A National Situational Analysis on Migration Health in Myanmar

Ministry of Health and Sports

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Executive summary

This situational analysis was carried out on behalf of the Ministry of Health and Sports in Myanmar to help guide technical cooperation among relevant stakeholders towards developing a National Migration Health Policy in Myanmar. The process included exploring existing literature and evidence, reviewing current and previous policies and legal frameworks, and through a series of stakeholder consultations, consultations and identifying and analyzing gaps and priority issues regarding migrants' health in Myanmar with the goal to develop a plausible and practical National Migration Health Policy. It comprises of three parts. The first part illustrates the literatures reviewed on migration, migrants' health, gender, relevant law and policy, health financing and health information. The second part includes the data review from the Myanmar Census and Myanmar Demographic and Health Survey. The third part provides a qualitative summary of the information from Key Informant Interviews. The situational analysis concludes with some constructive recommendations.

The Ministry of Labour Immigration and Population has estimated that approximately one fifth of the population in Myanmar have migrated at some point, with high regional variation. According to the Census data, the recent internal migration rate (within the past 5 years) is 7% of the total population. Total lifetime internal migrants contribute to 19% of population with obvious regional differences. Yangon received the largest number of inbound internal migrants with 1.44 million, followed by Mandalay with 0.4 million inbound migrants. Outbound migration was high in the western regions of the country (Ayeyarwady, Bago, Chin, Magway, Rakkhine and Sagaing).

Regionally, Myanmar has grown to be the largest migration source country in the Greater Mekong Sub-region (GMS). The Myanmar Government estimate that there are 4.25 million Myanmar nationals living abroad. Regionally, drivers of migration can include higher wages in neighbouring countries, conflict and environmental migration due to natural disasters among other factors. It is also reported that up to 70% of migrants living abroad are based in Thailand, followed by Malaysia (15%), China (4.6%), Singapore (3.9%) and the USA (1.9%).

Health consequences among migrants could be identified and grouped as; 1) Accidents, injuries, violence due to unsafe working condition, 2) Maternal and reproductive health problems; 3) Life style and socioeconomic related health problems; Mental health problems malnutrition, drug abuse, alcoholism and NCDs, and 4) Infectious diseases like TB, HIV, Dengue, skin infection, vaccine preventable diseases.

Limited education, low literacy levels and inadequate language skills were barriers for most migrants while obtaining and understanding basic health information and services, which consequently had a negative impact on their health seeking behaviours

Essential health services for migrants include maternal and child health, worksite safety, injury management and referral, environmental sanitation, life style improvement, and health literacy promotion. During emergency situations, rapid response teams were organized with staff from local areas and supervised by State/Region Health Departments. People residing in hard-to-reach areas could receive health care from mobile teams arranged by local health authorities. If migrants are located at the areas covered by these teams, they would receive health services provided by mobile teams in those areas.

Current migration laws in Myanmar haven't been revised in the last 60 years old and are limited in scope, with no mention of migration health. Existing policies relevant to migrants vary among different sectors.

Social, economic and environmental policy options are scarce and does not adequately protect the poor population moving to urban areas seeking job opportunities. The health impacts, vulnerabilities and social consequences resulting from such migrant flows in Myanmar had been poorly explored. Health vulnerabilities were resulted from poor access to primary health care services, lack of education, training and awareness on the receiving country's working conditions and laws. The role of government institutions in internal migration is almost non-existent, except in cases of permanent migration. The legislation does not distinguish between the various types of migrants e.g. migrant workers, victims of trafficking, unaccompanied children, refugees or stateless persons. Additionally, the legislation did not cover any areas relating to migration; for example, rules concerning taking up employment in Myanmar.

There was no specific health system management of internal migrants. Migrants were not included in any of the health care registry and have faced obstacles with affording transportation and health care costs. It was difficult to set target population prior to providing necessary services for migrants. Basic Health Staff also had barriers to provide services such as work overload, limited human resources and transportation. During emergency situations, some relevant health sectors had management procedures with central level supports of technical, logistics, updated SOP and guidelines. Some sectors were going with need-based approach, some are using all-inclusiveness approach, some are with humanitarian setting. However, there was no systematic operating procedure nor guidelines for internal migrants in non-emergency situations including at factories. Many collaborative activities are not implemented with standardized instructions and guidelines.

Recommendations

Migrant Health Policy recommendations were made to recognize that securing the health of migrants is a critical public health issues to be addressed by multi-sectoral approach; to ensure mechanisms, infrastructure for migrant health management, and political consideration to protect, maintain and promote the health of migrants, and to ensure the improved accessibility in health status among migrant populations and minimizing the negative health outcomes of migration.

Country specific policy development: A National Migration Health Policy should be developed, in line with recommended global principles as already endorsed by Myanmar via the World Health Assembly resolutions and Global Compact on Migration: The policy should be 1) clearly formulated, 2) requires coherence with a full range of policies across relevant sectors, such as immigration, labour, social protection, housing, education and health, 3) need to annex with the legislation and effective strategies in line with standards, 4) be aligned with existing National Health Plan, 5) augmented with inter-country and multi-sectoral dialogue, coordination and sharing of good practices, and 6) be gender sensitive.

Primary Health Care Approach: Existing primary health care services should additionally promote and provide specific migrant sensitive services for migrants in line with the governments goals of reaching Universal Health Coverage.

Coordination mechanism: A migrant health focal body should implement the following activities; 1) collaboration with relevant government sectors and partner organizations by sharing information and resources, harmonizing targets and activities, 2) Partnerships and collaboration with private sectors in the health care industry for migrants in urban setting, and 3) recruiting migrant community based volunteers, training and engaging community oriented health activities, 4) encompassing a wide variety of government-community interactions ranging from information sharing to community consultation.

Financing for health: Migrant Health Care should be based on health financing mechanisms with appropriate options of pre-payment scheme by contributions of government, employers, migrant workers and partners.

Leadership and governance: Migrant Health services should; 1) link, align and synchronize existing residential health services of EPHS and NHP, 2) be based on baseline information by mapping, listing, estimating migrant typology in areas covered by local health staff, 3) connect with HMIS, 4) have a cost-based strategic plan with coordinated and collaborative actions among related health sectors, 5) develop standard operating procedures (SOP), guidelines and instructions to be provided to relevant implementers which include logistic management, workplace assessments, medical checkup procedures, setup of mobile medical teams, and instructions for voluntary health workers, 6) embed migrant health implementation research addressing needs, gaps and barriers to healthcare access among migrants, and providers should be engaged in priority activities.

Abbreviation

ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ASEAN	Association of Southeast Asian Nations
BHS	Basic Health Staff
CSO	Community Service Organization
EHP	Essential Health Package
HMIS	Health Management Information System
IDP	Internally Displaced People
IRD	International Relation Division
KII	Key Informant Interview
LHV	Lady Health Visitor
MDHS	Myanmar Demographic Health Survey
MMP	Migrant and Mobile population
MOHS	Ministry of Health and Sports
MOLES	Ministry of Labour, Employment and Social Security
NCD	Non-Communicable Diseases
NHP	National Health Plan
NV	Nationality Verification
OCP	Oral Contraceptive Pills
OEHD	Occupational & Environmental Health Division
OOP	Out of Pocket expenditure
OPD	Out-Patient Department
PNC	Postnatal Care
SOP	standard operating procedures
STI	Sexually Transmitted Infection
UHC	Universal Health Coverage
UHC	Universal Health Coverage

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Introduction

According to the Myanmar Population and Housing Census Report (2014), 19.3 per cent of the population (9 million) in Myanmar are defined as lifetime migrants with 7% of the population as recent migrants. Approximately 4.25 million Myanmar migrants are overseas and this number is projected to increase in the future. With the migrants abroad, most of the dependents are left behind who face tremendous social burdens. It is essential to extend health and social protection for the dependents left behind, on the verge of departure and during their return.

Driving forces of migration include rapid globalization, urbanization, and being forcibly displaced against their will due to poverty, political and ethnic conflict-driven mobility, climatic change, natural disasters, and epidemic emergency outbreaks. Many of these driving forces may be beyond the scope of the health sector, however the field of migration health is considered important from a sustainable development point of view. It is now generally acknowledged that migration brings development potential, owing to migrants' intellectual, cultural, social and financial capital. Being and staying healthy is a key necessity for migrants to work, be productive and contribute to the social, cultural and economic development of their communities of origin and destination.

Today more than ever, migration is recognized as a social determinant of health. Therefore, migrants, and consequently communities at large, can be vulnerable to ill-health and disease. This indicates the need to draw more significant attention towards migrants' and migration affected communities' health and well-being in current debates on global health security development. From a global health security perspective, the paucity of targeted outreach health services and surveillance through mobility flow undermines the efficiency of disease control measures. This renders internal and cross-border human movement as a risk factor in the spread of communicable diseases, both within and from countries with weak health systems.

In 2008, the resolution from World Health Assembly called on member states to construct policies and systems to approach migrants' health and promote greater multi-national and inter-sectoral collaboration. The Ministry of Health and Sports (Myanmar) is increasingly aware of the migration health challenges, especially in meeting the health demands of the various types of migrant and mobile population (MMP). The MOHS have been working in close partnership with the International Organization for Migration (IOM) since 2014 to enhance the health of migrant and mobile population (MMP) and increase their accessibility of health care services.

In 2016, a Technical consultation workshop was conducted to assure engagement of relevant ministries in Migrant Health Agenda. After a series of discussions, meetings and workshops at Ministerial level, The MOHS (Myanmar) committed to develop a "National Migrant Health Policy". The National Migrant Health Policy stems from Myanmar overall vision for the protection of rights of all migrant populations, as part of the country's vision for development. Myanmar is committed to place the migrant health agenda within the national health policies and health care system. Initiative of the present "Situational Analysis" is part of the process in conceptualize the National Migrant Health Policy.

The present situational analysis was conducted in close cooperation and coordination between the Migrant Health Desk within the International Relation Division (IRD) of MOHS and IOM. With the technical assistance of the IOM, the situational analysis explores existing gaps and issues regarding migrants' health in Myanmar with the goal to develop for plausible and practical policy in regards to National Migration Health Policy.

The situational analysis comprises of three parts. The first part illustrates the reviewed literature on migration, migrants' health, gender, relevant law and policy, health financing and health information. The second part included data review on Myanmar Census and MDHS. The third part is review on qualitative information from Key Informant Interviews. The last part concludes the situational analysis with constructive recommendations.

Objectives

By providing a situational analysis of migrant health in Myanmar, this study is expected to serve as an input to guide the technical cooperation among stakeholders in forming the National Migration Health Policy.

The specific objectives are:

i. To identify the main problems regarding migrants' health in Myanmar.
ii. To underline the gaps in policy and practice related to the health issues of migrants.
iii. To describe existing initiatives responding to migration health challenges in Myanmar.
iv. To report feedbacks and recommendations from both individual and group consultations with key stakeholders to improve health status of migrants in Myanmar.

Methodology

As the first step in conceptualizing Myanmar Migrant Health Policy, this situation analysis is carried out primarily by conducting desk reviews, based on; 1) review of the current body of literature and scholarly works, 2) review on national data including Census and the Myanmar Demographic and Health Survey (MDHS), and 3) review of qualitative data from individual key informant interviews. The second step involves a review of primary data from a consultative workshop involving key representatives from relevant sectors. They include representatives from various relevant ministries and International Non-Governmental Organizations (INGOs). The consultative workshop will be conducted to obtain the perspectives and recommendations in forming the National Migration Health Policy.

Information from literature and scholarly works contributed to the study context. Documents relevant to this subject such as media review, reports, scientific articles, policy briefs, advocacy documentation were also gathered to enhance understanding of the study's context. The work aimed at getting supportive evidences, previous experiences and relevant information to be considered in the development of migration health policy. The literature search was conducted to capture the three core themes: migration, migrant health, and migrant health policy. The search was performed on multiple databases such as Google Scholar, MEDLINE, Scopus, JSTOR, Science Direct (Elsevier), PubMed, ProQuest Research Library and others. Besides, the search was conducted on Google and the websites of the following organizations/institutions/projects/networks: World Health Organization (WHO), United Nations Population Fund (UNFPA), and others. In addition, the review of reports and meeting minutes from Myanmar Migration Health Task Force Meeting, Multi-sectoral Consultation Meetings on Migrant Health and migration reports from various UN Agencies and relevant sector Ministries in Myanmar were undertaken.

Regarding information needed for migrant health policy, migration characteristics emphasizing on health determinants were also analysed through desk reviews on; 1) aggregated data on Myanmar Census 2014 Thematic reports for Migration and Urbanization and 2) Myanmar Demographic Health Survey (MDHS) 2015-2016 Dataset (MMIR71FL). Number of migrants, different types of migration, different streams, patterns and reasons for migration, sociodemographic background, area of residence in terms of State/Region were reviewed.

