



Migration and Health in ASEAN: Regional Case Studies

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one vision
one identity
one community



Migration and Health in ASEAN: Regional Case Studies

The Association of Southeast Asian Nations (ASEAN) was established on 8 August 1967. The Member States are Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam.

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Foreword

The Southeast Asian region has long been a major hub of origin, transit, and destination countries for migrants and their families. In the past three decades, international migration rates amongst countries within the ASEAN region has dramatically increased as people of all genders, ages, abilities, sexual orientations, and ethnicities migrate due to multiple push and pull factors. These factors range from improved socioeconomic opportunities and increased labour demand from abroad, to the emerging and ever-present threats of violent conflict or climate change or public health emergencies such as the COVID-19 pandemic.

Migrants have continually contributed to their respective communities, whether in an origin, transit or destination country, through cultural influences and economic growth, thus allowing their communities and regions to flourish. Nevertheless, there is a pressing need to ensure that the positive aspects of migration are maintained by ensuring that migrant workers' human rights are vigilantly protected throughout the cycle of migration, as the experience of migration itself is a key determinant of health and wellbeing.

Guided by the 2030 Agenda for Sustainable Development particularly Goal 3 *Ensure healthy lives and promote well-being for all at all ages*, it is therefore imperative to improve migrant health by ensuring that all migrants are included in national health systems within their host communities. Health systems should strive to be migrant-sensitive and ensure that migrants have the capacity to and are able to access high quality healthcare and any necessary health resources without financial or social barriers.

Due to the COVID-19 pandemic, migration and mobility have been severely impacted and disrupted, due to the ensuing lockdowns, travel bans and travel restrictions.

As of early 2022, COVID-19 continues to have an impact on migration patterns and migrant healthcare services globally. Additionally, migrants have been disproportionately impacted by the short-term and long-term effects of COVID-19 which include financial burdens, health disparities, lack of access to vaccinations and care services, social ostracization and xenophobia.

I am encouraged by the solidarity displayed by the ASEAN Member States, which have steadfastly pursued the roll out of COVID-19 vaccines and have also remained committed to addressing the social, financial, and environmental impacts of COVID-19 on all peoples with a heightened sense of urgency.

The ASEAN and IOM remain committed to protecting the livelihoods of migrants and host communities, and previous examples of this can be seen through IOM's commitment to fostering and facilitating orderly, safe and responsible migration as detailed in the *Asia-Pacific Migration Data Report 2020*. This joint endeavour is also clear in the *ASEAN Comprehensive Recovery Framework* which outlines ASEAN's various COVID-19 mitigation and recovery strategies throughout COVID-19's various recovery stages and highlights ASEAN's focus on groups who have been severely and disproportionately impacted by COVID-19's devastating impacts.

To pursue the goals and objectives of the Global Compact for Safe, Orderly and Regular Migration (GCM), the first intergovernmental framework for cooperation and addressing all aspects of migration governance in a holistic and comprehensive manner, adopted on 10th December 2018 by all United Nations Member States, gathering comprehensive, reliable and up-to-date data on migrant health is of utmost importance in order to address Objective 1 of the GCM, which underlines the need to "collect and utilize accurate and disaggregated data as a basis for evidence-based policies."

This report, *Migration and Health in ASEAN: Regional Case Studies*, provides a wide snapshot of the status of migrant health within each ASEAN Member State, which is crucial as 'migrant health' has been identified in the ASEAN Post-2015 Health Development Agenda as one of 20 priorities. Notably, migrants' health is also under the purview of the *ASEAN Health Cluster 3 on Strengthening Health Systems and Access to Care*.

I am pleased to say that this Report represents a positive step towards achieving a greater understanding of migrant health in ASEAN through taking stock of the recent developments, commitments, legal frameworks, efforts and initiatives within migration and health in ASEAN.

I look forward to this Report significantly contributing to multi-sectoral, whole-of-government and whole-of-society dialogues, advocacy for evidence-based policy development around migrant health, inclusion of migrants in health systems.

As we continue to live and work amidst the still evolving COVID-19 pandemic, I am encouraged that further regional collaborations and partnerships through the implementation of migrant-sensitive, well-planned and well-managed migration policies will ensure no one is left behind.



Maria Nenette Motus
Regional Director (2016-2022)
IOM Regional Office for Asia and the Pacific

Foreword

Coronavirus disease (COVID-19) is continuing to pose longstanding challenges to countries and populations around the world since it was declared a pandemic by WHO on 11 March 2020. One of the vulnerable groups affected by the pandemic are the migrants. Based on estimates, the number of international migrants worldwide has continued to exponentially grow rapidly in recent years, reaching 281 million in 2020. However, 2020 also saw a sharp decline of labour migration from Asian countries and to Asian destination countries (ADB, OECD and ILO, 2022). Assessment reports have shown that migrant workers can be made vulnerable in pandemic situations due to inadequate access to needed health care and services.

In ASEAN, health of migrants is a standing priority of the ASEAN Health Sector and was incorporated in the regional programme in 2010. The current cooperation around migrants' health as well as universal health coverage (UHC) are operationalised in the Work Programme of ASEAN Health Cluster 3 on Strengthening Health Systems and Access to Care under the ASEAN Post 2015 Health Development Agenda for 2021-2025. The ASEAN Health Sector's activities on migrants' health are aligned with the ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers (2017).

This timely publication covers two complementary documents, **Migration and Health in ASEAN: Regional Case Studies** and the **ASEAN Framework on Health Coverage for Documented Migrants including Migrant Workers and Special Populations**. *Special Populations* is defined by ASEAN Health Cluster 3 as to comprise documented migrants including migrant workers, as defined by the ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers, women /mothers and children.

The Regional Case Studies aimed to take stock of the recent developments, commitments, efforts and initiatives in the field of migration and health within the ASEAN region while the ASEAN Framework contributes to the vision of the ASEAN Health Cooperation by improving the quality of life of its people such that no ASEAN migrant is left behind.

These are vital outputs of the ASEAN Health Sector in setting a regional baseline pertinent to migrants' health and to further ensure that health populations in ASEAN are addressed.

I congratulate the ASEAN Senior Officials on Health Development (SOMHD), particularly ASEAN Health Cluster 3, lead countries Philippines and Indonesia as well as the International Organisation for Migration (IOM) for their extensive collaboration and commitment to develop relevant regional documents which will pertinently contribute to the work of the ASEAN Health Sector in achieving a healthy, caring and sustainable ASEAN.



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AHMM Chair
Minister of Health of the Lao PDR



**Migration and
Health in ASEAN:
Regional Case Studies**

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List of acronyms

AIDS	Acquired immunodeficiency syndrome
ASEAN	Association of Southeast Asian Nations
COVID-19	Coronavirus disease 2019
EFMA	Employment of Foreign Manpower Act
FOMEMA	Foreign Workers Medical Examination Monitoring Agency
GDP	Gross domestic product
HIV	Human Immunodeficiency Virus
HMIS	Migrant Health Management Information System
ILO	International Labour Organization
IOM	International Organization for Migration
MoU	Memorandum of Understanding
MYR	Malaysian Ringgits
OECD	Economic Co-operation and Development
SHI	Social Health Insurance
SGD	Singapore dollars
SSS	Social Security Scheme
SOCISO	Social Security Organization
SPIKPA	Foreign Workers Hospitalization and Surgical Insurance Scheme
TB	Tuberculosis
THB	Thai Baht
UHC	Universal Health Coverage
UN	United Nations
USD	United States dollars
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Section 1:

EXECUTIVE SUMMARY

A migrant is defined as any individual who is in the process of moving or has already moved across an international border or within a State away from their dominant place of residence; irrespective of their legal status; whether the migration is voluntary or involuntary; what the causes for their movement are; and what the length of their stay in their host community is (IOM, 2019).

Protecting migrants' health has been identified as one of the 21 priorities under the "ASEAN Post-2015 Health Development Agenda." Thus, in collaboration between the Association of Southeast Asian Nations (ASEAN) Secretariat and the International Organization for Migration (IOM), this "ASEAN Regional Case Studies on Migration and Health in ASEAN" Report aims to examine and explain recent migration trends, flows and patterns throughout the 10 ASEAN Member States, while taking into consideration recent developments, legislative commitments, efforts and initiatives in the field of migration and health.

A scoping review of all relevant databases, literature and research related to migrants' health in ASEAN was conducted, to be collated and analysed for inclusion in this report. "Migration and Health in ASEAN: Regional Case Studies" carefully details each Member State's overall general country profile, migrant profile, health governance and financing structures, health service delivery mechanism and identifies each Member State's key challenges to implementing migrant health policies and strategies.

The findings highlight that key challenges towards achieving optimal migrant health include the following gaps: in **Brunei Darussalam**, while it is a legally binding requirement for employers to obtain medical insurance for their migrant workers for the full duration of their employment, not all employers fulfil this obligation; in **Indonesia**, no coordination mechanisms exist between social health insurance provided by the government and overseas providers of migrant workers; in **Lao People's Democratic Republic** and the **Philippines**, multisectoral governmental coordination to specifically address health issues that migrant workers experience appears to be lacking; in **Malaysia**, when inpatient medical bills exceeds 20,000 Malaysian Ringgits (MYR), that is, approximately 4,776 United States dollars (USD), migrant workers may experience out-of-pocket expenses that could result in financial difficulties when attempting to settle hospital bills; in **Myanmar**, the absence of culturally sensitive and tailored health services for migrants such as language barriers makes it difficult for them to access all national health services; in **Singapore** and **Viet Nam**, no dedicated migrant worker health information system exists; in **Thailand**, although a wide range of health-care insurance options provided by the government exists, migrant workers may face difficulties when attempting to access health care due to frequent changes to their employment; in **Cambodia**, no legislation mandates employers to provide health insurance for their migrant workers.

Overall, the findings also highlight the varying barriers to health-care services and systems that numerous migrants experience across ASEAN – barriers that have increased because of the coronavirus disease 2019 (COVID-19) pandemic – and underscore the importance of migrant integration, cohesion and capacity-building within a health context to promote health equity for all and ensure healthy societies for migrants and host communities alike.

Section 2:

INTRODUCTION

2.1 Background

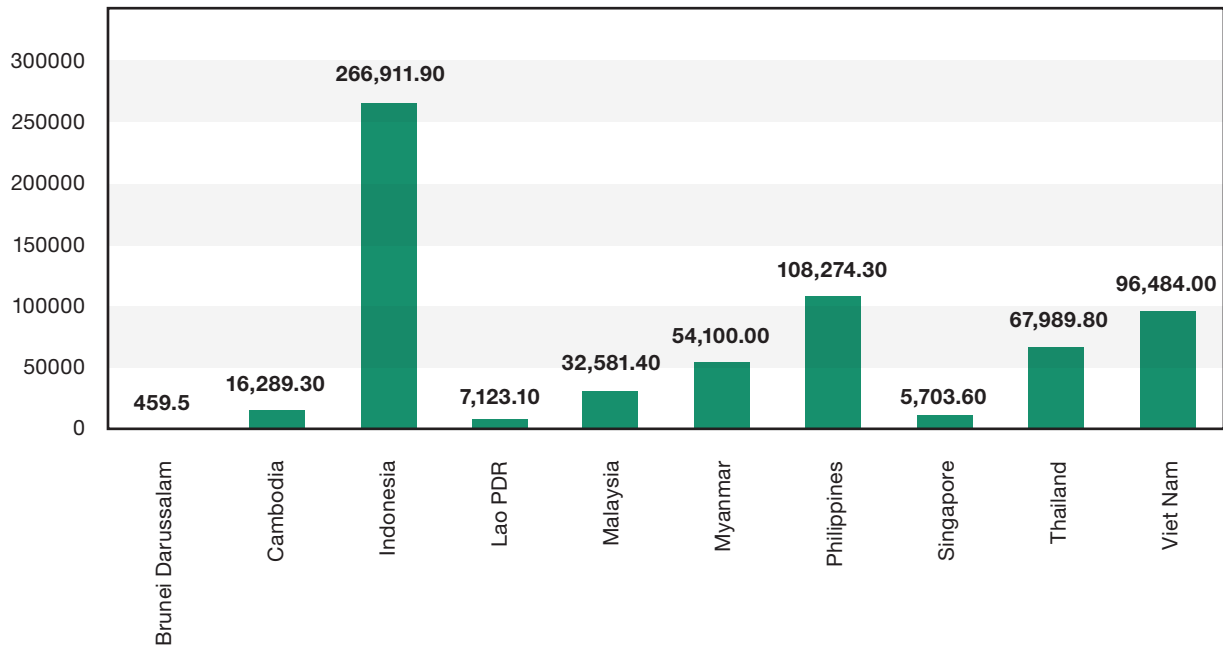
The number of international migrants worldwide has continued to exponentially grow rapidly in recent years, reaching 281 million in 2020. A significant number of migrants (106 million) were born in Asia and over 60 per cent of all international migrants live in Asia (80 million). The Association of Southeast Asian Nations (ASEAN) region records the highest number of international migrants (outbound) in Asia, following India and China (1). World Health Assembly Resolutions on “Health of Migrants” (WHA 60.26, WHA 61.17 and WHA70.15); (2), two Global Consultations (2010 (3), 2017 (4)), and numerous regional and subregional declarations on advancing the health of migrants have signaled commitments by governments and the international community in framing “migration health” as a key global health issue that is also critical for development. The Global Compact on Migration adopted in December 2018 – the first comprehensive cooperative framework on international migration developed through intergovernmental negotiations – reaffirms the global commitments to ensure safe, orderly and regular migration (5). While acknowledging state sovereignty, the Global Compact reiterates that no government can address the issues of international migration alone. Health is enshrined as a cross-cutting priority within the ASEAN region and all Member States within the region have ratified the Global Compact on Migration.

Established on 8 August 1967 with its 10 Member States (Brunei Darussalam, Cambodia, Indonesia, Lao People’s Democratic Republic, Malaysia, Myanmar, the Philippines, Singapore, Thailand, and Viet Nam), ASEAN forms one of the most dynamic regions in the world. With a total combined population of almost 650 million (6), ASEAN is the third largest market in the world, and the world’s sixth largest economy with almost 3 trillion United States dollars (USD) in gross domestic product (GDP); (7) and an economic growth rate of 5 per cent. ASEAN Member States are extremely diverse in terms of culture, language, ethnicity, economic development, forms of government and degrees of political freedom. The largest economies in the region (Indonesia, Malaysia, the Philippines, Singapore, Thailand and Viet Nam) make up 85 per cent of the region’s GDP.

2.1.1 Basic Demographic data

Figure 1. Population in ASEAN countries

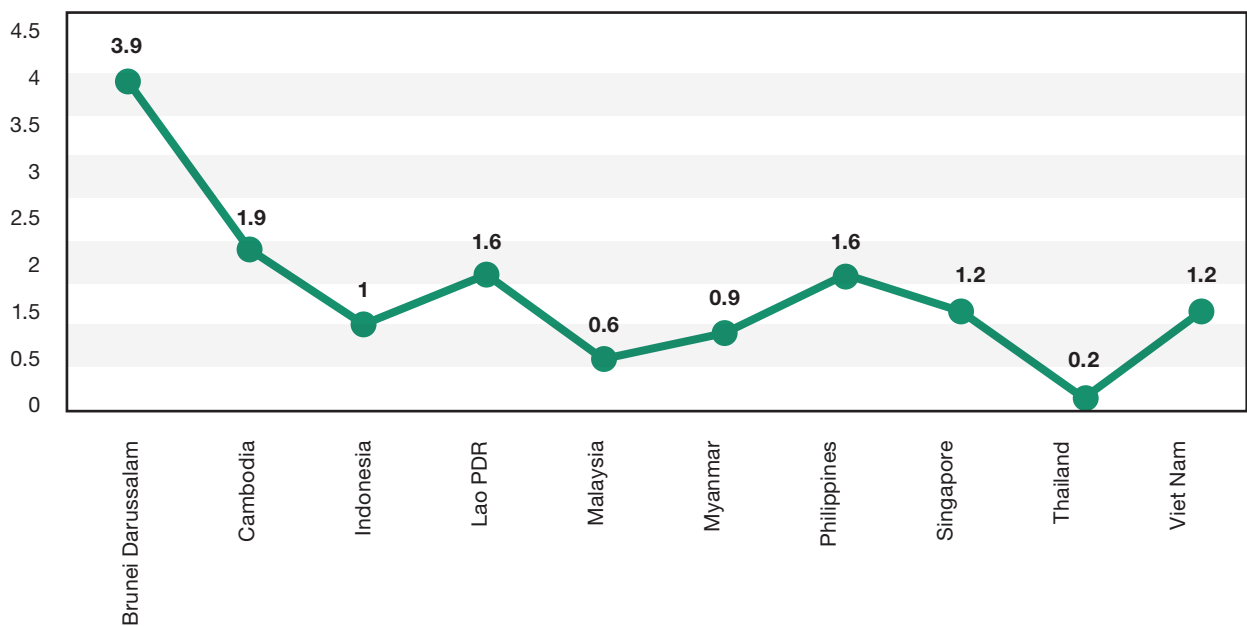
Population in ASEAN countries (population in thousands, 2019)



Source: ASEAN Statistical Yearbook 2020

Figure 2. Annual population growth in ASEAN countries

Annual population growth in ASEAN countries



Source: ASEAN Statistical Yearbook 2020

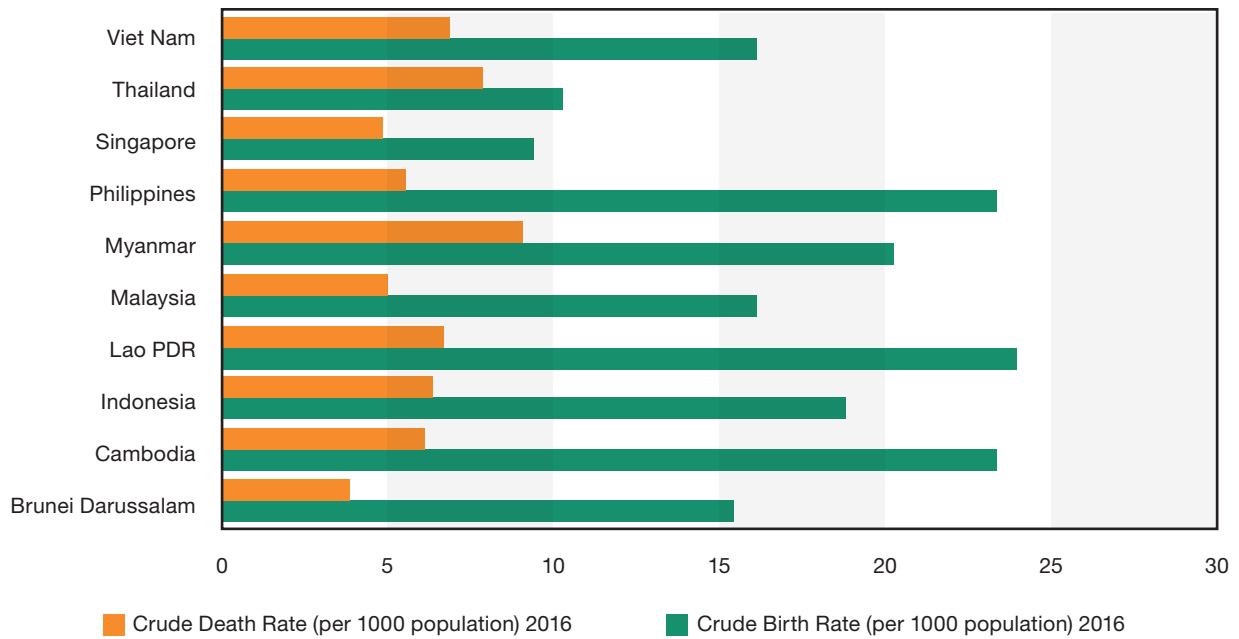
Table 1. Basic demographic data of ASEAN countries

Country	Ethnicity	Language/s	Human development index	Median age (years)	Birth rate (per 1000)	Death rate (per 1000)
Brunei Darussalam	Malay (65.7%), Chinese (10.3%), Others (24.0%)	Bahasa Melayu, English, Chinese dialects	0.712	31.1	16.3	3.8
Cambodia	Khmer (97.6%), Cham (1.2%) Others (1.2%)	Khmer, English, French, Minority languages	0.581	26.4	20.8	7.2
Indonesia	Javanese (40.1%), Sundanese (15.5%), Malay (3.7%), Batak (3.6%) Madurese (3%) Betawi (2.9%), Others (31.2%)	Bahasa Indonesia, English, Dutch, local dialects	0.701	31.1	15.6	6.7
Lao PDR	Lao (53.2%), Khmou (11%), Hmong (9.2%), Phouthay (3.4%), Others (23.2%)	Lao, French, English	0.604	24	22.7	7.1
Malaysia	Bumiputera (62.5%), Chinese (20.6%), Indian (6.2%) Others (10.7%)	Bahasa, Malaysia, English, Mandarin, Tamil	0.804	29.2	14.7	5.7
Myanmar	Myanmar (68%) Shan (10%), Kayin (7%), Rakhine (4%)	Myanmar Ethnic languages	0.585	28	19.3	8.5
Philippines	Visayan (33.7%), Tagalog (24.4%), Ilocano (8.8%), Bicolano (6.8%), Others (26.2%)	Tagalog and English	0.712	24.1	22.7	6.0
Singapore	Chinese (75.9%), Malay (15.0%), Indian (7.5%), Others (1.6%)	English, Malay, Mandarin, Tamil	0.935	35.6	9.1	3.9
Thailand	Thai (86%), Khmer (3%), Malay (2%), Others (9%)	Thai, Isan, Kam Mueang, Pak Tai, Malay	0.765	39	10.3	7.7
Viet Nam	Vietnamese (85.32%), Others (14.68%)	Vietnamese	0.693	31.9	16.0	5.8

