision**
   - In the new UNAIDS strategy, culture is not really addressed (in fact, it is mentioned only once). If people do not receive information that is culturally and linguistically appropriate, prevention programs are not going to be successful.
   - It is particularly important to look at how we address all those who don’t fit the ‘norm’, those who are cut off from information and who are not even aware of what treatment they are allowed to access.
   - In order to develop tailored strategies, we need to develop ethnically-disaggregated data, for use in correctly focus and direct our efforts.

2) **Health insurance coverage**
   - Migrants only pay under one of the two programs discussed in this presentation. Either 1300 baht under temporary registration, or under social security if they have a passport. One person, one program, one time.
   - With regard to OHS issues, bigger employers are bound by law to adhere to OHS standards of care for all employees (including migrants). However, it is also true that many of the employers who hire migrant workers may be small employers or from informal sectors, so they can slip below this law.

3) **Prevention and Treatment Programs**
   - The Global Fund program has two parts - one is prevention, the other is treatment. It is important to note that care and support is included under treatment, however provisions for this are small. The question remains as to how we can get government to support these care and support programs.
Sessions 3-6 of the meeting each focused on one of the four pillars of the Operational Framework, introduced in Session 1 (see page 13), as follows:

- **Pillar One:** Policies and Legal Frameworks Affecting Migrant Health
- **Pillar Two:** Monitoring Migrants’ Health
- **Pillar Three:** Partnerships, Networks and Multi-Country Priorities
- **Pillar Four:** Migrant Sensitive Health System

Each session commenced with a presentation from an expert speaker on a topic related to the specific pillar under discussion. This was then followed by a short intervention by meeting facilitator, Ms Jacqueline Weekers, who briefly introduced the pillar under discussion and gave an overview of priorities under this pillar.

The ten country groups then split into three large groups for 60 minute break-out sessions, addressing the following three questions:

1. On which priorities has progress been made? What has been achieved or partly achieved and by whom? What were the supporting factors?
2. On which priorities has there been a lack of progress and why? What were the challenges or obstacles?
3. What is missing in the framework for your region and country? Any suggested new priorities?

After group break-out sessions a plenary was held where group rapporteurs shared with the group the results of group discussions.
SESSION 3: PILLAR ONE, POLICIES AND LEGAL FRAMEWORKS AFFECTING MIGRANT HEALTH

Pillar One priorities

- Adopt and implement relevant international standards on protection of migrants and respect for rights to health in national law and practice
- Develop and implement national health policies that incorporate a public health approach to health of migrants and promote equal access, regardless of their status
- Monitor the implementation of relevant national policies, regulations and legislations responding to the health needs of migrants
- Promote coherence among policies of different sectors that may affect migrants’ ability to access health services
- Extend social protection in health and improve social security for all migrants

PRESENTATION: RECOMMENDATIONS CONCERNING HIV AND THE WORLD OF WORK, 2010 (REC. 200)

Speaker Mr Richard Howard, Senior Specialist on HIV and AIDS, International Labour Organization (ILO)

Migrant Vulnerabilities

Migrant workers make the best contribution to economic and social development in host and source countries if they enjoy decent working conditions, and if their fundamental human and labour rights are respected.

ILO definition of Decent Work

- Fair working conditions: wages, occupational health and safety, working hours
- Access to social protection: health insurance, unemployment compensation, pensions
- Non – discrimination
- Freedom of association: worker’s right to organize and negotiate their rights

International Labour Standards

- Conventions: Become international law when countries voluntarily ratify them
- Recommendations: Apply immediately as guidelines for national policy and practice

ILO Labour Standards and Migrants

- All ILO labor standards, including core Conventions enshrined in the ILO Declaration on Fundamental Principles and Rights at Work, apply to migrant workers unless stated otherwise in the instruments
- Much more remains to be done regarding enforcement of rights protections and ensuring access to redress mechanisms
- 8 Fundamental standards – include protection of migrant workers – labor rights, freedom of association, OSH, social security
- Conventions 97 and 143 - offer comprehensive protection for documented and undocumented migrants
- Multilateral Framework on Migration – includes key principles from labor standards
- Domestic Workers – standard and anticipated convention
- Standard on HIV and AIDS in the Workplace – Recommendation 200
Eight Core Conventions on Human Rights

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<tr>
<th>Convention</th>
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<tbody>
<tr>
<td>29</td>
<td>Forced Labour, 1930</td>
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<tr>
<td>87</td>
<td>Freedom of Association and Protection of the Right to Organise, 1948</td>
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<td>98</td>
<td>Right to Organise and Collective Bargaining Convention, 1949</td>
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<tr>
<td>100</td>
<td>Equal Remuneration Convention, 1951</td>
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<td>105</td>
<td>Abolition of Forced Labour Convention, 1957</td>
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<td>111</td>
<td>Discrimination (Employment and Occupation), 1958</td>
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<tr>
<td>138</td>
<td>Minimum Age Convention, 1973</td>
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<td>182</td>
<td>Worst Forms of Child Labour Convention, 1999</td>
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Migrant Specific Conventions

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<tr>
<th>Convention</th>
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<tr>
<td>97</td>
<td>Convention concerning Migration for Employment (Revised 1949)</td>
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<td>143</td>
<td>Migrant Workers (Supplementary Provisions) (1975)</td>
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<td>Viet Nam</td>
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ILO Recommendation 200

Universal access to prevention, treatment, care and support services for all workers working under all forms or arrangements, and at all workplaces, regardless of legal status or occupation.

Emphasis on Migrants

- prohibits mandatory testing, screening, or disclosure at any stage of migration
- prohibits discrimination in or exclusion from migration on the basis of real or perceived HIV status
- migrants should have universal access to HIV education, information, treatment, care and support and that, whenever appropriate, agreements should be concluded among the countries concerned
- provides for training, safety instructions and any necessary guidance to be given in a clear and accessible form to ensure a safe and healthy work environment for migrant workers
- all measures for migrant workers apply to countries of origin, countries of transit and countries of destination

GROUP BREAKOUTS

Groups for this session were as follows:

- Group 1: Thailand, Laos
- Group 2: Cambodia, Myanmar, Singapore, Philippines
- Group 3: Brunei, Malaysia, Indonesia, Vietnam

Following is a brief summary of key points raised during group discussions on the five priorities under this pillar. See Annex I (p.47) for a complete matrix of responses from individual countries.

In terms of the adoption and implementation of relevant international standards, all Member States have endorsed both the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers (2007) and the Resolution on the Health of Migrants (2008), although a regional instrument on the ASEAN Declaration is yet to be developed. Member States have also ratified between two (Brunei) and eight (Cambodia, Indonesia, Philippines) of ILO’s eight fundamental conventions on Human Rights. The great challenges under this priority, as reported by country delegates during group discussions, remain in: (i) implementation and follow-up at the national level; and, (ii) lack of awareness among stakeholders of the existence of, or protections afforded by, various conventions and resolutions.

With regard to priorities on development, implementation and monitoring of national health policies responsive to migrants’ health needs, a number of countries noted the gulf between the international law that comes into existence following convention ratification, and the national laws and policies that might subsequently be implemented under guidance of these conventions. While some delegates noted that their countries were very good at signing conventions, key challenges under the second and third priorities were related to: (i) who would be monitoring the implementation of international law within ASEAN; and, (ii) which sector or focal point might take charge of implementation within the national environment. Again, the issue of awareness was a key challenge under these two priorities, with countries noting that even in those cases where equal access existed, migrant workers were unaware such access applied to them.

Regarding HIV in particular, countries noted the framing of both migrants and HIV in terms of security, national territory and boundaries has meant that policies do not focus on public health but rather health status. HIV in particular, has become another category by which to restrict the movement of people. As a
result of this framing of migrants and health issues, migrants often perceived embassies and consulates with some level of fear and were not confident about approaching them for assistance.

Under the fourth priority, **promoting coherence among policies of different sectors**, countries raised a number of key questions related to the multi-sectoral nature of migrant health policies and protections, asking: (i) who might be the leads or focal points at the national level; and, (ii) who might monitor compliance against international law and national policies. The consensus among all countries was that in order to properly tackle the challenge of providing health access for migrant workers, a coherent multi-sectoral response was necessary.

One of the most frequently raised questions under this pillar related to the final priority of **extending social protection in health for all migrants**, namely ‘Who pays? Countries raised the issue of differing priorities between sending and receiving countries. While sending countries might work towards improvements in health care access for their migrant workers going abroad, receiving countries were more concerned with potential economic costs of providing equal access. In order to combat this, countries noted the need for: (i) greater awareness on costs/benefits of providing social protection; (ii) greater advocacy on the point that both sending and receiving countries benefit from migrant workers; and, (iii) the need to address myths, stigma and discrimination against migrants and health issues, particularly HIV.

**Multi-country and regional initiatives** raised as examples under this pillar included memoranda of understanding (MoU) between Thailand and Laos, Thailand and Myanmar and Thailand and Cambodia. Each of these MoU were focused primarily on labour migration management rather than social protection, health and HIV, although it was noted that the legalization of migrant workers under these MoU and flexibility of workers to change employers could ease ability for migrants to access health schemes available in Thailand.

In addition to those challenges addressed above, a key point raised across all priorities was the question of how to address undocumented workers within policy and legal frameworks on migrant health.
SESSION 4: PILLAR TWO, MONITORING MIGRANTS’ HEALTH

Pillar Two Priorities

- Ensure the standardization and comparability of data on migrant health
- Support the appropriate disaggregation and analyses of migrant health information in manners that account for the diversity in migrant populations
- 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
- Identify and map: 1. good practices in monitoring migrant health; 2. policy models for equitable access to health; and 3. migrant-inclusive health systems models and practices
- Develop useful data for decision-making and monitoring of the impact of policies and programs

PRESENTATION: STRENGTHENING HEALTH SECURITY IN THAILAND BY IMPROVING HEALTH STATUSES OF MYANMAR REFUGEES AND DISPLACED PERSONS IN THAILAND

Speaker Dr. Brent Burkholder, Border and Migrant Health Team Leader, World Health Organization (WHO)

Presentation Objectives

- Provide a brief overview on the status of refugees (‘displaced persons’) and migrants in Thailand
- Describe current health surveillance and provision of health services for this population
- Describe the WHO-MoPH project to strengthen health security (focus on health surveillance)

Refugees and Migrants in Thailand

Myanmar refugee camps (‘temporary shelters’) in Thailand

Population in 9 camps:

- Registered: 95,330
- Unregistered: 45,746
- Estimated total: 141,076

*Source: Thailand Migration Report 2011
Health care services for refugees

- NGOs provide basic primary care, water, sanitation, and prevention services
- Tertiary care provided by local district/provincial hospitals

Migrants in Thailand

<table>
<thead>
<tr>
<th>Status</th>
<th>Estimated Population (end 2010)</th>
<th>Health care provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under MOU</td>
<td>78,686</td>
<td>Eligible for Social Security</td>
</tr>
<tr>
<td>Entered or Completed National Verification process</td>
<td>932,255*</td>
<td>Eligible for Compulsory Migrant Health Insurance Scheme</td>
</tr>
<tr>
<td>Unregistered and family members</td>
<td>1,444,803</td>
<td>NGO, out of pocket, or deferred care</td>
</tr>
<tr>
<td>Total</td>
<td>2,455,744</td>
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</tbody>
</table>

*87% Myanmar, 6% Lao, 6% Cambodian  
Source: Thailand Migration Report 2011

Disease Surveillance Systems—refugees and migrants

Existing surveillance systems

Key Challenges

- Thailand is not a signatory of the UN Convention on Refugees
- Uneven policies regarding migrants result in uneven access to health services and limited coverage of health insurance for non-Thai populations
- Gaps in health services for migrants/refugees as a result of inaccessibility, language barriers
- Sustainability of funding to NGOs and unfunded services covered by districts/provinces for those unable to pay
- Lack of timely, accurate demographic and health data on migrant populations
- Improve surveillance and disease control coordination among all key actors (GOs, IGOs, NGOs, local administration office, communities)
- There is a need for broad health system strengthening to achieve equitable and sustained improvement
Strengthening health security in Thailand by improving health statuses of Myanmar refugees and displaced persons (AUP Project)

Funding

- EU funded under “Aid to Uprooted People Program” for 2011-14

Objectives

- To develop appropriate long term policies and mechanisms to ensure equitable access to government mainstream health services for refugee and MDPs living in camps and surrounding areas.
- To ensure public health security of society by strengthening disease surveillance and outbreak response and outbreak prone disease preparedness in refugee camps and surrounding areas.
- To ensure that public health gaps of the target populations are well defined and addressed.