Information from focal points within relevant sectors were collected to explore existing issues related to migrants, health management mechanisms, health infrastructure and political considerations using key informant interview (KII) method. This formulated the situation analysis report to make recommendations for the policy brief on improving the accessibility to health care and services for migrants within the national health system. A total of 22 KIIs from different sectors of government ministries that are related to health services for migrants and different divisions under Ministry of Health and Sports were conducted.

Key findings from each sector were analysed in a combined fashion using qualitative thematic analysis focusing on specific objectives of the situation analysis and aiming to conceptualize the migrant health policy.

Limitations

The data sources used for this study, while fairly reliable overall, suffer from some shortcomings. Firstly, the nature of different types of migrants makes it challenging to gather reliable data. A systematic review by Hannigan, O'Donnell, O'Keeffe & MacFarlane (2016) reports that there is no universally accepted definition for migrant at an international level. The heterogeneity of definitions and its consequences are problematic

towards health system policies and migrants' access to health care. For example, this issue can create a barrier to develop the evidence base for public health care policies as it limits the comparability of data collected in health information systems or public health research.

Secondly, while there is abundant data on documented migrants within the Southeast Asia region and from Myanmar, information on internal and irregular migration is extensively incomplete and existing estimates are likely to be inaccurate. Nevertheless, existing data allows to paint a somewhat reliable picture of migrants in Myanmar.

Next, the term 'migrant' is barely used in available documentation circulated in the health sector. As migration significantly contributes to the socio-economic development of the country, MOHS is now putting more effort to align with the prevailing developmental situation of the country.

Lastly, many existing laws relating to migration haven't been revised in the last 60 years old and are very limited in scope with any updated migration laws relating exclusively to labour migration channels. This is a result of several decades of political isolation, where Myanmar has only recently begun a wide range of social and political reforms that take into consideration expanded social protection concepts.

Analysis results

A. Literature review

This section provides an overview of migration, migration health and related health policies, and practice. The study begins with understanding the range of terminology used in literature to describe migrants and health. The section continues with a brief description on migration in Southeast Asia, which is followed by migration and gendered migration within Myanmar. Migration health is reviewed with regards to the environmental and individual risk factors that migrants face. The laws, legal framework and policy related to the health of migrants are examined as well. The section ends with a brief description on the health financing and health information system in Myanmar.

A1. Notes on Terminology

There is a growing concern within the public domain, health sector and academic field regarding the different definitions used for "migrants" and the various groups of migrants. For this situational analysis, it is deemed essential to clarify some of the terms and definitions currently used in the literature (see Table 1).

IOM defines a **migrant** as,

" any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is."

Table 1. Operational definitions of migrants (within the context of Myanmar)

No.	Type	Operational Definitions
1	Migrant	A person who lived away from their town or village of origin
2	Internal migrant	A person who migrated to some other place within Myanmar
3	In-migration	Person(s) who moved from one village/town or State/Region or countries to current village/town of study for any reason
4	Out-migration	Person(s) who moved out of village/town of study to other village/town or State/Region or countries for any reason
5	Inbound migrant	An individual who originates from outside of the study area (village) and has lived in the area or made intermittent day time or overnight visits into the study area
6	Mobile hawkers	A person or families who regularly moves around various locations from one place to another within Ayeyarwaddy Region in a relatively shorter time-span (days or weeks) for selling goods on their boat.
7	Outbound migrants	An individual or families who originate from the study area (village) and moved outside of the study area with an intent to stay for more than 30 days. It includes movement of people from Ayeyarwaddy to Yangon in terms of rural to urban migration and an individual or families who migrate out of

		their village/town for their work dependent on seasonal conditions performed during part of the year. E.g. Farmers, Brick kiln workers
8	Local Mobile	An individual or families who originate from the study area (village) made intermittent day time or overnight visits outside of the study area with an intent to stay not more than 30 days in each visit. It includes forest goers and fishermen.

Source: IOM Myanmar, 2015

The 1946 constitution of the World Health Organization (WHO) defines **health** as,

A "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

"Migration health" refers to the well-being of migrants, mobile populations, their families, and communities affected by migration.

A2. Migration in Southeast Asia region

Migration has emerged as an essential part of the economic and social development globally and this is unlikely to change in the near future. Southeast Asia has experienced high levels of migration, predominantly intraregional migration since the 1980s (Kaur, 2010). In 2015, more than 14 million cross-border labour migrants originated from within the region. More than 6 million of these migrants move to work in other countries within the region, while the remaining move to other regions, such as Europe and the Arab States (UNDP, 2015). In addition, displacements occur such as environmental refugees (in addition to political refugees and migrant trauma survivors) due to growing conflicts and environmental degradation.

The forming of Association of Southeast Asian Nations (ASEAN) in 1976 including Philippines, Cambodia, Burma, Lao PDR, Viet Nam, Indonesia, Singapore, Malaysia and Thailand (with Brunei joining later) aimed to initiate common political and economic interests. Some countries have experienced rapid economic growth due to the 'push' factors that has contributed to a surge in labour migration (both skilled and low-skilled workers) from neighbouring countries. Within ASEAN, two main categories arise. Primary sending countries are Cambodia, Lao PDR, Indonesia, Myanmar, Philippines, and Viet Nam, whereas primary host countries are Malaysia, Thailand, Singapore, and Brunei Darussalam.

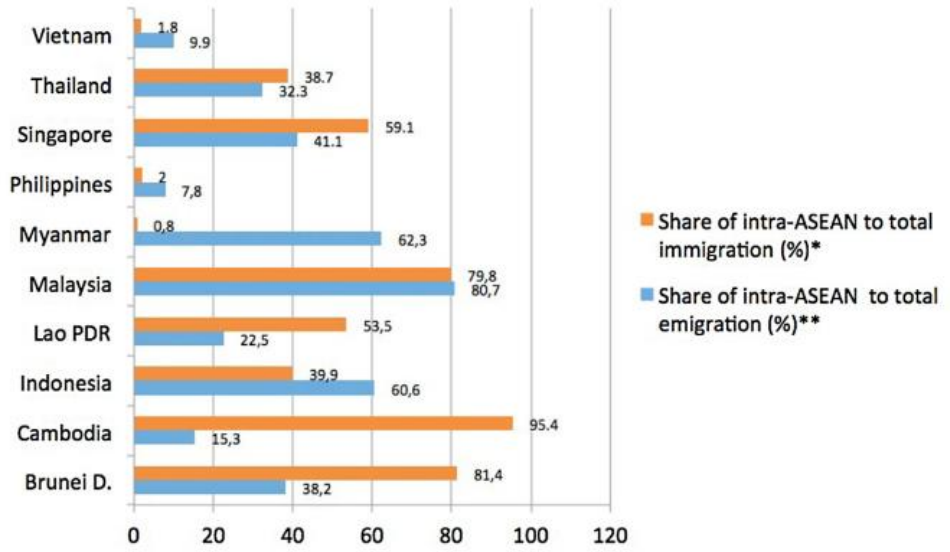

Figure 1. Association of Southeast Asian Nations (ASEAN) Migration Stocks

Source: World Bank, 2013

**Share of migrants from ASEAN countries to total immigration in country.*

*** Share of nationals who migrate to another ASEAN country to total emigration.*

However, labour-sending countries and labour-receiving countries having different interests and agendas hinder regional agreement. The differing positions are noted in various statuses of international conventions in the region. For instance, the International Convention on the Rights of Migrant Workers has only been ratified by the Philippines, Indonesia and Cambodia (UNDP, 2015).

In addition to the disparate standards and approaches to dealing with migrant workers' health, ASEAN as a region encounters technical challenges in cooperation to provide health care to the migrant population. According to a study by Nodzenski, Phua and Bacolod (2015) on regional health governance in Southeast Asia, member-states possess different social security systems, where such coordination issue can also be attributed to the operational and administrative capacity. Structural inequalities between member-states persist under such circumstances as well.

In ASEAN, successful cooperation in health has so far been limited to health concerns such as infectious diseases. For instance, Human Immunodeficiency Virus infection and Acquired Immune Deficiency Syndrome (HIV/AIDS) have often been highlighted through the support of the ASEAN Task Force on AIDS, who've held high-level multi-stakeholder meetings focusing on HIV prevention, treatment and care among migrant population (UNDP, 2015).

On the other hand, ASEAN's health-related discussions have mainly centered around attaining Universal Health Coverage (UHC) in the region. On the 12th ASEAN Health Ministers Meeting held in September 2014, member-states declared their willingness to 'improve equitable access to health care for all groups' (ASEAN, 2014). The emerged core priority of the post-2015 health agenda regarding migrants' health depends on the collaboration and coordination within the operational aspects of health (Nodzenski, Phua & Bacolod, 2015). Nevertheless, it may be debated that low level of institutionalization in ASEAN, as well as the lack

of inclusion of different stakeholders in the regional processes form significant barriers to the development of a regional governance framework for the health of migrants.

In light of increased involvement of states in the political regulation of economic activities, policies are established and coordinated for immigrant's recruitment that shaped (and continue to shape) the 'new' migration geography in the region. Hence, health agenda should be prioritized for the overall regional holistic development.

A3. Migration in Myanmar

Migration is the consequence of a complex decision by an individual to move from one place to another to find a better life. There are multiple factors pushing the decision to make moving from place of origin to destination, which includes economic, social, security and safety factors of daily life, disasters, and promise of well-being and a better future in the area of destination.

Myanmar is a low income country and the largest migration source in the Greater Mekong Sub-Region, sending an estimated 10 per cent of its 50-million population[1] abroad, mainly to Thailand and Malaysia, as well as other destinations in Asia and beyond. According to 2014 Census, around 70 per cent of those living outside Myanmar were reported to be living in Thailand, while 15 per cent were in Malaysia. Other main destination countries include China (4.6%), Singapore (3.9%).

According to the latest national census, Lifetime migrants, defined as having moved at least once between townships since birth comprise 19.3 percent of the population (over 9 million people). Recent migrants, defined as those who have moved from one township to another at least once in the 5 years prior to the census comprised almost 3.4 million population, or 7 percent of the total population[2].

Migration has a direct impact on the population growth and the socio-economic development of the country, in terms of employment and provision of social services to the migrants and their families. The surge of migrants into Yangon Region, deteriorates the livelihood of the population in the city including those of the migrants. The changing trend observed is the migration from Yangon to other cities, with a clear increase in the urban-urban migration. In addition to the lack of social, economic and environmental protection, most migrants moving to urban areas are already poor, less educated and low-skilled, compounding vulnerability and placing individuals and families at greater risk of poor health and social outcomes.

The research on Levels, Trends and Patterns of Internal Migration in Myanmar which was conducted by UNFPA and Ministry of Immigration and Population suggested conducting more detailed research on migration both internal and international, and their linkage to development. This is essential for evidence-based policy dialogue, development and programme formulation. The study provides limited information on levels, trends and patterns of internal migration of Myanmar with no conclusive evidence regarding all migration issues, particularly related to the determinants and consequences of internal migration in Myanmar. In addition, study on international migrants from Myanmar would be very relevant as well for future policy development of the country3.

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[1] Migrant from Myanmar and Risks Faced Abroad, A Desk Study, 2016

[2] The Republic Of The Union Of Myanmar. The 2014 Myanmar Population and Housing Census. Census Report Volume 4-D (Migration and Urbanization (2014) https://myanmar.unfpa.org/en/publications/thematic-report-migration-and-urbanization

[3] Levels, Trends and Patterns of Internal Migration in Myanmar, UNFPA, Department of Population, Sept 2013

A4. Internal migration:

Findings from the study on Levels, Trends and Patterns of Internal Migration in Myanmar show that internal migration within Myanmar has increased over the last few decades and the pattern of migration has significantly changed overtime[3].

The Dry Zone is a major source area for both internal and international migration. Mon State in the Southeast and Shan State are origin, transit and destination for internal and international migrants. It is also a transit point for cross-border/ international migrants from other areas and a major origin/source area for international migration. The role of government institutions in internal migration is almost non-existent, except in cases of permanent migration. However, some activities/programmes of the government and non-government organizations have directly or indirectly benefited the migrant population, such as malaria, HIV/AIDS, tuberculosis programme, social welfare, immigration and border security, forced labour, rights of women and children, vocational training etc.