Source: The World Factbook 2021

Figure 3. Crude birth rate and crude death rates in ASEAN countries

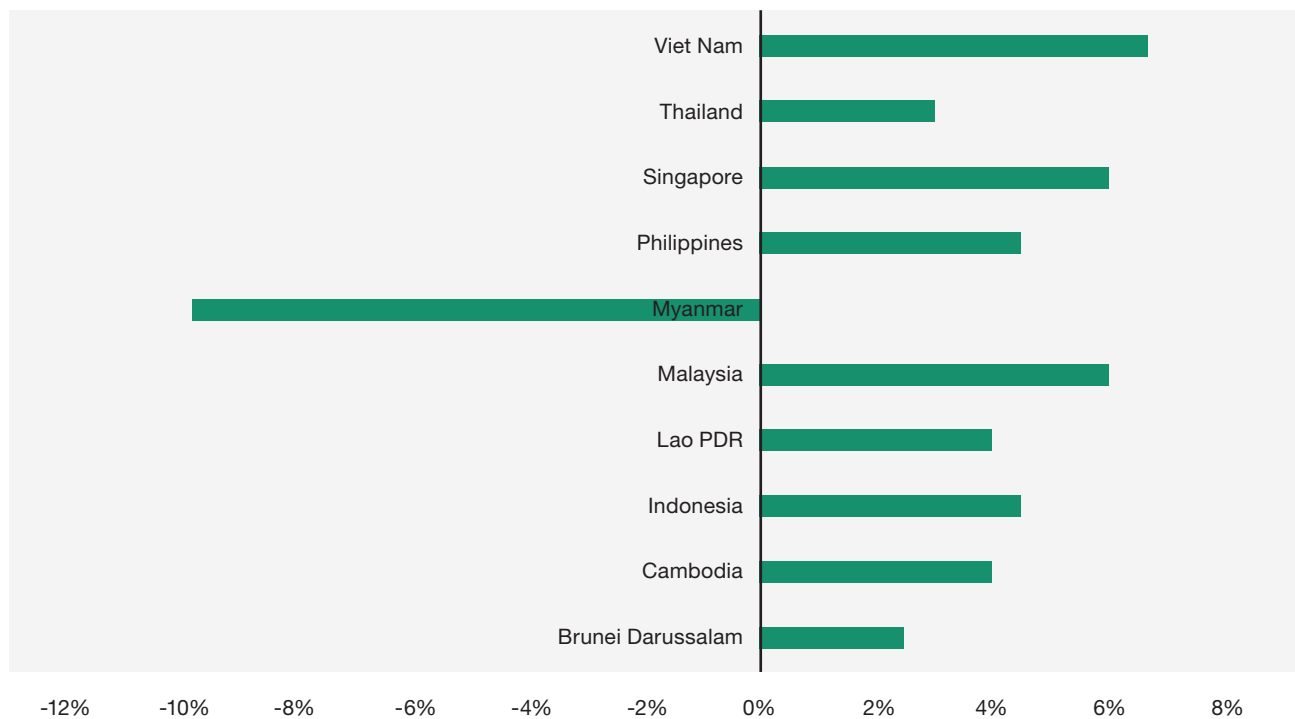
Birth and death rates in ASEAN countries



Source: ASEAN Statistical Yearbook 2020

Figure 4. GDP growth rate (2021 forecast) for ASEAN countries

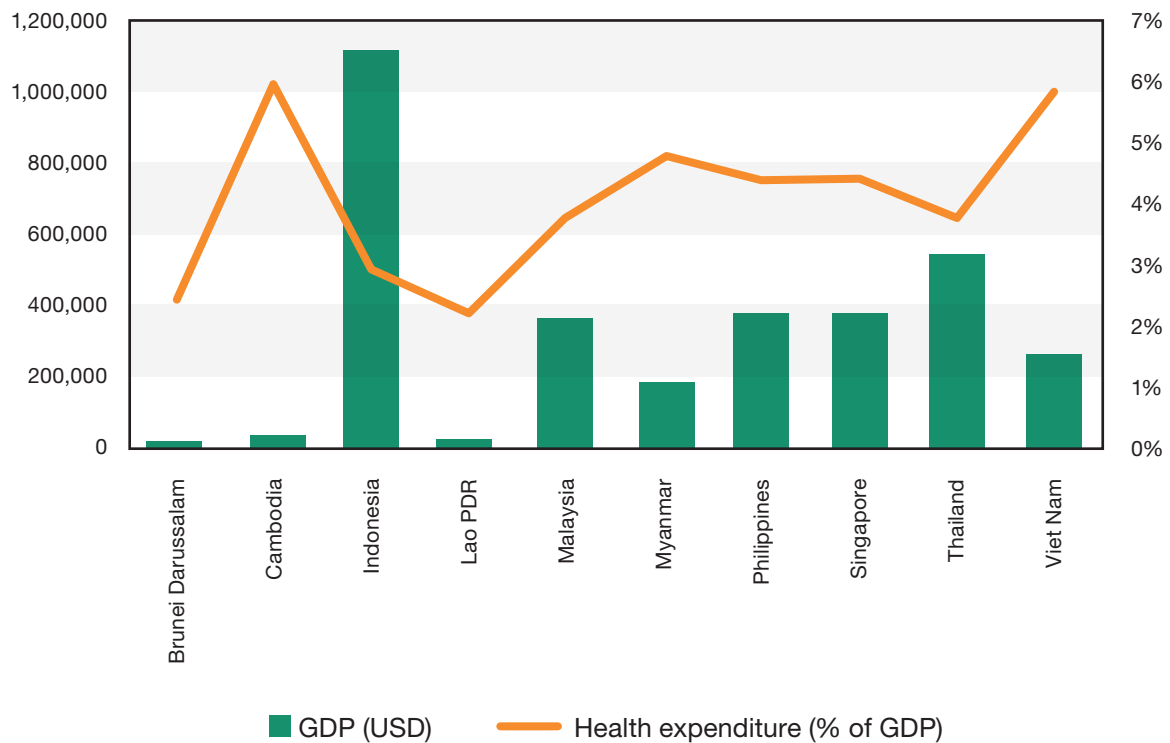
GDP Growth Rate, 2021 forecast



Source: Asian Development Outlook 2021

Figure 5. GDP and health expenditure in ASEAN countries

GDP and health expenditure in ASEAN countries



Source: ASEAN Statistical Yearbook 2020

2.1.2 Health services in ASEAN

Across ASEAN, much heterogeneity exists in health service delivery systems. Health expenditure varies from the highest, in Cambodia, to the lowest in Brunei Darussalam (9). Achieving Universal Health Coverage (UHC) remains a remote dream for even the Member States' citizens, let alone for migrants (15).

The burden of health issues within ASEAN are complex and include infectious diseases, occupational health hazards and injuries, poor mental health, non-communicable diseases (such as cardiovascular disease and diabetes) and maternal and child health problems. Infectious diseases including human immunodeficiency virus (HIV) / Acquired immunodeficiency syndrome (AIDS), tuberculosis (TB) and malaria are major concerns (16). Some countries in the region are recorded amongst the countries with the highest prevalence of TB, HIV and Malaria (17). The Philippines, Myanmar, Indonesia, Cambodia, Thailand and Viet Nam are among the top 30 countries with the highest TB incidence in the world (18).

Table 2. Current values of the UHC service coverage index of essential health services and values of each of the tracer indicators used to calculate the index, by country

	UHC service coverage index (SDG 3.8.1)	Index data availability	Family planning demand satisfied with modern methods (%)	Antenatal care, +4 visit	Child immunization (DTP3)	Care seeking behaviour for child pneumonia	TB-effective treatment)	HIV treatment	At least basic sanitation	Normal blood pressure	Mean fasting plasma glucose	Tobacco non-use	Hospital bed density	Health worker density	International Health Regulations core capacity index
Brunei Darussalam	77	medium	76	≥80	≥80	≥80	71	≥80	≥80	23	68	76	≥80	≥80	≥80
Cambodia	61	high	61	76	≥80	69	≥80	63	66	57	≥80	68	50	21	50
Indonesia	59	high	≥80	≥80	≥80	75	24	66	≥80	33	≥80	46	65	31	73
Lao PDR	50	high	70	62	≥80	40	50	61	79	53	≥80	53	43	11	35
Malaysia	76	high	55	>80	>80	>80	50	>80	>80	32	76	67	≥80	≥80	≥80
Myanmar	61	high	77	59	≥80	58	≥80	77	73	38	≥80	35	57	33	64
Philippines	55	high	57	≥80	77	66	43	68	≥80	44	≥80	66	56	12	51
Singapore	≥80	medium	77	≥80	≥80	≥80	76	≥80	≥80	48	≥80	76	≥80	≥80	≥80
Thailand	≥80	high	≥80	≥80	≥80	≥80	75	≥80	≥80	52	≥80	68	≥80	≥80	≥80
Viet Nam	70	high	79	74	≥80	≥80	65	60	≥80	51	≥80	64	≥80	34	66

Source: Tracking Universal Health Coverage 2021: Global Monitoring Report

2.2 Objective and scope of the report

2.2.1 Objective

Publish the “*ASEAN Regional Case Studies on Migration and Health in ASEAN*” report to take stock of the recent developments, commitments, efforts and initiatives in the field of migration and health within the ASEAN region.

2.2.2 Scope of the report

Migrants’ health is identified as one of the 21 priorities under ASEAN Post-2015 Health Development Agenda. Prior to 2015, the concern of the health of migrants was lodged directly under the Senior Officials’ Meeting on Health and Development. A workshop on “Migrant Health in ASEAN Countries” was held on 14–15 June 2012 in Bogor, Indonesia, where a draft terms of reference on the implementation of Migrants’ Health activities in ASEAN Member States was discussed.

With the new Health Cluster mechanism in place, migrants' health is under the purview of the ASEAN Health Cluster 3 on Strengthening Health systems and Access to Care. This case study builds on the previous work of ASEAN's Member States, with a focus on the development of guidelines on health coverage for documented migrants, including migrant workers and special subpopulations, such as mothers and children.

This report has the following objectives: 1) become an avenue to gather experts on migration and health from ASEAN countries, 2) take stock of the recent developments and updates on various policies, commitments, efforts and initiatives in the field of migration and health, 3) conduct assessments and situational analyses of the health coverage amongst documented migrants within ASEAN, including migrant workers and special subpopulation groups (mothers and children); and 4) provide a platform for dialogue – including the discussions of ideas, experiences and perspectives on migrant health issues – among stakeholders relating to the current health issues faced by documented migrants.

Section 3: METHODOLOGY

A scoping review was undertaken to gather all relevant data, literature and research published in English from 2018 to 2021, from various resources including government factsheets, reports from civil society organizations, non-governmental organizations and intergovernmental organization and statistical demographic data from online databanks for inclusion in this case study.

Published data, literature and research that focused on the health of migrants in ASEAN countries were collated and analysed. Namely, the ASEAN Statistical Yearbook 2020 was a key text used in this case study. Additionally, information from presentations by ASEAN Member States at the two consultative meetings in December 2018 and September 2019 were included in this case study for analysis.

A tool was developed for the assessment of the current situation of health coverage among documented migrants. Using recommendations from the assessment and situational analysis tool, a workshop was organized to develop guidelines on health coverage for documented migrants including migrant workers and special subpopulations (mothers and children) during 4–6 December 2018 in Makati City, the Philippines. Experts and/or representatives from ASEAN Member States were invited to participate in the workshop. One of the recommendations from the participants of the workshop was to collate the rich information gathered from the assessment tool and to publish it as a “Migration and Health in ASEAN: Regional Case Studies” report.

The limitations of this study's methodology are that offered data were not verified and were analysed as presented in their original form. This scoping review was limited to literature published in English, which excluded a wide range of data published in the Member States' languages. Moreover, this scoping review was limited to examining published literature on documented migrant workers exclusively, which excluded other forms of migrants such as refugees, asylum seekers or internally displaced persons.

Section 4:

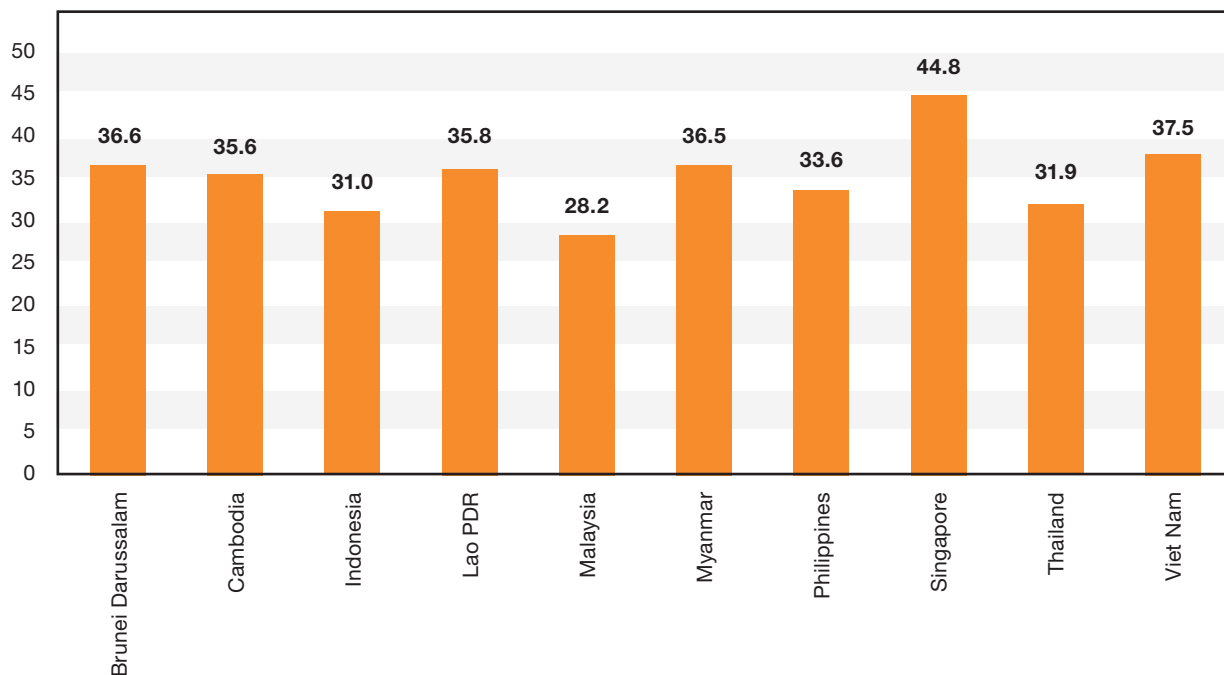
ASEAN CASE STUDIES

4.1 Migration trends in ASEAN region

Out of the total labour force of 326 million in ASEAN countries, over 7 million people from ASEAN work in another ASEAN country (9). Migration has played and continues to play a crucial role in the political economy of the region. Intraregional migrants account for two thirds of the region's total international migrant stock (1). ASEAN's urbanization is occurring in parallel with economic growth. Due to foreign direct investment and participation in global value chains, the economy has shifted from an agriculture-based economy, to an industry-based one, and now towards a service-based economy. ASEAN cities have acted as hubs of economic growth and attracted millions of people from the countryside, while lifting many out of poverty.

Figure 6. Median age of international migrants in ASEAN countries

Median Age of International Migrants



Source: United Nations Department of Economic and Social Affairs, International Migrant Stock 2020.

ASEAN Economic Blueprint 2025 aims to achieve seamless movement of goods, services, investment, capital and skilled labour within ASEAN to enhance ASEAN's trade and production networks, as well as to establish a more unified market for its firms and consumers (12). ASEAN economies are underpinned by migrant workers and a steady increase of population mobility across borders is expected.

However, despite their substantial contribution and indispensability, migrant workers are often faced with contradictory treatment in ASEAN (13).

Table 3. Bilateral agreements on regulating migration among ASEAN countries

Country	Brunei Darussalam	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore	Thailand	Viet Nam
Brunei			✓							
Cambodia					✓		✓		✓	✓
Indonesia	✓				✓		✓			
Lao PDR							✓		✓	✓
Malaysia		✓	✓							✓
Myanmar									✓	
Philippines		✓	✓	✓						
Singapore										
Thailand		✓		✓		✓				
Viet Nam		✓		✓	✓				✓	✓

Source: United Nations, International Migration Report 2017.

Some countries in the region have entered into bilateral agreements to regulate or better facilitate migration in all its forms.

The top five countries of origin for international migrants in ASEAN are: the Philippines (9.7 million), Myanmar (2.2 million), Indonesia (1.2 million), Malaysia (1.0 million), Lao People's Democratic Republic (0.9 million) and Cambodia (0.8 million). The top five countries of destination for nationals abroad from ASEAN are: the United States of America (4.3 million), Thailand (3.6 million), Malaysia (1.5 million), Saudi Arabia (1.4 million) and Singapore (1.2 million); (10) (11). The Philippines is the largest sending country in ASEAN, deploying an average of 968,600 workers abroad each year since 2000. In 2014, 14.2 per cent of Filipino overseas workers were employed in other ASEAN countries, mainly Singapore (140,205). In Singapore, migrant workers made up more than one third (approximately 33%) of the total workforce in 2021 (Ministry of Manpower Singapore, 2021).

Table 4. Migration trends in ASEAN region

Country	Brunei Darussalam	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore	Thailand	Viet Nam
Number of International Migrants (2020)	111 959	79 341	355 505	48 731	3 476 560	76 446	225 525	2 523 648	3 632,496	76 767
International Migrants as % of Total Population	25.6%	0.5%	0.1%	0.7%	10.7%	0.1%	0.2%	43.1%	5.2%	0.1%
% of Female Migrants	43.4%	46.1%	41.9%	35.6%	38%	45.2%	48.1%	55.9%	49.8%	42.1%

Source: United Nations Department of Economic and Social Affairs, International Migrant Stock 2020.

4.2 Migrants' Health in ASEAN

In 2007, the ASEAN Member States signed the Declaration on the Protection and Promotion of the Rights of Migrant workers, which laid down the obligations of sending and receiving States in promoting the fundamental rights and dignity of migrant workers and their families (20). Protecting migrants' rights was also identified as a strategic objective under the ASEAN Socio-Cultural Community Blueprint (12). However, neither of these regional instruments explicitly mentioned migrants' right to health or health-related obligations of ASEAN Member States toward migrant workers and other people on the move.

Now more than ever, addressing migrant health is necessary, as health problems faced by migrants have become increasingly glaring in recent years. Most recently, the devastating and disproportionate impact of COVID-19 on migrants within ASEAN has highlighted the need for including migrants within national health-care policies, as they are often excluded and left behind, thus increasing their vulnerability to harmful health consequences. In addition to the impact of COVID-19, HIV/AIDS has been a major concern among migrants in Southeast Asia (21), particularly among migrant workers entering Thailand (22), and 'Overseas Filipino Workers' returning or even deported back to the Philippines (23) (24). In addition, limited access to health care among migrants has also been featured in recent regional dialogues organized by various intergovernmental organizations (25). Little information is known about other health vulnerabilities commonly experienced by migrants such as occupational hazards, injuries and chronic non-communicable diseases.

Thus, in this context, considering the large number of migrants in the region and the importance of migration for economic development in ASEAN region and possible public health risk if health services are not extended to migrants, including migrants in UHC targets while ensuring sustainable ways to fund their national health systems is vital. Ensuring health protection for the diverse flows of migrants in the ASEAN region requires a better understanding of migration dynamics and health issues.

4.3 Mapping of international legal and policy frameworks

Within ASEAN, the Philippines and Indonesia are the only Member States to have ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Although Cambodia signed the convention in 2004, it has yet to ratify it (14).

Ratification of international conventions pertaining to international migration:

- Regional Policy frameworks related to migration health;
- Bilateral agreements that include health components;
- Mapping domestic legal and policy frameworks pertaining to health of migrants across all ASEAN Member States.