Key Partners

- WHO and Bureau of Policy and Strategy, Thailand Ministry of Public Health
- Other key collaborators include the Bureau of Epidemiology, Provincial/district health offices, Mae Sot Hospital, NGOs, Institute for Population & Social Research at Mahidol University

Target

- Refugees (140,000) and displaced persons: migrants (+/- 300,000) in 4 provinces (Mae Hong Son, Tak, Ratchaburi and Kanchanaburi)
- Medical staff, approximately 150 from 5 medical agencies (AMI, ARC, IRC, MI and SMRU) in refugee camps
- Wider Thai and migrant populations

Objective 1: Develop long term policies and mechanisms

- ‘Migrant regularization policy’
- Recognition that health of migrants is an important issue from the perspective of human rights, public health, and economics
- Address three major health policy issues: how to pay for the system, how to ensure that migrants can access the health system; and, how to improve the quality of services migrants receive

Key strategies

- Support development of revised Border Health Master Plan for MoPH
- Provide evidence base to formulate coherent policy across sectors to promote the right to health of refugee/non-Thai displaced persons

Objective 2: Strengthen health information system and outbreak response

Key strategic activities

- Establish “border health units” within BPS and at provincial/district levels to compile and update all relevant health information of refugees/migrants; coordinate with other NGOs and other relevant collaborators
- Provide revised surveillance guidelines, including standardized reporting formats and feedback mechanisms
- Develop standard operating procedures for outbreak response and preparedness in refugee camps
- Establish rapid response teams with links between NGOs and Ministry of Public Health
Key components of refugee health information system

- Demographic data updated annually
- Disease surveillance, including immediate notification for 8 diseases (Avian influenza, influenza A, cholera, measles, AFP, meningitis/encephalitis, dengue and death of unknown etiology), plus weekly reporting on others
- Reporting on MCH and reproductive services

Status of implementation

- Border Health Units established in BPS and all provinces/districts
- Expanded migrant data
- Standardized forms

Challenges/Lessons Learned

- Need to engage all relevant parties in the process
- Acknowledge differing agendas and allow for flexibility as long as key objectives are met
- Need for dedicated staff
- Emphasize importance and utility of using data for decision making and public health planning
- Importance of addressing sustainability early in the process

GROUP BREAKOUTS

Groups for this session were as follows:

- Group 1: Indonesia, Laos, Myanmar
- Group 2: Thailand, Cambodia, Singapore
- Group 3: Philippines, Brunei, Malaysia, Vietnam

Following is a brief summary of key points raised during group discussions on the five priorities under this pillar. See Annex I (p.47) for a complete matrix of responses from individual countries.

The consensus among countries in each of the three groups was that there is still a great deal of progress to be made under all five of the priorities listed under the pillar of Monitoring Migrants’ Health. With regard to standardization and comparability of data, as well as disaggregation and analysis, while countries were able to offer certain specific examples of instances where surveillance systems were in place or being developed, a range of key challenges were still to be addressed. These included: (i) lack of both funding and capacity for data collection; (ii) lack of comparability as a result of key differences in countries’ national health systems; (iii) lack of coordination on data consolidation among the various stakeholders who collect data, including various government sectors, CSOs and private recruitment agencies; and, (iv) lack of good practice examples for data collection and disaggregation. It was also noted that efforts should be made to ensure undocumented workers were accounted for in data collection and analysis.

The general lack of consolidated data collection on both documented and undocumented migrant workers leads to the need for strong improvements in monitoring migrants’ health-seeking behaviours, access to, and utilization of health services. The general pattern, as identified by a number of country delegates was that governments will focus on disease surveillance and reportable medical conditions, while CSOs and
private research organizations will focus on behavioural surveillance. The difficulties in tracking migrants throughout the whole migration cycle means very little consolidated data on overall health-seeking behaviour is available.

All three discussion groups for this pillar agreed with the need to identify and map good practice examples on data monitoring, and policy and practice models for equitable access to health, calling for: (i) the ‘pioneering’ or piloting of data collection and projection systems; (ii) the creation of standard sets of indicators and data models to assist country endeavours in this area; and, (iii) training of partners on how to use data tools. Better regional coordination and advocacy at higher levels to increase awareness and support would help countries to successfully engage in these processes.

With regards to the final priority under this pillar, developing useful data for decision-making and monitoring of policy and program impacts, delegates raised key issues related to the lack of clear purpose for data collecting and a lack of relationship to programming. At the moment, in many cases, the data that exists is not being used for programming, but rather for profiling purposes, to ‘weed’ out certain individuals. The potential for misuse of data collected only for such purposes, and related issues of breach of confidentiality and stigma and discrimination, were noted by a number of delegates as key challenges to be addressed.

One Multi-country raised as examples under this pillar included memoranda of understanding (MoU) between Thailand and Cambodia, which allows for the transfer of health records for returning migrant workers who need ARV, as well as providing for the establishment by Cambodia of two centres that provide ARV at the border. Myanmar representatives also noted that they exchanged data on migrant workers with China and Thailand, albeit on an ad hoc basis.
SESSION 5: PILLAR THREE, PARTNERSHIPS, NETWORKS & MULTI-COUNTRY FRAMEWORKS, PRIORITIES

Pillar Three Priorities
• Establish and support ongoing migration health dialogues and cooperation across sectors and among large cities and countries of origin, transit and destination
• Address migrant health matters in global and regional consultative migration, economic and development processes (e.g. Global Forum on Migration & Development, Global Migration Group; UNGA HLD on International Migration & Development)
• Harness the capacity of existing networks to promote the migrant health agenda

PRESENTATION: JOINT UNITED NATIONS INITIATIVE ON MOBILITY AND HIV/AIDS IN SOUTH-EAST ASIA (JUNIMA)

Speaker Ms Marta Vallejo Mestres, Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia (JUNIMA)

What is JUNIMA?
• A Joint UN Initiative on Mobility and HIV/AIDS in South East Asia
• Brings together Governments, leading CSOs, the UN Family and Asian Development Bank
• Aims to promote Universal Access to HIV services for people on the move

Overall Strategy
• Promote Universal Access to HIV Prevention, treatment, care and support to mobile and migrant populations in South East Asia and Southern China.

Key Focus Areas
• Intellectual Leadership, Research and Analysis
• Standards Based Advocacy and Policies
• Multi-sector mechanisms at regional and national level

Key Highlights in 2009-2011

Intellectual Leadership, Research and Analysis
1. Paper on the possible impact of the economic crisis on migration and HIV in South East Asia
2. Develop a methodology for conducting BBS so countries can do research on migration & HIV
3. Develop a consultants Database
4. Develop an easy-to-use diagnostic tool to track progress of countries against their commitments to promote access to health by migrants

Policy and Advocacy
1. High Level Multi-Stakeholder Dialogue on HIV Prevention, Treatment Care and Support, February 2009
2. JUNIMA at the PCB meeting special session people on the move, June 2009

Multi-sector mechanisms at regional and national level
1. Bilateral dialogues: Indonesia / Malaysia, Cambodia / Thailand
GROUP BREAKOUTS

Groups for this session were as follows:

- Group 1: Vietnam, Laos, Cambodia
- Group 2: Thailand, Myanmar
- Group 3: Brunei, Singapore, Malaysia, Philippines and Indonesia

Following is a brief summary of key points raised during group discussions on the three priorities under this pillar. See Annex I (p.47) for a complete matrix of responses from individual countries.

The majority of countries were able to provide a number of examples of support for ongoing migration health dialogues and cooperation across sectors, in working to achieve improved health access for migrant workers. Example partnerships involved different government sectors, CSOs and private organizations. A number of delegates noted the need to ensure that migrant workers’ themselves were also included in dialogues and cooperation initiatives. Aside from this point, the key challenges related not so much to participation in dialogues, as implementation and follow-up on multi-sectoral discussions, agreements and recommendations.

With regard to addressing migrant health matters in global and regional processes and harnessing existing networks to promote the migrant health agenda, countries agreed that greater advocacy efforts were required to first ensure migrant health was on the agenda in ASEAN. To ensure that such efforts would be effective, sustainable, and lead to improvements for migrant workers, CSOs and migrant workers themselves should be involved in both new and existing networks. Partnerships should not be limited to the agreement on regional declarations, instruments and recommendations, but also extend to specific initiatives such as data-sharing, monitoring of migration patterns and mutual sharing of research and documentation.

There were a number of Multi-country and regional initiatives raised as examples of progress under this pillar, including the ASEAN Senior Labour Officials Meeting (SLOM) Working Group on HIV, the CARAM Asia regional CSO network, the Colombo Process and the ASEAN Task Force on AIDS (ATFOA).
SESSION 6: PILLAR FOUR, MIGRANT SENSITIVE HEALTH SYSTEMS, PRIORITIES

Pillar Four Priorities

- Ensure that health services are delivered to migrants in a culturally and linguistically appropriate way and to enforce laws and regulations that prohibit discrimination
- Adopt measures to enhance the ability of health systems to deliver migrant inclusive services and programmes in a comprehensive, coordinated, and financially sustainable fashion
- Enhance the continuity and quality of care received by migrants in all settings, including from NGOs and alternative providers
- Develop the capacity of the health and relevant non-health workforce to understand and address health issues associated with migration

MIGRANT SENSITIVE HEALTH SYSTEMS

Speaker Ms Malu Marin, Executive Director, ACHIEVE

Sensitivity as a starting Point

We need to approach this issue with sensitivity; looking at the migrant deep into the eyes; building self esteem and safeguarding the migrants’ dignity in the health care encounter.

Migrant-Sensitive Health Systems

- Health systems that consciously and systematically incorporate the needs of migrants into health financing, policy, planning, implementation and evaluation
- Understand the needs of migrants at their various locales (origin, transit and destination), including the health needs of migrant returnees and their families.
- Ensure that migrants have access to health information and services.
- Ensure participation of migrant communities at all levels: in policy development, implementation, monitoring and evaluation.