A5. Seasonal migration:

After the Cyclone Nargis in 2008, 42 per cent of households migrated from Ayeyarwaddy to other regions internally due to food insecurity and response to income loss[4]. Many people moved from Ayeyarwaddy to Yangon (rural to urban migration) for work. Seasonal Migrants are individuals or families who migrate out of their village/town for their work dependent on seasonal conditions performed during that part of the year. e.g. Farmers, Brick kiln workers, Salt-making firm. They live alternatively between their place of origin and location of destination. Seasonal migrants involved in paddy growing are typically dispersed in small migrant clusters and temporarily live in wide farming areas[5].

A6. International migration:

Rural poverty, unemployment, lack of economic opportunity, and fragile livelihoods comprise the key drivers for both domestic and international migration in Myanmar[5]. There are approximately 2 million former household members living outside of Myanmar. The main reason for movement was "following family" and "employment/seeking employment" and the rest are due to education and conflicts6. The factors contribute to Myanmar's migration trends, in addition to poverty and unemployment, include discrimination and statelessness in areas of origin, and the desire to improve livelihoods by accessing better opportunities for employment in countries of destination. Some migrants use formal, safer migration routes and modes of travel allowing them better access to basic services, resources and assistance in areas of destination while undocumented migrants face many challenges and crises in their place of destination. Myanmar endorsed Laws Related to Overseas Employment that can protect overseas Myanmar workers who use formal routes to ensure the rights and privileges of workers. However, the same support could not be extended for undocumented migrants workers.

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[4] Research on key drivers for migration in Myanmar, LIFT
[5] Access and Utilization of MCH service among migrants in Bogale and mawlamyinegyun, IOM Myanmar and DMR, July 2015
[6] Myanmar Census Report, 2014

A7. Displacement:

Conflict, insecurity, political violence and natural disasters are also contributing factors to mobility[7]. There are up to 642,600 internally displaced people (IDPs) in Myanmar, forced to flee their homes by armed conflict and inter-communal violence. The figure includes up to 400,000 people living in prolonged displacement as a result of conflict in the south-east of the country, including southern Shan, Kayah, Kayin and Mon states and Bago and Tanintharyi regions and 98,000 displaced by conflict in Kachin and northern Shan states since 2011. This also includes around 140,000 people displaced by inter-communal violence in Rakhine state since 2012[8].

Myanmar is also highly prone to natural disasters leading displacement and affecting migration flows. In 2008, cyclone Nargis affected 2.4 million people, killing 140,000 and displacing 800,000 people, of which migrated from the affected Ayeyarwady Delta to different places. Cyclones have caused massive displacements in 2010 (100,000 IDPs) in Rakhine State as well, while an estimated 38,000 people were displaced by floods in Rakhine, Kayin and Mon states and in Tanintharyi and Ayeyarwady regions in July 2013. Recurrent disasters contribute to cross-border mobility of affected persons into Thailand, Bangladesh, Malaysia and China. Displaced persons and vulnerable migrants often resort to smuggling networks in order to cross borders. Hundreds of thousands of Myanmar migrants are smuggled each year to various destinations in South-East Asia and beyond, with the majority to Thailand and Malaysia[9]. This particular migrant group could face challenges when accessing healthcare and in turn in achieving UHC, as current health systems lack a migrant inclusive component.

A8. Gendered Dimensions of Migration

The rise in feminization of migration in general and within this region has raised new concerns and challenges relating to institutions, processes and outcomes associated with female migration. Gender is central to any debate particularly within the realm of regular and irregular migration and forced displacement. Why are female migrants more vulnerable? One reason is that they are prone to exploitation where they are paid low wages and work for long hours. Also, potential physical and emotional abuse by employers and social isolation increase the vulnerability of female migrants. Even with voluntary regular migration, female migrants continue to face challenges, for instance insecurity due to separation from families and friends. Moreover, female migrants are at greater risk of abuse, including trafficking and gender-based violence.

Labour migration in Southeast Asia and Myanmar is unquestionably a gendered process and interlinked closely with age, economic status and cultural restrictions on women in this region. Nevertheless, female immigrant's contribution to the host country labour force has often been overlooked since the immigration systems in both sending and receiving countries of the Southeast Asia is gender biased, such as, the gender-selective policies of labour-importing countries and the emergence of gender-specific employment niches (Kaur, 2009). More gender-specific policy regarding migration should be emphasised in protecting the rights of female migrants.

[7] Migrant from Myanmar and Risks Faced Abroad, A Desk Study, 2016
[8] IDMC Myanmar, comprehensive solutions needed for recent and long-term IDPs alike, Jul 2014
[9] Migrant from Myanmar and Risks Faced Abroad, A Desk Study, 2016

A9. Migrant Health in Brief

With the increasing challenges related to the volume, speed, and complexity of modern migration, can policy keep pace with the shifting migration patterns? A report by IOM (2010) underlines that policies and approaches to managing the health consequences of migration have not been able to keep up with the current fast evolving developments in addressing health inequities and determining factors of migrant health. Traditional strategies often use security and disease control as the primary rationales. However, the strategies may exclude migrants with certain health conditions. The extent of health problems that can be linked with migration is unavoidably broad. It ranges from communicable and non-communicable diseases, injuries associated with work environments, to psychosocial issues.

The most prevalent health problems of recently arrived migrants and refugees include accidental injuries, hypothermia, burns, gastrointestinal diseases, cardiovascular incidents, pregnancy and delivery-related complications, diabetes and hypertension (WHO, 2017). Female migrants and refugees continuously encounter particular hurdles, especially in maternal, newborn and child health, sexual and reproductive health, and gender-based violence. The vulnerability of migrants and refugees to the risks associated with population mobility– psychosocial disorders, reproductive health problems, higher newborn mortality, drug abuse, nutrition disorders, alcoholism and exposure to violence – increase their susceptibility to non-communicable diseases (NCDs). The crucial issue regarding NCDs is the disruption of care that is critical for chronic conditions. In addition, vulnerable groups, especially children, are inclined to respiratory infections and gastrointestinal illnesses due to impoverished living conditions, poor hygiene and deprivation during migration.

A10. Migrant Health Issues in Myanmar

To improve the health outcomes, identifying the essential health package to be made available at the service delivery point is crucial. The essential health package (EHP) of the National Health Plan (2017-2021) addresses the inequities and service availability gaps at each locality. The components in broader categories can be defined based on the unique situation of the locality at the operation level. EHPs aim to concentrate on scarce resources and interventions which provide the best 'value for money'. EHPs are often expected to achieve multiple goals: improved efficiency; equity; political empowerment, accountability, and altogether more effective care. EHPs are intended to be a minimum standard that can enhance equity.

Myanmar has experienced large volumes of migration within and beyond its borders. In a study conducted in 2003, many participants reported to have undergone several periods of migration, with some of them reporting more than 1,000 migration episodes (Skidmore and Wilson, 2007:58; Bosson, 2007). Current policy transition in Myanmar has observed large scale changes in population flows which is expected to increase in the coming years as new economic investment, more job opportunity, a pleasant physical setting and desired climate and environment will influence people to move from one place to another. Consideration of Migrant Health will be a part of the Health System Strengthening measures in Myanmar as migrant are always left behind in the provision of health care services.

Most migrants are healthy young people, and some may even benefit from a 'healthy migrant effect' when they first arrive in their host community. However, conditions surrounding the migration process can increase vulnerability to ill health. This is particularly true for people who migrate involuntarily, flee natural or man-made disasters and human rights violations, and for those who find themselves in an irregular situation, such as those who migrate through illegal channels or have no documents. Other risk factors include poverty, stigma, discrimination, social exclusion, language and cultural differences, separation from family and socio-

cultural norms, administrative hurdles and legal status. Migrants are particularly vulnerable during disease outbreak such as influenza due to lack of access to health care, as well as dangerous and risky jobs they perform.

Commonly, there are inequalities in accessing health services, sub-standard quality of care and negative outcomes for migrants and communities (WHO, 2008). Although healthy migrants integrate into host communities for work, they do not receive adequate health education and proper health care services, particularly seen among migrant clusters working at Rubber plantations, Gold Mines, Quarry and road construction, Fishery and cold storage, and Salt Farm[10] .

Mobile, migrant, and scattered population usually reside in non-residential temporary settlements and sometimes unbeknownst to the host community rendering them hard-to-access for providing primary health care services. These populations usually tend to have low immunization coverage, low ante-natal care coverage and higher maternal and child death rate. There are barriers for accessibility of health care services from both supply and demand side. Migrants are not included in any of the health care registry and face difficulties in affording transportation and health care. Basic Health Staff also have barriers to provide services for migrants due to already overburdened workload and task requirements, large and geographically dispersed migrant groups, limited human resources and lack of additional funding for transportation and supports.

Migrant women are especially vulnerable to ill health during the migration process due to poor living conditions, unsafe and physically demanding work, low wages and their precarious legal status. Rigid health care systems exclude people who do not have documentation, or who have not contributed to a health insurance scheme. Undocumented workers working in informal sectors face significant difficulties due to their undocumented status and less access to health care information. There are gaps in specific types of health care particularly for mental health, sexual and reproductive health, as well as preventive health care. Sometimes health care policies and programming with a focus on migrants only cover HIV/AIDS without providing information on any other health conditions and health care services.

All these challenges on migrant health services illustrate the need to bring greater attention to migrants' and migration affected communities' health and well-being.

A11. Environmental vulnerability factors

The dynamics of the high-risks that migrants encounter along their migration routes threaten their safety, dignity and well-being. Migrants' vulnerability is likely to be complicated by the circumstances of their migration experience. Regular and documented migrants are inclined to use formal, safer migration routes and modes of travel, which allows them access to basic services, resources and assistance in countries of destination. On the other hand, aspiring migrants who are ineligible or unable to migrate through legal channels often resort to irregular channels. Their irregular status increase the risk and susceptibility towards hazards of all kinds.

Besides, migrants struggle with a variety of natural and man-made hazards that can lead to unnecessary situations during their journey or at the countries of destination. The risk factors and migrant vulnerability in major countries of destination are natural hazards, economic crisis, industrial/occupational accident, exploitation, disease outbreak, mass return/deportation and conflict violence, which are summarized in table

[10] Data Mapping for Public-Private Partnerships for Malaria in Mon State, Myanmar, 2014

2. Exploitation is also elaborated further in the individual risk factors as it is a combination of both environmental and individual risk factors.

Table 2. Risk factors and migrant vulnerability in major countries of destination

Potential crises	Causes/Effects
Natural hazard	Earthquakes, cyclones, floods, landslides, droughts, tsunamis, volcanoes and fires resulting in destruction of infrastructure, displacement, loss of livelihood and economic loss, hunger, injury and death.
Economic crisis	Global economic crisis, Asian economic crisis, poor economic conditions in host or sending country, structural economic problems, underinvestment, underdevelopment.
Industrial/Occupational accident	Poor regulation in factories, industrial standards enforcement, poor safety and environmental standards leading to industrial accidents and fires, migrants performing 3D (Dangerous, dirty and demeaning) jobs
Exploitation	Enslavement, forced labour, debt bondage, trafficking, restricted movement, rape, physical injury, death; relying on smugglers, brokers and traffickers or emigrating via sea and border crossing through jungle
Disease Outbreak	Outbreak of pandemic such as influenza, lack of access to health care, dangerous and risky jobs.
Mass return/ Deportation	Irregular and undocumented immigrants face arrest and deportation
Conflict and violence	Internal Myanmar conflict/long-standing conflict inside Pakistan pitting Shiha and Shitte Muslims, border conflict with India over Kashmir, historical tensions with Afghanistan and Bangladesh. Other parts of the country are also targeted with terrorist attacks.

Source: IOM, 2016

A12. Individual risk factors

Besides environmental risk factors, migrants face numerous individual risk factors. Linguistic difficulties and the unfamiliarity of the surroundings in area of destination poses significant barriers towards Myanmar migrants' safety and security in their host countries. As a result, migrants' dependence on brokers and agents is heightened, which increases their risk of being exploited and abused. Moreover, a recurrent challenge is that migrants also face frequent arrest and have little or no legal protection in their host countries.

Without legal status, both skilled and low-skilled migrants are subjected to salary differences according to their precarious circumstances, forming a productive, flexible and low-wage workforce. However, the vilification and criminalization of immigrants marginalise their social status further. This threatens their limited bargaining power while negotiating for better labour conditions causing them to remain in the cycle of poverty.

Deprivation of access to right-to-life commodities such as residing in conditions that make them ill, without a basic shelter, clean water, necessity sanitation or adequate food can have dire consequences on migrant's

health(WHO, 2003). Health is a vital economic asset especially for the poor since their livelihoods rely on it. When immigrants become ill or pregnant, they are most inclined to be trapped in a double burden situation of lost income and high health care cost. This is a chain reaction that may involve averting time from earning an income to seeking care for their health. They may even be forced to sell off assets required for livelihoods and sometimes relying on loans just to survive.