Table 5. International legislations on the right to health

	Brunei Darussalam	Cambodia	Indonesia	Lao PDR	Malaysia	Myanmar	Philippines	Singapore	Thailand	Viet Nam
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990	No	Signed 27 September 2004	Signed 22 September 2004, Ratified 31 May 2012	No	No	No	Signed 15 November 1993 and ratified 5 July 1995	No	No	No
Universal Declaration of Human Rights, 1948	Universal recognition	Universal recognition	Universal recognition	Universal recognition	Universal recognition	Universal recognition	Universal recognition	Universal recognition	Universal recognition	Universal recognition
Convention relating to the Status of Refugees, 1951	Not party	Ratified 15 October 1992	Not party	Not party	Not party	Not party	Ratified 22 July 1981	Not party	Not party	Not party
International Covenant on Economic, Social and Cultural Rights, 1966/1976	No	Signed 17 October 1980 Ratified 26 May 1992	Ratified 23 February 2006	Signed 7 December 2000 Ratified 13 February 2007	No	Signed 16 July 2015 Ratified 6 October 2017	Signed 19 December 1966 ratified 7 June 1974	No	Ratified 5 September 1999	Ratified 24 September 1982
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979	Ratified 24 May 2006	Signed 17 October 1980 Ratified 15 October 1992	Signed 29 July 1980 Ratified 13 September 1984	Signed 17 July 1980 Ratified 14 Aug 1981	Ratified 5 July 1995	Ratified 22 July 1997	Signed 15 July 1980 Ratified 5 August 1981	Ratified 5 October 1995	Ratified 9 August 1985	Signed 29 July 1980 Ratified 17 February 1982
Convention on the Rights of the Child, 1990	Ratified 27 December 1995	Ratified 15 October 1992	Ratified 21 August 1990	Ratified 8 May 1991	17 February 1995	Ratified 15 July 1991	Signed 26 January 1990	Ratified 5 October 1995	Ratified 27 March 1992	Signed 26 January 1990 Ratified 28 February 1990
Migration for Employment Convention (ILO No. 97)	No	No	No	No	No	No	Ratified	No	No	No
Migrant Workers (Supplementary Provisions) Convention (ILO No. 143)	No	No	No	No	No	No	Ratified	No	No	No
Domestic Workers Convention (ILO No. 189)	No	No	No	No	No	No	Ratified	No	No	No

Table 6. Policy and legal frameworks on migration

	Ratification of international convention pertaining to international migration	Regional Policy frameworks related to migration health	Bilateral agreements that include a health component	Mapping domestic legal and policy frameworks pertaining to health of migrants across all ASEAN Member States
Brunei Darussalam	<p>International Labour Organization (ILO), 2007</p> <p>World Health Organization UN (1984), ASEAN (1984)</p>	<p>ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>	<p>Memorandum of Understanding (MoU) between Brunei Darussalam and Indonesia in the field of Health Cooperation</p>	<p>Employment Order</p> <p>Workmen Compensation Act</p> <p>Workplace Safety and Health Order</p> <p>Anti-Trafficking in Persons Order</p>
Cambodia	<p>Discrimination against Women (CEDAW), 1979</p> <p>Convention on the Rights of the Child, 1990</p>	<p>In 2007, heads of states from ASEAN signed a declaration on the Protection and Promotion of the Rights of Migrant Workers.</p> <p>In 2017, the leaders of the ASEAN signed the Consensus on the Protection and Promotion of the Rights of Migrant Workers. The consensus obliges both sending and receiving States to share responsibilities to support and protect migrant workers.</p> <p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>	<p>In 2003, Cambodia and Thailand signed a MoU on Cooperation in the Employment of Workers. In 2015, the MoU was revised to broaden the cooperation on labour issues to include skills development and reemployment.</p> <p>In 2015 Cambodia and Malaysia signed two MoUs for sending general workers and domestic workers to Malaysia lifting the suspension of recruitment agencies sending domestic workers to Malaysia that had been in place since 2011.</p> <p>An agreement on the recruitment of domestic workers and general workers was also signed with Saudi Arabia in February 2016 but no timeline has been set for implementation.</p>	<p>There are multiple laws, sub-decrees and Prakas available. Details are presented in the country profile.</p>

	Ratification of international convention pertaining to international migration	Regional Policy frameworks related to migration health	Bilateral agreements that include a health component	Mapping domestic legal and policy frameworks pertaining to health of migrants across all ASEAN Member States
Indonesia	<p>Discrimination (Employment and Occupation) Convention 1958</p> <p>Equality of Treatment (Accident Compensation) Convention</p> <p>Promotional Framework for Occupational Safety and Health Convention</p> <p>International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families</p> <p>Protocol Against the Smuggling of Migrants by Land, Sea and Air</p> <p>Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime, 2000</p>	<p>ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>	<p>MoU between Indonesia and Malaysia on recruitment and placement of Indonesian domestic workers</p> <p>MoU between Indonesia Brunei Darussalam in the Field of Health Cooperation</p> <p>Joint Declaration of Indonesia and the Philippines on the Protection of Migrants and Migrant Workers</p> <p>Mandatory Consular Notification agreement between Indonesia and Brunei Darussalam (2011) and the Philippines (2014)</p>	<p>There are multiple laws, details are presented in the country profile.</p>

	Ratification of international convention pertaining to international migration	Regional Policy frameworks related to migration health	Bilateral agreements that include a health component	Mapping domestic legal and policy frameworks pertaining to health of migrants across all ASEAN Member States
Lao PDR	<p>Universal Declaration of Human Rights, 1948</p> <p>International Covenant on Economic, Social and Cultural Rights, 1976/1966 (Signed 17 October 1980, ratified 26 May 1992)</p> <p>Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979</p> <p>Convention on the Rights of the Child, 1990</p>	<p>ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social protection</p>	<p>Cooperating with Viet Nam through a joint survey and programmatic review to improve malaria control methods between the two nations (2010)</p>	
Malaysia	<p>See Table 5</p>	<p>ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>	<p>There are multiple bilateral agreements, details are provided in the country profile.</p>	<p>Employment Act 1955 [Act 265]</p> <p>Immigration Act Malaysia 63/ 1959 (Act 155)</p> <p>Passport Act 1966 (Act 150)</p> <p>Employees' Social Security Act 1969 [Act 4]</p> <p>Fees Act 1951 (Amendment 2017)</p> <p>International Health Regulations 2005</p>
Myanmar	<p>Universal Declaration of Human Rights, 1948</p> <p>International Covenant on Economic, Social and Cultural Rights, 1976/1966 - Ratified 16 July 2015, signed 6 October 2017</p>	<p>ASEAN consensus on the protection and promotion of the Rights of Migrant Workers</p> <p>ASEAN declaration on the protection and promotion of the Rights of Migrant Workers</p>	<p>Not found</p>	<p>Not found</p>

	Ratification of international convention pertaining to international migration	Regional Policy frameworks related to migration health	Bilateral agreements that include a health component	Mapping domestic legal and policy frameworks pertaining to health of migrants across all ASEAN Member States
	<p>Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979 – ratified 16 July 2015, signed 6 October 2017.</p> <p>Convention on the Rights of the Child, 1990. Ratified 15 July 1991</p>	<p>ASEAN Convention against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>		
Philippines	<p>United Nations (UN) Human rights instruments</p> <p>1979 Convention on the Elimination of All Forms of Discrimination Against Women</p> <p>1989 Convention on the Rights of the Child</p> <p>1990 UN Migrant Workers Convention</p> <p>2000 Human Trafficking Protocol</p> <p>2000 Migrant Smuggling Protocol</p> <p>2006 Convention on the Rights of Persons with Disabilities</p> <p>ILO conventions ILO Core Conventions: C29, C87, C98, C100, C105, C111, C138, C182 C97 Migration for Employment (Revised) C143 Migrant Workers (Supplementary Provisions) Convention C189 Domestic Workers Convention</p>	<p>ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>	<p>With Indonesia on migrant workers</p> <p>With Lao PDR on technical cooperation on labour</p> <p>With Cambodia</p>	Multiple legal tools are available, specified in the country profile
Singapore	See Table 5	<p>ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers</p>	Not found	<p>Employment Act</p> <p>Workplace Injury Compensation Act</p> <p>Workplace Safety and Health Act</p>

	Ratification of international convention pertaining to international migration	Regional Policy frameworks related to migration health	Bilateral agreements that include a health component	Mapping domestic legal and policy frameworks pertaining to health of migrants across all ASEAN Member States
		<p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>		<p>Employment of Foreign Manpower Act</p> <p>Foreign Employee Dormitories Act</p> <p>Employment Agencies Act</p>
Thailand	See Table 5	<p>ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>	Not found	Multiple laws are detailed in the country profile.
Viet Nam	See Table 5	<p>ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers</p> <p>ASEAN Convention Against Trafficking in Persons, Especially Women and Children</p> <p>ASEAN Declaration on Strengthening Social Protection</p>	<ol style="list-style-type: none"> 1. MoU on labour cooperation and agreement on labour recruitment between Thailand and Vietnam 2. MoU on dispatching and receiving labour between Thailand and Viet Nam 3. MoU in relation to the field of labour between Viet Nam and Cambodia 4. MoU on labour and employment between Viet Nam and Malaysia 5. MoU on cooperation on education and human resources development, focusing on building strategies in the field for the 2030–2020 period between Viet Nam and Lao PDR 	Multiple laws are detailed in the country profile.

4.4 ASEAN health strategy in addressing the health of documented migrants

The ASEAN Post-2015 Health Development Agenda's mission statement is to promote a healthy and caring ASEAN community, where people achieve full health potential through a healthy lifestyle, have universal access to quality health care and financial risk protection; have safe food and healthy diets, and live in a healthy environment with sustainable inclusive development where health is incorporated in all policies. To succeed in the new health agenda, ASEAN has developed goals and lists of health priorities. Specifically, Health Cluster 3, "Strengthening Health systems and Access to Care," listed migrants' health as a priority.

ASEAN Health Cluster 3 (AHC 3) Goals:

1. To provide the ASEAN Community with universal access to safe, affordable, quality, holistic health care and essential medical supplies, including traditional and complementary medicines;
2. To advance health care deliveries by adapting and working towards innovation and digital health technology.
3. To promote health care delivery to vulnerable populations, such as women, children and migrant workers, among others.

AHC 3 Programme Objectives:

1. To ensure people's continuous access to safe, affordable and quality of health care goods and services by improving strategies to achieve UHC.
2. To enhance health systems resiliency at the regional level to complement national interventions on UHC, HRH, health financing, pharmaceutical development and T&CM.
3. To ensure adequate level of health resources which include financial and HRH
4. Enhance health systems' capacity and capability to seek to improve services for documented migrants and including migrant workers, mothers/women and children (special populations).

AHC 3 Indicators and Targets:

Theme 1: ENTITLEMENT/ACCESS TO AFFORDABLE PACKAGE OF GOODS AND SERVICES (end-user perspective)

By 2025:

1. Increase in insurance coverage (% of total pop) is reached based on 2019 ASEAN UHC report

Theme 2: AVAILABILITY AND QUALITY OF CARE (provider perspective)

By 2025:

2. Regional interventions to promote UHC including health financing are increased.
3. Regional interventions to promote HRH, adequate levels of HRH and financing are implemented based on lessons learned from health system challenges during the COVID-19 pandemic.
4. Regional pharmaceutical development interventions on Rational Use of Medicines, Drug Price Transparency and Anti-toxin, Antidote, anti-poison are implemented.
5. Implementation of regional action plans and programmes on ASEAN Vaccine Security and Self-Reliance, ASEAN Drug Security and Self-Reliance and combating Substandard and Falsified Medicines are ensured and documented in the ASEAN Comprehensive Recovery Framework and its Implementation Plan
6. ASEAN Pharmaceutical Regulatory Policy / ASEAN Pharmaceutical Regulatory Framework have been

developed collaboratively by AHC 3 and Pharmaceutical Product Working Group and endorsed.

7. AMS capacities and capabilities of ASEAN Member States (AMS) on T&CM are improved
8. Secured Health Information System and Knowledge Management Platform are populated with relevant and timely health data, regional data/information for use of AMS.
9. AMS capacities on use of digital health technology for supporting the health system and improve access health care are improved.

Theme 3: SERVICES FOR SPECIAL POPULATIONS

By 2025:

10. AMS policies and interventions on reproductive, maternal, neonatal and child health is complemented by regional policies and capacity building interventions.
11. AMS have benefit packages for documented migrants including migrant workers and special populations guided by the ASEAN Consensus and according to the ASEAN Framework on Health Coverage of Documented Migrants including migrant workers and special populations.
12. Health research agenda on special populations is implemented.

Section 5:

MIGRATION HEALTH PROFILES IN ASEAN COUNTRIES

5.1 Brunei Darussalam

5.1.1 Country profile

On 8 January 1984, Brunei Darussalam joined ASEAN as the smallest country in ASEAN, both in terms of population (459,500) (27) and land area (5,765 km²) (28). The two main ethnic groups of its population are Malay (65.7%) and Chinese (10.3%). Brunei Darussalam is a multilingual (Bahasa Melayu, English) and multireligious (Islam, Buddhism, Christianity, others) nation.

Brunei Darussalam has the highest rates of macroeconomic stability in the world and is the second richest country in the ASEAN region with a GDP per capita (as of 2011) at USD 38,703, coming only after Singapore. Its inflation rate is the lowest in the region at 0.1 per cent in 2018.

5.1.2 Migrant profile

The documented migrant population in Brunei Darussalam was 72,713 in 2019; most were in low-skilled (35.1%), service and sales (17.7%), and semi-skilled occupations (16.7%). In the industry sector, 30.1 per cent were in construction; 17.5 per cent in wholesale and retail trade, repair of motor vehicles and motorcycles; 12.6 per cent in accommodation and food service activities; and 12.3 per cent in manufacturing.

Table 7 Migrant profile of Brunei Darussalam

Category	Number/Type
Documented migrant workers (inbound)	71 713
Occupation of documented migrant workers	Low-skilled (e.g., general workers, domestic workers) services and sales, semi-skilled
Migrant stock by origin	Indonesia, Bangladesh, Philippines, India, others

Source: Labour Department, Ministry of Home Affairs, Brunei Darussalam

(a) International migration (inbound)

Documented non-citizen migrant workers are adequately covered with workmen compensation insurance. Employers of non-citizen documented employed migrants are required to pay for the workmen compensation insurance (under Workmen Compensation Act Rev 1984) and medical insurance coverages for the prospective employed migrants when they register with the Labour Department, Ministry of Home Affairs. However, adequate full medical insurance coverage is lacking, both for employees and their dependents.

5.1.3 Health governance

(a) Legal and policy frameworks

Documented non-citizen migrant workers are adequately covered with workmen compensation insurance. Employers of non-citizen documented employed migrants are required to pay for the workmen compensation insurance (under Workmen Compensation Act Rev 1984) and medical insurance coverages for the prospective employed migrants when they register with the Labour Department, Ministry of Home Affairs. However, adequate full medical insurance coverage is lacking, both for employees and their dependents.

Table 8. Legal and policy frameworks in Brunei Darussalam

National Legislation	International Legislation
Employment Order, 2009	Universal Declaration of Human Rights, 1948
Workmen Compensation Act, 1984 (Rev)	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979
Workplace Safety and Health Order, 2013 (Rev)	Convention on the Rights of the Child, 1990
Anti-Trafficking in Persons Order, 2019	International Health Regulations, 2005

(b) Focal point within the Ministry of Health

- Occupational Health Division, Department of Environmental Health Services;
- Department of Policy and Planning.

(c) Focal point within other offices/agencies outside the Ministry of Health

- Labour Department, Ministry of Home Affairs;
- Department of Immigration and National Registration, Ministry of Home Affairs.

5.1.4 Health financing

The country's total health expenditure is 2.27 per cent of the GDP (29). Basic health services including primary health-care services, maternal and child health services including vaccinations, and health care for diseases of epidemic potential are provided to citizens free of charge through the Ministry of Health.

5.1.5 Health service delivery

(a) Health services available for documented migrants

Health services for documented migrants are provided through government funding, private health insurance and out-of-pocket payments. Information and data on the annual premium requirement and the number of immigrants enrolled in health insurance schemes are not available. As well, on enrolment criteria are not available.

According to data gathered through the data collection tool and the country presentations, documented migrants are covered through private health insurance and the government's health system for primary health care, inpatient care and emergency care.

However, data on utilization rates and type of payment mechanisms used by documented immigrants are not available. Documented migrants pay out-of-pocket for services (consultations, diagnosis and treatment) related to non-communicable diseases such as cancer, hypertension, diabetes mellitus, respiratory diseases, mental health disorders, sexual and reproductive health services and occupational health services when they are seen in a public or private health facility. Consultations for emergency care in a government health facility are provided free of charge; however, diagnostic services and treatment will be out-of-pocket expenses.

Dependents of documented migrants are covered under private health insurance if they are enrolled through individual payments. Dependents and family members of documented migrants can obtain health services through the government health system or at private health facilities if evidence of registration is provided (Identity Card issued by the Department of Immigration and National Registration). However, these services are not transferrable abroad, and consumers will not be able to obtain such services when they are out of the country.

5.1.6 Health information system

The Department of Policy and Planning of the Ministry of Health in Brunei Darussalam has the responsibility of updating and storing the data on health services for documented migrants who are seen in government health facilities. The Department of Immigration and National Registration of the Ministry of Home Affairs is responsible for registering and issuing such national identity card. The department is in the process of establishing an electronic intergovernmental system to collect, store and disseminate data pertaining to documented migrants.

5.1.7 Key challenges in implementing migrant health care

- Although there is a national legal requirement for employers to obtain workmen compensation insurance and medical insurance for the migrant workers for the duration of their employment, not all employers obtain such coverage.

- Lack of an effective information system on insurance coverage for documented migrants.
- Data on documented migrants disaggregated by their direction of migration, that is, whether they are outbound (citizens leaving the country) or inbound (non-citizens residing within the country) are not available. Therefore, ascertaining the service coverage (accessibility and the affordability) for documented migrants is difficult.
- Available data is mainly on migrant workers. Data on other categories of migrants such as students and family members (dependents) are not available.
- Data on health governance primarily consists of a listing of few international organizations such as ILO, the World Health Organization (WHO) and other United Nations (UN) agencies and ASEAN. Commitments to specific international, regional and domestic legal and policy frameworks are not available.
- Documented migrants can seek health care from either a government or a private health facility. However, due to lower costs, documented migrants tend to seek health care from public health-care facilities.
- Emphasis on gathering empirical evidence on health issues of documented migrants is recommended as an immediate priority to ensure evidence-based programme and policy planning.

5.1.8 Additional notes

Close collaboration with other government institutions such as the Labour Department and Department of Immigration and National Registration (Ministry of Home Affairs) is required to ensure that all documented migrants including their dependents have adequate coverage for workmen insurance and medical insurance.

5.2 Cambodia

5.2.1 Country profile

Cambodia is reported as the fastest growing economy amongst the ASEAN Member States. With a steady economic growth of around 7 per cent in recent years, which was forecasted to continue in 2019, Cambodia is on a steady path of economic improvement (30). In 2018, the garment industry and tourism sector contributed most to the economic performance of the country. With its proximity to China, Cambodia – along with Thailand and Viet Nam – Cambodia has also become an attractive destination for investors. Cambodia's Special Economic Zones heavily attract foreign investments, especially along the border areas.

5.2.2 Migrant profile

With Cambodia's rapid development, an increasing population mobility has been observed in the country. This population movement is dominated by internal migration, with around 4.1 million migrants reported in 2013. International migrants accounted only for 2.6 per cent of the total migrants within Cambodia.

Table 9. Migrant profile of Cambodia

Country	Number
Country or area of origin	
Viet Nam	37 225
Thailand	31 472
China	1 550
France	281
Lao PDR	265
Country or area of destination	
Thailand	750 109
United States	173 462
France	62 289
Australia	33 616
Canada	23 344

Source: United Nations, International Migration Report 2017.

(a) Internal migration

In 2013, 97.4 per cent of all migrants were internal migrants. Internal migration is predominantly rural-to-rural (58.4%) and only 24.5 per cent of internal migrants had migrated from rural to urban areas, mainly to Phnom Penh, which receives half of all of Cambodia's rural migrants, followed by other economically active provinces such as Siem Reap, Battambang and Kampong Cham. Most (>98%) garment factory workers in Phnom Penh moved from other parts of the country with 85 per cent being females of reproductive age (19–40 years) (31).

Of the 7.2 million employed persons in the country, around 5.9 million (81%) work in the informal sector and only around 18 per cent (1.3 million) work in the formal sector. Closer to 1 per cent (75,729 persons) are employed in a household.

(b) International migration (outbound)

According to United Nations Department of Economic and Social Affairs 2017 statistics report, approximately 1.1 million Cambodians live overseas. Thailand ranks as the primary destination with 750,109 Cambodian migrants (72% of all Cambodian international migrants) while the Republic of Korea ranks second. Malaysia (for domestic workers), Japan, Singapore, Hong Kong, Qatar, Saudi Arabia and Kuwait are some other popular destinations for Cambodian migrants.

Of those Cambodians migrating to Thailand, less than 10 per cent use regular channels under the MoU between the two countries. As of June 2018, 226,452 Cambodian migrant workers in Thailand were registered under the MoU and 148,109 workers under the national verification criteria. Approximately half of them were from three provinces: Siem Reap, Battambang, and Banteay Meanchay.

Cambodian outbound migrants are predominantly employed in “3D” jobs (dirty, difficult and dangerous) in agriculture, livestock, construction, manufacturing, fishing and service industries sectors.

(c) International migration (inbound)

Cambodia aims to achieve middle-income country status in the next twelve to fifteen years, and with rapidly rising minimum wages in the country, it is also becoming a country of destination (32) attracting migrants from neighbouring countries, predominantly China, Thailand, Viet Nam and Lao People's Democratic Republic. According to the United Nations Children's Fund (UNICEF) migration profile (32), there were around 70,793 foreign migrants in Cambodia in 2013. Information about their employment, health condition, access to health care and their occupation in Cambodia is scarce.

5.2.3 Health Governance

(a) Legal and policy frameworks

Cambodia has a robust health governance structure, as numerous legal frameworks pertaining to migrant workers health and rights have been implemented.