Rationale

- Migrants have specific needs
- Migrants have a right to care
- Need for health care providers to improve efficiency and efficacy
- Utilization benefits public health and other outcomes

Migrant-Sensitive Health Systems

- Migrant-Sensitive Workforce
- Language services
- Culturally informed care delivery
- Culturally competent support staff
- Availability, accessibility and affordability
- Enabling for migrants to access
**Hong Kong**

**Equal Opportunities Commission (EOC)**
- provides migrant workers with a handbook, *Your Guide to Services in Hong Kong*, including employment legislation; info on health care system; address/hours of operation of major health institutions, including charges; list of essential medical-related questions

**Race Discrimination Ordinance**
- prohibits discrimination on the basis of race
- allows for an interpreter for migrants if needed in the hospital

**Sex Discrimination Ordinance**
- prohibits employers from refusing to hire or terminating a woman on the basis of pregnancy (includes migrant domestic workers)

**Mandatory Health Insurance**
- HK$100 fee inclusive of check-up, laboratory exams, medicines, etc. for any kind of illness in designated government hospitals

**No mandatory HIV testing**

**Philippines**

**Deployment of Filipino Medical Attaches and Social Welfare Officers in selected foreign posts**
- Countries with high numbers of women migrant workers (7 countries)
- Dispense medical advice and information

**PhilHealth Overseas Workers' Programme**
- Offices in Hong Kong, Saudi Arabia, Malaysia, etc.
- Premium payment for OFWs is lower than non-OFWs
- Standard medical benefits (for Filipino citizens)
- Coverage for dependents in the Philippines
- Reimbursement for confinement abroad
- Special package includes TB, SARS, Avian Flu, Malaria, etc.

**Thailand**

**NGO services**
- Hiring trained migrant health assistants
- Able to provide outreach, translation in hospitals, including VCCT

**Thailand government**
- Health insurance for registered migrants comparable to Thai nationals
- Annual health exam for treatment, not for exclusion
GROUP BREAKOUTS

Groups for this session were as follows:

- Group 1: Thailand, Laos
- Group 2: Cambodia, Myanmar, Singapore, Philippines
- Group 3: Brunei, Malaysia, Indonesia, Vietnam

Following is a brief summary of key points raised during group discussions on the five priorities under this pillar. See Annex I (p.47) for a complete matrix of responses from individual countries.

Most countries raised similar challenges in regard to the delivery of health services in a **culturally and linguistically appropriate way** noting that there were insufficient mechanisms for dealing with this issue for a number of reasons, including: (i) lack of data on migrant locations and linguistic needs; and, (ii) lack of budget for providing materials and services in a potentially large range of languages. While some countries were able to share very positive examples of longer term migrant workers’ being involved into culturally and linguistically diverse service delivery to new migrant workers, it was also noted that in order to ensure further progress, measures of success under this priority should be based not purely on existence and delivery of appropriate service initiatives, but also level of uptake and receipt by migrant workers.

In relation to the ability of **health systems to deliver migrant inclusive services**, certain countries noted real progress, for example the use of migrant health assistants to deliver VCT or the establishment of hotlines staffed by experienced migrant workers. However the lack of capacity of many staff to deal with migrant health issues, as well as a lack of coordination – between government departments, CSOs, private organisations and migrant workers themselves – meant that services were often only available on an ad hoc basis. Stigma and discrimination was still experienced by migrant workers accessing health services, as well as fear of confidentiality breaches.

This lack of coordination between different stakeholders both within national settings and across borders meant that **continuity and quality of care** could not be ensured, with many migrants falling through the cracks at key points in the migration cycle. In particular, a number of countries cited the absence of functioning referral mechanisms found to be HIV positive and subsequently deported as a key challenge in realising continuity and quality of care.

Under the last priority in this pillar, which calls for **capacity development of the health and non-health workforce**, a key suggestion included capacity building for embassy and consulate staff on dealing with migrant workers’ health issues, increasing awareness and sensitivity to specific challenges faced by migrant workers. The importance of gender sensitivity within the broader umbrella of migrant sensitivity was also raised during discussions.

The main **regional initiative** discussed under this pillar, although it is also relevant to all four pillars, was the work of the ASEAN Committee on the Implementation of the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers (ACMW). Although the ACMW was first established in 2007, it is only in 2011 that the drafting team resumed work on drafting an instrument for the implementation of this ASEAN Declaration. ASEAN Secretariat members advised that the best way for participants to feed recommendations from this, and other, Dialogues, would be to coordinate with ACMW focal points at national level to advocate for inclusion of migrant health in the instrument.
In the final working session of this Dialogue, participants worked towards consensus on a set of agreed joint priorities, derived from the global priorities of the 2010 WHO Operational Framework on Migrant Health.

**REGIONAL AND MULTICOUNTRY PRIORITIES ON MIGRANTS’ HEALTH**

**Cross-cutting principles**

- Protect the fundamental human rights, including the right to health, promote the welfare and uphold human dignity of migrants
- Ensure that systems, policies and frameworks for migrants’ health are gender-responsive
- Consider ASEAN Countries as potentially simultaneously countries of origin, transit and destination

**Pillar 1 – Policy and Legal Frameworks Affecting Migrant Health**

1. MoUs, bilateral and multilateral agreements to be more inclusive and participatory (including CSO and migrant community) and to include health issues in addition to HIV
2. Mapping and sharing social protection frameworks and mechanisms on health for migrants (beyond HIV, SARS and Avian Influenza)
3. Enhance inter sectoral collaboration on migrants’ health concerns with respect to the ASEAN mechanisms such as AICHR, ACWC, ACMW as part of the protection and the promotion of the rights of migrant workers
4. Integrate health into the draft ASEAN Instrument on the protection and promotion of the rights of migrant workers

**Pillar 2 – Monitoring Migrants’ Health**

1. Develop and agree on standard migrant health indicators (access, quality and cost) /disaggregated data, while ensuring the confidentiality, privacy and safeguarding against harmful use of the data
2. Improve national monitoring systems and advocate for sharing migration health data among sectors and countries for the purpose of enhancing migrants’ health
3. Incorporate participation of multiple sectors in the data collection of migrants’ health such as health, labour, immigration and security sectors, consulates, unions, civil society organizations, employers, etc.
4. Expand monitoring beyond disease outcomes by also focusing on health behaviour, utilization of services, barriers to access, occupational safety, sanitation, etc., throughout the migration process
5. Reach out to undocumented migrant populations through targeted surveys to identify effective health interventions

**Pillar 3 – Partnerships, Networks and Multi country Frameworks**

1. Ensure that migrants’ health is included in regional and global platforms (e.g. GFMD, UN GA HLD 2013, WHA, ASEAN Summits, etc.)
2. Develop and strengthen inter-sectoral and inter-country health partnerships and include mental health, reproductive health, communicable and non communicable diseases, social protection mechanisms, etc. beyond HIV
3. Involve migrant communities, civil society organizations and unions as active partners in particular for advocacy and service delivery
Pillar 4 - Migrant Sensitive Health Systems

1. Increase collaboration between countries of origin, transit and destination, and involve migrants to promote culturally and linguistically sensitive health systems
2. Mitigate the burden of out of pocket funding for all migrants and move towards social security systems that involve pooling of financial resources (employers, migrants / remittances, governments) in countries of origin, transit and destination. Work towards portability of health benefits across the region.
3. Study the costs and benefits of providing migrant sensitive health services to migrants
4. Increase awareness among foreign service personnel, health workforce, migrants and other stakeholders about social protection and health entitlements in countries of origin, transit and destination
On behalf of the ASEAN Secretary General, Dr Ferdinale Fernando - Assistant Director of the Health and Communicable Diseases Division of the ASEAN Secretariat - thanked participants for their participation in this Multi-Stakeholder Dialogue on Migrants’ Access to Health and HIV Services. He agreed that the task of achieving universal health access for migrants was complex and difficult and that this dialogue was an important step toward multi-sectoral cooperation on migration, health and HIV/AIDS. Dr Fernando noted that the four working sessions of the Dialogue, based around the Operational Framework for Migrant Health, provided a good approach for addressing migrant health in the ASEAN region, and an important opportunity for participants to share progress, challenges and opportunities.

Dr Fernando reiterated that ASEAN’s Framework for Health Development included a focus on migrant health and assured participants that the discussions and set of regional priorities would be reported to the Senior Officials Meeting on Health Development in March 2012, for their consideration. He also noted that the regional priorities agreed on by participants could be utilized in a variety of different ways depending on the perspective and aims of each person attending.

Dr Fernando thanked Jacqueline Weekers, IOM Senior Migration Health Officer, for her important inputs and facilitation of the meeting. He also thanked other divisions with the ASEAN Secretariat for their assistance in the invitation process for this Dialogue. Finally, he thanked event co-convenor, UNDP Asia Pacific Regional Centre, noting that UNDP was a very important partner in implementing the ASEAN Work Programme on AIDS and supporting related projects of the ASEAN Socio-Cultural Community.

Closing the event, Ms Marta Vallejo Mestres – HIV/AIDS Programme Specialist at the UNDP Asia Pacific Regional Centre – thanked both the ASEAN Secretariat and the JUNIMA Working Group for their collaboration in convening this meeting. On behalf of UNDP, she expressed thanks to meeting facilitator Ms Jacqueline Weekers, noting that participants had been very privileged to benefit from her wealth of knowledge on the issue of health access for migrants. Ms Vallejo Mestres stated that this Dialogue had been planned for a very long time, and that the commitment of participants was evident in the fact that multiple government sectors of all ten countries of ASEAN were represented. She thanked both government representatives and civil society participants for their strong contributions during the Dialogue, and expressed hope that the set of joint regional priorities could be used as a tool to guide future interventions and advocacy at country, bilateral and regional levels.
### ANNEX I: COUNTRY RESPONSE MATRICES, SESSIONS 3-6

#### PILLAR ONE: POLICIES AND LEGAL FRAMEWORKS AFFECTING MIGRANT HEALTH

- Adopt and implement relevant international standards on protection of migrants and respect for rights to health in national law and practice
- Develop and implement national health policies that incorporate a public health approach to health of migrants and promote equal access, regardless of their status
- Monitor the implementation of relevant national policies, regulations and legislations responding to the health needs of migrants
- Promote coherence among policies of different sectors that may affect migrants’ ability to access health services
- Extend social protection in health and improve social security for all migrants