A13. Laws and legal framework and policy towards migrant health

There are no existing Laws or Legal frameworks in Myanmar which explicitly refer to the health of migrants and their access to services in Myanmar. All citizens of Myanmar are entitled to access health care according to the constitution, however there are no provisions in Laws to describe access to services for non-citizens, undocumented migrants, internationally or internally displaced persons or other migrant categories.

Several health sector policy documents, however, do recognize the importance of providing access to health services for migrants. The National Health Plan 2011-2016 does mention internal migration and its aims to provide basic and essential health services for migrants:

> *"With changing economic policy and certain extent of industrial development rural to urban migration for seeking job and economic opportunities is another phenomenon raising health issues particularly in the peri-urban areas. Having no better choice these migrants have to live in substandard dwelling in places which are overcrowded with poor environmental situation. In addition to the need for expanding health service coverage for the rural population and for those in the border area, health sector is now facing another challenge for providing equitable access to health care for the entire population. Current cycle of the National Health Plan will have to take into consideration provision of basic and essential health services for the peri-urban population."*

Myanmar signed the ASEAN Declaration on the Protection and Promotion or the Rights of Migrant Workers in 2007 which describes the obligations of sending and receiving states in promoting the fundamentals rights and dignity of migrant worker and their families. There is, however, no explicit mention of access to health care under this declaration.

The National Strategic Plan for the National Malaria Control Programme specifically recognizes migrants and mobile populations as particularly vulnerable. The plan recognizes migrants as particularly at risk due to social and economic factors, as well as environmental factors relating to their movement into malaria prone areas such as forested areas, plantations, mining and rural construction projects.

The Myanmar National Strategic Plan on HIV and AIDS does explicitly recognize migrants and mobile populations as a key target group and outlines a range of recommended interventions to "reduce HIV-related risk, vulnerability and impact amongst mobile and migrant populations". 3 Overall activity areas aim to: ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender, literacy, language and transmission behavior; promote meaningful involvement and empowerment of vulnerable groups including PLLHIV; strengthen the enabling environment through advocacy and education. A Social Security Law was passed in 2012, though there is no mention of migrants within the document.

Table 3. List of Existing National Laws and Policies that relates to the health and social protection of migrants

Legal /policy document (title / nature / date)	Authority	Summary of content as it relates to migration/access to health services	Diseases or health coverage (e.g., HIV, TB, Malaria, SRHR, MCH, (PHC), Occupational Health (OH) etc.
Prevention and Control of communicable Diseases Law (1995) (Revised in 2011)	Ministry of Health	Describes functions and responsibilities of health personnel and citizens in relation to prevention and control of communicable diseases. Describes measures to be taken in relation to environmental sanitation, reporting and control of outbreaks of epidemics, quarantine and penalties for those failing to comply. The law also authorizes the Ministry of Health to issue rules and procedures when necessary with approval of the government. Chapter VII - Quarantine 14. An organization or an officer on whom power is conferred by the Ministry of Health may issue a prohibitive order or a restrictive order in respect of the following matters:- (a) right of the person suffering from Principal Epidemic Disease to leave and return to his house; (b) right of people living in the house, ward, village or township infected by Principal Epidemic Disease to leave and return thereto; (c) right of people from outside to enter the house, 'ward, village or township infected by Principal Epidemic Disease; (d) if there is a person suffering from Principal Epidemic Disease among those people arriving by train, motor vehicle, aircraft, vessel or any other vehicle, right of such person put under quarantine up to a period necessary for medical examination, to leave and return thereto; (e) when an outbreak of Principal Epidemic Disease occurs during the time of fair and festival, right of the public to visit the site and right to continue the festival.	Quarantine provisions relate to Principle Epidemic Disease, defined in the law as Cholera, Plague, Dengue Hemorrhagic Fever (DHF) or Acquired Immunodeficiency Syndrome (AIDS) or Communicable Diseases prescribed as Principal Epidemic Disease by the Ministry of Health by notification
ASEAN Declaration	ASEAN	Describes obligations of sending and receiving states in promoting the fundamental rights and	

on the Protection and Promotion or the Rights of Migrant Workers (2007)		dignity of migrant workers and their families. No explicit mention of Migrants' right to health or health-related obligations of ASEAN member states toward migrant workers and other people on the move.	
Constitution of the Republic of the Union of Myanmar (2008)	Constitution	367. Every citizen shall, in accord with the health policy laid down by the Union, have the right to health care. No mention of migrants within the constitution	
National Health Plan 2011-2016	Ministry of Health	Recognizes importance of migration to communicable disease, health security, public health, social determinants of health. Includes some indicators on reaching migrants (HIV). Includes indictors on improving health status of border areas	HIV, Malaria, Leprosy, Health system development
National Strategic Plan Malaria Prevention and Control 2010-2015	National Malaria Control Programme	Recognizes migrants as key population and prioritizes for interventions in prevention, behavior change communication, research, and access to diagnosis and treatment	Migrant workers, internal migrants, forest workers
Myanmar National Strategic Plan 2011-2015	National AIDS Programme	Inclusion of migrants and mobile populations as key affected populations	HIV

A14. Labour Law and Policy Framework enabling migrants access to health care at the national level

Official Labour migration (out migration) in Myanmar is overseen by the Ministry of Labour, Employment and Social Security (MOLES), under the 1999 Overseas Employment Law, which mandates the training and recruitment of outgoing migrants from Myanmar. Outgoing migrant workers must pass a medical screening in Myanmar before being issued a labour card, however there is no stipulation about what this medical screening should include and no requirement for malaria testing and treatment. In the case of official Labour Migration to Thailand, a second medical screening is also performed in Thailand (Mae Sot, day border crossing) before final clearance for employment and signing of agreement with recruitment agency. This examination is part of the migrant health insurance scheme of the Government of Thailand (with frequent changes to the migrant health insurance scheme details, IOM Thailand in best position to outline current status)

Chapter 2 of the Overseas Employment Law does aim to ensure that there is no loss of the rights and privileges of workers and that they receive the rights they are entitled to. The standard employment contract for labour migrants (to Thailand) does include a stipulation that the employer provide medical treatment free of charge if an illness or injury is caused by the work.

The Ministry of Labour, Employment and Social Security (MOLES) does have a "Five-year National Plan of Action for the Management of International Labour Migration in Myanmar 2013-2017" which includes as a main strategic objective the increase the protection and empowerment of migrant workers. Again, there is no specific or explicit mention of health issues within this National Plan of Action.

It should be noted that the Department of Labour is currently leading an internal process of drafting a new law to be submitted to the Myanmar parliament. Among the objectives of this review are to enhance the protection of migrant workers. MOLES is also in the process of drafting new laws regarding Occupational Safety and Health as well a Foreign Workers Bill.

Current Laws regarding immigration to Myanmar are over 60 years old and are limited in scope, with no mention of any health related issues. They provide a very limited set of rules and guidelines surrounding migration in Myanmar mainly concerning entry, standards for carriers and detention. The legislation does not distinguish between the various types of migrants e.g. migrant workers, victims of trafficking, unaccompanied children, refugees or stateless persons. Additionally, the legislation does not cover any areas relating to migration; for example, rules concerning taking up employment in Myanmar.

A15. Health and social protections which include occupational and non-occupational health insurance

Of existing laws, Article 24(a) of the Overseas Employment Law describes the right to claim full compensation for any work-related injury through the Service Agent – "*[a worker] has the right to claim through the Service Agent full compensation to damages to which he is entitled for injury sustained at a foreign worksite*". In practice, this provision is usually omitted from the standard agreement that migrant workers sign with their recruitment agency. In the case of Myanmar-Thailand MOU, it stipulates that migrant workers are entitled to the benefits of local workers without discrimination.

A newly updated Social Security Act (2012) does outline provisions for employment injury insurance and a right to access medical care and other benefits including temporary and permanent disability benefits and provides protections for injured employees against termination. This new law also outlines steps for establishing a Social Security Fund that is to be made up of the contributions of employers, workers and the government which includes ability to support non-occupational health costs. This is yet to be widely practiced or enacted. Again, there is no mention of migrants within this law and no provisions of how they may be included.

Table 4. List of Labour Law and Policy Framework enabling migrant's access to health care services including Malaria at the national level

Legal/policy document (title / nature / date)	Authority	Summary of content as it relates to access to health services	Type of Migrants benefiting from the law (inbound, outbound, internal)

Law Relating To Overseas Employment, No 3/99, On 9 July 1999	Ministry of Labour and Social Security (MOLES)	To ensure that there is no loss of the rights and privileges of workers and that they receive the rights they are entitled to. Although Chapter 2 of the Law refers to rights and privileges, there is no reference to the relevant legislation that ensures such rights and their scope is not defined Chapter 8 describes the duties and rights of workers which includes to undergo a medical examination and obtain a health certificate. There are no specifications or associated guidelines as to what the medical examination No provisions on compulsory testing or travel restrictions Chapter VIII The Duties and Rights of Workers 20. A worker before going abroad: - (a) shall undergo a medical examination as directed by the Supervisory Committee, and obtain a health certificate Although paragraph 24 (a) of the Law states that a worker "has the right to claim through the Service Agent full compensation to damages to which he is entitled for injury sustained at a foreign worksite", this provision is omitted from the standard agreement that migrant workers sign with their recruitment agency	outbound
ASEAN Declaration on the Protection and Promotion or the Rights of Migrant Workers (2007)	ASEAN	Describes obligations of sending and receiving states in promoting the fundamental rights and dignity of migrant workers and their families. No explicit mention of Migrants' right to health or health-related obligations of ASEAN member states toward migrant workers and other people on the move.	
The Burma Immigration Act (Emergency Provisions) XXXI 1947	Immigration	No reference to access to health services or other social services	The Burma Immigration Act (Emergency Provisions) XXXI 1947
The Burma Immigration Detention Rules 1951	Immigration	No reference to access to health services or other social services	The Burma Immigration Detention Rules 1951

The Registration of Foreigners Act (Burma Act VII, 1940)	Immigration	No reference to access to health services or other social services	The Registration of Foreigners Act (Burma Act VII, 1940)

The Constitution of the Republic of the Union of Myanmar states that "Every citizen shall, in accord with the health policy laid down by the Union, have the right to health care." There is no specific mention of the rights of migrants or those without citizen status to health care.

Myanmar is a signatory to the following regional/international instruments

- The ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers
- The ASEAN Declaration on Strengthening Social Protection
- The ASEAN Declaration of Human Rights
- The Ha Noi Declaration on the Enhancement of Welfare and Development of ASEAN Women and Children
- The Convention on the Rights of the Child
- The Convention on the Elimination of All Forms of Discrimination Against Women
- The Universal Declaration of Human Rights

A16. Bilateral cooperation / Memorandum of Understanding with another GMS country

In September 2013, the Myanmar and Thai Ministries of Health signed a Memorandum of Understanding (MoU) on cooperation in several public health areas. This was the first MOU between Thailand and Myanmar related to public health and it outlines a framework in which both nations propose to cooperate on matters relating to health on the basis of reciprocity and mutual benefit for both countries. The agreement is signed for the next five years; covering cooperation in information sharing, personnel development, co-research on native herbs, disease awareness, disease control in border areas, and prevention of emerging and communicable diseases. This Bilateral Partnership is a model for other activities, especially in the cross-border areas.

In 2013, the Myanmar Ministry of Health entered a tri-lateral cooperation with the Thai Ministry of Health and the USAID (Regional Development Mission for Asia and the Control and Prevention (CAP) Malaria Programme), which focused on five sets of "twin cities" on the Myanmar –Thailand border to provide a platform to synchronize malaria control activities in both countries. Specifically, Malaria control will be strengthened through capacity building of Myanmar's Malaria Control Programme staff on diagnosis, treatment, mosquito vector control and support for operational costs for delivering services in the 5 twin cities.

The twin cities are:

- Tarchileik, Myanmar and Maesai, Thailand
- Myawaddy, Myanmar and Tak (Mae Sot), Thailand
- Phayathongzu, Myanmar and Kanchanaburi, Thailand
- Dawei, Myanmar and Kanchanaburi, Thailand
- Kawthaung, Myanmar and Ranong, Thailand.

Myanmar has migrant labour related Memoranda of Understanding with Thailand (signed in 2003) and with the Republic of Korea (EPS system). The MOU with Thailand has enabled successive regularization of undocumented Myanmar workers in Thailand; according to MOL figures, up to 1 million workers have completed the nationality verification (NV) process.