Table 10. Legal frameworks in Cambodia

Laws	Subdecree	Prakas	Memorandum of Understanding (MoU)	Regional legal frame-work
<p>Cambodia's 1993 constitution guarantees human rights for all Cambodian people including the rights to social and health-care services without discrimination.</p> <p>The Labour Law of 1997 requires all business enterprises to provide health protection to workers, including include hygiene, health safety, nursing care and treatment.</p> <p>In 2002, the parliament adopted the Social Security Law, which mandates the introduction of a contributory social insurance system.</p> <p>In 2005, Cambodia ratified the Constitution of IOM.</p>	<p>In August 2011, subdecree No. 190 (Management of the Sending of Cambodian Workers Abroad through Private Recruitment Agencies)</p> <p>In 2007, the Prime Minister signed a subdecree to establish the National Social Security Fund.</p> <p>In 2016, the Prime Minister signed a subdecree to expand health coverage under the National Social Security Fund to cover health prevention, medical care and daily allowance for medical leaves due to treatment or other non-occupational accidents and maternity leave.</p>	<p>In 2017, Prakas No. 448 on the Registration of Enterprises, Establishments, and Workers in the National Social Security Fund. The Prakas is applicable to enterprises, establishments, and workers including those with only one worker, and whether they are created for public, semipublic, or private interests.</p> <p>In 2017, Prakas No. 404 on the implementation of health care scheme through a health equity fund system for informal workers and provision of an additional allowance for female workers when they give birth.</p> <p>In 2017, Prakas No. 17/049 on the inclusion of health prevention services in social security schemes on health care. These health prevention services cover rabies vaccination, antirabies serum, antitetanic serum, antivenom immunoglobulin, blood tests for goiter for cancer. These health prevention services shall be granted by public health facilities or public institutes.</p>	<p>In 2003, Cambodia and Thailand signed a MoU on Cooperation in the Employment of Workers. In 2015, the MoU was revised to broaden the cooperation on labour issues to include skills development and reemployment.</p> <p>In 2015, Cambodia and Malaysia signed two MoUs for sending general workers and domestic workers to Malaysia, lifting the suspension of recruitment agencies sending domestic workers to Malaysia that had been in place since 2011.</p> <p>An agreement on the recruitment of domestic workers and general workers was also signed with Saudi Arabia in February 2016 but no timeline has been set for implementation.</p>	<p>In 2007, heads of states from ASEAN signed a declaration on the Protection and Promotion of the Rights of Migrant Workers.</p> <p>In 2017, the leaders of the ASEAN signed the Consensus on the Protection and Promotion of the Rights of Migrant Workers. The consensus obliges both sending and receiving states to share responsibilities to support and protect migrant workers.</p>

(b) Multistakeholder collaboration

Collaboration of all relevant stakeholders is required to ensure the protection of migrant health at all steps of the migration process, from the recruitment to the returning stage. Migrants should be well informed about access to health and health information, insurance options in destination countries and their health rights. Providing access to such information requires an effective collaboration among recruitment agencies, unions, civil society organizations, employers and the Ministry of Labour and Vocational Training. Stakeholders have their own strategies as well as priorities in addressing health challenges faced by migrants. For example, the National Social Security Fund provides health insurance, while sexual and reproductive health programmes are implemented mainly by the national sexual and reproductive programme, with support from partners such as the Reproductive Health Association of Cambodia.

A mechanism should be set up to ensure coherence and coordination of interventions across sectors. Such coordination can be achieved by establishing a national technical working group under the leadership of the Department of Hospital Services, Ministry of Health. This group would have the mandate to develop a migrant health policy and an action plan, to coordinate all health-care services activities for migrants, to mobilize resources to implement the action plan, and monitor and evaluate the activities.

5.2.4 Health financing

Cambodia has a wide variety of health-care providers. According to the World Bank, total health expenditure in 2018 was 5.8 per cent of the GDP.

5.2.5 Health service delivery

The large number of private health-care providers are loosely regulated. While the public sector is dominant in activities for the promotion of essential reproductive, maternal, neonatal and child-care health, and major communicable diseases control, private practitioners remain particularly frequented for curative care. According to the 2010 Cambodian Demographic and Health Survey, only 29 per cent of patients first sought care in the public sector, while 57 per cent sought care for their last ailment in the private sector. While government funding for health care has increased significantly, it remains at 1.4 per cent of the GDP. Official development assistance is stable at 20–15 per cent of total health expenditure. Out-of-pocket payments constituted 61 per cent of the total health expenditure. National data indicate that an overwhelming proportion of the out-of-pocket expenditure is paid to private providers. Several demand-side financing schemes provide social health protection, including Health Equity Funds, voucher schemes, voluntary community-based health insurance and, to a lesser extent, private health insurance.

(a) Health services available for documented migrants (outbound migrants)

Migrants who travel out of the country are found to have poor and unhygienic living conditions, with limited access to health-care services and lack of health insurance coverage. No health insurance scheme exists for Cambodian migrant workers except for those residing in Thailand as registered migrant workers. Information on health services available for Cambodian migrants in other countries such as Japan and Korea is scarce. Although migrant workers are generally healthy, they are still facing a wider range of health conditions that could be attributed to poor living conditions and nutrition. Cambodian outbound migrant workers are usually low-skilled or unskilled and heavily involved in dirty, difficult and demeaning jobs, which further contributes to ill health. Employers show little concern for occupational safety of migrant workers and rarely provide proper safety equipment.

However, based on the immigration requirements of the country of destination, some Cambodian migrants are required to undergo pre-departure or upon-arrival health assessments. For instance, Cambodian migrants who depart for Thailand and who register for a work permit are required to pass a health screening for seven diseases/health conditions (TB, malaria, elephantiasis/filariasis, syphilis, leprosy, substance addiction/alcoholism, and intestinal worms). For Japan, HIV, hepatitis and drugs check are also required in addition to basic physical, eye and TB checkups. In the Republic of Korea, only the Department of Occupational Safety and Health provides health checks for migrants, while Malaysia conducts health assessments through designated panel physicians at both pre-departure and upon-arrival stages.

Information on health access and affordability or insurance schemes available for outbound migrants by the country of origin or destination could not be ascertained.

- o Some Cambodian migrants who leave the country for long-term stay in some countries of destination such as Australia, Canada, Malaysia, New Zealand and the United Kingdom of Great Britain and Northern Ireland undergo pre-departure or upon-arrival checks based on the immigration requirements of the countries of destination. The Government of Cambodia does not require any such pre departure health assessment for outbound migrants.
- o Prakas of Notice of Work-Related Accidents, Compensations and Invalidity cover all national and international workers who have contracted with any employer.
- o The Department of Labour Health provides orientation programmes for outbound migrants, which covers common hazards in workplace and how to prevent them, first aid and infectious diseases.
- o Although no dedicated migrant resource centres that aid potential outbound migrants are available, they can seek assistance at the Department of Labour Health, Ministry of Labor.

(b) Health services available for documented migrants (in-bound migrants)

- o Cambodia does not make any form of health assessment mandatory upon arrival or prior to departure for its inbound migrants arriving from other countries.
- o The country's labour Law (Chapter 8); Prakas of Notice of Work-Related Accidents, Compensations, and Invalidity applies for both citizens and non-citizens in the country.
- o There is no rule or regulation that forces employers to provide health insurance for their migrant workers, and provision of health insurance depends on each employment contract.

(c) Health services available for international migrants

Migrant workers have limited access to health services in Cambodia, especially for those who work in the informal sector and are not registered with the national social security fund. Health status, health service availability and affordability for foreign nationals in Cambodia is scarce and in rare supply.

5.3 Indonesia

5.3.1 Country profile

Indonesia considers itself the primus inter pares within ASEAN, based on its territorial dimension, strategic location at one of the world's busiest shipping lanes (the Strait of Malacca), its population, vast domestic market, and historical role as a founding member of the organization. With over 16,056 islands and a total population of 266,911,900, Indonesia is the fourth most populous country in the world. The country has an approximate population growth rate of 1 per cent, with a population density of 140 people per square kilometer.

5.3.2 Migrant profile

Table 11. Migrant profile of Indonesia

Types of migration	Number
Documented immigrants	157 792 (from top 5 countries of origin in 2013) (34)
Cumulative emigrant in 2018	2 989 306 (35)
Migrant worker by destination	1) Malaysia (77 888), 2) Taiwan, China (282 167), 3) Hong Kong (152 532), 4) Singapore (67 626), 5) Saudi Arabia (48 617), 6) Brunei Darussalam (30 034). By AMS as destination: Brunei Darussalam (30 034), Cambodia (4), Lao PDR (2), Malaysia (359 244), Myanmar (19), Philippines (49), Singapore (67 626), Thailand (113), Viet Nam (23) (36)
Migrant stock by origin	1) China (63 172), 2) Republic of Korea (27 907), 3) United Kingdom of Great Britain and Northern Ireland (27 351), 4) Timor Leste (19 681), 5) Singapore (19 681) (34)
Migrant workers by origin	1) China (29 575), 2) Japan (13 718), 3) South Korea (9 912), 4) India (6 666), 5) Malaysia (4 719), 6) Australia (2 651), 7) Philippines (3 439), 8) United States (2 513), 9) United Kingdom (2 117), 10) Singapore (1 968)
Occupation of documented migrants (emigrants)	1) Domestic worker: 239 803, 2) caregiver: 131 337, 3) plantation worker: 119 673, 4) operator: 95 014, 5) worker: 64 943
Occupation of documented migrants (immigrants)	1) professional: 27 451, 2) manager: 21 060, 3) director 16 371, 4) advisor/consultant: 13 498, 5) technician: 10 034, 6) commissioner: 2 256, 7) supervisor: 2 223
Occupational-related injuries	1) illness (105), 2) abuse (24), 3) human trafficking (25), 4) withholding of passports or other documents (26), 5) accident (6), 7) escaped from the employer (3), 8) death (13). These data are available in the Manpower Social Security Organizing Agency (BPJS Ketenagakerjaan).
Deported migrant workers	250 293
Inflow of remittances	USD 5.81 billion

5.3.3 Health governance

(a) Legal and policy frameworks

Indonesia has a robust health governance structure, as numerous legal frameworks pertaining to migrant workers' health and rights have been implemented.

Table 12. International legal and policy frameworks of Indonesia

International	Regional	MoUs (kindly check with Ministry of Manpower Indonesia for more complete MoU since Indonesia only send documented Migrant Workers to Countries that already have MoUs)	National policies
Discrimination (Employment and Occupation) Convention 1958 (1984))	ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers(1984)	<p>MoU between Indonesia and Malaysia on the recruitment and placement of Indonesian domestic workers – signed on 13 May 2016</p> <p>Both parties agreed on the list of issues and currently in the process of renewal of the MoU</p>	<p>Law No. 18 Year 2017 on The Protection of Indonesian Migrant Workers</p> <p>Law No. 13 Year 2003 on Manpower</p> <p>Law No. 36 Year 2009 on Health</p> <p>Law No. 40 Year 2004 on National Social Security System</p> <p>Law No. 21 Year 2007 on Extermination of Human Trafficking</p> <p>Law No. 39 Year 1999 on Human Rights</p> <p>Law No. 39 Year 2004 on the Placement and Protection of Indonesian Overseas Workers and its Implementing Regulations</p> <p>Law No. 21 Year 2007 on Against Trafficking of Migrant Workers</p> <p>Law No. 11 Year 2009 on Social Welfare</p> <p>Law No. 24 Year 2011 on Social Security Administrator</p> <p>Law No. 1 Year 1970 on Work Safety</p> <p>Law No. 47 Year 2016 on Health Service Facilities</p> <p>Ministry of Foreign Affairs Regulations No. 8 Year 2008 on Citizen Service in Indonesian Missions abroad</p>
Equality of Treatment (Accident Compensation) Convention	ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers	MoU between Indonesia Brunei Darussalam in the Field of Health Cooperation	

International	Regional	MoUs (kindly check with Ministry of Manpower Indonesia for more complete MoU since Indonesia only send documented Migrant Workers to Countries that already have MoUs)	National policies
Promotional Framework for Occupational Safety and Health Convention	ASEAN Convention Against Trafficking in Persons, Especially Women and Children	Joint Declaration of the Indonesia and the Philippines on the Protection of Migrants and Migrant Workers	
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families		Mandatory Consular Notification agreement between Indonesia and Brunei Darussalam (2011) and the Philippines (2014) to ensure prompt notification in case of arrest, detention, death or legal problem facing citizens of respective countries. Mandatory Consular Notification is also addressed within bilateral agreement	
Protocol Against the Smuggling of Migrants by Land, Sea and Air			Law No. 21 Year 2007 on Extermination of Human Trafficking
Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime, 2000			Law No. 21 Year 2007 on Extermination of Human Trafficking

(b) Bilateral Labour Agreements

- o MoU between Indonesia and Malaysia on recruitment and placement of Indonesian domestic workers – signed on 13 May 2016. Both parties agreed on the list of issues and currently in the process of renewal of the MoU;
- o MoU between Indonesia and Brunei Darussalam in the Field of Health Cooperation;
- o Joint Declaration of Indonesia and the Philippines on the Protection of Migrants and Migrant Workers.

(c) Focal point within the Ministry of Health

- Directorate of Occupational and Sports Health as the coordinator for migrant health;
- Port Health Office as the technical unit of the Ministry of Health at points of entry;
- Directorate of Referral Health Services as focal point for health services for migrants;
- Bureau of International Cooperation as the coordinator for international cooperation in health (agreement, manage international relations/ cooperation).

(d) Focal point within other offices/agencies outside the Ministry of Health

- Ministry of Manpower;
- National Body on the Placement and Protection of Migrant Workers;
- Ministry of Social Affairs;
- Ministry of Foreign Affairs;
- Ministry of Law and Human Rights.

5.3.4 Health financing

Indonesia's health services are mainly financed through Social Health Insurance (SHI), which covers 17.3 per cent of all users of health-care services. Social health insurance is subsidized by the government at 23,000 Indonesian rupees/month/capita. Other mechanisms of health financing exist, such as Private Health Insurance and Health Maintenance Organizations which cover 3.2 per cent of users; public national and local agencies, 31.5 per cent; private sector, not-for-profit sector, 13 per cent; out-of-pocket payments, 35 per cent. Social security is a form of social protection to ensure that all people can fulfill their basic needs for a decent life. The health insurance scheme is mandatory for all, including migrants. BPJS Kesehatan, the Manpower Social Security Organizing Agency, is the public legal entity that has the duty to organize national health insurance for all Indonesians. All residents, including non-citizens who work for at least six months in Indonesia, and who have paid contributions can enroll in this scheme.

Social health insurance covers the consultation and diagnosis of most communicable diseases including malaria, HIV, TB, hepatitis and diseases of epidemic potential. This insurance also provides adequate coverage for maternal and child health and non-communicable diseases such as cancer, hypertension, diabetes, mental health conditions and occupational health and safety.

No published data are available on the number of documented immigrants and emigrants enrolled in social health insurance. Financing mechanisms for documented immigrants cover primary health care, inpatient care and emergency care through occupational health-related insurance. Occupational injuries insurance is

included in the employment contract, while health-care services insurance is based on agreements between workers and their employers.

However, the coverage is not transferrable to other countries, and therefore the services can be obtained only within Indonesia. Generally, health coverage is provided for the dependents of registered migrant workers.

Table 13. The estimated population covered by types of health insurance (2018) in Indonesia

Type of Insurance	Members (in Millions)
Civil Servant Health Insurance	15.6
Military/ Police Health Insurance	2.9
National Medicaid Programmes (covered by Ministry of Health)	92.3
Workers' social security scheme	27.9
Local Government Medicaid Programmes (covered by various regional governments)	25.1
Corporate Insurance (self-insured)	27.6
Commercial Health Insurance	5.1
Total	196.7

Source: Center for health financing, Ministry of Health, Republic of Indonesia

5.3.5 Health service delivery

Table 14. Health-care use in Indonesia

Type of healthcare	Proportion
a. Primary care	70.33/1 000
b. Inpatient / Hospitalization	Inpatient: 4.42/1,000 Outpatient: 28.68/1 000
c. Emergency care	Outpatient and Emergency: 31.59/1 000

Source: BPJS Kesehatan, 2016

Workers should also be covered by the Manpower Social Security Organizing Agency, a public legal entity whose mandate is to protect all workers through four employment social security programmes: a) accident insurance; b) pension plan; c) pension guarantee; and d) life insurance. Employers are obliged to ensure their own enrollment and that of their employees, including their families, as participants of the Manpower Social Security Organizing Agency in accordance with the Social Security programme.

5.3.6 Health information system

- Data and information about migration are available and can be accessed at The Ministry of Law and Human Right Commission, Directorate General of Immigration.
- Data on migrant workers can be accessed at the Ministry of Manpower and the National Body on the Placement and Protection of Migrant Workers.
- Country profiles can be obtained from the Indonesian Central Bureau of Statistic.
- Information on SHI can be obtained from Indonesia's social security agencies (BPJS Kesehatan)

and BPJS Ketenagakerjaan).

- Specific data on migrant workers are captured by the Ministry of Manpower and Transmigration & National Body on the Placement and Protection of Migrant Workers.

5.3.7 Key challenges in implementing migrants' health

- The Indonesian social health insurance providers do not coordinate with overseas providers. For Indonesian outbound migrants, health insurance is provided based on individual employment contracts.
- In case of an emergency, for migrants who have no health insurance or for those who cannot verify the employment status or their employment contracts, emergency health services are provided in coordination with representatives of the country of origin. In such cases, the payments for the emergency health services are facilitated by the country of origin. Available data do not provide adequate details on the operational aspects of this mechanism.
- While expatriates can be treated in local public hospitals, doctors and staff will most likely be Indonesian and there can be no guarantee that they will speak English, so communication may be an issue. For foreigners who do not contribute to national health insurance scheme, doctors and public hospitals will likely expect payment in cash up front. For these reasons, expatriates in Indonesia tend to opt for private health care, which is relatively expensive but offers far better facilities and coverage.
- Health insurance coverage for all Indonesian migrant workers is yet to be regulated and still operates as a voluntary system. However, the occupational health insurance is compulsory for migrant workers.

5.3.8 Recommendations

- Indonesia recommends ASEAN to establish a regional platform that engages in consultation and negotiation to handle health issues of migrant workers as part of implementing the ASEAN guideline on health protection. Such platform could be a technical body or regional consultation forum that consists of focal points from each ASEAN Member State and reports to ASEAN Health Cluster 3 and the ASEAN Senior Officials Meeting for Health Development on the progress of the implementation of the ASEAN consensus and health protection of ASEAN migrants, including the self-assessment tool related to the health of migrant workers. The ASEAN Senior Officials Meeting for Health Development will engage in collaboration with the other relevant ASEAN bodies.
- To encourage countries to alter the eligibility criteria of the national SHI to include migrant workers and to establish regional SHI for migrants.
- Health services for emergency lifesaving purposes should be accessible and affordable to all ASEAN people, regardless of their status. A potential effective mechanism should be discussed, and a social scheme might be applied.

5.4 Lao People's Democratic Republic

5.4.1 Country profile

Lao People's Democratic Republic is one of the fastest growing economies in East Asia and Pacific. It is a landlocked country located in the heart of the Indochina peninsula of South-East Asia and shares borders with Cambodia, China, Myanmar, Thailand and Viet Nam. The country covers 236,800 square kilometers of land and its population as of 2020 is 7,123,100. Recently, the Government of Lao People's Democratic Republic has claimed itself to be a 'land-linked' country, to reflect economic development and the many efforts to improve links to other countries in the region, including through building bridges.

According to UNDP, around 68 per cent of Lao People's Democratic Republic population is still living in rural areas. Although it is a least developed country, Lao People's Democratic Republic has made significant progress in poverty alleviation over the past two decades, with poverty rates declining from 46 per cent in 1992 to 23 per cent in 2015 and it has achieved Millennium Development Goal target of halving poverty. The country has improved access to electricity, schools and roads, and has become an important energy exporter in the region.

5.4.2 Migrant profile

Table 15. Migrant profile of Lao People's Democratic Republic

Type of migrant	Number
Documented migrants	22 260
Female migrants	5 569
Documented migrant workers	22 260
Occupation of documented migrant workers	Health and beauty treatment provider, engineer, miner, financing, international auditor, agriculture, industry service sector, etc.

Patterns of migration in Lao People's Democratic Republic are complex across all types of migration including internal, inbound and outbound flows of migrant workers. On average, about 25,000 young people (15–18 years) enter the labour market each year and only around 6 per cent of the workforce were paid employees in formal sector; the vast majority were self-employed or worked in the informal sector. More men than women migrated internally. Among the population of internal migrants, 42.5 per cent migrated to the Vientiane capital.

Limited availability of economic opportunities in Lao People's Democratic Republic has forced the majority to seek employment overseas. Financial remittances from migrant workers is a significant source of income in Lao People's Democratic Republic and an estimated USD149 million were received in remittances in 2018 (41).

More women sought international migration than men, while 21.4 per cent of the total number of international migrants leaving the country were younger than 18 years. Thailand is the most sought-after destination, with 81.5 per cent of migrants from Lao People's Democratic Republic residing there. A revised MoU between Thailand and Lao People's Democratic Republic was signed in 2016, broadening a previous agreement on labour migration to include cooperation on social security and skills development. However, maybe due to the lack of clarity about the legality of regular recruitment and placement for domestic workers, many Laotian women seek economic opportunities and jobs in Thailand through informal and illegal recruitment networks.