<table>
<thead>
<tr>
<th>Country</th>
<th>Individual Country responses</th>
</tr>
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</table>
| Brunei    | • Brunei has ratified 2 of the 8 fundamental ILO conventions on human rights (138, 182) about people’s rights at work  
            • Brunei is in the process of adopting ILO standards into its Labor Act, although they are not fully enforced  |
|           | • Although treatment of medical conditions is paid by some employers, migrants do not have proper full access to social protection in health  
            • Key challenge in extending social protection and implementing equal access health policies is ‘who pays?’ |
| Cambodia  | • Cambodia has ratified all 8 fundamental ILO conventions on human rights (29, 87, 98, 100, 105, 111, 138, 182)  
            • Policies on governance of labour migration and protection and empowerment of migrant workers exist, eg. Policy on Labour Migration for Cambodia 2010 and Sub-decree 57 on Sending Khmer Migrants Abroad, 1995 (although they do no cover health rights specifically).  |
|           | • Gulf between international conventions as guidelines and national law/enforcement in practice. How do you bridge this?  
            • Weak implementation of laws protecting migrant workers  
            • Lack of monitoring on implementation of standards and policies at country level.  
            • Lack of awareness of conventions, standards and policies. Even if they have been ratified/do exist, many key stakeholders do not know about them or the protection they might afford.  
            • Lack of coordination between ministries within Cambodia  
            • Differing priorities between sending and receiving countries are a challenge. Receiving countries think about their own economic costs/benefits so education on costs/benefits must be part of push for better migrant health policies in ASEAN  
            • In many countries, restrictive policies mean that migrant workers are unable to move employers, if they ‘become’ undocumented and loose access to any protection that documented workers have |
# Annex I: Country Response Matrices

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| **Indonesia** | • Indonesia has ratified all 8 fundamental ILO conventions on human rights (29, 87, 98, 100, 105, 111, 138, 182)  
  • Has ratified ILO Recommendation 200 (universal access to treatment, care and support)  
  • Supports ILO Recommendation 189 (domestic workers)  
  • A mechanism exists for monitoring implementation of health policies  
  • Signed, but not ratified, the *International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families* in  
  • *HIV/AIDS National Action Plan for Migrant Workers 2012-2015*  |
|   | • Lack of progress on *International Convention on the Protection and Promotion of the Rights of All Migrant Workers and Members of their Families*  
  • Lack of Implementation, or partial implementation, of international conventions/standards  
  • Lack of coordination between ministries  
  • No social security system for migrant workers is in place  
  • In terms of health protections for migrant workers, there needs to be a mechanism for Integrated referral systems for migrant workers living with HIV/AIDS |
| **Laos** | • Laos has ratified 5 of 8 fundamental ILO conventions on human rights (29, 100, 111, 138, 182)  
  • Full health benefits are available to workers  
  • Businesses with more than 10 workers (foreign or local) must provide social security protection (govt, employer, employee pay for social security)  
  • ADB MOU includes provision of HIV Services for Migrant Workers working on road construction in Laos  
  • ILO has provided HIV prevention education for migrant workers in the workplace  
  • The 2004 Lao-Thai MoU on Employment Cooperation afforded some increased protection by legalizing irregular workers and aiming to develop formal system for recruiting workers from Laos to Thailand.  |
|   | • Obligation and cost for providing social security is largely the employers’ responsibility, not always enforced  
  • Loose enforcement of HIV discrimination laws  
  • Lack of access to social protection for undocumented migrant workers who have very little opportunities to provide for their own healthcare  
  • Questions on how sex workers might use protective laws and policies when sex work is illegal?  
  • Laws providing for social security protection/health access should require regular review in order to be able to respond to changes in the environment |
| **Malaysia** | • Malaysia has ratified 6 of the 8 fundamental ILO conventions (29, 98, 100, 105, 138, 182).  
  • National Policies on occupational health of workers cover migrant workers:  
    - eg. *Occupational Safety and Health Act 1994* is currently undergoing amendment. This makes safety and health a priority for all workers in on the national agenda  
    - eg. *NAOPOD 2004* makes reporting accidents and hazards in the workplace mandatory  
  • Both local employees and foreign employees are covered when it comes to occupational disease. If such disease gets reported to doctor who further reports to the department, department must take action no matter who the person. Employer is liable for covering treatment, regardless of whether worker is migrant (documented only) or not Regular audits/inspections checking compliance are carried out by MOL.  
  • (Documented) migrants have free access to public health, right down to provincial level  
  • HIV/AIDS awareness and counseling implemented in the workplace  
  • Some inter-ministerial collaboration, with different agencies required to report to the Deputy Prime Minister on health care access  |
|   | • Financial constraints are a challenge. For example, how do meet the challenge of addressing small industries who have real budget constraints  
  • Difficulties in getting industries to engage and be willing to join with government to address issues and/or adopt new policies.  
  • Need for a compliance support program to ensure that initiatives addressing workers’ health are budgeted. Government needs to improve guidelines and monitoring of non-compliance.  
  • Lack of access to health care for undocumented migrants |
## ANNEX I: COUNTRY RESPONSE MATRICES

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Points</th>
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</table>
| **Myanmar** | • Myanmar has ratified 2 of the 8 fundamental ILO conventions (29, 87)  
• International standards have been adopted in some ways, eg. through National Strategic Plan on HIV/AIDS which addresses mobile populations  
• Agreement between Thailand and Myanmar to issue limited passports and IDs to migrant workers from Myanmar, allowing access to health benefits  
• Weak implementation of standards and laws protecting migrant workers  
• Monitoring is very weak. In particular, the lack of strong relationships between sending and receiving countries means that it is difficult to implement and monitor health access and protection  
• Lack of coherence across ministries means there are a number of conflicting policies  
• Lack of any policy or agreed approach on how to deal with migrant workers returning to Myanmar with HIV |
| **Philippines** | • Philippines has ratified all 8 fundamental ILO conventions (29, 87, 98, 100, 105, 111, 138, 182)  
• National strategic plans and programs exist to address migrants’ health and HIV.  
• Standards exist in terms of health care and social protection for migrant workers going abroad. In particular, there is a criterion that requires certain standards to be met before workers can be deployed.  
  - eg. in 2011 Philippines were planning to ban 41 countries for deployment because they had not met the right policies for protection.  
• Lack of awareness within Philippines,  
  - eg. among migrant workers and other stakeholders, that conventions, standards, protective policies exist  
• Weak implementation of laws protecting migrant workers  
• Weak monitoring and lack of sustainability of programs  
• Lack of clarity at the national level on who will lead, who will monitor, who will be the focus point for these issues  
• Lack of coordination between ministries  
  - eg. gaps in relationships between Department of Labor and embassies in countries receiving Filipino workers  
  - eg. undocumented workers are handled by Department of Foreign Affairs, documented handled by Department of Labor with no mechanism for referral. Whether documented or undocumented everything should pass through embassy and services should be given by the embassy.  
• Difficulties in balancing the need for deployment with the need to protect migrant workers and not send them to certain countries that do not provide for protection of migrant workers.  
• Inability to influence receiving countries, and a need to better understand what the constraints are which prevent receiving countries from moving forward on this issue, eg. financial, myths around HIV  
• Migrant workers’ fear or negative perception of the embassies and consulates means they are not confident about approaching their own embassies when in need. |
| **Singapore** | • Singapore has ratified 6 of the 8 fundamental ILO conventions (29, 98, 100, 105, 138, 102)  
• All medical and hospital costs should be paid by employer for migrant workers (note, this means workers covered under the Employment Act, and does not include domestic workers)  
• The government has put together health promotion materials to promote awareness of HIV and AIDS  
• Government appoints NGOs to provide services, eg. health promotion and awareness, on its behalf  
• Lack of awareness of conventions, standards and policies  
• Lack of implementation and monitoring of laws and policies protecting migrant workers  
• Need to address stigma around migrants and HIV  
• Lack of coordination between ministries  
• Lack of funding for NGOs. While government uses NGOs to provide services, there are not enough funds for delivery of these services  
• Mandatory testing of HIV for all migrant workers, and deportation/banning for those testing positive.  
• Exclusion of HIV and pregnancy from health insurance |
## Thailand

- Thailand has ratified 5 of the 8 fundamental ILO conventions (29, 100, 105, 138, 102)
- Government health care is provided (see Promboon’s presentation in Session 2 (page 25), but only with formal work
- Migrant health assistants are being utilized within the health system, however participation is still low
- A number of MoUs between Thailand and neighbouring countries are in place, see matrix on regional and multi-country initiatives, below
- Lack of inclusion/involvement of all stakeholders (civil society, authorities, various ministries such as labor, interior) in efforts to improve provision and use of health care for migrant workers
- Lack of coordination between sending and receiving countries to provide continuous treatment
- Government health care only provided with formal work
- Lack of full access to public health care system for fishermen (both Thai and migrant workers) and domestic workers. These workers are still under individual health insurance, and are also cut off from information which limits effective prevention programmes
- It is easy for migrants to drop out of sight, as it difficult to change employers under certain visa conditions.
- Difficult labour conditions plus exclusion can lead to HIV vulnerability.
- Conflict between health and security, ie. ‘progressive’ social aims (human rights) are often overridden by archaic security approaches,
  - eg. security forces who continue to target migrants

## Vietnam

- Vietnam has ratified 5 of 8 fundamental ILO conventions (29, 100, 111, 138, 182)
- Laws and policies exist to address HIV/AIDS in Vietnam, including protections of migrant workers,
  - eg. Prime Minister’s Decision 38 deals with collaboration and cooperation in preventing cross border HIV transmission
  - eg. Party’s Directive No 54 calls for strengthening the leadership in HIV/AIDS prevention and control
- There is high-level leadership on HIV/AIDS: the Deputy PM chairs the committee on prevention of HIV/AIDS
- Lack of human resources and capacity to address issues related to migrant health and HIV care
- Lack of experience and international integration or relationships with other sending or receiving countries to properly address migrant health issues

### Multi-country or regional initiatives

#### Thailand/ Laos MoU

- MoU between Thailand and Laos is mainly about labor issues, focusing on legalizing irregular Lao workers working in Thailand and developing a formal system for recruiting Lao workers to work in Thailand legally
- The MoU was originally signed in October 2002, however due to complexities in authorizing and validating workers, the regularization of Lao migrant workers in Thailand only started in May 2005
- While this MoU legitimizes workers, it does not go far enough to state recognition of right to health. However, a flow-on effect of legalization of working status means that workers are eligible under the social security act.
- MoU also addresses problem of non-fully legal migrants becoming indentured if work permits are not portable, eg. on a temporary work permit you must inform authorities and obtain permission if you want to change employers or move provinces. Under the MoU, this permission is not necessary and movement is possible
- Issues still to be addressed include the lack of coordination between the two countries on providing continuous treatment for returning migrant workers returning who are HIV positive
- In addition, involvement of other stakeholders such as CSOs, authorities and various ministries should be increased
### Thailand/Myanmar MoU
- MoU between Thailand and Myanmar deals with labor issues, facilitating employment of migrant workers and legalization of irregular workers and their families
- The issue of limited passports and IDs to migrant workers from Myanmar allows access to social security scheme/health benefits

### Thailand/Cambodia
- This MoU includes exchange of HIV records
### PILLAR TWO: MONITORING MIGRANTS’ HEALTH, PRIORITIES

- Ensure the standardization and comparability of data on migrant health
- Support the appropriate disaggregation and analyses of migrant health information in manners that account for the diversity in migrant populations
- 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
- Identify and map: 1. good practices in monitoring migrant health; 2. policy models for equitable access to health; and 3. migrant-inclusive health systems models and practices
- Develop useful data for decision-making and monitoring of the impact of policies and programs