The Government of Myanmar has identified the effective implementation of the MOU as a priority, and requests that it be reviewed in line with the changed political circumstances and increased knowledge about irregular migration. The draft NPA calls for the re-negotiation of the MOU with Thailand to include a push to expand the registration of workers, an effort to ensure documentation for migrant workers' children, and the establishment of a government-to-government channel for safer return of workers to Myanmar. The MOU mentions that the respective governments shall ensure "*health insurances or health services*"for workers, though this is not expanded on. In practice, whilst Thailand does have a migrant health insurance system that is mandatory for official migrant workers and from time to time becomes open to undocumented migrants, Myanmar has no such reciprocal system of immigrants to Myanmar.

Table 5. List of Bilateral Cooperation and or MOUs with another GMS country

Bilateral cooperation/MOU (title / nature / date)	Authorities	Summary of content as it relates to migration/access to health services	Diseases or health coverage
Memorandum of Understanding on Health Cooperation Between the Government of the Kingdom of Thailand and the Government of the Republic of the Union of Myanmar (2013)	Ministry of Health, Myanmar and Ministry of Public Health, Thailand	Outlines cooperation on a range of health issues and topics through: exchange of information, human resources development, joint research and studies, other types of cooperation as mutually determined	Disease surveillance; substandard food and drugs; traditional medicine; medical and cosmetic products; communicable and emerging infectious diseases especially cross border disease outbreak control; health promotion; health service system development for migrant workers and cross border population
Trilateral Cooperation for Health: Burma, Thailand and United States Cross-Border Partnership	Ministry of Health, Myanmar; Ministry of Public Health, Thailand, Thailand International Development Cooperation (TICA), USAID Regional Development Mission for Asia; USAID Control	Outlines specific cooperation and funding for a 4 year project on malaria in 5 'twin-city' locations.	Malaria

	and Prevention (CAP) Malaria Programme		
Memorandum of Understanding Between the Government of the Kingdom of Thailand and the Government of the Union of Myanmar on Cooperation in the Employment of Workers (2003)	MOLES	Article VII – the authorized agencies shall ensure …… Health insurances or health services	Occupational Health
Memorandum of Understanding for Joint Action to Reduce HIV Vulnerability Related to Population Movement in the Greater Mekong Subregion (2011)	Ministry of Health, Myanmar; National ADIS Authority, Cambodia; Ministry of Heath, Lao PDR; Ministry of Heath, China; Ministry of Public Health, Thailand; Ministry of Health, Vietnam	Objective is to reduce HIV vulnerability and promote access to prevention, treatment, care and support among migrants and mobile populations and affected communities in the GMS countries by collaborating in the following areas: promote improving policy environment and enabling mechanism; promote community-based strategies that reduce HIV vulnerability; promote access to HIV and ADIS prevention treatment care and support	HIV

A17. Financing and coverage of health insurance

Health financing regards to the capacity of a health system concerned with the mobilization, accumulation and allocation of money to meet the health demands of the population, both individually and collectively. Nevertheless, access to affordable and adequate health care is a significant barrier in low and middle-income countries.

Financing health care in most developing countries immensely depends on out-of-pocket payments. Health care financing also relies on most donors and global health initiatives such as the Global Fund. However, their prime focus are on particular diseases or interventions rather than the general health system (O'Donnell, Doorslaer, Rannan-Eliya, et al., 2008). Out of pocket expenditure for health care is a leading cause of impoverishment. Therefore, placing health equity as the ultimate goal of health system requires robust and coordinated reorientation through re-framing of policy and institutional transformation.

Demand side and Supply side intervention in health care service delivery needs to be harmonized to expand the health care services to the entire populations. There was demand side financing to target poor

populations and vulnerable groups (World Development Report, 2004) which has been successful to cover to vulnerable populations.

Myanmar allocated 3.65 per cent of its total budget on health in 2015-2016, which was double the budget allocated in 2011-2012, however, still lower than Global and Regional Standard (NHP 2017-2021). Previously, on the demand side, less attention was given to health finance planning, which is currently being recognized as there is an increased need for it from the demand side. NHP (2017-2021) includes enhancing and improving demand side health service and responsiveness, as well as developing a risk pool mechanism to improve the accessibility and affordability for health care services. This would reduce the out-of-pocket expenditure on health, especially for the poor and vulnerable populations. A recent nationally representative survey found that out of pocket expenditure (OOP) covers roughly 75 per cent of total health spending. It is a major cause of catastrophic expenditure by households, and especially for the poor. In addition, it prevents seeking essential health care.

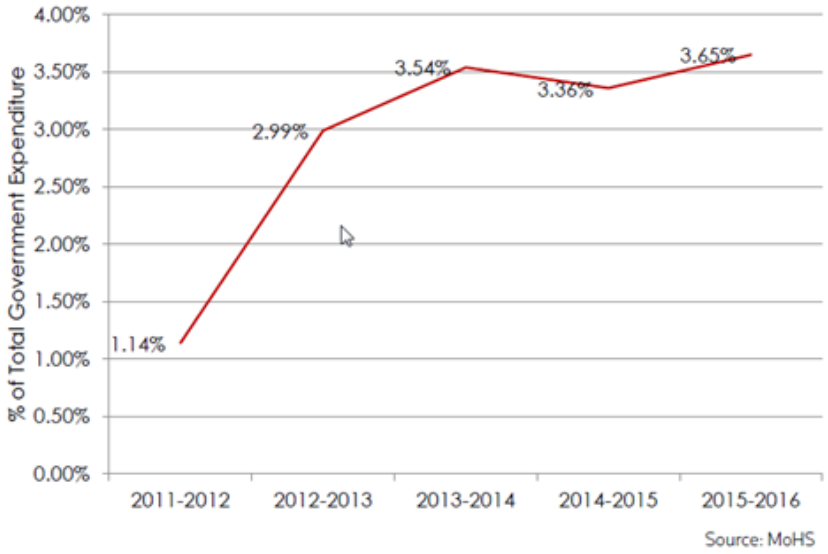

Figure 2. Government spending on health as a per centage of total government expenditure

Financial allocation to the health and education sector was increased in the fiscal year 2012-2013. The government share to the health sector as a per centage of general government expenditures for last five financial years are indicated in the following table (Health in Myanmar, 2014)

Table 5. Government Health Expenditures as per centage of GDP and as per centage of General Government Expenditures

Financial Year	Government Health Expenditures as % of Gross Domestic Product	Government Health Expenditures as % of General Government Expenditures
2010-11	0.20	1.03
2011-12	0.21	1.05
2012=13	0.76	2.82
2013-14	0.89	3.15

2014-15	0.99	3.38

Source:

The government has shown an early commitment by substantially heightening its health expenditure in the recent national budget. Nonetheless, this level of health investment is still inadequate to sustain the current level of health service provision. More financial support is crucially needed due to the rising public expectations, shifting in demographic and epidemiologic trend, and advancing health care technologies and rising costs resulting to inflation

Since the 1990s, user charges for government health services were initiated as part of a series of political and economic reforms. With the shift in health service provision charges, out-of-pocket payment became, and continues as the primary mode of spending for health care. Furthermore, patients also responsible for the full price to receive services and medication from private-owned pharmacies, clinics and hospitals, as well as traditional healers. The outcome shows out-of-pocket expenditure estimated for higher than 80% of THE between 2001 and 2009.

Government health financing is too low to meet population's health demands, and the proportion of the population covered by insurance is almost negligible. For instance, social security has been in place for many years in the country, and recently updated in 2012. However, social security is limited for the formally employed workers. Social security scheme is still in its infancy where only roughly 1% of the population is under protection coverage (WHO, 2015). As a result, individuals or families suffer a stark choice in the situation of severe illness: either delay treatment and face the outcomes, or incur what can amount to catastrophic expenses and a downward spiral of poverty. Expanding health services to attain universal coverage will inevitably require increasing health expenditure further.

A18. Universal Health Coverage

Myanmar aspires to achieve Universal Health Coverage (UHC) as part of its vision 2030 for a healthier and more productive population. It is extremely important to include migrants in achieving UHC. Mobile, migrant, and scattered populations in non-residential temporary settlements would find it hard-to-access primary health care services. UHC is basically inclusive of the entirety of a population, including migrants as it is important to protect financial risk and access to quality essential health care services. To achieve the target goals of strengthening the health systems towards the provision of equitable universal coverage it is vital to focus on ways to improving health outcomes, enhancing the financial protection and ensuring the consumer satisfaction.

Myanmar is undergoing rapid demographic, health and social transition with an aging, mobile and urbanizing population. WHO (2012) stated that there is available evidence that non accessibility to health care services is associated with locations, socio-economic status and education levels. Persisting inequities and very steep social gradients for mortality and health care access between socio economic groups and between geographic locations present significant challenges for UHC strategy.

"Colombo Statement" from the Second Global Consultation on migrant health includes taking the lead on mainstreaming the migration health agenda within key national, regional and international forum, in domains such as migration and development, disease control, global health, health security, occupational safety, disaster risk-reduction, climate and environmental change, and foreign policy as guided by the 2030 Agenda for Sustainable Development. Global health leaders adopted the Colombo Statement on 23

February 2017, which calls for international collaboration to improve the health and well-being of migrants and their families. The move aims to address the health challenges posed by increasingly mobile populations.

Senior officials from MOHS attended the Second Global Consultation on migrant health in February 2017 and endorsed the "Colombo Statement" which calls for increased efforts to address the health of migrants.

A19. Health information system of migrants

Migration flows in Myanmar are significant, complex, long-standing and influenced by a range of different factors. Myanmar is the largest source country for migrants to Thailand, most of whom migrate through informal channels. There is limited data on internal migration within the country. There is no specific Migrant HMIS (Health Management Information System) data in a functional HMIS unit under MOHS, consequently, migrant's data are not counted for the health care service delivery.

The NHP strategy (2017-2021) will enhance equity, inclusiveness, accountability, efficiency, sustainability and quality of health care services. Currently, migrant health is one of the projects under Rural, Peri-urban and Border Health of NHP. NHP's direction includes a functional HMIS unit to be a more integrated and expanded HMIS.

B. Data Review on Myanmar Census (2014)

The review aimed to provide nation-wide internal migrant information by review of census data searching for the socio-epidemiology of migrant in Myanmar which contribute to the health of populations both in receiving and sending areas. Specifically, it reported; 1) the magnitude of various dimensions of migration, 2) types of migrants related to vulnerable situations, and 3) pattern of migration and association with health risks. Myanmar Census 2014 was a nationwide census that took place between 30 March and 10 April 2014 in Myanmar (Burma). It was the country's first national census in 30 years which was undertaken by the Ministry of Immigration and Population with technical support from UNFPA. 110,000 enumerators visited over 12 million households to gather data to provide social, economic and demographic characteristics of people and households for the purpose of on-going reforms, development planning and good governance.

Among many thematic reports, thematic report on Migration and Urbanization presented the findings on Migration and Urbanization. Review report was primarily a descriptive analysis on migration status. Aggregated data on thematic reports for migration and urbanization, were extracted into separate spread sheets showing parameters such as number of migrants, different types of migration, different migration stream, different pattern, and reasons for migration, socio-demographic background, area of residence in terms of State/Region. There were some limitations in this review. At first, mortality data were not included in the Thematic report for migration, thus aggregate data from two different thematic report could not be compared in the analysis. This review could not describe how recent migration effect on mortality and morbidity.

Migration is measured either over the lifetime of individuals or in terms of more recent moves. The scale of internal migration in Myanmar is similar to that of neighbouring countries. Over the lifetime of individuals, 19.3 reported moving at least once. For internal migration within the five-year period before the Census, 7% reported moving. A large proportion of movements within Myanmar revolved around Yangon, either as movement into Yangon or movement among Districts within Yangon. Among recent migrants to Yangon, the primary origin of move was Ayeyarwady. Almost half of recent migration occurred between urban areas and about 10% was from rural to urban. More permanent migration from rural was directed towards other rural areas.

B1. Lifetime migration

Nation-wide total lifetime migrants contributed to 19% of population with obvious regional difference, highest being at Yangon (50%) and 49% of whom were "between State/Region" migrants. The highest rates of "between State/Region" migration were at Nay Pyi Taw (82%), Kayin (71%) and Kayah (69%).

"Between State/Region" migration rates in Kachin, Kayah, Kayin, Chin, Tanintheri, Bago, Mon, Rakkhine and Shan were predominated by males. Male preponderance of "between State/Region" migration was mostly marked in Kachin State. Yangon is deemed to be female preponderant in "between State/Region" migration rate.

B2. Recent migration status

The largest amount of migrants were in Yangon standing at 1.44 million, followed by recent migrants in Mandalay hosting 0.4 million. "Between State/Region" migration was also markedly observed in Yangon and Mandalay (0.8 million and 0.2 million respectively).