(a) International migration (outbound)

According to UNICEF, about 1.2 million Lao nationals are overseas, mainly in Thailand, the United States, Bangladesh, France and Canada (42).

(b) International migration (inbound)

In 2013, there were 17,596 foreign nationals in the country, of which 65 per cent were from Viet Nam.

Table 16. Migration by country of origin and destination of Lao People's Democratic Republic

Country	Number
Country or area of origin	
Viet Nam	11 447
China	3 014
Thailand	1 652
Myanmar	1 201
Country or area of destination	
Thailand	926 427
United States	196 959
Bangladesh	86 526
France	41 914
Canada	16 565

5.4.3 Health Governance

The health ministry /National Health Insurance Bureau operates as the national focal point for migration health-related issues in Lao People's Democratic Republic. The National Social Security Organization facilitates the process.

The health-care system in Lao People's Democratic Republic is government-owned, with three administrative levels: central (Ministry of Health), provincial (provincial health offices) and district level (district health offices).

5.4.4 Health Financing

Despite progress on the national front, not all population groups benefit from improvements in health care. The disease burden from non-communicable diseases has surpassed that of communicable diseases. With its robust economic growth in the past decade and preparation to graduate from a least developed country to an upper-middle-income country by 2030, Lao People's Democratic Republic also expects to face declining funding from external sources.

The country is targeting to achieve UHC by 2025 but facing challenges in financing UHC initiatives in a fiscally sustainable manner. Out-of-pocket spending is the largest source of health financing, with 45.1 per cent of health spending financed by households in 2016. The health share of 6 per cent of the national budget is

low compared to other countries in the region, and health financing depends on external sources for some priority health programmes such as for tuberculosis, malaria, and immunization response.

Four prepayment schemes were gradually launched in the 2000s: (1) Social Security Organization for private employees as part of a comprehensive social security scheme that is mandatory by law; (2) State Authority for Social Security for civil servants; (3) Community-Based Health Insurance for non-poor workers in the informal sector; and (4) a Health Equity Fund for the poor population groups.

Community-Based Health Insurance covered only 10 per cent of the target population, amounting to just 2.4 per cent of the national population.

5.4.5 Health service delivery

(a) Health services available for documented migrants

- Financing mechanisms cover documented immigrants if they pose an identification or social protection cards. Coverage includes primary health care, emergency health care and inpatient care for migrants and their dependents (spouse and children). Provision for health financing is in place in employment contracts for health care services and occupational-related injuries (premium payer/health benefit package). However, the number of formal employees with employment contract is low.
- All migrant workers should also have their own Private Health Insurance Card from the country of origin or country related to their insurance company. In Lao People's Democratic Republic, they can obtain services in public and private health facilities for any health condition. The cost of health services received will be reimbursed by the migrant worker's company. In case of emergency care where the patient needs to be managed by a hospital in a neighbouring country, patients with lower and middle health insurance coverage will have to pay by out-of-pocket money; the internal health service in Laos People's Democratic Republic (public and private) will collaborate with the insurance company to facilitate the referral process for those with high insurance coverage.

Table 17. Health service utilization rate by documented migrants of Lao People's Democratic Republic

Type of healthcare	Proportion
a. Primary care	0.51 case/head/year
b. Inpatient / Hospitalization	0.04 case/head/year
c. Emergency care	0.26 case/head/year

Source: BPJS Kesehatan, 2016

5.4.6 Health information system

The Ministry of Health is responsible for health information. Specific information on migrant workers such as demand labour market, vocational training, providing employment in internal and external departments of the ministry, and registration required to work, are covered by the Ministry of Labour and Social welfare.

5.4.7 Key challenges in implementing migrant health

- Sources of payment for the social health insurance coverage of migrant workers in the country are not clear. No legal or immigration requirement stating that employers should obtain health insurance for all migrant workers could not be found in the details of coverage of the health insurance. Information to whether the insurance covers all health conditions including chronic diseases and mental health conditions, or whether it provides coverage throughout the stay in the country could not be found.
- No multisectoral coordination seems to exist to address migrants' health issues.
- The health profile of outbound migrants can be accessed through the pre-departure or upon-arrival health assessment providers according to the requirements of each destination country.

5.5 Malaysia

5.5.1 Country profile

Malaysia joined ASEAN on 8 August 1967 and remains the third largest source of outward investment within the region, with USD 5.3 billion. With its strategic location in the Asia-Pacific rim between continental and island Asia, Malaysia is considered an economic hub and gateway between the China Sea and the Indian Ocean. Its robust economy with diverse labour-intensive sectors, continues to attract overseas migrants, and Malaysia has become one of the most sought-after countries of destination. International migrant workers constitute 15 per cent of the country's labour force and the Ministry of Home Affairs estimates that 3.3 million documented migrants live in the country. Malaysia's economy continues to accelerate, recording a 4.9 per cent growth in the second quarter of 2019 and cross-border migration is predicted to continue with an upward trajectory.

5.5.2 Migration profile

Table 18. Migration profile of Malaysia

Migrant type	Number	Data source	Year
Documented migrants	918 883	Foreign Workers Medical Examination Monitoring Agency (FOMEMA)	2017
Female migrants	439 404	Foreign Workers Hospitalization and Surgical Insurance Scheme (SPIKPA) Data (Ministry of Health)	2016
Migrants younger than 18 years	28	SPIKPA Data (Ministry of Health)	2016

Source: United Nations, International Migration Report 2017.

The demand for low-skilled labour in Malaysia is largely filled by immigrant workers. Common occupations of documented migrant workers are manufacturing (48%), construction (23%), services (19%), farming (7%) and plantation (1%). The main countries of origin are Nepal (30%), Indonesia (29%), Bangladesh (19%), Myanmar (9%) and India (5%).

(a) Internal migration

In 2018, according to the migration survey 2018 published by the Malaysia Department of Statistics, 89.3 per cent internal migration movements took place, with 66.9 per cent of urban-to-urban migration. For Intra-State Migration, the highest proportion of intra-state migration in Malaysia was urban-to-urban, although it decreased to 66.9 per cent in 2018 from 71 per cent in 2016. Population movements were also largely to urban areas within the same State for 2018, except for Kelantan and Sabah, which recorded the highest movement from rural to urban areas. The main reasons for internal migration in Malaysia were due to following family members, pursuit of a career and seeking a new house/new environment.

(b) International migration (outbound)

In 2017, it was reported that about 1 million Malaysians worked abroad. A World Bank report in 2015 showed that many Malaysians in four key countries – Australia, the United Kingdom, Canada, and the United States – were working in sectors such manufacturing, health care, and scientific and technical services.

(c) International migration (inbound)

The number of international migrant workers in 2019 who passed through the FOMEMA screening and were eligible to work in Malaysia was 1,326,466. These migrant workers were mainly from Bangladesh, Indonesia, Nepal and Myanmar, followed by workers from India, Pakistan, the Philippines, Viet Nam, Sri Lanka, China, Cambodia and Thailand. Most of the migrant workers are working in highly populated areas such as Kuala Lumpur, Selangor and Johor Bharu. They are mainly working in factories sector, as workers at building sites, in services as well as in the plantation sector.

5.5.3 Health governance

(a) Legal and policy frameworks

Table 19. Legal and policy frameworks of Malaysia

Name of the International legislation	Commitment
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990	No commitment
Universal Declaration of Human Rights, 1948	Universal recognition
International Health Regulations	2005
Convention relating to the Status of Refugees, 1951	No commitment
International Covenant on Economic, Social and Cultural Rights, 1966/1976	No commitment
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979	Ratified 5 July 1995
Convention on the Rights of the Child, 1990	17 February 1995 a
Migration for Employment Convention (ILO No. 97)	No commitment
Migrant Workers (Supplementary Provisions) Convention (ILO No. 143)	No commitment
Domestic Workers Convention (ILO No. 189)	No commitment

(b) Legal Framework related to health

- Immigration Act Malaysia 1959 /63 (Act 155);
- Passport Act 1966 (Act 150);
- Fees Act 1951 (Amendment 2017);
- International Health Regulations 2005;
- Anti-Trafficking in Persons Act 2007 (Amendment Anti-Trafficking in Persons and Anti-Smuggling of Migrants Act 2010);
- Employment Act 1955 [Act 265];
- Workers' Minimum Standards of Housing and Amenities Act 1991 [Act 446];
- Employment Injury Scheme for Foreign Workers under Employees' Social Security Act 1969 [Act 4].

(c) Bilateral Labour Agreements

- MoU between Malaysia and Cambodia on the recruitment and placement of foreign workers – signed on 15 December 2015.
- MoU between Malaysia and Indonesia on the recruitment and placement of Indonesian domestic workers – signed on 13 May 2016. Both parties agreed to sign a new bilateral agreement to enhance the protection for domestic workers working in Malaysia – signed on 1 April 2022.
- MoU between Malaysia and Sri Lanka on the recruitment and placement of foreign workers – signed on 16 December 2016.
- MoU between Malaysia and Nepal on the recruitment and placement of foreign workers – signed on 28 October 2018.
- MoU between the Malaysia and the Bangladesh on the employment of workers – signed on 19 December 2021.
- MoU between the Malaysia and the Viet Nam on the recruitment, employment and repatriation of workers – both parties agreed to sign on 21 March 2022 (no further update as of time of writing).

(d) Focal point within the Ministry of Health

- Global Health Section of the Public Health Development Division;
- International Regulations and Travel Health Sector of the Disease Control Division;
- Primary Health Care Section of Family Health Development Division;
- Medical Development Division;
- Policy and International Relations Division.

(e) Focal point within other offices/agencies outside the Ministry of Health

- Ministry of Health is the key focal point to coordinate migration health;
- Ministry of Home Affairs (Immigration Department) and the Ministry of Foreign Affairs facilitate the other offices/agencies.
 - o Ministry of Human Resources - Policy Division;
 - o Ministry of Home Affairs - Immigration Department;

- o Ministry of Foreign Affairs;
- o Migrant Workers Health Research Network of faculty and students at Management & Science University in Malaysia.

The Joint Committee of the Ministry of Home Affairs and Ministry of Human Resources on the Management of Foreign Workers was established on 29 August 2018. The main function of this committee is to determine policies for hiring policy foreign workers in all sectors, and policies on illegal foreign workers. This committee co-chaired by Ministry of Home Affairs and Ministry of Human Resources. It consists of eight controlling agencies namely Ministry of Transport, Ministry of Agriculture and Food Industry, Ministry of Tourism, Arts and Culture, Ministry of International Trade and Industry, Ministry of Domestic Trade and Consumer Affairs, Ministry of Works, Ministry of Plantations Industries and Commodities and Ministry of Energy and Natural Resources.

5.5.4 Health financing

The Foreign Workers Hospitalization and Surgical Insurance Scheme (SPIKPA) is a mandatory accident and illness (inpatient) coverage scheme designed for non-professional documented foreign workers (except for foreign domestic helpers and workers in the plantation sector). This annually renewable health insurance plan is restricted to foreigners aged 18 to 45 years at time of initial application for the work permit, but the age constraint does not apply to renewals of work permits, which covers until 60 years of age.

Approximately 1.6 million documented foreign workers were insured by 2016. Foreign workers pay an annual premium of MYR 120 (USD 28.66) to one of the 26 designated private insurance providers to receive medical coverage capped at MYR 20,000 (USD 4,776) in Ministry of Health hospitals.

SPIKPA is designed to pool health expenditures for documented foreign workers by lowering financial access barriers to inpatient services and protecting employers from uncertain health expenditures for their foreign workers.

The SPIKPA benefits package covers daily hospital room and board (up to a maximum of 30 days), intensive care (up to a maximum of 15 days), hospital supplies and services, operating theatre, surgical and anaesthetist fees, in-hospital physician visits (up to a maximum of 30 days), in-hospital specialist consultation visits (up to a maximum of 30 days), ambulance fees and medical report fees. Documented migrants who are not within the SPIKPA scheme need to pay out of pocket when seeking health care at any health facilities. Emergency life-saving treatment is provided to all who seek treatment at any healthcare facility in Malaysia.

An insured documented foreign worker seeking care at a Ministry of Health hospital will have their eligibility for cashless admission to health services verified using their passport and an online or telephone-based system. There is no separate 'health card' issued to prove eligibility. Upon admission, hospital staff will verify the passport details with an online web portal or with a 24-hour free interactive voice response system (for instance if internet access is not available), to determine whether the foreign worker is eligible for cashless admission to hospital without a guarantee letter or deposit. If eligibility cannot be determined, a foreign worker can still be admitted following payment of a deposit and issuance of a guarantee letter by the employer. On discharge, the employer or the admitted foreign worker will need to settle the hospital charges first but can subsequently make a reimbursement claim from the insurer under the SPIKPA scheme.

5.5.5 Health service delivery

The health-care system in Malaysia has experienced considerable transformation since independence in 1957. Malaysia provides comprehensive range of health services through a dual system involving health-care providers from the public and private sectors. The Ministry of Health is the main custodian of health-care services and is committed to providing access to high-quality health care to the population. Other providers in the health system pyramid include university hospitals, army hospitals as well as non-governmental organizations.

Health services are provided through more than 3,000 static public primary care facilities and 146 public hospitals. The rural population is served through an extensive network of health clinics and mobile health teams. The private sector has also developed and evolved alongside the government delivery system and is particularly strong in urban areas. As of 2020, health services by private facilities include 8,222 medical clinics and 202 private hospitals. The public sector is heavily subsidized and health care is paid through the general taxation of income, where patients only need to pay nominal fees. The private sector is financed on a fee-for-service basis, where the services are being funded mostly through out-of-pocket payments by the public, private health insurance and corporation arrangements.

Socioeconomic development in Malaysia, over the past six decades, has brought about significant improvement in the general health status of the population. Life expectancy in 2019 was 72.5 years for males and 77.4 for females, compared to 56 years and 58 years respectively in 1957. Malaysia has managed to significantly reduce infant mortality rate from 75.5 per 1,000 live births in 1957 to 6.4 in 2019 and maternal mortality ratio from 530 per 100,000 live births to 21.1 during the same period.

The health system is facing challenges partially arising from demographic and epidemiological changes in the country. By 2030, Malaysia will reach the status of ageing population and 15 per cent of the population will be aged 60 years and above. The nation is also faced with the dual burden of diseases, the rapid increasing prevalence of non-communicable diseases alongside persistent problems of infectious disease, particularly dengue and tuberculosis.

(a) Health services available for documented migrants

All non-citizens need to pass the FOMEMA assessment for them to be eligible for the Foreign Worker Hospitalization and Surgical Insurance, which is the mandatory health insurance scheme (SPIKPA) offered by a consortium of private insurers overseen by the Ministry of Health.

Accordingly, all foreign workers are required to undergo mandatory medical screenings in their country of origin, again within a month upon arrival in Malaysia, and then annually for the first two years of employment within the country. After they complete the three compulsory FOMEMA medical examinations, foreign workers are required to undergo alternate years additional medical examinations once in every two years, that is, on the fourth, sixth, eighth and tenth year of the “Pas Lawatan Kerja Sementara” permit and continuously until they go back to their country of origin.

Foreign workers who fail their medical screening by testing positive for tuberculosis, HIV, malaria, substance abuse and other conditions are repatriated. Women are also required to take a pregnancy test besides the mandatory screening and are repatriated if pregnant. According to the Immigration Department, around 2.6 per cent of foreign workers fail their medical tests in Malaysia.

Treatment for ten communicable diseases is provided free of charge. These diseases are: tuberculosis, (first-line drugs), yellow fever, Ebola virus, typhoid, malaria, plague, cholera, leprosy, influenza and COVID-19). Migrants will have to pay out of pocket for HIV, hepatitis B, non-communicable diseases (hypertension, heart disease, diabetes, respiratory disease, mental health, sexual and reproductive health and occupational health and safety) treatment, immunization and complementary and alternative medicine.

Table 20. Regulations on foreigner’s health-care responsibilities in Malaysia

Category of documented migrants	Medical screening required	SPIKPA required	Private health insurance required
Foreign workers	Yes	Yes	Yes, by the employer
Corporate expatriates	No	Yes	No, but encouraged
Internal students	Yes	No	Yes
Malaysia My Second Home (MM2H) participants	Yes	No	Yes, but can be temporary
Medical tourists (only) and conventional tourists (general tourism)	No, but boarder control checks	No	No, but encouraged

Domestic legal instruments/ immigration regulations that obligate employers to obtain health insurance for non-national migrant employees.

A. Foreign Workers Medical Examination Monitoring Agency (FOMEMA)

Section 8, Subsection 3 (b), and Immigration Act 1959 (Act 155).

“FOMEMA” is the concession company appointed by the Government of Malaysia to manage, monitor and supervise a mandatory comprehensive health and medical screening programme for all foreign workers employed in the country, under Section 8, Subsection 3 (b), and Immigration Act 1959 (Act 155).

B. Employer’s Circular No. 3 Year 2018 Employees’ Social Security Act, 1969

Security Act 1969 (Act 4) covering the Employment Injury Scheme only

Effective from 1 January 2019, employers in Malaysia who hire foreign workers (excluding domestic workers), including expatriates, with valid documents must register their employees with the Social Security Organization (SOCSO) and contribute to the Employment Injury Scheme under Employees’ Social Security Act 1969 [Act 4]. The scheme provides protection to employees against accidents or occupational diseases arising because of and within the course of their employment.

However, effective 1 June 2021, foreign domestic workers are also covered through the Employment Injury Scheme under the Act 4. Under the Employment Injury Scheme, foreign workers, including expatriates and domestic workers, are eligible for medical benefits, temporary/permanent disability benefits, dependents’ benefits, funeral benefit and rehabilitation benefits. However, benefits from the Invalidity Scheme do not extend to foreign workers, including expatriates.

With regards to foreign workers, including expatriates, employers are required to contribute to SOCSO and there is no contribution by the employees. Employers would contribute 1.25 per cent of an employee’s monthly wage to SOCSO monthly (subject to the insured wage ceiling of MYR 4,000 per month and capped at MYR 49.40).

All foreign workers must register to obtain a Foreign Worker Social Security number (a 12-digit number), which is compulsory for the submission of the employees' contribution record. This 12-digit number must be referred to when corresponding with SOCSO on all matters related to foreign workers, irrespective of any subsequent changes to the worker's passport details, valid working permit, or equivalent document in the future.

Health services are delivered at the Immigration Detention Centres. The Assistant Medical Officers conduct health assessments for migrants and will refer to the medical officers or hospital for further management.

(b) Health services for outbound migrants

- No health financing mechanism by the government is in place to provide health services for Malaysian migrants who depart the country. Outbound migrants will either have to pay out of pocket for medical care or some employers and/or sponsors may provide health-care facilities, based on their employment contract.
- Malaysia does not have any legal requirement that obligates the overseas employers to provide health and occupational health coverage for migrant workers through their employment contracts. Health coverage will depend on the discretion of the overseas employer.
- Malaysia does not offer any pre-departure orientation or health education programmes for outbound migrants
- Malaysia does not have any migration resource centre that assists prospective outbound migrants. Respective embassies function as the resource centre for the migrants overseas.
- As of 2021, free COVID-19 tests are provided for free to migrants who need to be repatriated depending on the requirement of the country of origin.

5.5.6 Health information system

Several divisions within Ministry of Health and other ministries such as the Home Ministry store and update data on migrant workers.

- National ID card issuance is carried out by the National Registration Department.
- Divisions within Ministry of Health that are involved in data for migrant workers include Finance Division, Medical Development Division, Disease Control Division, Family Health Development Division, and the Malaysian Health Data Warehouse.

5.5.7 Key challenges in implementing migrant health

All documented migrants who work in Malaysia are covered under SPIKPA.

- Key challenges in the implementation of health coverage occur when the health insurance coverage exceeds MYR 20,000 (USD 4,776) for inpatient medical bills, which may result in potential difficulties in settling the hospital bill.
- SPIKPA only covers hospital care, excluding coverage at primary care level.
- SPIKPA only permits health care provided at Ministry of Health hospitals.

5.5.8 Additional notes

SOSCO has taken the initiative to update the details of Foreign Workers' Dependents to further improve the delivery process of benefit payments under the Employment Injury Scheme for Foreign Workers.

An amendment was introduced to the Workers' Minimum Standards of Housing, Accommodation and Amenities Act 1990 (Amendment);(Act 446) to set the minimum standards of accommodation, housing and working environment to prevent communicable diseases and improve workers' living conditions. The amendment aims to facilitate efforts to eradicate elements of forced labour and human trafficking in the labour industry. This Act and its accompanying regulation have been in force since 1 June and 1 September 2020 respectively.

Malaysia has issued recommendations for an accountability mechanism in upholding obligations of receiving and sending countries: all sending countries need to ensure that their citizens are protected through health insurance during their stay in the receiving country.

5.6 Myanmar

5.6.1 Country profile

Myanmar is the largest country in mainland Southeast Asia and considered one of the fastest growing economies in East Asia and the Pacific region, as well as globally. Joining ASEAN on 23 July 1997, Myanmar is one of its newest members. With its active engagement with Member States, Myanmar has increased its share of intraregional trade from 1.1 per cent in 2010 to 2.08 per cent in 2015. GDP growth rate in 2022 was -0.3 per cent which was much improved from -18.4 per cent in 2021. In this context, population mobility within and across the borders of Myanmar has shown a rapid increase over the last decade.