<table>
<thead>
<tr>
<th>Individual Country Responses</th>
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<tbody>
<tr>
<td><strong>Progress</strong></td>
</tr>
<tr>
<td>Brunei</td>
</tr>
<tr>
<td>- Little progress under this priority, inadequate surveillance systems mean that there is almost no data</td>
</tr>
<tr>
<td>- Inadequate surveillance systems mean almost no data</td>
</tr>
<tr>
<td>- Lack of collaboration with sending countries in collecting data and sharing between countries, eg. migrant workers must do medical fitness tests before working overseas but there is no policy on collection and delivery of this, or other health-related data, to Brunei</td>
</tr>
<tr>
<td>- Differences between countries’ health systems, priorities and concerns leads to difficulties in collecting and consolidating data in a way that will address different, sometimes conflicting country priorities</td>
</tr>
<tr>
<td>- Issues with privacy and confidentiality</td>
</tr>
<tr>
<td>Cambodia</td>
</tr>
<tr>
<td>- Data collected on pre-departure training</td>
</tr>
<tr>
<td>- Monitoring of health exams for migrants going to certain countries, eg. for workers going to Korea, certain health data is recorded and blood test samples are retained for at least three months</td>
</tr>
<tr>
<td>- Collaboration between governments in terms of sharing data for specific purposes, eg. test results for work permit purposes</td>
</tr>
<tr>
<td>- Lack of aggregated data from private agencies. Health assessments are done in accordance with the needs of the receiving countries, eg. for work permit requirements</td>
</tr>
<tr>
<td>- Proper monitoring can only be carried out for certain destination countries as data collection methods differ according to migrant worker destination - eg. work permit system for workers going to Korea means government coordinates health screening and is able to collect data/keep statistics</td>
</tr>
<tr>
<td>- eg. workers going to Malaysia and Thailand can go through private brokers for testing. It is difficult to get data from these private testing facilities</td>
</tr>
<tr>
<td>- Lack of funds to spend on data surveillance systems</td>
</tr>
<tr>
<td>- Lack of data on returning migrants, including no clear data on how many have been deported, which would help shape return and reintegration programs and services</td>
</tr>
</tbody>
</table>
## Annex I: Country Response Matrices

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| **Indonesia** | - Indonesia is interested in the health-seeking behaviour of migrants, and seeking to improve data collected from health services  
- Mapping of migrant workers by the Ministry of Labor, aggregated by appropriate indicators (e.g., sex, country, occupation)  
- Data from VCT, STI clinics available and disaggregated on appropriate levels (provinces, districts, elected PHC)  
- Indonesia Health Information System (HIS) has web-based data collection system  
- Undocumented workers still uncounted, need to document all data of MWs into the integrated database  
- Issues of stigma, discrimination and negative use of data  
- Lack of commitment of stakeholders to maintain data collection, aggregation and analysis  
- Lack of official data disaggregated by status as migrant worker. Data collected (from medical centres and CSOs) is based on employment sector  
- Web-based HIS requires further development |
| **Laos** | - Embassies and consulates work in some capacity as monitoring systems, connecting migrants to social support services  
- Difficult to ascertain numbers of migrant workers in the first place, let alone data on health or health-seeking behaviour  
- Lack of funding, capacity and human resources for managing data collection and monitoring systems,  
  - Eg. Centre for Epidemiology should send regular reports to the Ministry of Health  
  however this does not happen due to lack of human resources  
- Limited multi-sectoral involvement in monitoring systems. Involvement should be expanded from Ministries of Labor and Health and embassies, to also include CSOs, unions)  
- Lack of monitoring of returning migrants  
- Lack of data on the education and background knowledge on health amongst migrants |
| **Malaysia** | - There is an agreement between Ministries of Home Affairs (lead agency), Human Resources and Health to consolidate data  
  - eg. creation of a Biometric surveillance system in which all data on migrant workers will be collected. The first step will be to share data between agencies, with the possible next step of sharing between countries.  
- A reporting mechanism exists between Ministry of Health and World Health Organization but unclear whether data gets aggregated according to migrant workers  
- Ministry of Health has received funds from the Global Fund, part of which has been channelled to the National AIDS Commission to run a project looking at surveillance of health status and behaviour  
- CARAM Asia’s research on migrant populations means that some data exists (country based and regional)  
- Lack of clear purpose for data. We can collect as much as we want but need to address the question of what we are going to do with it  
- Lack of data consolidation. Data collection mechanisms exist, but no consolidation from cross-sectoral sources  
- Lack of disaggregated data on migrant workers, eg. no UNGASS indicators for migrant workers that to draw on  
- Absence of data on undocumented migrant workers  
- Lack of cross-sectoral cooperation. Different ministries are not aware of what other ministries are doing in terms of data collection, and there is no decision on who from within the various ministries might lead ministries in data collection or consolidation  
- Lack of collaboration on data collection and consolidation between government and CSOs. Norm seems to be that governments focus on disease surveillance/reportable medical conditions, while NGOs and private research organizations focus on behavioural surveillance  
- Lack of good practice examples of data models. Someone needs to ‘pioneer’ data collection/projections so that we can use as a model |
<table>
<thead>
<tr>
<th>ANNEX I: COUNTRY RESPONSE MATRICES</th>
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<tbody>
<tr>
<td><strong>Myanmar</strong></td>
</tr>
<tr>
<td>• Migrants are one of top priorities in the National Strategic Plan on HIV/AIDS, leading to improved data on migrant workers. Regular collection mechanisms have been established, with standard data collection formats in use.</td>
</tr>
<tr>
<td>• Lack of funding</td>
</tr>
<tr>
<td><strong>Singapore</strong></td>
</tr>
<tr>
<td>• New priorities and more funding now that government has appointed certain NGOs to carry out work on these issues. • Some health records are exchanged across borders (however much monitoring on migrant health - covering HIV, pregnancy, cancer, TB, pregnancy - is used for exclusionary purposes) • Appeals have been made to the government not to carry out HIV testing without counseling</td>
</tr>
<tr>
<td>• Health exam data is used for exclusionary purposes, not for services or programming. Testing regularly occurs without counseling • Reporting of accidents and death is kept confidential, so this data cannot be collected/consolidated</td>
</tr>
</tbody>
</table>

[54]
### ANNEX I: COUNTRY RESPONSE MATRICES

| Vietnam | • There are some small initiatives working on these issues, but not run by government,  
| | - eg. IOM-funded project to develop a system to address the health of migrants. This project focuses on migrants who are leaving Vietnam, and started with a mapping/assessment of situation of migrant health in Vietnam (although it is currently stalled). |
| | • Inadequate surveillance systems means almost no data  
| | • While health examinations and health care checks are required for migrant workers, government does not keep surveillance for any other purpose beyond compliance.  
| | - eg. responsibility of labour export enterprises to keep record or workers sent overseas, the government keeps no data.  
| | • For Vietnam workers leaving the country, there is no mechanism for monitoring what happens to them after they leave or upon return.  
| | - eg. sometimes we hear anecdotal evidence of Vietnamese migrant workers encountering certain difficult situations in other countries, but no mechanisms exists to collect concrete data.  
| | - eg. sometimes when Vietnamese workers are sent in a group, one doctor might be sent to provide clinical health care to these workers while abroad, however there is no mechanism for data collection or reporting on health issues  
| | • No data on Cambodian workers in Vietnam |

### Multi-country or regional initiatives

| Thailand/ Cambodia MoU | • MoU between Thailand and Cambodia allows for transfer of health records for those returning migrant workers who need ARV, as well as the establishment by Cambodia of at least two centres that provide ARV at the border |
| Myanmar/ China/ Thailand | • Myanmar exchanges information with China and Thailand on an *ad hoc* basis |
### ANNEX I: COUNTRY RESPONSE MATRICES

## PILLAR THREE: PARTNERSHIPS, NETWORKS & MULTI-COUNTRY FRAMEWORKS

- Establish and support ongoing migration health dialogues and cooperation across sectors and among large cities and countries of origin, transit and destination
- Address migrant health matters in global and regional consultative migration, economic and development processes (e.g. Global Forum on Migration & Development, Global Migration Group; UNGA HLD on International Migration & Development)
- Harness the capacity of existing networks to promote the migrant health agenda

### Individual Country Responses

<table>
<thead>
<tr>
<th>Country</th>
<th>Progress</th>
<th>Lack of Progress/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei</td>
<td></td>
<td><em>No existing national networks to support migrant health, we don’t separate migrant workers from the general workforce.</em></td>
</tr>
</tbody>
</table>
| Cambodia | • MoUs with other countries are examples of successful partnerships for addressing migrant health issues:  
- eg. Cambodia have set up an office of the Ministry of Labor in Bangkok to reach migrant workers  
- eg. Healthcare points set up at two border crossings between Cambodia and Thailand  
- eg. Vietnamese entertainment workers can now access HIV treatment in Cambodia, as well as act as peer educators for other Vietnamese sex workers  
| *While partnerships might exist to increase cooperation, on the ground language is still a barrier in providing services to migrant workers* |
| Indonesia | • Examples of partnerships and networks include:  
- Indonesian Business Coalition on AIDS  
- National Commission on Women  
- Internal National Summit on AIDS which happens every 2 years. This is a multi-sectoral event, also involving UN and CSOs, and at last National Summit, migrants were involved  
• National AIDS Commission cooperates with Indonesian Business Coalition, works with civil societies, Ministries of Health and Labor, and military to address health issues of domestic workers and provide training on workplace health and safety  
| *Lack of involvement of CSOs and migrant workers in existing networks  
- eg. when Indonesian government set up MoU with Malaysia there was/is no mechanism for involvement of civil society  
- While dialogues have taken place, recommendations and other outputs have not generally been translated at country level. Those that do reach national level may not filter down to regional, provincial, local level* |
<table>
<thead>
<tr>
<th>Country</th>
<th>Partnership Projects and Collaboration Needs</th>
</tr>
</thead>
</table>
| Laos    | • Laos has a number of partnership projects in place:  
  - eg. small projects along the border with Vietnam, funded by various donors such as ADB  
  - IOM working on two migrant health projects in Laos: one working on HIV awareness for road construction workers; and the other involving active TB mass screening in hard to reach populations. Under this second program, those migrant workers detected to have TB, receive free treatment in Laos  
  - MoU with Thai government, entitling legal workers to health insurance and annual health checks  
  - MoU with Vietnamese government  
  • Collaboration needs to extend to include data sharing on health and HIV issues  
  • Undocumented workers are not covered in dialogues and consultations. Need to be promoted as part of the migrant health agenda.  
  • No real support network for migrant workers with HIV at the moment, and very few NGOs allowed in the country  
  • Laos is now a receiving country of migrant workers (from China, Cambodia, Vietnam), which requires development of new approaches |
| Malaysia | • Examples of government partnerships include:  
  - eg. national Labour Advisory Council, run under Ministry of Labor, including trade unions and federation government agencies, meets 2 times per year  
  - Malaysian Business Coalition on AIDS, with CSO as lead agency, has carried out training on HIV/AIDS in the workplace  
  - eg. migrant health is being addressed under National Strategic Plan on HIV/AIDS, lead by MOH  
  - eg. Joint programs under the Malaysian AIDS Commission  
  • In terms of regional processes, Malaysia is currently Vice chair of Senior Labour Officials’ Meeting (SLOM). As part of their role in leading this working group, they will deliver train the trainer sessions on implementation of code of practice on HIV/AIDS in the workplace  
  • Lack of mechanisms to involve CSOs and migrant workers in new and existing networks  
  • eg. when Indonesian government set up MOU with Malaysia there was no mechanism for involvement of civil society. MoUs need to take into consideration involvement of CSO from migrant health.  
  • Lack of implementation of results from global and regional Dialogues. While these have taken place, they have not necessarily been translated at country level. Even if they have reached the national level it may not filter down to regional, provincial, local level) |
| Myanmar | • Existing national migrants committee and network.  
  • Regional strategies,  
  - eg. In Mon State, close to Thai border, regional level strategies (involving Thailand) are in place and there is a focus on migrant health system and local networking system for care of the migrant  
  • Consultative national strategy for migrants  
  • Lack of funding for migrants/migrants’ health programs. Most funding is earmarked specifically for HIV.  
  • CSOs and migrants themselves need to be more involved in migration, economic and development processes |
| Philippines | • The Philippines National AIDS Comission has 17 national agencies (government and CSO) represented, including one migrant worker representative  
  • In Philippines, CSOs work together with governments as there is recognition that government needs to work with networks to provide needed services.  
  • Philippines, also works well with other countries to address service needs (eg. Philippines with HK, one of partners there is St Johns cathedral which undertakes health seminars for domestic workers – good model of partnership in a destination country)  
  • Lack of identification of intervention  
  • Lack of capacity from sending countries  
  • Lack of incentive for host countries. While migrant sending countries want to do something, for receiving country it is against the bottom line  
  • Lack of data on migrant health to support all these initiatives. If we don’t have enough data how can we support our decisions (interlinked to monitoring, if we cant support what we are saying, how can we set something up). Partnerships need to first bring together data, and only then can we work on actual interventions. |
### Annex I: Country Response Matrices