Nation-wide recent migration rate is 7% of total population. It was highest in Yangon (21%), and Nay Pyi Taw (13%). Kayin State also had relatively higher recent migration rates compared to national level. "Between State/Region" migration rates were high in Nay Pyi Taw, Yangon and Mandalay Regions which are urban cities and Kayin, Kayah, Kachin and Tanintheri which are at the eastern border. Out-migration

are high in the west of the country (Ayeyarwady, Bago, Chin, Magway, Rakkhine and Sagaing). Among those, Chin, Bago, Magway, and Ayeyarwady had more female out-migration than other areas. So, recent migration is streaming from west areas directing to urban large cities and east border areas of Myanmar. Females are especially large level migrating towards Yangon, Nay Pyi Taw Regions and Kayin State.

Female preponderance was at Mandalay (52% for female and 50% for male) and Yangon (56% for female and 55% for male). Male preponderance of the "Between State/Region" rates was high at Kachin and Tanintheri. Of those three Regions with relatively higher rate of recent migration (i.e. Yangon, Nay Pyi Taw and Kachin), only Kachin had a higher male "between State/Region" migration rate.

B3. Rural migration status

Total percentage of "towards rural area" migration (whether both within or between State/Region) was at 42%. Rural migration rates were higher in all areas except Yangon (28%) and Nay Pyi Taw (35%). Rural migration rates were highest at Ayeyarwady (70%), Sagaing (62%) and Rakkhine (61%). These three areas had already noted having high out-migration rates. Another high out-migration area Chin State had female preponderance of rural migration rate (56% vs. 53%).

B4. Reasons for recent migration

"For employment" and "to follow with family" were two most frequent reasons (75%) among all recent migrants. Forty four per cent of “Between State/Region” migrants had search for employment as their reason for migrating and 38 per cent of the general total recent migrants stated the same reason as well. Female recent "between State/Region" migrants stated their reason for migration was for marriage or to follow with family.

B5. Education level of migrants

Thirty-five per cent of the migrants had a primary level education background, while 26 per cent had a middle level education. Holding a higher level school education and college/university degree comprised on 30 per cent of the total. Some migrants had no education at all, which were found to be higher with "rural to rural" migrants compare to "urban to rural" migrants (14% vs. 7%). Similarly, primary education level were found to be higher among "rural to rural" migrants compare to "urban to rural" migrants (48% vs. 41%). All other levels of education were more frequent in "urban to rural" migrants.

B6. Occupation of migrants

Skilled agricultural, forestry and fishery workers, and other elementary occupations were more frequent among "rural to rural" migrants, especially male. Craft and related trade workers, as well as plant and machine operators and assemblers were more frequent among "urban to rural" migrants especially female.

B7. Access to health conditions

Households of migrants at Ayayarwady, Tanintheri and Rakkhine areas had the lowest level of three healthy environments (access to electricity, drinking water and sanitation status). These areas were also noted to have high out-migration and high rural migration rates.

C. Data Review on MDHS (2016)

The 2015-16 Myanmar Demographic and Health Survey (2015-16 MDHS) is the first DHS survey to be conducted in Myanmar. A nationally representative sample of about 13,260 households was selected. All women age 15-49 who were usual residents of the selected households or who slept in the households the night before the survey were eligible for the survey. The primary objective of the 2015-16 MDHS was to provide up-to-date estimates of basic demographic and health indicators. Specifically, the survey collected information on fertility levels, marital status, fertility preferences, awareness and use of family planning methods, breastfeeding practices, nutrition, mother and child mortality and health, HIV/AIDS and other sexually transmitted infections (STIs), and other health-related issues, such as smoking and knowledge of tuberculosis.

Out of the available 7 datasets, *MMIR71SV individual dataset* was used for review analysis. More than 4900 variables and 12885 records were analysed using SPSS software. Migration information was extracted using variables S115A, S115B, S115C, S115D, S115EA, S115EB, and S115EC. Change of residency within last five years was used to define the terms. Migrants' records were filtered for further descriptive analysis for background information, socio-demographic information, migration pattern, and health information.

Review data was filtered into migration across the State/Region within last five years regardless of frequency, gender, intention. Among the total of 12885 sample women in MDHS data, 332 (2.6%) was identified as change of their residence in the last one year of survey, 680 women within the last five years. The rate of migration was 5.3%. 10.3% of migrants was noted frequent migrants.

C1. Recent characteristics of migrants

The distribution of migrants was clustered more towards Kachin (13.4%), Naypyitaw (12.5%) and Magway (11.9%). This was followed by Yangon and Mandalay (9.7% and 7.4% respectively).

Two most frequent age groups were 20-24 years and 25-29 years (18.7% and 16.6% respectively). Urban to rural ratio was 1.1:1 with majority having primary and secondary level education. Higher level education accounted for 18.8%. Majority of the origin were noted as Magway (13.4%), Yangon (13.1%), Mandalay (11.6%) and Kachin (10.5%).

C2. Household condition of the migrants

Eighty six per cent of migrants described they had access to electricity (79.1% of HHs), television (73.8%), and motorcycle/scooter (63.3%), as well as bicycle (40.5%), refrigerator (30.6%) and radio (33.7%). Among the different HH assets, sofa, electric fan, air conditioner and sewing machine were less frequent than HH furniture. Half of the migrants' family size were 3-5 individuals, with the median family size being 5. Not all HHs had children under the age of five. Median number of eligible women was one.

C3. Migration pattern

Their origin area was described by recent residential State/Region in per cent (Intra-regional migration), showing most frequent origination from Magway, Shan, Kachin Rakkhine, and Tanintheri. Highest dispersion to other areas was observed among migrants of Yangon origin (reaching to 12 other regions out of 15

regions) and Mandalay origin (reaching 11 out of 15 regions) origin. Least dispersed migrants' origin was Kayah (reaching 1 other region) and Chin (reaching 3 other regions).

Receiving areas have different mix of origin of migrants. Highest mix of origins among recent migrants were observed in Yangon and Mon having 11 origins and Mandalay having 10 origin areas. In Yangon, there was no migrants of origin from Kayah, Chin, and Rakkhine. In Mon, Chin, Sagaing, Magway and Shan origins were not observed. In Mandalay, Kayah, Kayin, Tanintheri and Mon origins were not observed. The least-mixed recipient was Shan and Ayeyarwady receiving migrants from 3 different origin areas. Shan has migrants from Magway, Mandalay and Rakkhine. Ayayarwady has migrants from Yangon, Mandalay and Mon.

About 30% of migrants are recorded as the most recent migrant (within one year). Of them, majority (37%) were urban to urban migrants. Urban to rural migrants were at 19%, rural to urban 16% and rural to rural was 28%.

C4. Maternal and Reproductive Health practices

Termination of pregnancy: Pregnancy termination rate among the migrant women was 12.8%.

Current contraception: 98.5% of the migrant women have knowledge on modern methods. Use rate for modern method is 34.3%. Mostly used methods were "injection" (13.8%) and OCPs (11.5%). Among the current users, three most frequent sources were " Private hospital/clinic " (18.6%), " Private pharmacy" (16.9%) and " Government health post (sub-centre)" (12.1%). 186 women gave reasons for not using contraception as "not having sex" (33.3%), "fear of side effects/health concerns" (14%).

ANC for last pregnancy: 32.8% of women got ANC, out of which 54.8% were provided by "nurse/midwife/LHV" and 35.7% from "doctor". Most women sought ANC from "govt hospital" (31.1%), "sub-centre" (21.4%), "private hospital/clinic" (18.1%) and "RHC" (10.1%). More than 55% women who sought ANC received TT injection at least two times before birth.

Delivery: Of 223 women (32.8% of total) who got pregnant, two most frequent birth attendants were "doctor" (41%) and "nurse/midwife/LHV" (39.9%).

Postnatal care (PNC): 52% of deliveries got PNC, mostly from "nurse/midwife/LHV" (49.1%) and "doctor" (39.7%).

Fertility preference among the migrants: 40.9% of women wanted to have another pregnancy. 25.2% of those women preferred less than 12 months for interval between children. 27% liked the interval between 2-3 years. 65.9% stated 2-3 number of children as being ideal. Unmet needs for birth spacing was about 11.2%. Among the contraceptive users, 62% decided to use based on joint decision between the couple.

C5. Risk of infectious diseases

TB: Thirty (4.4%) female migrants had been diagnosed with TB infection. Correct knowledge about spread was found among 91.6%. However, misunderstandings were observed among one-fifth of migrants.

Sexually Transmitted Infection (STI): Almost all women had ever heard of STI and AIDS. Majority knew about condom uses and single partnership as preventive behaviour for STI/HIV (70.8% and 81.2% respectively). 70.6% knew that "A healthy looking person can have HIV". Misunderstandings were also apparent. 36.5% believed mosquito bite can transmit the HIV infection. Incidence of STI in last one year was reported by very

few (0.1%) only. However, 22 women (3.2%) reported they had experience of seeking any treatment for STI. Majority of treatment seekers (50%) went to "private hospital/clinic/doctor" (50%) and " government hospital" (31.8%).

HIV: Prevalence of having correct knowledge were high. But few items like " A female teacher infected with HIV, but is not sick, should be allowed to continue teaching", " Children should be taught about condoms to avoid AIDS" and " Would buy vegetables from vendor with HIV" were relatively low (59.7%, 45.7% and 47% respectively). Services related to prevention of mother to child transmission were too low having received around 10% of women. Misunderstanding was also low. Incidence of blood test for HIV was found among 34.6% of migrant women. Awareness of place for test was 77.1%. Women went to seek for test to " government hospital" by 91.1% and " private hospital/clinic/doctor" by 30.6% as majority.

C6. Treatment seeking for the last child

Diarrhoea: 13.6% of women who have a child experienced diarrhoea. Forty per cent of women did not seek any treatment for diarrhoea of their child. 43.3% gave self-medication and 16.7% got treatment from " private hospital/clinic" and 10% from "government hospital".

Fever/cough: 31% of women who have children experienced "fever/cough" of their last child. Self-medication was used by majority of women (52.9%). 36.8% of women did not get any treatment. Private hospital/clinic was used most frequently (19.1%). RHC and government hospital were used by 10.3% and 11.8% respectively.

C7. Violence

There was very few (16.8%) who mentioned decision making for their health care was made by someone else. Majority (83.3%) stated decision was made by the woman herself. However, decision making by someone else for purchasing large HH assets was higher than for health care decision having 27.3%. Per cent of exclusiveness in decision making for visit to family or relatives was 13.9%. Per cent of incidence of physically violence (beating) was 18.5%. About 60% of women did not own the house or land. 79 (11.6%) women respond the questions regarding soft (social) indicators for violence. Most frequent statements were " Husband/partner jealous if respondent talks with other men" (70.9%) and " Husband/partner insists on knowing where respondent is" (44.3%). Experiences of severe physical violence was 17.7% and sexual violence was 10.1% among the women.

D. Key Informant Interview on migration health services in Myanmar

Key Informant Interview using KII Guides were conducted to identify existing issues migrants encounter in terms of health, infrastructure for migrant health management, and political consideration to protect, maintain and promote the health of migrants. Focal persons from relevant sectors were requested to participate in the interviews. International Relation Division (IRD) of MoHS arranged for official invitations and contacts. One focal person from each sector was requested. Interviews were carried out from 14 Feb 2019 to 20 Mar 2019. Qualitative Analysis was made manually. Content analysis followed by thematic analysis were mainly used.

D1. Migrant Health Issues

It is difficult to set target population prior to providing necessary services for migrants. Existing HMIS do not include denominator for migrant population. Magnitude of health problems, logistic requirements and implementation plans need to be based on the size of the target population. Thus, it is important to collate information on size, types, areas and seasonal patterns of migration around high migration regions of the country. Migrant mapping provides basic important information for health managers for planning, preparation of HR and logistics, and systematic implementation of the services.

There are some laws and regulations that ensure security and rights for safe working environment for labour migrants working at formal sectors. Many employees in these formal sectors are internal urban migrants. This is a good example of the efforts put in place to promote the welfare of migrant workers in other sectors.

Health consequences among migrants could be identified and grouped as,

1. Accidents, injuries, violence due to unsafe working condition, instability of life style and poverty
2. Maternal and reproductive health problems such as unwanted pregnancy, sexual violence, abortion
3. Mental health problems such as stress related to life style, working environment, and poverty
4. Infectious diseases like TB, HIV, Dengue, skin infection, vaccine preventable diseases related to life style, malnutrition, personal hygiene and low health literacy

All health issues among migrant are mainly based on poverty. Severe crowding, remoteness of location, instability of life style, lack of documents and identities diminishes their accessibility to health services.