With over 9 million migrants or almost over 20 per cent of its total population, internal migration is highlighted as the most common type of migration in Myanmar. There is a clear variation in indicators related to health, education, employment, water and sanitation and housing among the countries in the region. Additionally, according to the Global Climate Risk Index 2019, Myanmar is rated as the third highest out of 184 countries affected by climate change in the past 20 years. These economic and social pull and push factors along with natural and human-made disasters have induced a colossal wave of population mobility within and across the country's borders.

5.6.2 Migration profile

Outmigration across Myanmar's international borders shows an upwards trend, and the country is one of the largest source countries within the ASEAN region. According to the Myanmar Population and Housing Census Report (2014), approximately 4.25 million Myanmar migrants live overseas with over 3 million of them employed in Thailand and Malaysia (ILO, 2015). Other main destination countries are China and Singapore. Myanmar outmigrants account for 62.3 per cent of total emigration to another country in the ASEAN region. This cross-border migration has greatly contributed to Myanmar's economy in recent years and the World Bank estimates that around USD 2.754 billion was remitted by international migrants in 2018 which accounts for approximately 3.9 per cent of the GDP of Myanmar. There is also a significant amount of remittance taking place through informal methods such as brokers or money hand carried back home that is not captured in the World Bank estimates.

In parallel with positive economic and social benefits, reportedly migrants from Myanmar are becoming increasingly vulnerable to abuse and exploitation within the migration continuum. In this context, authorities have recognized the importance of mitigating the negative outcomes of migration to maximize its positive outcomes. Migrant workers' health issues have been identified by the Government and the Ministry of Health as a key priority area to be addressed. In response, the Government – in collaboration with the ministries of Social Welfare, Relief and Resettlement the Ministry of Labour and other ministries – has established policies, legal frameworks and regulations to address the inequalities of health and social determinants of

Table 21. Migration profile of Myanmar

Top 5 countries of origin (inbound migrants)		Top 5 countries of destination (outbound migrants)	
China	47 742	Thailand	1 892 480
India	37 004	Malaysia	247 768
Pakistan	3 683	Bangladesh	197 625
Bangladesh	1 648	United States	98 344
		Pakistan	93 057
Total	90 077	Total	2 529 274

health of migrant workers, as well as refugees.

5.6.3 Health governance

(a) Legal and policy frameworks

Myanmar has a robust health governance structure, as numerous legal frameworks pertaining to migrant

Table 22. International legal and policy frameworks, Agreements and Partnerships in Myanmar

International legal and policy frameworks
Convention on the Rights of the Child, 1990 Ratified on 15 July 1991 a
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979 – ratified on 16 July 2015, signed 6 October 2017
International Covenant on Economic, Social and Cultural Rights, 1966/1976 - Ratified on 16 July 2015, signed 6 October 2017
Universal Declaration of Human Rights, 1948
No commitment:
• Convention relating to the Status of Refugees, 1951
• Domestic workers convention (ILO No 189)
• Migration for Employment Convention (ILO No. 97)
• Migrant Workers (Supplementary Provisions) Convention (ILO No. 143)
• International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990

workers health and rights have been implemented.

According to the national situational analysis on migration health conducted in 2018, there are no existing laws or legal frameworks in Myanmar that explicitly refer to the health of migrants and their access to services in Myanmar. Although all citizens of Myanmar are entitled to access health care according to the Constitution, 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.

However, some national plans and policies recognize migrants and mobile populations, including the following:

- o Constitution of the Republic of the Union of Myanmar (2008): Although the 2008 Constitution does recognize the rights of all Myanmar citizens for health care, it does not specifically capture the health of migrants.
- o Prevention and Control of Communicable Diseases Law (1995) (Revised in 2011): Existing legislation specifically mentions the quarantine requirement for those coming from endemic areas crossing the country's international or national borders, thus capturing both internal and international migration.
- o National Health Plan 2011–2016: Recognizes the importance of migration in relation to spread of communicable diseases, health security, public health and social determinants of health. Includes some indicators on reaching migrants with HIV, specifically through outreach programmes. Includes indicators on improving health status of border areas.
- o National Health Plan 2017–2021: The plan aims to strengthen the country's health system and anticipate towards UHC, choosing a path that is specifically pro-poor. Under the plan, 'Rural, Peri-urban and Border Health' is a programme and one of the projects under this programme is 'migrant health'.
- o National Health Plan 2011–2016: Mentions internal migration and aims to provide basic and essential health services for migrants.
- o 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 and mining and rural construction projects.
- o Myanmar National Strategic Plan on HIV and AIDS: Explicitly recognizes 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".
- o Law Relating to Overseas Employment, No. 3/99, 9 July 1999: Focuses on outbound regular migrants. However, the law has been recognized as lacking in clarity in terms of scope, definitions, specifications or guidelines related to pre-departure medical examinations and testing, travel restrictions, etc. It may also lack enforcement capacity as the rights stated within the legislation may not manifest in the contracts signed by the migrants.
- o Immigration Acts (the Burma Immigration Act (Emergency Provisions) XXXI 1947: The Burma Immigration Detention Rules 1951 and the Registration of Foreigners Act 1940). None of the Acts related to immigration refers to access to health services.
- o ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers (2007).

(b) Bilateral Labour Agreements and partnerships

- MoU on Health Cooperation between Thailand and Myanmar (2013): 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
- Trilateral Cooperation for Health: Burma, Thailand and United States Cross-Border Partnership – Outlines specific cooperation and funding for a four-year project on malaria in five 'twin-city' locations
- MoU between Thailand and Myanmar on Cooperation in the Employment of Workers (2003)
- MoU for Joint Action to Reduce HIV Vulnerability Related to Population Movement in the Greater Mekong Subregion (2011)

(c) Focal point within the Ministry of Health and with other offices/agencies outside the Ministry of Health

Myanmar embarked on a migration health policy development process in 2014. This process identified a multistakeholder national framework.

Migrant Health Secretariat:

Permanent coordination hub within the Ministry of Health with a national migration health coordinator.

Migration Health Task Force: This multistakeholder taskforce was established in 2016 with the aim of:

- o Creating awareness among different government entities regarding the importance of migrant health;
- o Work towards the development of a migration policy framework for the country to achieve equitable access to health promotion and care for migrants within the laws and practices in view of enhancing the health among the migrant population.

Composition of the Migration Health Task Force:

- o Chairperson (Director General/ Permanent Secretary, Ministry of Health);
- o Secretary (Assistant Secretary, International Relations Department);
- o Members (Focal points from different ministries), civil society organizations, international non-governmental organizations, UN agencies.

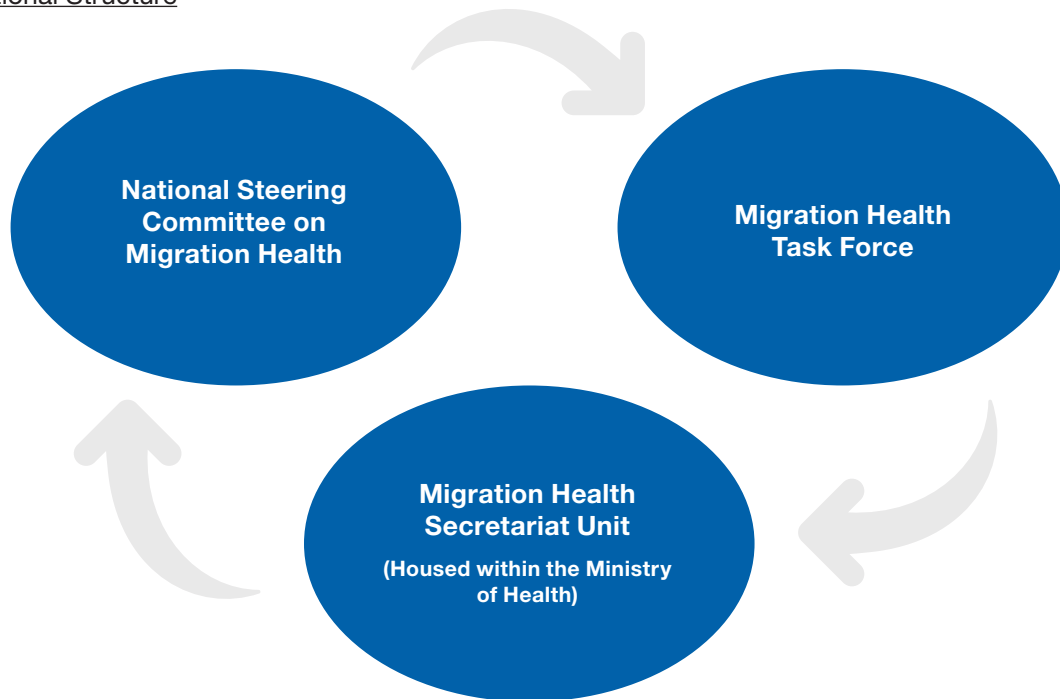
National Steering Committee on Migrant Health

The committee is expected to be the decision-making body to which the taskforce would report and make recommendations to. The committee will also oversee the policy and programme development process, and garner the necessary support and approvals to establish and implement the national migrant health policy.

Composition of the committee:

- Chairperson (Union Minister, Ministry of Health);
- Deputy Chairman (Deputy Minister of Ministry of Health);
- Secretary (Permanent Secretary of Ministry of Health);
- Members (Permanent Secretaries from other ministries, officials from different Ministries, Parliamentary members).

Organizational Structure



5.6.4 Health financing

In 2015, total health spending in Myanmar was approximately 4.7 per cent of the GDP. The public share of total health spending was **15 per cent** or about **0.74 per cent** of the GDP. This spending was among the lowest compared to countries at a similar level of development. With the low level of public spending on health, out-of-pocket payments have become the main source of health-care financing, accounting for 76 per cent of the total health expenditures in 2019. Approximately 16 per cent of Myanmar households face catastrophic health spending, and 3.4 per cent of the population is pushed into poverty due to health spending each year (WHO: Global Health Expenditure Data, 2022).

5.6.5 Health service delivery

(a) Common health issues among the migrants in Myanmar

Evidence shows that health issues and migration in Myanmar are multifaceted. Both international and internal migrants face a wide range of health issues at different stages of the migration cycle including pre-departure, transit, at destination and upon return. Although the current body of literature does not provide a representative and comparable data on migration health, in general, communicable disease including malaria, TB, HIV/AIDS, filariasis and parasitic diseases are described as the most common diseases among both internal and international migrants. Tuberculosis is highlighted as one of the major health challenges in Myanmar, which has now been complicated by the emergence of multidrug resistant strains. Data on non-communicable diseases among the migrants are scarce. However, evidence suggests a significant challenge with occupational, reproductive and mental health issues among the migrants.

(b) Health services available for documented migrants

Article 24(a) of the Overseas Employment describes the right to claim full compensation for any work-related injury through the Service Agent. However, in practice, this provision is usually omitted from the standard agreement that migrant workers sign with their recruitment agency. The Myanmar-Thailand MoU stipulates that migrant workers are entitled to the benefits enjoyed by local workers without discrimination.

Social Security Act (2012) outlines provisions for employment injury insurance and a right to access medical care and other benefits including temporary and permanent disability benefits and provides protections for injured employees against termination. This new law also outlines steps for establishing a Social Security Fund with contributions from employers, workers and the government, which could also support non-occupational health costs. However, there is no mention of migrants within this law and no provisions on how they may be included.

5.6.6 Health information system

Data on migration in Myanmar is limited. No specific Migrant Health Management Information System (HMIS) data exists in a functional HMIS unit under the Ministry of Health. Consequently, migrants' data are not counted in health-care service delivery. It is expected that the National Health Plan's 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 the national plan, which also includes a functional HMIS unit to promote a more integrated and expanded HMIS.

5.6.7 Key challenges in implementing migrant health

Some of the major challenges identified are:

- Lack of access to primary health-care services including vaccination, antenatal and post-natal care, family planning services and emergency contraceptive methods.
- Absence of culturally sensitive health services and difficulties in accessing health services for migrants due to language barriers.
- Migrants tend not to access health services due to the double burden of health-care cost and the loss of daily income alongside the fear of losing the job.
- Lack in continuity of care, especially when migrants move back and forth between the locations of origin and destination.
- Non-inclusion of health service provision for migrants in bilateral agreements.
- Lack of provisions to provide occupational health services in employment agreements.
- Lack of awareness and training among the border health, immigration and diplomatic staff to identify and refer the victims of abuse, trafficking and smuggling.
- Health services awareness and integration of health issues of migration in other development programmes.
- Non-integration of the pre-departure immigration health assessment services with the national health programmes.

5.7 Philippines

5.7.1 Country profile

The Philippines is one of the founding members of ASEAN and actively participates in the shaping of ASEAN's regional agenda to ensure the association's relevance and importance in the international arena. The Philippines continues to advocate for strengthening the regional order that promotes international trade and that adheres to internationally accepted norms and rules for the benefit of the region in line with the development of the ASEAN Economic Community. The Philippines also has the second largest population (over 108 million citizens) and the third largest economy (USD 304.9 billion) in the ASEAN region. Annual economic growth rate is fourth in the region. The Philippines' annual Inflation rate is 3.1 per cent and the health expenditure 4.41 per cent of GDP. The Philippines is one of the largest countries of origin in the ASEAN region and migration is deeply ingrained in the social, economic and cultural fabric of the Philippines. Today, more than 10 million Filipinos – or about 10 per cent of the population are working and/or living abroad. The country is the fourth largest remittance recipient in the world, with around USD 33 billion in 2018. The Philippines also has around 3.7 million foreign nationals including nearly 350,000 foreign migrant workers residing within the country, with a large number from China and Japan

5.7.2 Migrant profile

Table 23. Migrant profile of the Philippines

Types of migrants	Numbers
Documented migrants	177 368
Female migrants	3 034
Documented migrant workers	12 218
Occupation of documented migrants	Administrative, executive, and managerial workers (56.1%), technicians and associate professionals (36.4%), professionals (5.9%), service workers and shop and market sales workers (1.5%), farmers, forestry workers, and fishermen (0.1%)
Occupational-related injuries	1.08 / 1 000
Deported migrant workers	1 508
Migrant stock by origin	China (36 171), United States (35 779), Japan (13 834), India (10 705), Republic of Korea (6 948)
Migrant stock by destination	United States (3 176 208), Saudi Arabia (1 075 148), Canada (662,600), Malaysia (620 043), United Arab Emirates (537 393)

Table 24. Estimated number of Filipinos overseas 2016-2021

Region	2016	2017	2018	2019	2020	2021
Americas	4 104 295	4 404 798	4 056 615	6 323 298	4 674 124	4 674 341
Asia and Pacific	1 917 775	1 777 786	1 828 033	2 404 660	2 404 660	2 300 013
Europe	549 867	561 624	424 024	474 264	474 264	459 497
Middle East and Africa	2 280 314	2 056 449	1 939 493	2 200 670	2 200 670	2 096 676

According to the Department of Tourism, the Philippines had 2,204,564 foreign visitors from January to March 2019. Some of these tourists also visit the country for business or employment. With this influx of foreign workers, the government has set stringent regulations. The Department of Labor and Employment, the Bureau of Internal Revenue, the Department of Justice and the Bureau of Immigration have developed guidelines according to which all foreign workers are required to apply for a Tax Identification Number, regardless of the duration of their assignment. The most common type of work visa issued in the Philippines is the 9 (G) visa, also known as the Pre-arranged Employment Visa.

5.7.3 Health governance

(a) Legal and policy frameworks

The Philippines has a robust health governance structure, as numerous legal frameworks pertaining to migrant workers' health and rights have been implemented.

Table 25. Migrant profile of the Philippines

International	National laws	Bilateral agreements
UN Human rights instruments <ul style="list-style-type: none"> • 1979 Convention on the Elimination of All Forms of Discrimination Against Women • 1989 Convention on the Rights of the Child • 1990 UN Migrant Workers Convention • 2000 Human Trafficking Protocol • 2000 Migrant Smuggling Protocol • 2006 Convention on the Rights of Persons with disabilities 	<ul style="list-style-type: none"> • PD 442: Labour Code of the Philippines • LOI 537: Welfare and Training Fund for Overseas Workers • Batas Pambansa 79: Commission on Filipinos Overseas • EO 797: Philippine Overseas Employment Administration • RA 6768: Balikbayan Programme • EO 74: One Country Team Approach • RA 8042: Migrant Workers and Overseas Filipinos Act 	<ul style="list-style-type: none"> • With Indonesia on migrant workers • With Lao People's Democratic Republic on technical corporation on labour • With Cambodia
ILO conventions <ul style="list-style-type: none"> • ILO Core conventions: C29, C87, C98, C100, C105, C111, C138, C182 • C97 Migration for Employment (Revised) • C143 Migrant Workers (Supplementary) • Provisions) Convention • C189 Domestic Workers Convention 	<ul style="list-style-type: none"> • RA 7875: National Health Insurance Act • RA 9189: Overseas Absentee Voting Act • RA 9208: Anti-Trafficking in Persons Act • EO 182: Transfer of OWWA Medicare Fund to PhilHealth • RA 10022: Amendment to RA 8042 • RA 10364: Amendment to RA 9208 • RA 10606: Amendment to RA 7875 	
	<ul style="list-style-type: none"> • CA 613 - Philippine Immigration Law of 1940 • RA 562 - Alien Registration Act of 1950 	

International	National laws	Bilateral agreements
	<ul style="list-style-type: none"> • RA 9225 - Citizenship Retention and Reacquisition Act of 2003 • MCL006-08 - Revised Rules Governing Philippine Citizenship Under Republic Act 9225 and Administrative Order No. 91 Series of 2004 • RA 9139 - Administrative Naturalization Law of 2000 • RA 9208 - Anti-Trafficking in Person Act 2003 • RRI-RA 9208 - Rules and Regulations Implementing the Anti-Trafficking in Persons Act of 2003 • RA 8042 - Migrant Workers and Overseas Filipinos Act of 1995 • RA 10022 - Amendment of R.A. 8042 known as Migrant Workers and Overseas Filipinos Act of 1995 • PD 1034 - Authorizing the Establishment of an Offshore Banking System in the Philippines • RA 8756 - Ombudsman Investments Code of 1987 - Incentives to Multinational Companies Establishing Regional or Area Headquarters and Regional Operating Headquarters in the Philippines • AO 091 - Implementing Agency of Republic Act 9225 known as Citizenship Retention and Reacquisition Act of 2003 • LML-M-03-A001-12 - Guideline on Departure Formalities for International Bound Passengers in all Airports and Seaports in the Country • RA 7919 - Social Integration Program in the Philippines Under Certain Conditions • RA 10364 - Expanding RA 9208 - To Institute Policies to Eliminate Trafficking in Persons • RA 8247 - Alien Social Integration Act of 1995 Under Executive Order 324 • PC 1987 - The 1987 Constitution of the Republic of the Philippines • MO 036 - Inter-Agency Council Against Trafficking (IACAT) Revised Guidelines on Departure Formalities for International -Bound Passengers 	

(b) Bilateral Labour Agreements

The Philippines has 42 valid bilateral labour agreements with 26 destination countries. In particular, the Philippines through the Department of Labor and Employment has forged bilateral labour agreements with three ASEAN countries – Cambodia, Indonesia, and Lao People’s Democratic Republic.

1. Memorandum of Agreement between the Philippines and Cambodia Concerning the Cooperation in the Field of Labour (2016);
2. MoU on Technical Cooperation on Labour and Employment between the Philippines and Lao People’s Democratic Republic (2005);
3. MoU between the Department of Labor and Employment of the Philippines and the Department of Manpower and Transmigration of Indonesia Concerning Migrant Workers (2003).

Table 26. Bilateral agreements between the Philippines and countries in Asia and the Pacific Region

	Country	Bilateral Agreements	Year Signed
1	Japan	Memorandum of Cooperation between the Department of Labor and Employment of the Philippines and the Ministry of Justice, the Ministry of Foreign Affairs, the Ministry of Health, Labour and Welfare and the National Police Agency of Japan for the Proper Operation of the System Pertaining to Foreign Human resources with the Status of Residence of “Specified Skilled Worker”	2019
2	People’s Republic of China	MoU on the Employment of Filipino Teachers of English Language in China	2018
3	Japan	Memorandum of Cooperation on the Technical Intern Training Program between the Department of Labor and Employment of the Philippines and the ministries of justice, foreign affairs, and health, labor and welfare of Japan	2017
4	Republic of Korea	MoU between the Department of Labor and Employment of the Philippines and the Ministry of Labor of the Republic of Korea on the Sending and Receiving of Workers under the Employment Permit System of Korea	2017
5	Kingdom of Cambodia	Memorandum of Agreement between the Philippines and the Cambodia Concerning the Cooperation in the Field of Labour	2016
6	New Zealand	Arrangement on the Principles and Controls on the Recruitment and Protection of Filipino Workers in New Zealand	2015
7	Republic of China (Taiwan)	Joint Implementing Guidelines of the Special Hiring Program for Taiwan for the implementation of the International Direct E-Recruitment System	2015
8	Papua New Guinea	Memorandum of Agreement on Labour cooperation between the Philippines and Papua New Guinea	2013
9	Japan	MoU between the Philippines’ Overseas Employment Administration and the Japan International Cooperation of Welfare Services on the Deployment and Acceptance of Filipino Candidates	2009
10	Lao People’s Democratic Republic	MoU on Technical Cooperation on Labor and Employment between the Philippines and Lao People’s Democratic Republic	2005
11	Republic of Indonesia	MoU between the Department of Labor and Employment of the Philippines and the Department of Manpower and Transmigration of Indonesia Concerning Migrant Workers	2003
10	Northern Marianas Islands	MoU between the Department of Labor and Employment of the Philippines and the Commonwealth of the Northern Mariana Islands	2000

(c) Focal point within the Ministry of Health

- Migrant Health Unit in the Bureau of International Health Cooperation, Health Policy and Systems Development Team, Department of Health.