<table>
<thead>
<tr>
<th>Country</th>
<th>Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Singapore</strong></td>
<td>• There is a global partnership on maritime workers and HIV/AIDS – eg. members union of seafarers</td>
</tr>
<tr>
<td></td>
<td>• HOME has worked closely with the Health Promotion Board of Singapore on social protection of migrants. The Health Promotion Board called on HOME to do seminars, outreach, specific contract for outreach for sex workers (survey and research), work with cross-border partners (Singapore is very close to islands of Indonesia). HOME will report to Promotion Board upon return and feed this into action plan for next year</td>
</tr>
</tbody>
</table>
| **Thailand** | • Thailand is a stakeholder in various bilateral MoU and multi-sectoral platforms  
  - eg. ACMECS (Ayewady, Chao Phraya, Mekong Economic Cooperation Strategy)  
  - eg. Thailand-Myanmar, Thailand-Malaysia, Thailand-Cambodia  
  - Thailand-Laos MoU for migrant management, with each bilateral agreement depending on context of country relationship and migrant movement.  
  • Achievements in migrant health matters in global and regional, include:  
  - eg. addressing migrant health in the WHA, in many international meetings about Thai migration and also in Madrid.  
  - eg. Regional dialogue on HIV and the law where migrants came up as one of the groups. |
| | • No partnership framework as transit country.  
  More emphasis on security than health and human rights.  
  • Lack of implementation, and follow-up on many recommendations and MoU components |
| **Vietnam** | • Very few official agreements with neighbours, however part of MoU with Laos (under ADB) in ten provinces along the border to prevent HIV |
| | • Programmes now only focus on the border, and thus do not always reach the whole population  
  • Very little data on occupation/numbers, and could be a new priority |

### Multi-country or Regional Initiatives

<table>
<thead>
<tr>
<th>SLOM Working Group on HIV</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| • Senior Labour Officials Meeting (SLOM) Working Group on HIV met for the first time in July 2011  
  • Migration is one of the components, and is on the agenda, although it is not going to be tackled soon  
  • As this is an ASEAN regional initiative, this means that every country in the region will hold dialogues in their countries looking at migrant issues and HIV and will report by end 2013. These dialogues will be specifically on HIV, after which the focus can move to broader health issues  
  • While SLOM is a labour initiative, health ministries are also involved in the working group.  
  • Malaysia and Singapore have agreed to be lead countries, delivering train the trainer workshops on HIV in the workplace  
  • Philippines will also be reviewing current practice on HIV, recruitment and mandatory testing and reporting back to SLOM in 2013 |
## Annex I: Country Response Matrices

| **CARAM Asia Regional Network** | • CARAM Asia is a regional network, originally formed to do specific work on HIV  
• The network is now also doing work on labour rights issues, and HIV has broadened to health.  
• The network’s Migration Health and HIV Taskforce has 38 members across 18 countries, including Asia and the Middle East  
• Scope of work includes action research, exchange, advocacy, annual multi-stakeholder meetings |
| **Colombo Process** | • The Colombo Process deals mainly with labour migration and economic development  
• 11 member countries, four of which are from ASEAN (Indonesia, Philippines, Thailand and Vietnam)  
• In 2011, its scope broadened to include social protection issues, under which there have been attempts to integrate health issues.  
• Outcome statements from consultations can be viewed online at www.colomboprocess.org |
| **ATFOA** | • ASEAN Task Force on AIDS (ATFOA), including focal points from ASEAN governments’ ministries of health  
• Aims to prevent further transmission of HIV and mitigate the impacts of HIV and AIDS in ASEAN, by improving regional responses and enhancing Member Countries’ development of people-centred initiatives  
• At its 2011 summit, members adopted the ASEAN Declaration of Commitment on HIV/AIDS |
### PILLAR 4: MIGRANT SENSITIVE HEALTH SYSTEMS, PRIORITIES

- Ensure that health services are delivered to migrants in a culturally and linguistically appropriate way and to enforce laws and regulations that prohibit discrimination
- Adopt measures to enhance the ability of health systems to deliver migrant inclusive services and programmes in a comprehensive, coordinated, and financially sustainable fashion
- Enhance the continuity and quality of care received by migrants in all settings, including from NGOs and alternative providers
- Develop the capacity of the health and relevant non-health workforce to understand and address health issues associated with migration

<table>
<thead>
<tr>
<th>Individual Country Responses</th>
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</thead>
<tbody>
<tr>
<td><strong>Brunei</strong></td>
</tr>
<tr>
<td>Equal access to health services for all is provided, however migrant workers are charged for services, as per locals (but this cost can be covered by health insurance, provided by employers)</td>
</tr>
<tr>
<td>Certain initiatives mean that migrant workers are better prepared in terms of culture and language of country to which they are going, eg. Cambodian workers that are sent to Korea need to study Korean language and pass an exam</td>
</tr>
<tr>
<td>If a migrant worker requires health support, it is provided and they pay like local people, however if an NGO refers them the service is free</td>
</tr>
<tr>
<td>Cambodia reports back on situation to regional migrant forums which happen every year, sharing with other countries on what has been achieved</td>
</tr>
<tr>
<td>Insurance is available for (documented, not undocumented) workers going in country</td>
</tr>
<tr>
<td>Cambodia will be chairing the ASEAN migrant forum in 2012, this could provide an opportunity to put migrant sensitive health care on the agenda</td>
</tr>
<tr>
<td><strong>Cambodia</strong></td>
</tr>
<tr>
<td>Regulations from MOH, that medical professionals have to follow 3Cs (counseling, confidentiality and informed consent) of ILO policy</td>
</tr>
<tr>
<td>Although there is no proper Centre for Migrant Health, some universities providing health care education have an interest in migrant health, but this is on an individual basis</td>
</tr>
<tr>
<td><strong>Indonesia</strong></td>
</tr>
<tr>
<td>No special policies or training with regard to culturally and linguistically sensitive services</td>
</tr>
</tbody>
</table>
Currently there is a hotline service for Indonesian migrant workers, as well as Centres they can visit (with anecdotal suggestion that 30% of migrant workers are making calls to these lines) | simply deported
- Violation of confidentiality frequently occurs
- Insufficient mechanisms for dealing with language issues:
  - eg. Some migrant workers come from rural areas, so may not understand Bahasa. At the moment informal translators/sponsors will assist with translation, as there is no formal program for provision of translators/interpreters.
- Lack of education for migrant workers on forms that are signed, for example they cannot read information regarding informed consent and medical testing.
- Lack of gender sensitivity for female migrant workers, leaving them vulnerable to sexual harassment by medical service providers. There have been a number of complaints on this from migrant workers, and some research has been done on this in Indonesia.
- It is difficult to know how to monitor the process of health care (in terms of ethics, gender and religious sensitivities).

Initiative exists to promote annual health checks for employed migrants
- Both documented and undocumented migrants can go to village health centres (usually employer pays, although undocumented workers must pay)
- MSF was doing an HIV project on the border providing medicines to migrant workers. Although MSF have now withdrawn from Thailand, the project has been taken over by the Global Fund, so provision of medicines remains sustainable

Laos

The health care act ensures that health care access is available for all, which means that no patient (including migrant workers) should be turned away. If an individual happens to be turned away, the organization preventing access is theoretically liable
- In rural clinics, we try to disseminate information in native language. Migrant workers who have been working in Malaysia for a longer are also trained to translate from Malay to native language to work in outreach with workers
- Foreign Workers Insurance covers most foreign workers in Malaysia. Discussions between Ministries of Health and Human Resources and Immigration Department are currently looking at how this can be expanded to include all workers, eg. domestic workers, plantation workers
- UN Task Force is also looking at the two different social security systems in place in Malaysia (one for local workers, one for foreign workers) and looking at making two systems more equal
- CARAM Asia’s NGO partners in Malaysia are responding to health rights cases and engaging with hospital and health services and providing training where necessary

Malaysia

- Financial issues, and the cost of providing health care to migrant workers, are a challenge. Unpaid bills for migrants and refugees amount to millions of dollars per year
- Lack of guidance from funding agencies (eg. UN). These agencies should have set criteria for tackling migrant sensitive health provision
- While insurance exists to cover most foreign workers, the issue is that it does not cover domestic workers and plantation workers
- Migrant workers are often not aware of their rights under the applicable social security scheme in Malaysia
## ANNEX I: COUNTRY RESPONSE MATRICES