Previous experiences on resettlement effort for migrants (from urban slums, armed conflict areas, re-entry from illegal cross-border migration and disasters) showed unsatisfactory results due to lack of job opportunities and inability to adapt to new surroundings. Insufficiency in accommodation, land space, food and water supplies due to limited time and lack of proper planning can affect the settlement of migrants. In addition to this, providing vocational training, livestock training, financial support for developing small business, infrastructure development for accommodation/business/employment and living status are to be considered as well. These efforts are essential for development, sustainability and social security of migrants.

Essential health services for migrants include maternal and child health, worksite safety, injury management and referral, environmental sanitation, life style and diet improvement, and health literacy promotion. Surveillance activities for timely control infectious diseases among cross-border migrants and refugees are being carried out but there is no emphasis on internal intentional migrants.

D2. Limitations in securing migrants' rights

In Myanmar, overall human resources for health are highly insufficient which limits the provision of health care services for resident people from rural, urban, as well as non-residents. This limitation could also affect those living in remote and less accessible locations. Even in urban setting for migrant workers, health care services arranged by employers varies. Some areas have formal health care services, while some do not. This leads to inconsistency in the awareness of employers and limited enforcement of existing regulations by authorities.

Many sectors including health had no migrant specific service provision system. Relief activities for emergency situations could cover migrants during conflict and disasters. Internal migrant workers could not be specifically covered by existing health services system. Since there is no specific system, there would be no formal action plan, human resources, budget and supplies.

Camps for resettlement due to conflict/disaster could provide relief materials from reserved supplies and stock. However, quality, sufficiency and timelines are normally overlooked. Many farms and factories do not consider supporting the social welfare of their employees. There are no medicinal supplies with special considerations for migrants, however, the health sector has no differentiation on providing services and supplies to migrants in routine system.

Sectorial collaboration mechanism has been established for migration due to conflicts and disasters. But formal procedures for coordination and collaborations are quite difficult to be timely for emergencies. Even for migrant laborers in formal sector (such as factories), employers and managers show a lack of interest and collaboration which are gaps seen when developing efforts and plans.

Although there were some sectors providing services for migrants with the existing system, lack of awareness among migrants prevents them from accessing those services. Low health literacy among migrants are similar to non-migrants. Challenging situations in a new environment makes them more vulnerable to health risks in migrating areas.

D3. Current management mechanism for migrants

Team are normally assembled to provide health care service for cross-border migrants in special emergency circumstances. In these circumstances, a rapid response team is organized with staff from the local area and is supervised by State/Region Health Departments. Technical, logistics, updated SOP and guidelines were provided by central level health authorities. These services are not considered a special entity for migrant population, but are services are available to cover migrant population as well if there are any. Another example for routine circumstances with no emergency situation on managing health issues of cross-border migrants is the organization of a surveillance team. No specific mention was made for internal migrants. People residing in hard-to-reach areas could receive health care from mobile teams arranged by local health authorities. Recent setting for mobile team includes Basic Health Staff (BHS) as well as community volunteers specially trained for helping BHS in maternal and child health, malaria, TB and vaccinations services. If migrants are located at the areas covered by these teams, they would receive health services provided by mobile teams in those areas.

Planning for emergency situations include capacity building, reserving logistics & supplies, providing guidelines & SOP to implementing teams. Ad hoc arrangement example are recruitment of health staff with financial support/salary, provision of medicines and supplies, provision of accommodation for health team in circumstances of mobile construction worksites at remote areas. Systematic planning was also observed at

Social Security Board, Social welfare and Relief sectors, who have their own hospitals, OPD clinics, health manpower, partner clinics as well as hardware and budget system, regular HR system, supply system, information system and interestingly, a health insurance system as well. Most of the beneficiaries of this mechanism are migrants, refugees, cross-border migrants and migrant workers in factories and development projects.

The military health care system also shows the presence of a built-in medical care system which can be moved by soldiers to the frontiers. The system includes health staff, supplies, accommodation arrangement and transportation arrangement, thereby having a sustainable access to health care wherever they move. The system also showed linking and synchronizing existing residential health services for mobile persons which could reduce inequity in accessing the services and vulnerability to risks among migrants.

Guidelines and SOPs for providing services for migrants are found mostly among CSOs and Occupational & Environmental Health Division of MOHS. Many collaborative activities are not implemented by standardized instructions and guidelines. Instead, there are preliminary informal communication & negotiations followed by official communication between relevant sectors for effective collaboration. Some activities are carried out without standardized procedures.

Basic needs such as accommodation, food and water, clothes were provided to migrants following conflicts and disasters. In some circumstances, more systematic activities like case assessment before supporting activities are carried out. Health care services are also provided on needs basis, in collaboration between remote services and facility-based services especially if referral is needed. More systematic services such as social welfare and health insurance system are provided for SSB workers whether they are migrants or not. According to high endemicity and vulnerability, urban slum areas had health care services for migrants and workers for important infectious diseases like HIV, TB etc.

In some sectors, relevant information sharing, awareness raising, health education, health literacy promotion activities targeted specific groups of migrants for the prevention of human trafficking, sexual violence, infectious diseases, and harmful life style/behaviors. For their social security, vocational training and skills development was also provided to migrants in collaboration with other relevant sectors.

Strong collaboration and coordination in the management for the welfare of migrants at emergency situations has been observed. Many health sectors had the ability to communicate with internal sub-sectors for networking and arranging of activities. Military health sector also synchronize their actions with their civil counterpart for health care services for migrants in case of needs.

Although, existing health services has no systematic operating procedure nor guidelines for internal migrants in non-emergency situations including at factories.

D4. Existing policy

Existing priority actions relevant to migrants are also varying among different sectors. Rule of law, enlisting migrants, urgent provision of essential food/shelters and long-term action for vocational training and support for job opportunities are prioritized by some sectors. Health sectors' mainly prioritize maternal and child health and control of communicable diseases when collaborating with other relevant sectors.

Existing policies relevant to migrants were varying among different sectors. Some sectors go with need-based approach as there is no specific action plan and specific target groups set. Some sectors use all-inclusiveness approach whichinclude vulnerable groups like disabled persons and PLHIV etc. Other sectors

put their action specific to migrants' health under humanitarian setting. Client-centric approach is similar to need-based approach. Although all approaches are different from each other, they all lack in systematic planning, targeting and preparation for migrants before service provision.

D5. Suggestions for policy

Although the focal persons agreed to migrant health issues being important for the country, they expressed that it should not be prioritized over other important health issues of the country. They did state that internal migrants should be prioritized more than the other types. Migrants in informal sectors should not be neglected in Migrant Health Policy. Linking to this, getting baseline information by mapping, listing, estimating of various types of migrants in areas covered by local health staff in connecting with HMIS will be helpful for effective planning and implementing. Migrant health research informing needs, gaps and barriers to access healthcare among migrants and providers should be embedded in priority activities.

It has been strongly recommended that while developing the Migrant Health Policy, it should be aligned with existing Migration Policy, Labor Policy and NHP. The policy should aim towards maximizing benefits and minimizing risks on migrants. Baseline database, infrastructures and strategic costed-plan should be pilot tested in an appropriate area. Rather than creating a new system, expanding existing service components effecting the migrant community, with adaptation and modification are recommended.

System components in migrant health policy should include continuity and sufficiency of supplies and HR. Both legal and illegal migrants should have equal rights to get health services as non-migrants. Inclusion of migrant workers in health insurance system providing master patient register card would be helpful for identification system for migrants. Effective coordination among service providers, sectors, CSOs, employers and community volunteers are also essential components of the policy. Down-the-line structure of migrant health management starting from the Cabinet and ending at the migrant community volunteers also needs to be described.

Providing systematic and consistent care for migrants should also include providing standard operating procedures (SOP), guidelines and instructions to relevant implementers. Apart from medical guidelines, inclusion of guidelines and SOP related to logistic management, workplace assessments, medical checkup procedures, setup of mobile medical teams, and instructions for voluntary health workers.

Government should take the lead in developing a migrant support community which should include a multi-sectorial body using one-health approach. The body should identify needs and barriers of migrants such as; physical barriers, financial barriers, environmental barriers, psychosocial barriers, educational barriers, health literacy barriers, which are different from those of residential population. On the other hand, it should also consider needs for providers such as reaching to hard-to-reach, needs for special arrangement/plan, needs for providing logistics and supplies both routine as well as emergency management.

Migrant health actions should be made in stepwise through situation analysis, needs & gaps analysis, and challenges analysis. Migrant Health Package should be aligned with EPHS of NHP. If the system is developed, HR recruitment and drawing costed-strategic plan are needed for coordinating and collaborating actions among related health sectors. Synchronized mechanism for logistic management and exchange of Information among collaborating sectors are also necessary. Migrant community-based volunteer workers would be effective in engaging with the community.

Addressing the needs of migrant is essential to include in the policy. Basic needs of migrants are security, safe and adequate water supply, transportation to the clinic/hospital. Health needs are categorized as

preventive measures (anti-Smoking and alcoholism, nutrition promotion, health education, school education and development for children), curative measures, rehabilitative measures and referral services. Health literacy promotion (environmental sanitation, maintenance of environment, rational use of agricultural chemicals and ways to adaptation in migrated area) is also suggested.

Partnership and networking among service providers, partners, employers and migrant community a harmonized action plan is crucial for effective management of securing migrants' welfare including health. Agreement between governments of cross-border migrations could reduce risks and raise benefits for the migrants.

E. Discussion

E1. Main problems regarding migrants' health in Myanmar,

Migration magnitude: Ministry of Labour estimated that, in Myanmar, migrants contribute about one-fourth of total population, with high regional variation. According to Census data, nation-wide recent migration rate is 7% of total population. Total lifetime migrants contributed 19% of population with obvious regional difference.

Locations: Determinants of migrants' health are shaped by their experiences and situations in the place of origin, transit and destination. The highest amount of recent migration is in Yangon hosting 1.44 million. The second highest number of recent migrants are in Mandalay hosting 0.4 million. Out-migration are high in the western regions of the country (Ayeyarwady, Bago, Chin, Magway, Rakkhine and Sagaing). Recent migration is streaming from the western regions into the central urban large cities and eastern border areas of Myanmar. The place of origin benefit from out-migration due to relief from unemployment pressures and contributes to development through remittances, knowledge transfer, and the creation of business and trade networks, on the other hand, destination areas may suffer from social and health impacts due to lack of systematic management and control over high load of incoming migrants. Migration itself is a social determinant of health, given that being a migrant can make persons more vulnerable to negative influences on their health. Migration also has health implications from the region migrants have left. Individuals who emigrate for economic opportunities may lead to brain drain in their place of origin, with technical skills or knowledge gap, potentially depleting the local infrastructure. To balance between the risk and benefits of migration, there should be clearly formulated policies across relevant sectors, legislation and effective strategies in line with standards.

Gender differentials; Gender differences in the reasons for migration were noted in census data. Female recent "between State/Region" migration stated their reason as following with family or for marriage). The number of females migrating towards Yangon, Nay Pyi Taw Regions and Kayin Statehave increased significantly recently. Female preponderance was mainly at Mandalay (52% for female and 50% for male) and Yangon (56% for female and 55% for male). Male preponderance of the "Between State/Region" rates was high at Kachin and Tanintheri. Male recent migration is streaming towards Kachin State. High out-migration area Chin State had female preponderance of rural migration rate (56% vs. 53%)."For employment" and "to follow with family" were two most frequent reasons (75%) among all recent migrants.

MDHS data showed most frequent origin areas of female migrants were Magway, Shan, Kachin Rakkhine, and Tanintheri. Highest mix of origins among recent migrants were observed in Yangon and Mon. Majority (37%) were urban to urban migrants. There was very few women (16.8%) who stated that decision making for their health care was made by someone else. Decision making by someone else for purchasing large HH assets was higher than for health care decision having 27.3%.

Gender differential in migration can mean the different health impact and thus make health providers implementing a project successful by addressing the specific needs and capacities of migrants to ensure equity in health. Migration also brings risks and may establish inequalities around gender. The positive impacts of greater gender equality on sending and receiving areas are that women tend to spend most of their time on household management and child-rearing rather than on working to generate an income, women tend to be self-employed and become empowered in the sense that they have control over the household finances while their husbands are away.

But a woman leaving her family behind has a rather negative impact on any children staying in the country of origin of the woman – mainly affecting the health, education, social relations and family cohesion. Children

left behind tend to experience emotional instability and poor educational achievement. The higher vulnerability of women to sexual abuse and violence also places them at risk of STDs, including HIV, and a range of post-traumatic stress disorders associated with sexual violence. Their reproductive health needs often go underestimated even in formal migrant situations, and the insensitivity of health staff to the needs of women is often more pronounced in involuntary migrant contexts. Health monitoring of women in all migration-related situations must be given greater priority. Similarly, much more attention at a health policy level is called for if the needs of women migrants are to be secured, and their contribution to health and social development is to be acknowledged and promoted.