(d) Focal point within other offices/agencies outside the Ministry of Health

- Department of Labor and Employment;
- Overseas Workers Welfare Administration;
- Department of Foreign Affairs;
- Philippine Health Insurance Corporation.

5.7.4 Healthcare financing

Health care is mainly provided by the state owned, single payer social health insurance scheme (PhilHealth). Around 92 per cent of the population is covered through Phil health. Around 371,000 documented migrants and 335,000 migrant workers were enrolled in the social health insurance scheme in 2018. Annual premium requirement is 2,400 Philippine peso (USD 45.7) per person. It covers primary care, emergency care and hospitalizations.

Table 27. Health financing sources in the Philippines and their relative contribution to health care

Health financing source	Proportion
Government	10%
SHI	17%
Private Health Insurance/ Health Maintenance Organizations	9%
Out of pocket	55%
Unaccounted	7%
Others	2%

5.7.5 Health service delivery

(a) Health services available for documented migrants

Around 10 million Filipinos work or live overseas and around 4.2 million of them are enrolled in PhilHealth Overseas Filipinos programme through over 400 PhilHealth offices overseas. This programme also covers the migrants' dependents.

Some Filipino citizens who leave the country undergo pre-departure health assessments as per the requirement of some of the destination countries such as Australia, Canada, Gulf Cooperation Council countries, Malaysia, New Zealand, the United Kingdom, the United States and others. Those who migrate to countries such as Thailand and Malaysia undergo health assessment upon arrival at the destination country.

(b) Health of non-citizens in the country

Medical certificates or health assessments are not required for issuing work / long-term stay visas in the Philippines. Starting from July 2017, foreign nationals and former Filipino citizens who have chosen to retire in the Philippines may avail themselves of social health insurance benefits. Citizens of other countries residing or working in the Philippines with a valid Alien Certificate of Registration Identity Card issued by the Bureau of Immigration and their qualified dependents shall be entitled to inpatient and outpatient benefits and other special benefit packages through any of the PhilHealth-accredited health-care institutions nationwide. The annual premium contribution rate for foreign citizens is 17,000.00 Philippine pesos.

5.7.6 Health information system

Table 28. Health information system in the Philippines

Data	Responsible Agency
Stock: Stock Estimate of Filipinos Overseas	Department of Foreign Affairs, Commission on Filipinos Overseas
Outflow: Deployment of overseas Filipino workers	Philippine Overseas Employment Administration
Outflow: Registered Filipino Emigrants	Commission on Filipinos Overseas
Inflow: Aliens and Foreign Nationals	Bureau of Immigration
Inflow: Alien Employment Permit	Department of Labor and Employment
Number of overseas Filipino workers, socioeconomic characteristics and remittances : Survey on Overseas Filipinos	Philippine Statistics Authority
Foreign Migrants in the Philippines: Census of Population and Housing	Philippine Statistics Authority

5.7.7 Key challenges in implementing migrant health

- Only 4.2 million out of the 10 million Filipinos abroad, or around 42 per cent, are enrolled in PhilHealth.
- High out-of-pocket health expenses at around 55 per cent in the Philippines.
- Enhancing multisectoral collaboration on the management of health of migrants.

5.7.8 Recommendations

- Harness ASEAN open dialogue approach to advance migration health.
- Ensure accountability in the implementation of the resulting guidelines.
- Build data and evidence base on migration health.
- Recognize UHC and migrant health as part of the social protection agenda.

5.8 Singapore

5.8.1 Country profile

Singapore, with its population of 5.7 million, is one of the most developed economies in the world. Singapore is a high-income economy with a gross national income of USD 54,530 per capita in 2017. The country provides one of the world's most business-friendly regulatory environments for local entrepreneurs and is ranked among the world's most competitive economies. Singapore is a country of destination for migrant workers, attracting approximately 1.2 million documented migrants within the country (Ministry of Manpower Singapore, 2021).

5.8.2 Migrant profile

As of 2021, the documented migrant non-resident population is 1,466,700 and the documented migrant worker population is 1,197,100 (approximately 82% of the documented migrant non-resident population); (Ministry of Manpower Singapore, 2021). International migrants within the country are mainly from Malaysia, China, Indonesia, India and Pakistan, while the top destinations for outbound migrants are Malaysia, Australia, the United Kingdom, the United States and Indonesia.

Table 29. Migration by country of origin and destination in Singapore

Country	Number
Country or area of origin	
Malaysia	1 044 994
China	380 766
Indonesia	152 681
India	136 177
Pakistan	118 765
Country or area of destination	
Malaysia	78 092
Australia	63 077
United Kingdom	41 143
United States	37 106

5.8.3 Health governance

(a) Legal and policy frameworks

Laws safeguarding protection of migrant workers:

Singapore has adapted a differentiated work pass framework where privileges and controls are calibrated along the skills continuum. Broadly, there are three types of work passes for migrant workers in Singapore, as follows:

1. Employment pass for foreign professionals, managers and executives;
2. S-Pass for mid-level skilled workers;
3. Work permits for semi-skilled workers.

The Ministry of Manpower oversees the proper management of migrant workers in Singapore. It does so via a two-pronged approach – enforcement of legislation and education on rights and obligations of migrant workers and employers.

Migrant workers are afforded the same protection as Singaporean citizens under its civil and criminal laws. The relevant employment laws are detailed below. Some of these Acts are specifically catered to migrant workers. These include the Employment of Foreign Manpower Act (EFMA), which covers areas relating to employer and worker responsibilities in relation to work passes, including applications, cancellations, medical insurance, levy and repatriation, and the Foreign Employee Dormitories Act, which seeks to complement the EFMA by ensuring that dormitory operators house migrant workers at premises that comply with standards on physical and structural safety, land use, hygiene and cleanliness. Brief details of these Acts can be found below:

a. Employment Act

The Employment Act is Singapore's main labour legislation; it specifies the basic employment terms and conditions, as well as rights and obligations of employers and employees. The Act covers all employees in Singapore except for seafarers, domestic workers and public servants who are covered under other regulations due to the nature of their work. The Act provides for basic terms and conditions at work, such as salary protection, minimum employment terms and recourse for resolving related disputes. It also regulates working conditions such as hours of work and overtime payment for eligible employees. On 1 April 2019, Singapore amended the Employment Act to provide better protection for more employees, greater business flexibility and enhanced dispute resolution mechanisms.

b. Workplace Safety and Health Act

The Workplace Safety and Health Act seeks to cultivate good safety and health habits and create a strong safety and health culture at the workplace. This Act has three guiding principles: (1) eliminating and reducing risks at source; (2) placing duties on persons who create and have control over the workplace safety and health risks to instill greater ownership; and (3) raising penalties to deter risk-taking behaviour and reflect the real cost of poor workplace safety and health management. All stakeholders, including employers and suppliers, are required to take reasonably practicable measures to comply with all workplace safety and health laws specific to the occupation and multitasking occupations of their employees. In 2017, amendments were made to the Act to:

1. Prevent the occurrence of unsafe work practices and health risks at work by setting strong deterrence;
2. Prevent its recurrence, especially for accidents that are complex, involving risks that are not well understood and have the potential for serious harm by enabling timely sharing of learnings from investigation;
3. Prevent workplace safety and health training courses from becoming outdated by enhancing training and certification on workplace safety and health.

c. Work Injury Compensation Act

The Work Injury Compensation Act allows employees to claim for compensation if they have been injured or contracted a disease because of work. The Act covers all employees, except for independent contractors and the self-employed, domestic workers and uniformed personnel, that is, members of the Singapore Armed Forces, Singapore Police Force, Singapore Civil Defense Force, Central Narcotics Bureau and Singapore Prison Service. In line with the Workplace Safety and Health 2028 Strategy, the Act has been amended to offer greater coverage and protection for workers. Some of the key amendments that took effect progressively from January 2020 are:

1. All non-manual employees earning up to 2,600 Singapore dollars (SGD) per month must be covered by work injury compensation insurance;
2. Maximum compensation for death and total permanent incapacity was raised by 10 per cent;
3. Employees on light duties due to work injuries will be compensated for their lost earnings based on their average monthly earnings;
4. Employers must report all work-related medical leave or light duties to the Ministry of Manpower;
5. Employees can apply to the Ministry of Manpower to have another doctor assess them if they have reasons to believe that they are not receiving adequate care or assessment;
6. Insurers must be designated to sell work injury compensation insurance policies, and the policy must contain the compulsory terms prescribed by the Ministry of Manpower. This prevents disputes on policy coverage and gives employees greater assurance of compensation.

d. Employment Agencies Act

The Employment Agencies Act provides the regulatory framework for the employment agency industry to ensure that these agencies' personnel are qualified, professional and effective in matching employers and workers; and only licensed agencies are allowed to operate. Under the Employment Agencies Act, employment agencies are allowed to charge workers up to a maximum of one month's salary for each year of employment, up to a maximum of two months of salary. Additionally, agencies are required to refund 50 per cent of the fee charged if the worker's employment is terminated within six months of employment. Action will be taken against employment agencies who breach Act.

e. Employment of Foreign Manpower Act

The Employment of Foreign Manpower Act (EFMA) regulates the employment of all migrant workers, including migrant domestic workers, to ensure their well-being.

The EFMA contains provisions to prohibit employers' collection of employment kickbacks and recovery of hiring costs from their migrant workers. Employers are also required to (i) pay salary in full and on time; (ii) bear the responsibility and costs of their migrant workers' upkeep and maintenance, including medical treatment and the purchase of medical insurance; and (iii) ensure acceptable accommodation and sufficient rest.

f. Foreign Employee Dormitories Act

All migrant worker housing is subjected to a comprehensive set of regulations and requirements imposed by various Government agencies covering areas such as fire safety, building safety, minimum living space, public hygiene, security and residents' well-being, to ensure a safe and well-maintained living space for

migrant workers.

The Foreign Employee Dormitories Act was enacted in 2015 to impose additional requirements on larger dormitories that can house 1,000 or more migrant employees. These additional requirements pertain to areas such as dormitory management, cleanliness and maintenance, public health and safety, as well as provision of recreational and commercial facilities and services to serve their residents' social and recreation needs.

g. In March 2021, the Minister of Manpower announced that the ministry was reviewing the scope of the Foreign Employee Dormitories Act to cover smaller dormitories that house fewer than 1,000 migrant employees. Bringing the regulations of all dormitories under a single Act would better allow the ministry to prevent and more quickly contain disease outbreak in the dormitories and implement a consistent framework of housing standards and safe living requirements across dormitories of different types and sizes.

(b) Bilateral Labour Agreements

It is not Singapore's practice to sign labour agreements. Singapore receives migrant workers from many countries and remains committed to ensuring the protection of all workers, both local and migrant workers. Singapore puts in place a robust legal framework to regulate the employment of migrant workers and protect their well-being, regardless of their nationality. In doing so, Singapore ensures the consistency in treatment of all migrant worker source countries.

5.8.4 Health financing

Singapore's health system has been applauded globally for its low GDP (5%) per capita spending on health care, impressive population health for being the most efficient health-care system in the world. All of Singapore's resident population (citizens and permanent residents) have access to appropriate and affordable health services. Singapore finances health care through an 'S+3M' model: S is for heavy means-tested subsidies provided by the Government for health care services across all public health-care settings, with more support provided to lower income patients; and the 3Ms represent MediSave, MediShield Life and MediFund.

- o MediShield Life is a national health insurance scheme designed to protect Singapore residents against large hospitalization bills, organized on actuarial principles with the scheme needing to be self-contained and self-sufficient. Those who require additional coverage can also purchase Integrated Shield Plans from private insurers.
- o MediSave, which is part of Singapore's retirement savings system, allows Singapore residents to set aside part of their income during working years to pay for the co-payment for their direct medical expenses, as well as national health-care insurance premiums, especially after retirement.
- o MediFund is a medical safety net that provides discretionary support to needy Singaporeans who face difficulties with paying their bills after receiving subsidies, insurance and MediSave.

For long-term care financing, residents can also benefit from means-tested subsidies for long-term care services. The newly introduced CareShield Life or the current ElderShield provide insurance coverage for long-term care costs. Eligible residents can also make withdrawals from MediSave for long-term care or benefit from means-tested cash grants for severely disabled individuals. No Singaporean will be denied health-care services due to inability to pay.

Health financing for foreigners is provided mainly through private health insurance provided by the employer or is self-funded. It is not mandatory for employers in Singapore to provide health insurance benefits to their employees or their dependents, other than for mid and low-skilled migrant workers (see Section 5.8.5(a)). Over 1 million migrants are currently enrolled in the health insurance schemes.

5.8.5 Health service delivery

Singapore's health-care system is designed to ensure that everyone has access to different levels of health care in a timely, cost-effective and seamless manner.

Primary care is the foundation of Singapore's health-care system. It is provided by an island-wide network of outpatient polyclinics and clinics run by private general practitioners. There are currently 20 polyclinics and about 1,700 general practitioner clinics in Singapore. As the first line of care in the community, primary care professionals are often the first point of contact with patients. They provide holistic and personalized care for patients of different age groups. They treat acute conditions such as upper respiratory tract infections, manage chronic illnesses such as diabetes, and keep the population healthy through preventive measures such as targeted health screening. They also help to coordinate patients' care with other providers and help patients who require more specialized medical attention to navigate the health-care system.

Singapore has eight public hospitals comprising six general hospitals, the Women's and Children's hospital, and a psychiatry hospital. General hospitals provide multidisciplinary inpatient and specialist outpatient services, and 24-hour emergency departments. Six national specialty centres provide cancer, cardiac, eye, skin, neuroscience and dental care.

The Government has restructured all its acute hospitals and specialty centres to be run as private companies wholly owned by the government. This enables public hospitals to have the management autonomy and flexibility to respond more promptly to the needs of patients. In the process, commercial accounting systems have been introduced, providing a more accurate picture of the operating cost and instilling greater discipline and accountability. Public hospitals are different from private hospitals in that they receive an annual government subsidy for the provision of subsidized medical services to patients. They are to be managed like not-for-profit organizations. Public hospitals are subject to broad policy guidance by the Government through the Ministry of Health.

The Government has also introduced community hospitals for intermediate health care for the convalescent, sick and elderly who do not require the care of the general hospitals.

(a) Health services available for documented migrants

For migrant workers (including Employment Pass holders) who are covered under the Employment Act and who have served an employer for at least three months, employers are liable to bear the fees of any medical examination of the worker if the worker is certified to be entitled to paid sick leave. In addition, for mid-level and low-skilled migrant workers who hold Work Permits and S Passes, employers are required to bear the costs of all medically necessary treatment (outpatient and inpatient) and to purchase a minimum of SGD 15,000 insurance coverage a year for inpatient treatment.

All migrant workers have access to medical services just as locals do, and these services include maternal and newborn care, communicable diseases control, non-communicable disease control, mental health, sexual and reproductive health, occupational health and safety, complementary and alternative medicine as well as immunization.

Table 30. Primary care service provision for migrants in Singapore

Type of Care (Consultation, Diagnostics, Medicines)	Out-of-Pocket Payment	Covered by Employer
Maternal and Newborn Care	✓	✓
Communicable Diseases Control	✓	By law, employers are required to reimburse medical consultation expenses incurred by employees if it leads to a paid sick leave
Non-communicable Diseases Control	✓	
Mental Health	✓	
Sexual and Reproductive Health	✓	Additional health coverage dependent on employer health packages
Occupational Health and Safety	✓	
Complementary and Alternative Medicine	✓ (Not applicable in public facilities, only in private)	
Immunization	✓	

Table 31. Inpatient service provision for migrants in Singapore

Type of Care (Consultation, Diagnostics, Medicines)	Medical Insurance	Out-of-Pocket Payment
Emergency Care	✓	✓
Maternal and Newborn Care including Post-partum Care	Employers not required to bear pregnancy related medical costs incurred by their foreign employees	✓
Surgeries and Procedures	✓	✓
Medical Cases	✓	✓

Note: Under the EFMA, employers must provide medical insurance that covers up to SGD 15,000 of medical treatment bills for inpatient and day surgery (Only for S-Pass or work-permit holders)

5.8.6 Health information system

Singapore does not have dedicated migrant worker health information system. However, the Ministry of Manpower requires employers to purchase medical insurance for the duration of the work pass and to provide the Ministry with information on the insurer and policy number.

5.8.7 Key challenges in implementing migrant health

One challenge in health-care financing is to balance the need for adequate insurance cover for large medical bills with the need to maintain affordable insurance premiums.

5.9 Thailand

5.9.1 Country profile

Thailand is one of the founding members of ASEAN and has made significant progress over the last four decades in social and economic development, moving from a low-income to an upper-income country. Located in mainland Southeast Asia at the crossroads of ASEAN and other dynamic markets in Asia, and with its world class infrastructure, Thailand offers abundant business opportunities across several industries. Thailand's economy grew steadily, creating millions of employment opportunities; poverty declined substantially over the last 30 years, from 67 per cent in 1986 to 7.8 per cent in 2017. The rapid development Thailand has made it an economic hub within the region that attracts many migrants from neighbouring countries. Both inbound and outbound migration show equally increasing trends and the country is recognized as a country of origin as well as a country of destination, making Thailand's migration flows heterogeneous and complex.

The number of non-Thai residents in the country has increased from an estimated 3.2 million in 2010 to 4.9 million in 2018. A report by the Organisation for Economic Co-operation and Development (OECD) and International Labour Organization (ILO) estimates that non-Thai migrants constitute over 10 per cent of Thailand's total labour force. Migrants from Cambodia, the Lao People's Democratic Republic, Myanmar and Viet Nam employed in Thailand constitute the largest share (approximately 3.9 million) of the migrant labour force in Thailand and contribute to around 6.6 per cent of the GDP. It is also estimated that migrants employed in Thailand send around USD 2.9 billion in remittances to their respective countries (2017).

Recognizing the significant impact of migration towards the socioeconomic development of the country, Thailand has made substantial efforts to facilitate safe and orderly migration. Nevertheless, irregular migration, camp-based and urban refugees seeking asylum from conflict and persecution from neighbouring countries continue to pose a major challenge for Thailand's policy makers.

5.9.2 Migrant profile

(a) International migration (outbound)

Thailand's outbound migration continues to play a significant role in the country's social and economic development. The Ministry of Foreign Affairs estimates that around 1.1 million Thai nationals currently reside overseas. In 2017, 115,215 migrant workers were deployed to other countries, the majority (to Asia (93.7%; 81,992), followed by the Middle East (15,385) and Europe (10,730). Taiwan (China), Israel, Japan, the Republic of Korea, Malaysia and Singapore are other key destination countries. In 2018, these migrant workers remitted an estimated USD 7.5 billion, which constituted 1.5 per cent of the GDP of Thailand.

Table 32. Countries of destination for migrant workers from Thailand

Country	Number of Migrant workers	%
Taiwan, China	35 199	30.6
Korea	12 609	10.9
Japan	9 196	8.0
Israel	7 494	6.5
Malaysia	7 141	6.2
Singapore	5 399	4.7
United Arab Emirates	3 270	2.8
New Zealand	911	0.8
Denmark	758	0.7
Myanmar	647	0.6
Others	32 591	28.3
Total	115 215	100.0

Source: Tracking Universal Health Coverage: Global Monitoring Report. World Health Organization, Geneva; 2017.

(b) International migration (inbound)

Both inbound and outbound migration continue to play a significant role in the social and economic development of Thailand. As a country of origin and destination, Thailand's migration flows remain complex and dynamic. Statistics on stock of migrants in Thailand is scarce and it is estimated that approximately three quarters of migrants in the country are undocumented or irregular, who enter and stay in the country without appropriate legal documentation or stay beyond the authorized time after legally entering.

With its increasing elderly population, low total fertility and extremely low population growth rates coupled with reluctance among Thai workers to take low-skilled jobs, Thailand's dependency on foreign migrant workers is predicted to be increasing in the coming years. The Royal Thai Government's ambitious plan to move the country from middle to high-income status, with growth driven by innovation, technology and creativity, will further increase this demand for migrant workers from neighboring countries in the coming years.

Table 33. Categories of migrants who work and stay in Thailand

Category	Number	%
Professional and skilled workers*	112 834	2.81
Work permits issued to migrants entering through MOU**	850 302	21.20
Work permits issued to migrants registered in Thailand	2 214 298	55.21
Seasonal work permits***	21 561	0.54
Irregular status	811 437	20.23
Total	4 010 432	100

Source: ASEAN Statistical Yearbook 2019

*Figures on foreigners holding work permits for professional and skilled work in October 2018 are provided by the Office of Foreign Workers Administration, Department of Employment, Ministry of Labour

**Office of Foreign Workers Administration, Department of Employment, Ministry of Labour (October 2018).

***Migrants who initially entered Thailand irregularly but had their nationalities verified and work permits issued during registration processes instituted by the Royal Thai Government. This number includes migrants who were regularized in the latest drive.