<table>
<thead>
<tr>
<th>Country</th>
<th>Observations and Recommendations</th>
</tr>
</thead>
</table>
| **Myanmar** | - For industries with large percentages of foreign workers (eg. plantation workers, who are 90-100% Bangladeshi and Nepali) employers are advised employers to provide signage and information in native language. Ministry of Labor audits workplaces attempt to ascertain whether/how workers receive information  
- Policies exist which require employers to adhere to confidentiality/non-disclosure criteria, for eg. if migrants are diagnosed with particular diseases, that these are not publicly disclosed  
- Despite sensitive health systems being in place, in theory, measurement of sensitivity focuses on delivery rather than how the information is received  
- In Thailand, one representative from Myanmar has been appointed as a labour attaché to cover migrant issues. Labor attaché is looking at doing social networking and training migrant workers  
- In Singapore, an association has been established to assist migrant workers. They are able to provide assistance such as translators, emergency money for transport and medical assistance  
- In Malaysia, a focal point for migrant issues has also been appointed. |
| **Philippines** | - Lack of mapping of migrant workers’ locations means it is difficult to know where services are required, let alone what information is required  
- Lack of free pre-departure training  
- Undocumented migrants are very challenging to identify. It could be useful to provide information in ‘hot spots’ to better reach these workers  
- Migrants have specific needs and vulnerabilities and it can be challenging for service providers to address these. Issues of stigma mean that migrant workers may stay away from regular service providers  
- While CSOs are able to support access to health care systems they also face limitations  
- Labour attachés are posted in host countries (although issues with capacity and manpower mean that more support is required on health issues)  
- In several embassies, migrant worker communities - especially health workers such as nurses – are being mobilized and utilized to pass on information and recommendations within diaspora communities  
- Philippines encourages overseas foreign workers to get insurance in Philippines in case their employer doesn’t cover anything. The provision of health insurance (eg. Philhealth) to migrant workers (informal workers can also enrol) provides migrants with the ‘purchasing power’ to access health systems and services, and currently seems a key solution as no matter how powerful the sending country is, you cannot set up a parallel health agency in the host country  
- Hong Kong was the first pilot country for Philhealth and take-up was so high that the decision was made to have a permanent office in Hong Kong  
- Lack of research/data on cost and scope of migrant sensitive health provisions. Further research could provide directions on key questions like ‘who pays?’, or address viability of financial solutions such as funding coming from remittances or other pools of funds  
- Need for stronger government partnerships between sending and receiving countries to ensure migrants are supported in accessing health services. For example it is useful for the sending country to have a government representative posted in the receiving country to provide assistance in migrant health issues in collaboration with government representatives in host country  
- Lack of collaboration between governments, embassies and CSOs. Governments and embassies/consulates might not even be aware of the services CSOs are providing  
- Lack of marketing and awareness of the access and protections that Philhealth provides, or understanding of how to make claims, especially since for some migrant workers all documents are processed by recruitment agents  
- Even if access to health services is available and/or sensitive to migrant needs, migrants still face many barriers in accessing services. For example, they may not be enabled by their employer to visit services. If sickness is a ground for termination migrant workers will continue working even if they are ill  
- The sponsorship system in the Middle East means that migrant workers can only go to the health service of their employer, with no right to choose provider  
- Some employers do not provide insurance, although it is often part of the standard contract for migrant workers |

[62]
### ANNEX I: COUNTRY RESPONSE MATRICES

<table>
<thead>
<tr>
<th>Country</th>
<th>Details</th>
</tr>
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</table>
| **Singapore** | • In order to do outreach for migrant workers, we have to use their native languages in order to be able to approach them. This has been done although it is very challenging.  
• When migrant workers are preparing to go through immigration to come to Singapore, their letter of approval is in the workers’ native language, to the hope is that this means the worker is more aware of the rights, benefits and obligations  
• Attempts have been made to enhance quality of care by setting up a 24 hour hotline for migrant workers, and, for example, engaging volunteer nurses from Philippines to help with outreach  
• Laws and regulations need to be translated into native languages according to the needs of migrant workers. Challenges lie in the large number of languages that need to be covered  
• Concerns relating to cost (to employers) of paying for migrant workers’ insurance. In the past Singapore had offered a special subsidized price to cover migrant workers who were hospitalized, however this is no longer the case. Some employers who found out about illnesses would then terminate employee  
• If migrant workers do not have access to insurance from their home country, their employer usually has the power in terms of facilitating or preventing health access, given that they are able to choose the cover they provide to the migrant worker  
• Stigma surrounding testing for STIs/HIV or carrying condoms means that migrant workers can be afraid to be tested or keep condoms. This makes them more vulnerable |
| **Thailand** | • Since 2009 the Ministry of Health has been able to use migrant health assistants, who provide translation services and community-based programmes. These migrant health assistants work in hospitals, and are trained through short courses using manuals in their own language. They are hired by CSOs on behalf of the government  
• Quality assurance program emphasizes migrant health issues, and migrants have the right to provide feedback to migrant health assistants  
• VCT is now provided by migrant health workers, (only 15% of counseling done by Thai nurses). This has lead to a greater uptake of services  
• Documented and undocumented workers can purchase health insurance from the government (1300BHT annually). Many undocumented workers don’t want to purchase health insurance, so when they go to the hospital they pay if they can, or receive free services (at the discretion of the health centre) if they can’t pay. Under the health service delivery law it is illegal to turn away patients  
• Thailand has a good policy with Cambodia whereby migrants have the option to go to border to pick up medicines, and return to work in Thailand. This could be explored for other neighbouring countries  
• Language remains a barrier, eg. not all Burmese are fluent in Burmese, so all materials must be translated into all ethnic minority languages  
• While radio programs targeted to migrants exist, not all languages and provinces are covered  
• Medical personnel need to be registered in Thailand to practice, so everything must go through translators (slow, and issues with confidentiality/anonymity)  
• Most CSOs focus on Burmese migrants, and very little attention is paid to migrants from other places (China, Subcontinent, Africa, elderly groups from the West)  
• Attitudes of doctors/medical personnel towards migrants can be a barrier  
• Funds from the Global Fund are used to support HIV treatment for migrants. As Thailand has limited medical resources migrant workers from Laos are sometimes encouraged to return to Laos to receive Global so they sometimes encourage people to return to Laos to receive ARVs funded by the Global Fund  
• New globalised patterns of migration are challenging traditional viewpoints. While the Ministry of Labour monitors all nationalities, they prioritize the three neighbours. However other migrants in the region include Nigeria, Pakistan, Bangladesh, and elderly Westerners. These migrants should be monitored and systems made flexible to include their needs, cultures and languages |
| **Vietnam** | • VCT and ART access are available to citizens from neighbouring countries without discrimination  
• For big contracts on construction sites, eg. South Korea and Taiwan, a Vietnamese doctor accompanies the group of migrant workers to the host country. In Taiwan, Vietnam has offices which provide medical services (but they focus on clinical care rather than mental health, psychological care, or legal support services)  
• No interpreters in government hospitals  
• By law, insurance is only provided for formal sector domestic workers. There is nothing for the informal sector. Such workers can buy their own foreign insurance but otherwise there are no policies or regulations to help them |
### Multi-country or regional initiatives

| Cambodia, Laos, Thailand, Myanmar | Government (ministries of health, labour and foreign affairs) and CSO representatives from these four countries will meet in early 2012 to discuss ARV access and treatment and look at improved measures for information collection, sharing and capacity building  
| | A pooling of resources on this issue, in order to lighten the load of all, is supported by all four countries |
| ACMW (all ASEAN) | ASEAN Committee on the Implementation of the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers  
| | First established in 2007, one of the key thrusts was establishment of a regional instrument to support the implementation of the declaration, although work on this was put aside until recently  
| | In 2011 the drafting team resumed work on the instrument. It has now been agreed that the instrument drafting will happen in phases, looking first at rights of migrant workers in general and issues which all member states were comfortable, then looking at irregular migrants, and then investigating whether the instrument would be legally binding  
| | The advantage of this instrument when complete will be that it will clearly define the rights and obligations of sending and receiving states, and ways to address undocumented migrants  
| | Instrument does not contain specific reference to migrant health, only general reference to promotion of welfare  
| | Challenge lies in how to feed recommendations from various dialogues and meetings into the working group. ASEAN representative noted that since this meeting was not part of formal working group proceedings, the best way to act would be for delegates attending this meeting to coordinate with their ACMW focal point at national level to advocate for the inclusion of migrant health in the instrument |
## ANNEX II: AGENDA

### DAY 1: Tuesday 29 November 2011

<table>
<thead>
<tr>
<th>Time</th>
<th>Session/Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 – 9:00</td>
<td>Registration</td>
</tr>
<tr>
<td>09:00 – 9:30</td>
<td>Welcome address</td>
</tr>
<tr>
<td></td>
<td>Dr Petschri Sirinirund, <em>Senior Expert in Preventive Medicine, Department of Disease Control, Thailand Ministry of Public Health</em></td>
</tr>
<tr>
<td></td>
<td>Dr Mandeep Dhaliwal, <em>Cluster Leader of Human Rights, Gender and Sexual Diversity, UNDP</em></td>
</tr>
<tr>
<td>09:30 – 10:45</td>
<td>Session 1: Overview of existing frameworks and commitments</td>
</tr>
<tr>
<td></td>
<td>Overview of Labour Migration, access to health and HIV in South East Asia</td>
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<tr>
<td></td>
<td>Ms Marta Vallejo Mestres, <em>HIV/AIDS Programme Specialist, UNDP Asia-Pacific Regional Centre</em></td>
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<tr>
<td></td>
<td>ASEAN Blueprint 2010-2015, health and development framework and commitments on HIV/AIDS</td>
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<td></td>
<td>Dr Ferdinal M. Fernando, <em>Assistant Director, Health and Communicable Diseases Division, ASEAN Secretariat</em></td>
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<td></td>
<td>World Health Assembly Resolution and Operational Framework on migrant health</td>
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<td></td>
<td>Ms Jacqueline Weekers, <em>Senior Migration Health Officer, International Organization for Migration (IOM)</em></td>
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<td></td>
<td>Open Discussion</td>
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<tr>
<td>10:45 – 11:15</td>
<td>Group Photo/Coffee break</td>
</tr>
<tr>
<td>11:15 – 12:30</td>
<td>Session 2: Sharing of Experiences on Initiatives on improving Migrant Workers’ Health and access to HIV Services</td>
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<tr>
<td></td>
<td>Indonesia, Dr Fonny Jacobus Silfanus, <em>Deputy, National AIDS Commission</em></td>
</tr>
<tr>
<td></td>
<td>Philippines, Government of Philippines</td>
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<td></td>
<td>Thailand, Mr. Promboon Panitchpakdi, <em>Raks Thai</em></td>
</tr>
<tr>
<td></td>
<td>Open Discussion</td>
</tr>
<tr>
<td>12:30 – 13:30</td>
<td>Lunch</td>
</tr>
<tr>
<td>13:30 – 15:15</td>
<td>Session 3: Operational Frameworks</td>
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<tr>
<td></td>
<td><em>Pillar One: Policies and Legal Frameworks Affecting Migrant Health</em></td>
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<tr>
<td></td>
<td>Expert Speaker: Mr Richard Howard, <em>Senior Specialist on HIV and AIDS, International Labour Organization (ILO)</em></td>
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<tr>
<td></td>
<td>Facilitator: Ms Jacqueline Weekers, <em>Senior Migration Health Officer, International Organization for Migration (IOM)</em></td>
</tr>
<tr>
<td></td>
<td>Group breakout sessions</td>
</tr>
<tr>
<td></td>
<td>3 groups (3-4 countries in each group)</td>
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<tr>
<td></td>
<td>Group reports/Plenary discussion</td>
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<tr>
<td>Time</td>
<td>Session</td>
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<tr>
<td>15:15 – 15:45</td>
<td>Tea break</td>
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<tr>
<td>15:45 – 17:30</td>
<td><strong>Session 4</strong>: Operational Frameworks</td>
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</table>