Education and health literacy level: Migrants with primary level education are most predominent (35%), followed by middle level education (26%). "Rural to rural" migrants had lower levels of education than "urban to rural" migrants. Limited education, low literacy levels and inadequate language skills were barriers for most migrants while obtaining and understanding basic health information and services, which consequently had a negative impact on their health seeking behaviours. In addition, barriers arise because healthcare professionals often inadvertently make it difficult for lay people to understand what to do. Providers have begun to recognize the need for simple language communication, and some are attempting to advocate for improving patient–provider communication.

Health risk of migration: Migration itself is not a risk to health. Migration is a social determinant of health. The risk factors and migrant vulnerability in major countries of destination are natural hazards, economic crisis, industrial/occupational accident, exploitation, disease outbreak, mass return/deportation and conflict violence. Seasonal migrants involved in paddy growing temporarily live in small migrant clusters in wide farming areas. Myanmar is also highly prone to natural disasters that lead to huge displacement and contribute to affecting migration flows. Pregnancy termination rate among the migrant women was 12.8%. Use rate for any modern contraceptive methods was 34.3% which was lower than of general community mCPR (51%). 32.8% of ANC rate which is also much lower than the 81% rate in general community. 4.4% of migrants had been diagnosed with TB infection (361/100000 general population). Forty per cent of women did not seek any treatment for diarrhoea for their child. Misunderstandings about STIs and HIV were also apparent. Incidence of physically violence (beating) was 18.5% and sexual violence was 10.1%. Migrant are at a potential risk during disease outbreak of pandemics such as influenza due to lack of access to health care and performing dangerous and risky jobs.

Health consequences among migrants could be identified and grouped as; 1) Accidents, injuries, violence due to unsafe working condition, 2) Maternal and reproductive health problems; 3) Life style and socioeconomic related health problems; Mental health problems malnutrition, drug abuse, alcoholism and NCDs, and 4) Infectious diseases like TB, HIV, Dengue, skin infection, vaccine preventable diseases.

Equitable access for low cost primary health care can reduce health expenditures, improve social cohesion and enable migrants to contribute substantially towards the development. The crucial issue regarding health problems among migrants is the disruption of care that is critical for chronic conditions. All prevalent health problems could be managed with integrated action of primary health care component of the national health system. Care for migrants is necessary to cover their prevailing needs, not only in hospitals but also in primary health care setting. The restrictions on urgent medical care for irregular migrants should be removed. Good practice for migrants however may require additional and specific efforts. These include altering service delivery with modifications to the routine practice, such as giving patients' with language needs more time, or seeking collaboration with social services that would be able to assist in legal and/or social issues. Problems and good practice components were largely consistent across the three very different types of

services, i.e. primary care, emergency hospital departments, and community mental health services for patients with long-term disorders.[11]

E2. Existing services for migrants' health

Essential health services for migrants are maternal and child health, worksite safety, injury management and referral, environmental sanitation, life style improvement, and health literacy promotion. In case of emergency situations, rapid response teams are organized with staff from the local areas and supervised by State/Region Health Departments. People residing in hard-to-reach areas, including any migrant living there, could receive health care from mobile teams arranged by local health authorities. However, some activities/programme of the government and non-government organizations have directly or indirectly benefited the migrant population, such as with the malaria, HIV/AIDS, tuberculosis programme, social welfare, immigration and border security, forced labour, rights of women and children, vocational training etc.

E3. Gaps in policy & practice

Current Laws regarding migration to Myanmar are over 60 years old and are limited in scope, with no mention of any health-related issues. Existing policies relevant to migrants were varying among different sectors. Social, economic and environmental policy options are scarce and affect migrants moving from poor arears to urban areas to seek for job opportunity. Majority of them are less educated and low-skilled labourers. Due to no clear law or institution to look into this issue, Management of migration is deemed to be weak.

The health impacts, vulnerabilities and social consequences resulting from such migration flows in Myanmar have been poorly explored. Health vulnerabilities are resulted from poor access to primary health care services, lack of education, training and awareness on the receiving country's working conditions and laws. Tackling health vulnerabilities of migrants substantially reduces financial and health costs for migrants and societies and enhances the development potential of migration. Inadequate health human resources could also affect the migrant population residing in remote and less accessible areas. If migrants' use primary health care and are treated early, the need for costly emergency care will be reduced, and both sustainable development and health equity goals can be achieved.

This is essential for evidence-based policy dialogue, development planning and programme formulation. Migration levels, patterns and trends should be considered in the formulation and implementation of social, economic and political policies. The main focus should also be on the elimination of urban poverty and creation of employment opportunities. Migration policy should be gender-specific in protecting the rights of female migrants. Addressing migrants' health, and more in general health outcomes of migration, requires

[11] Stefan Priebe,[1] Sima Sandhu,[1] Sónia Dias,[2] et. al. Good practice in health care for migrants: views and experiences of care professionals in 16 European countries. BMC Public Health. 2011; 11: 187. Published online 2011 Mar 25. doi: 10.1186/1471-2458-11-187

coherence of a full range of policies, such as immigration, labour, social protection, housing, education and health. Developing Migrant Health Policy should be aligned with existing Migration Policy, Labor Policy and NHP. The policy should aim at maximizing benefits and minimizing risks. Conducting more detailed research on migration (internal and international), and linking them with development is suggested.

E4. Gaps in system for migrant health

The Ministry of Labour, Employment and Social Security (MOLES) has a "Five-year National Plan of Action for the Management of International Labour Migration in Myanmar 2013-2017" which includes as a main strategic objective the increase the protection and empowerment of migrant workers. However, the role of government institutions in internal migration is almost non-existent, except in cases of permanent migration. The legislation does not distinguish between the various types of migrants e.g. migrant workers, victims of trafficking, unaccompanied children, refugees or stateless persons. Additionally, the legislation does not cover any areas relating to migration; for example, rules concerning taking up employment in Myanmar.

There was no mention of health systems for internal migrants. Many sectors including health had no migrant specific service provision systems resulting in lack of formal action plan, human resources, budget and supplies for migrants. Without consideration migrant specific component in the current health system, they could face a great challenge for achieving UHC.

Consideration of Migrant Health should be a part of Health System Strengthening in Myanmar as migrant are always left in the provision of health care services. Rather than creating a new system, it would be more practical by expanding existing service components, with adaptation and modification. The National Health Plan does mention internal migration and it aims at providing basic and essential health services for migrants. Linking, aligning and synchronizing existing residential health services of EPHS and NHP could reduce inequity in access to services and vulnerability to risks among migrants.

Migrants are not included in any of the health care registry and hence cannot afford the transportation and health care cost. It is difficult to set target population prior to providing necessary services for migrants. There is a research on Levels, Trends and Patterns of Internal Migration in Myanmar conducted by UNFPA and Ministry of Immigration and Population, which provides information on size, types, areas and seasonal pattern of migration around high migration regions of the country. Getting baseline information by mapping, listing, estimating of various types of migrants in areas covered by local health staff in and connecting it with HMIS will be helpful for effective planning and implementing.

Migrant health actions should be made in stepwise fashion through situation analysis, needs & gaps analysis, and challenges analysis. Existing services, which is not a special entity of care for migrant population, provide a very limited set of rules and guidelines. Basic Health Staff also have barriers to providing services due to the work overload, limited human resources, difficult transportation. Costed-strategic plan will be required for the coordinated and collaborative actions among related health sectors. Migrant community-based volunteer workers would be effective in engaging with the community. In this case, migrant health research addressing needs, gaps and barriers to access health among migrants and providers should be embedded in priority activities.

In case of emergency situations, some relevant health sectors have management procedures with central level supports of technical, logistics, updated SOP and guidelines. Some sectors go with need-based approach, some use an all-inclusiveness approach, others provide according to the humanitarian setting. However, there was no systematic operating procedure nor guidelines for internal migrants in non-emergency situations

including at factories. Care for migrants needs standard operating procedures (SOP), guidelines and instructions should be provided to relevant implementers. Instruction should be related to logistic management, workplace assessments, medical checkup procedures, setup of mobile medical teams, and instructions for voluntary health workers.

Many collaborative activities are not implemented with standardized instructions and guidelines. Effective coordination among service providers, sectors, CSOs, employers and community volunteers are also essential component of the system. Partnership, networking and inter-sectoral collaboration among service providers, partners, employers and migrant community for separated but harmonized action plan is crucial.

Conclusion

Migrants contribute to positive development outcomes. All migrants need to be able to work, integrate and contribute to full capacity, therefore, access to preventative and curative health services is crucial for migrants to remain healthy. This situational analysis report includes findings regarding the inclusion, exclusion or omission of migrant health considerations in national health and migration policy documents and guidelines as well as comprehensive documentation of existing migrant health initiatives within the country. Myanmar Census 2014 and MDHS 2015-2016 data were used to understand the situation of Myanmar's migrants specifically to identify the main picture emphasizing health. Information from focal persons from relevant sectors to migrations also provide recommendations in this situation analysis report on improving accessibility of health care and services for migrants within the national health system.

Migrant Health Policy recommendations were made; to recognize that securing the health of migrants is a critical public health issues to be addressed by multi-sectoral approach; to ensure mechanisms, infrastructure for migrant health management, and political consideration to protect, maintain and promote the health of migrants, and to ensure the improved accessibility in health status among migrant populations and minimizing the negative health outcomes of migration.

Recommendations

1. Country specific policy development

Objectives: 1) To improve positive development outcomes, and reduce potential negative public health outcomes, 2) to be able to integrate migrants into host communities, 3) To secure migrants' right to health; and addressing their health needs and vulnerabilities, 4) To enhancing the health of migrants throughout the migration continuum, 5) To enhance safer and healthier labour migration, avoid discriminatory health practices

Recommendation: Policy should be; 1) clearly formulated, 2) requires coherence with a full range of policies across relevant sectors, such as immigration, labour, social protection, housing, education and health, 3) need to annex with legislation and effective strategies in line with standards, 4) be aligned with existing NHP, 5) processed with inter-country and multi-sectoral dialogue, coordination and sharing of good practices, and 6) be gender sensitive.

2. Approach with primary health care

Objective: 1) To provide equitable access to low cost primary health care can reduce health expenditures, improve social cohesion, 2) To provide migrants good practice components consistent across the three very different types of services, i.e. primary care, emergency hospital departments, and community mental health services.

Recommendation: Existing primary health care services with additional and specific efforts for migrants should be initiated at the very first step. These include altering service delivery with modifications of the routine practice. If migrants 'use of primary health care and early treatment is promoted, the need for costly emergency care will be reduced, and both sustainable development and health equity goals can be achieved.

3. Financing for health

Objective: 1) To ensure the financial protection of the migrants, avoiding OOP expenditure and financial catastrophe, 2) To have sustainable and responsive actions on health care for different types of migrants.

Recommendation: Migrant Health Care should be based on a health financing mechanism that has appropriate options of pre-payment scheme by contributions of government, employers, migrant workers and partners.

4. Coordination mechanism

Objective: 1) To achieve a common goal with separate and harmonized actions for migrants' health, 2) To get self-reliance and need based actions, 3) To reinforce the health systems with all available resources, 4) To make the mechanism and setting user friendly and enhance the community satisfaction.

Recommendation: Migrant health focal body should implement the activities; 1) in collaboration with relevant government sectors, partner organizations by sharing information and resources, harmonizing targets and activities, 2) looking for ways to franchise with private sectors in health care services for migrants in urban setting, and 3) recruiting migrant community based volunteers, training and engaging community

oriented health activities, 4) encompasses a wide variety of government-community interactions ranging from information sharing to community consultation.

5. Leadership and governance

Objectives: 1) To reduce inequity in accessing services and vulnerability to risks among migrants, 2) To have more specific services to migrants, 3) to be able to have more effective planning and implementing, 4) To have coordinated and collaborative actions among related health sectors.

Recommendation: System should; 1) link, align and synchroniz existing residential health services of EPHS and NHP, 2) be based on baseline information by mapping, listing, estimating of various types of migrants in areas covered by local health staff, 3) connect with HMIS, 4) initiate costed-strategic plan in coordinated and collaborative actions among related health sectors, 5) develop standard operating procedures (SOP), guidelines and instructions provided to relevant implementers which include logistic management, workplace assessments, medical checkup procedures, setup of mobile medical teams, and instructions for voluntary health workers, 6) embed migrant health implementation research informing needs, gaps and barriers to access health among migrants and providers should be embedded in priority activities.