**DAY 2**: Wednesday 30 November 2011

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Topic</th>
<th>Expert Speaker</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:45 – 09:00</td>
<td>Summary of Day 1 and Agenda Presentation Day 2</td>
<td></td>
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</tr>
<tr>
<td>09:00 – 10:45</td>
<td><strong>Session 5</strong>: Operational Frameworks</td>
<td><strong>Pillar Three: Partnerships, Networks &amp; Multi-Country Frameworks, Priorities</strong></td>
<td>Ms Marta Vallejo, Joint United Nations Initiative on Mobility and HIV/AIDS in South East Asia (JUNIMA)</td>
<td>Ms Jacqueline Weekers, Senior Migration Health Officer, International Organization for Migration (IOM)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Group breakout sessions</strong></td>
<td></td>
<td><strong>3 groups (3-4 countries in each group)</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Group reports/Plenary discussion</strong></td>
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<tr>
<td>10:45 – 11:15</td>
<td>Coffee and tea break</td>
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<tr>
<td>11:15 – 13:00</td>
<td><strong>Session 6</strong> : Operational Frameworks</td>
<td><strong>Pillar Four: Migrant Sensitive Health Systems, Priorities</strong></td>
<td>Ms Malu Marin, Executive Director, ACHIEVE</td>
<td>Ms Jacqueline Weekers, Senior Migration Health Officer, International Organization for Migration (IOM)</td>
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<tr>
<td></td>
<td></td>
<td><strong>Group breakout sessions</strong></td>
<td></td>
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<td></td>
<td></td>
<td><strong>Group reports/Plenary discussion</strong></td>
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### 13:00 – 14:00
Lunch

<table>
<thead>
<tr>
<th>14:00 – 15:30</th>
<th>Session 7: Regional Priorities</th>
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</thead>
<tbody>
<tr>
<td></td>
<td><strong>Pillar One:</strong> Policies and Legal Frameworks Affecting Migrant Health</td>
</tr>
<tr>
<td></td>
<td><strong>Pillar Two:</strong> Monitoring Migrants’ Health</td>
</tr>
<tr>
<td></td>
<td><strong>Pillar Three:</strong> Partnerships, Networks &amp; Multi-Country Frameworks, Priorities</td>
</tr>
<tr>
<td></td>
<td><strong>Pillar Four:</strong> Migrant Sensitive Health Systems, Priorities</td>
</tr>
<tr>
<td></td>
<td>Facilitator: Ms Jacqueline Weekers, Senior Migration Health Officer, International Organization for Migration (IOM)</td>
</tr>
<tr>
<td></td>
<td>Plenary discussion</td>
</tr>
</tbody>
</table>

| 15:30 – 16:00 | Tea Break |
| 16:00 – 17:00 | Closing Statements |
# ANNEX III: LIST OF PARTICIPANTS

## GOVERNMENT AND CSO PARTICIPANTS

<table>
<thead>
<tr>
<th>Country</th>
<th>Title</th>
<th>Last Name</th>
<th>First/Middle Names</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRUNEI DARUSSALAM</td>
<td>Dr Yusma Jeffrin MD Yusof</td>
<td>Ministry of Health</td>
<td>Medical Officer</td>
<td><a href="mailto:drjeffrin@gmail.com">drjeffrin@gmail.com</a></td>
</tr>
<tr>
<td>CAMBODIA</td>
<td>Mr Naren Cheth</td>
<td>Ministry of Foreign Affairs</td>
<td>Director-General of ASEAN Cambodia</td>
<td><a href="mailto:naren_cheth@hotmail.com">naren_cheth@hotmail.com</a></td>
</tr>
<tr>
<td>CAMBODIA</td>
<td>Mr Leng Tong</td>
<td>Ministry of Labour</td>
<td>Director of Department of Occupational Safety and Health</td>
<td><a href="mailto:lengtongpachem@gmail.com">lengtongpachem@gmail.com</a></td>
</tr>
<tr>
<td>CAMBODIA</td>
<td>Dr Ly Penh Sun</td>
<td>Ministry of Health</td>
<td>Deputy Director, NCHADS</td>
<td><a href="mailto:penhsun@nchads.org">penhsun@nchads.org</a></td>
</tr>
<tr>
<td>CAMBODIA</td>
<td>Mr Ya Navuth</td>
<td>CARAM Cambodia</td>
<td>Director</td>
<td><a href="mailto:caram.cam@online.com.kh">caram.cam@online.com.kh</a></td>
</tr>
<tr>
<td>INDONESIA</td>
<td>Mr Dedi Adi Gumelar</td>
<td>Ministry of Manpower and Transmigration</td>
<td>Subdirectorate Head of Occupational Health Norm Supervision, Directorate General of Labour Inspection Development</td>
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ANNEX IV: CONCEPT NOTE

Background

Migration has become an integral aspect of our contemporary interconnected world, and the ASEAN region is no exception. Every year millions of people within ASEAN Member States migrate within and across borders. The UNDP Global Human Development Report 2009 states that there are approximately 55.6 million migrants from Asia, representing 29.6% of total global migrants.8

As migration is inherently a multi-sectoral issue, ASEAN and its Member States have indicated, through a number of recent declarations and agreements, its recognition that migrants’ health is an important issue for the region and that challenges affecting this should be supported through a collaborative approach.

Mandates: ASEAN leaders have adopted the ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers at the 12th ASEAN Summit in Cebu, Philippines last January 2007. This recognizes migrant workers as a vulnerable group whose rights require protection.

The WHO member countries – including all ASEAN Member States, have been signatories to the Resolution on the Health of Migrants adopted at the 61st World Health Assembly in May 2008. This Resolution asked Member States to take action on migrant-sensitive health policies and practices9 and to promote the exchange of information and dialogue among Member States. However, progress has been uneven and several challenges remain to be addressed particularly in the ASEAN region.

Challenges: The health of migrants is a complex issue that challenges public health systems worldwide, including those of ASEAN Member States. HIV is also a modern day reality, with an estimated 4.7 million people living with HIV in Asia in 200810 and 1.5 million in ASEAN region11. While migration is not in itself a risk factor for HIV, the conditions in which migrants find themselves (e.g. separated from families, communities and social support systems, experiencing newfound freedoms and increased disposable income, and without adequate access to public health services) do present a situation whereby they are more vulnerable to be exploited and victimized, or to engage in high risk behavior that can result in HIV infection. Moreover, migrant workers experience restrictions on entry, stay and residence based on their HIV status in several countries around the world, including in some countries of the ASEAN region.

Response: In response to an expressed need of countries to engage with each other on health issues of migration and looking in particular the challenges that migrant workers experience in the HIV response, the Joint UN Initiative on Mobility and HIV/AIDS in South East Asia (JUNIMA12) brought together government officials from ASEAN Member States and representatives from civil society organizations and United Nations agencies to a high level multi-stakeholder dialogue13 in February 2009. Country work plans on improving access to health and HIV services for migrant workers were developed, including a set of recommendations to ensure universal access of migrants to health and HIV services. The recommendations included encouraging and supporting governments to review policies, laws and practices related to HIV specific restrictions on migrants’ movement and their access to information, HIV prevention, treatment, care and support.

8 UNDP HDR 2009. Overcoming Barriers: Human mobility and development. Page 30, Table 2.1.
11 ASEAN Regional Report on HIV and AIDS 2010
12 For more information see www.junima.org
In the WHO-IOM Global Consultation on Migrant Health that took place in Madrid, Spain last March 2010, Member States discussed actions by countries and stakeholders, and reached a consensus on a common framework and focus areas to address migrants’ health. The identified priorities include: (1) Migrants’ health monitoring, (2) Policy – legal frameworks, (3) Migrant sensitive health systems, and (4) Partnerships, networks & multicountry frameworks.

Recognizing the need to broaden the discussion to include health of migrants, a second multi-sectoral meeting in ASEAN region shall be convened inviting the same sectoral representations from health, labour, foreign ministry and the civil society to address access to health and HIV services of migrants in the region. The dialogue contributes to the general principle and goals of healthy peoples of ASEAN, under the ASEAN Socio-Cultural Community Blueprint for 2010-2015 (ASCC).

The primary goal of the ASCC is to contribute to realising the ASEAN Community that is people-centred and socially-responsible with a view to achieving enduring solidarity and unity among the nations and peoples of ASEAN. This can be realized by forging a common identity and building a caring and sharing society which is inclusive and harmonious where the well-being, livelihood, and welfare of the peoples are enhanced.

The activity to provide a venue for multi-stakeholders platform was identified under the ASEAN Work Programme on HIV and AIDS IV by the ASEAN Task Force on AIDS. Migrants’ health is also a purview under the Senior Officials Meeting on Health Development (SOMHD), in which Indonesia, Philippines and Thailand are the lead countries. The Health and Communicable Diseases Division, under the Cross Sectoral Cooperation Directorate provides the main coordinating role for the activity. Coordination and collaboration are also being undertaken within the relevant divisions in ASEAN Secretariat regarding this multi-stakeholder such as the Division on Social Welfare, Women, Labor and Migrant Workers, and the Division on AIPA/ASEAN Foundation/AHRB/Other ASEAN Associated Entities.

The High Level Multi-stakeholder Dialogue on Migrants Health and Access to HIV services in the ASEAN region is an important dialogue that will provide venue to review country and regional level commitments, progress and implementation tools, and good practices developed. This will also identify the support needed by country partners in moving forward the commitments in improving migrants’ health and access to HIV services.

Objectives
The two main objectives for this meeting will include:
1) To bring together representatives from key line ministries of ASEAN Member States, leading civil society organizations and the UN family to:
   a. discuss challenges and opportunities to ensure universal access to health services in general and HIV in particular for migrants in the region;
   b. exchange views on identified priorities derived from the WHO Global Consultation on Health of Migrants, as part of the commitments made by all countries during the 62nd World Health Assembly and the 10 ASEAN Member States with regard to health-related and non-health-related concerns affecting migrants.
2) To explore critical regional directions on how to move forward and identify technical assistance and capacity building needs from country partners

Expected Outputs
1) Acknowledged critical core recommendations at regional and country level, in specific areas of concerns affecting the health of migrants in general, and HIV/AIDS in particular;

2) Reinforced commitments to address access to health in general and HIV in particular for migrant workers in the region;

3) Recognized technical assistance needs, that will support the recommendations and commitments identified.

Participants
The high level multi-stakeholder dialogue will bring together approximately 60 participants from the government, civil society and UN family, including several experts who will act as resource people.

Government:
Representatives from government will include senior level government officials from:
- Ministry of Foreign Affairs
- Ministry of Labor
- Ministry of Health and/or the ASEAN Task Force on AIDS Focal Points
- ASEAN Secretariat (ie. particularly divisions involved with health, labor, social welfare & development, and human rights)

Civil Society:
Representatives from civil society will include leading organizations on mobility and/or HIV such as:
- CARAM Asia Secretariat, and CARAM Asia National counterparts
- APN+
- And Migrant Forum Asia

UN Agencies:
Representatives from the UN family will include:
- ILO, IOM, UNAIDS, UNDP, UNESCO, WHO as members of JUNIMA
- OHCHR, ESCAP, UN Women as UN organizations also addressing migrants’ health concerns

Venue and Dates
The venue will be in Bangkok, Thailand.
The date of the event will be on the 29-30 November 2011.

Organizers
The event is organized by UNDP through the JUNIMA Secretariat (based in Bangkok) in collaboration with ASEAN Secretariat (based in Jakarta).

Logistics and Other arrangements
The cost of travel for participants from government and civil society organizations will be covered by UNDP. Coordinative activities will be undertaken by the JUNIMA and ASEAN Secretariats. A detailed logistics note will follow upon participants’ confirmation.