A recent publication also reported that there are around 3.1 million documented migrant workers and dependents in the country. MoUs with neighbouring countries (Cambodia, the Lao People's Democratic Republic, Myanmar and Viet Nam) and nationality verification processes are the two key process that facilitate documented migration.

According to the Thailand Migrant Profile 2019, Myanmar is recorded as the largest source country for low-skilled migrant workers and Japan is noted for the provision of professional and skilled migrants.

Table 34. Inbound labour migration stock of Thailand

Country	Number of Migrant workers	%
Myanmar	2 062 277	65.7
Cambodia	723 911	23.1
Lao PDR	223 827	7.1
Japan	36 550	1.2
China	23 633	0.8
Philippines	15 196	0.5
India	13 550	0.4
United Kingdom	10 392	0.3
United States	8 227	0.3
Korea	6 035	0.2
Taiwan, China	5 718	0.2
France	5 136	0.2
Russia	2 962	0.1
Others	9 143	0.3
Total	3 137 414	100.0

Source: United Nations, International Migration Report 2017.

5.9.3 Health governance

(a) Legal and policy frameworks

Table 35. International and domestic legal and policy frameworks related to health of migrants of Thailand

Legal and policy frameworks	Ratification
The Universal Declaration of Human Rights, 1948	
ILO Convention 1925 (No 19) Equality of Treatment (Accident Compensation)	5 April 1968
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	9 August 1985
1979 Convention on the Rights of the Child, 1990	27 March 1992
International Covenant on Economic, Social and Cultural Rights, 1966/1976	5 September 1999
New York declaration for refugees and migrants (Resolution 71/1)	
Global compact for safe, orderly and regular migration	
World Health Assembly resolution 70.15, 'Promoting the Health of Refugees and Migrants'	
Global Action Plan, 2019–2023	
Labour Protection Act 1998 applies equally to native-born workers and immigrant workers, thus providing a legal basis for equal pay, minimum wages, occupational safety and health, hours of work, over-time, protection against dismissal etc.	
Ministerial regulation on the fishing industry was published in 2014 and the Regulation of domestic work was approved in 2012.	
Social Security Act (1990)	
Workmen's Compensation Act (1994)	
National Education Act (1999)	
Ministry of Public Health Announcement on Health Examinations and Insurance for Migrant Workers from Myanmar, Lao PDR, and Cambodia (2009)	

In addition, Thailand implements provisions in the 2017 Royal Ordinance and the 2018 amendment to discourage irregular migration. Under these provisions, migrant workers who are found without a work permit are subjected to a fine of 5,000–50,000 Thai Baht (THB); (USD 157 –1,570). Migrant workers are required to notify the work permit officials of the details of their employer and the workplace within 15 days of commencement of employment. The ordinance also imposes a fine of THB 10,000–100,000 (USD 313–3,125) and imprisonment for unauthorized workers found repeating the offence.

Nevertheless, there is also ample evidence on exploitation of migrants, mainly due to the large scale of irregular migration from neighbouring Cambodia, Lao People's Democratic Republic and Myanmar. Deficiencies of the recruitment systems and migration governance frameworks that facilitate movement and regulate the employment of these migrants have resulted in a notable increase in human trafficking. A total of 455 individuals were officially identified as illegally trafficked into Thailand in 2017.

(b) Focal point within the Ministry of Health

- Division of Health Economics and Health Security;
- Office of Permanent Secretary, Ministry of Public Health;
- Health Administration Division.

(c) Focal point within other offices/agencies outside the Ministry of Health

- Department of Employment, Ministry of Labour;
- Social Security Office, Ministry of Labour;
- Immigration Bureau.

5.9.4 Health Financing

Health services in Thailand are financed through a health insurance system which established its first welfare scheme in 1972. Subsequently, several upgrades to this health insurance scheme were introduced with the aim of achieving universal health coverage.

Table 36. Health-care financing schemes in Thailand

Health scheme	Details
Social Security Scheme (SSS)	The Workers Compensation Scheme covers work-related illnesses and injuries. In 1990, the insurance expanded to cover non-work-related illnesses and injuries under the SSS and implemented through the Ministry of Labor. These two schemes are compulsory insurance programmes for employees of private businesses. SSS is financed equally by employers, employees and the government. Beneficiaries are liable for copayments for some services. SSS pays a fixed capitation rate per enrollee. Additional payments are made for certain high-cost services with budget capped.
Civil Servant Medical Benefit Scheme	This scheme was established in 1980 to provide health care to government employees, their dependents and government retirees. It is implemented through the Ministry of Finance and financed through general tax revenue with no premium payments from the beneficiaries. Beneficiaries are liable for copayments for the room and board charges associated with inpatient care that is over the set amount. The payment systems for this scheme use DRG (Diagnosis-related grouping) for inpatients and fees for services for outpatients.
Medical Welfare Scheme	The informal sector is covered under the health insurance implemented under the Ministry of Public Health, which was first introduced in 1975 to provide health care to the poor free of charge. This was later expanded to cover the elderly, children and other underprivileged groups.
Universal Coverage Scheme	In 1983, the Voluntary Health Card Scheme was introduced for families to opt on a voluntary basis and in 2002 and the latest the scheme was established to provide health insurance cover for all Thai citizens. The Universal Coverage Scheme is fully funded through general tax with no premium payments from beneficiaries. It covers outpatient services, disease prevention and health promotion. Inpatient services are paid prospectively using the global budget.

It is estimated that around 9 per cent of the total population is covered by the Civil Servant Medical Benefit Scheme and around 15 per cent is covered by the SSS. The Universal Care Scheme is expected to cover most Thai citizens about 75 per cent of the total population.

5.9.5 Health service delivery

Thailand achieved UHC for all its citizens in 2002. Recognizing the importance of migrants' contribution to Thailand's economic development, Thailand continues its efforts to extend services to migrants and their dependents.

In September 2015, Thailand joined 193 countries at the United Nations General Assembly to adopt UHC as a target of the Post-2015 Sustainable Development Goals for 2030. With the National Health Security Act passed in 2002, Thailand created the Universal Coverage Scheme, which included a benefit package covering health promotion, disease prevention, treatment and care services. High-cost services such as anti-retroviral treatment and renal replacement therapy were introduced in 2003 and 2006 respectively.

(a) Health services available for documented migrants (outbound migrants)

Each year, a significant number of Thai nationals undergo pre- departure health assessments as per the immigration requirements of some of the countries of destination. Statistics on the actual number of migrants who undergo these health assessments, and their health assessment outcomes are not readily available.

- o Non-Thai nationals who wish to work in Thailand are required to obtain a work permit. Work in Thailand without having a Thai work permit is a punishable offence and can be liable to imprisonment, a fine or both.
- o As a prerequisite to issue the mandatory work permit that is legally required, foreign nationals should also submit a recent and valid medical certificate as proof of absence of diseases such as – mental illness, leprosy, tuberculosis, drug addiction, alcoholism and elephantiasis (filariasis).
- o In Thailand, migrants who possess a work permit are fully covered by the Thai SSS. It is a mandatory tri-party scheme financed by payroll taxes, which is contributed to by Government (3.5%), employers (5%) and employees (5%). Migrants who contribute to this social security system have rights to access social security benefits equal to Thai nationals including non-work-related injury or sickness, maternity, invalidity, death, child allowance, old-age pension and unemployment benefit.
- o It is recorded that around 64 per cent of migrants (excluding irregular migrants) are enrolled in public health insurance.
- o Furthermore, in line with the vision of the National Health Security Office, in 2017 the Thai Government has endorsed a 20-year Master Plan for the Integration of Health Insurance Systems Development (2018–2037) with the aim to ensure that everybody in Thailand is covered by at least one of the public insurance schemes and is able to maximize their health potentials.
- o Thailand also supports the ASEAN Declaration on the ‘Protection and Promotion of the Rights of Migrant Workers’, which reflects a political commitment and progress towards better protection of migrants’ health not only in Thailand, but also in the Southeast Asia region.
- o The migrant health insurance scheme of the Ministry of Public Health is for all migrants (documented and undocumented) who do not fulfill the criteria to be included in the SSS such as those working in agriculture, livestock, fishery, housekeeper etc. This scheme was introduced by the MOPH in 2001. This scheme was further expanded in 2005 to include dependents and children. This scheme is a voluntary prepayment one, financed through an annual premium by the migrant workers with no employer or government contribution.

Premium of MOPH scheme

The Ministry of Public Health has four modalities of health insurance, depending on the condition of migrant workers:

1. Premium for three months for those in qualifying period of SSS and/or in an irregular situation;
2. Premium for one year, for those who are allowed to work in Thailand for one. Its cost is THB 1,600 (USD 50).

3. Premium for two years, for those who are allowed to work in Thailand for two years (THB 3,200, or USD 100).
 4. For depends younger than 18 years, the premium depends on their age group.
 - THB 365 (USD 11.4) per year for those younger than seven years.
 - THB 1,600 (USD 50) per year for those between 7 and 18 years old.
- o Benefit packages of the Ministry of Public Health scheme include outpatient care, inpatient care, dental care, medicine expenses, medical supplies, rehabilitation, emergency care, health prevention and promotion, disease surveillance and child immunization.
 - o The Migrant Fund is another provision for the migrants in Thailand. It is a voluntary, non-profit health insurance scheme operating along the Thai–Myanmar border in Thailand since 2017 and aims to protect the health of migrants not covered by existing government insurance schemes. This insurance scheme has contributed to improving access to care for migrants, raised awareness about migrant health protection, and reduced the financial burden for public hospitals.
 - o ‘Health Insurance for People with Citizenship Problems’ was introduced in 2010 and funded by the central budget of the Ministry of Public Health, with the benefit package almost comparable to Universal Coverage Scheme.

Migrant Worker Assistance Centres

This is a relatively new initiative established in 2016 and operated within the provincial employment offices with the intention of providing services for migrants in conjunction with labour protection and welfare offices, social security offices, social development and human security offices and non-governmental organizations. Despite the wide range of measures taken by the Thai Government to ensure fair access to health services for migrants, practical limitations continue to prevail and utilization of public health services by migrants remains low. A report on Thailand’s migration profile highlights that although it is estimated that 64 per cent of migrants (1.97 million) are enrolled in a public health insurance scheme, the share of irregular migrants drops to 51 per cent.

5.9.6 Health information system

Real time data collection, storage, issuance of national ID card, collection of data specific to documented migrants (nationality, gender, age, occupation, hospital, birthdate, name and last name) are done by the Ministry of Public Health.

5.9.7 Key challenges in implementing migrant health

- Despite the wide range of options for health-care access provided by the Government of Thailand, some migrants face difficulties in accessing the benefits of SSS due to frequent change of the employment and difficulties in seeking medical care at the hospital designated to them under the health-care package.
- Immigrants are not always able to exercise their right to benefits due to various reasons including the lack of employer compliance to pay into funds, discrimination, as well as the choice to avoid wage deductions.

- The percentage of migrants registered with the Ministry of Public Health insurance scheme remains low. Although it is compulsory to obtain health insurance, there is no legal avenue to impose penalty on migrants who do not comply or employers of migrants who leave their migrant employees uninsured.
- Although progress has been made, considerable gaps with regards to benefit accessibility for immigrant workers remain.
- Irregular or undocumented migration remains a major challenge. Tedious migration registration processes including the national verification process are another challenge, and more stringent and efficient coordination between countries of origin and destinations is needed.

5.10 Viet Nam

5.10.1 Country profile

Viet Nam, with its population of 96,484,000 in 2020, is now ranked as one of the fastest growing economies in the world and has become the largest exporter of clothing in the region and the second largest exporter of electronics. Viet Nam's GDP peaked at 7.1 per cent growth in 2018. Both internal and international migration in the country have shown a sharp increase over the last decade. In 2016, approximately 6 million people exited and nearly 6 million people entered the country. Viet Nam is a prominent country of origin in the ASEAN region and remittance from overseas Vietnamese is an important source of income for families and for the country's development.

5.10.2 Migrant profile

(a) International migration (outbound)

Table 37. Annual entry–exit trends of Vietnamese citizens, 2012–2016

Year	Exit			Entry		
	Male	Female	Total	Male	Female	Total
2012	2 718 523	2 628 316	5 346 839	2 592 887	2 495 390	5 088 277
2013	3 159 123	2 977 092	6 136 215	3 010 391	2 846 461	5 856 852
2014	3 336 895	3 236 792	6 573 687	3 114 133	3 006 551	6 120 684
2015	3 129 549	3 090 034	6 219 583	3 018 031	2 939 434	5 957 465
2016 (air)	1 484 355	1 745 579	3 229 934	1 452 884	1 676 044	3 128 928
2016 (land border)			2 689 728			2 729 600
2016			5 919 662			5 858 528

According to the Department for Overseas Labour statistics, the total number of outbound Vietnamese migrant workers in 2016 was around 126,296. The top five destinations were Taiwan Province of the People's Republic of China (274,890), Japan (107,975), Republic of Korea (36,417), Malaysia (31,534) and Saudi Arabia (16,412).

in 2016, the 1,465 Government-sponsored students departed Viet Nam, mainly to the Russian federation, Australia, France, Hungary and Germany (top five countries).

(b) Outbound migration - Data on migration profile - Migrant workers departing the country in 2016

Table 38. Government-sponsored Vietnamese students departing/returning in 2016 by destination countries/territories and sex

Country/Territory	Departing students in 2016	Percentage of departing females in 2016 (%)	Returning students in 2016	Percentage of returning females in 2016 (%)
1 Russian Federation	722	48.6	356	41.3
2 Australia	107	53.3	47	42.6
3 France	93	29.0	60	38.3
4 Hungary	67	55.2	8	50.0
5 Germany	52	28.8	33	33.3

(b) International migration (inbound)

Viet Nam hosts around 41,000 international migrants.

Table 39. Country of origin and country of destination of migrants in Viet Nam

Country	Number
Country or area of origin	
Libya	11 278
Myanmar	9 783
China	8 629
Indonesia	7 671
Lao PDR	4 284
Country or area of destination	
United States	1 381 076
Australia	225 749
Canada	184 799
France	123 638
Republic of Korea	122 449

5.10.3 Health governance

(a) Legal and policy frameworks

Table 40. International legal frameworks and policies of Viet Nam

International legal frameworks and policies	Year
1. Global compact on safe, orderly, and regular migration	2018
2. World Health Assembly Resolution 61.17 on Health of migrants	2008
3. World Health Assembly Resolution 70.15 on Promoting the health of refugees and migrants	2017
4. ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers	2018
5. ASEAN Declaration of commitment on getting to zero new HIV infections, zero discrimination, zero AIDS-related deaths	2011
6. ASEAN Declaration of commitment on HIV and AIDS: Fast-Tracking and Sustaining HIV and AIDS Responses to End the AIDS Epidemic by 2030	2016

International legal frameworks and policies	Year
7. Agreement between the Government of the Socialist Republic of Viet Nam and Government of the Laos Democratic Republic on Solving the Spontaneous Migration and Marriages without Registration in Border Areas of the two Countries (valid for 3 years from 14 November 2013)	2013
8. Amendment some articles in the health insurance law 2008 by Law No. 46/2014/QH13, enforced 2015	2014
9. Decree on elaborating and providing guidance on measures to implement certain articles of Law on health insurance; No. 146/2018/ND-CP on 17 October 2018	2018
10. Decree on elaborating social insurance law and occupational safety law regarding compulsory social insurance for foreign nationals working in Viet Nam; No. 143/2018/ND-CP on 15 October 2018	2018
11. Law on Prevention of Infectious Diseases 03/2007/QH12; 2007	2007
12. Law on Vietnamese Guest Workers (No: 72/2006/QH11); 2006	2006
13. Joint Circular on guidelines about medical check-up procedure and health certificates for Vietnamese employees working abroad; 16 December 16 2004	2004
14. Circular on guidance about medical examinations No: 14/2013/TT-BYT on 5 May 2013	2013
15. Decision on the approval of the healthcare target – population program period 2016 – 2020, No: 1125/QD-TTg on 31 July 2017	2017
16. Decision on the approval of the National Strategy for the Control and Elimination of Malaria in Viet Nam, period 2011–2020 and Orientations towards 2030 (Ref.number: 1920/ QD-BYT); 2011	2011
17. Decision on the promulgation of the Action Plan to Prevent Artemisinin-Resistance Malaria for the period 2015–2017 (Ref. number: 4718/QD-BYT); 2014	2014
18. National Tuberculosis Strategy Implementation Plan 2015–2020	2015
19. Decision on the promulgation of the National Strategy for Prevention and Control of Tuberculosis to 2020 and Vision to 2030; No. 374/QD-TTg; 2014	2014
20. Decision No: 608/QD-TTg on 25 May 2012 about approving National Strategy for HIV/AIDS prevention and control 2020–2030	2012
21. Law on HIV/AIDS Prevention and control No: 64/2006/QH11 on 12 July 2006	2006
22. Decision on mechanisms of cooperation in HIV/AIDS prevention and control in cross-border areas; No. 38/QD-TTg on 8 January 2008	2008
23. Decree on Detailing a number of articles of the Children law; No. 56/2017/ND-CP on 9 May 2017	2017

(b) Bilateral Labour Agreements

Table 41 Bilateral Labour Agreements of Viet Nam

Bilateral Labour Agreement	Year
1. MoU on labour cooperation and agreement on labour recruitment between Thailand and Vietnam	2015
2. MoU and agreement about dispatching and receiving labour between Thailand and Viet Nam	2015
3. MoU in relation to the field of labour between Viet Nam and Cambodia	2017
4. MoU on labour and employment between Viet Nam and Malaysia	2015
5. MoU on cooperation on education and human resources development, focusing on building strategies in the field for the 2020–2030 period between Viet Nam and Lao PDR	2019

(c) Focal point within the Ministry of Health

Department of Medical Service Administration of the Ministry of Health with the support of the International Organization for Migration acts as the national focal point for migration health related issues.

5.10.4 Health financing

Like many low- and middle-income countries in the world, Viet Nam has a mixed health financing system, in which the Government's budget has an important role to play, underpinning the State's functions in protecting public health and ensuring equity in health care. According to the Ministry of Health data, in 2014, the health expenditure accounted for 8.2 per cent of the total expenditure.

The out-of-pocket payments for health care are still high and accounted for 48.8 per cent in 2012. The percentage of public expenditure on health care (including the State budget and Health Insurance) was 42.6 per cent.

A SHI programme was implemented in Viet Nam in 1992 and has now become one of the key sources of health-care financing in the country. Participation is compulsory for some groups such as formal-sector workers, and voluntary for other groups. In 2013, around 68 per cent of the population was covered by SHI. Viet Nam's SHI does not cover health services used abroad.

Documented non-citizen migrant workers who have an official employment contract can obtain a SHI but it only covers the principal applicant.

5.10.5 Health service delivery

(a) Health services available for documented migrants

Most documented migrants are covered by SHI since it a legal obligation for anyone with a labour contract to enroll in SHI.

(b) Health services available for in-country migrants

Maternal and newborn care, as well as occupational and reproductive health services are covered under the SHI. SHI also covers non-communicable diseases such as cancer, hypertension, heart diseases, diabetes mellitus, and respiratory diseases. Consultation, diagnostics and the treatment and follow up for tuberculosis, HIV, Malaria and diseases of epidemic potential are provided by the national programmes, and so is immunization. Mental health services are provided by the National mental health programme.

If the migrant has private health insurance, then this insurance can reimburse for services provided by private facilities. Only a few private facilities offer co-payment with SHI. Otherwise, expenses are out of pocket.

The co-payment rate of SHI and patients varies depends on health insurance membership categories and whether the patients use services at their registered facility.

5.10.6 Key challenges in implementing migrant health

- No cross-border referral systems and collaboration exist: migrants cannot use Viet Nam's SHI when they are overseas.
- Inconsistency in policy implementation: the regulations on health coverage for documented migrants is not clear and detailed enough, leading to different local / grassroots organizations interpreting the regulations differently.
- Monitoring systems of migrant populations is still incomplete, especially for health-related information.
- Communication issues exist in providing services to expatriates: most of public health facilities do not have interpreters.
- Limited health communication programme to inform migrants about how to use health insurance.
- Mistrust in health services: many people have their SHI registered at CHS (commune health stations) (primary level), but they believe that the quality of care at primary level is not good enough and prefer to use services at national level hospitals, leading to higher out-of-pocket expenses.
- Limited understanding and knowledge of migrants on access to health-care services.
- Insufficient networking and collaboration across ministries and/or departments: the issue of migrants belongs to different ministries (The Ministry of Labour - Invalids and Social Affairs, Ministry of Health and Ministry of Foreign Affairs, among others), but these ministries have not been working together and sharing information effectively.

5.10.7 Additional notes

Recommendations for the accountability mechanism in upholding obligations of receiving and sending countries as stated in ASEAN Consensus:

- Viet Nam should pay more attention to its policy implementation, enhancing the existing monitoring and evaluation system; it should also strengthen communication between central and local governments.
- Each department and local government should be aware of the importance of sharing information about migrants and develop effective channels for daily communication.
- A ministry or a working group at the national level should be designated as the responsible focal point for dealing with issues related to migrants and coordinating with relevant governmental entities to foster the design and implementation of more migrant-friendly policies.
- The Government of Viet Nam should enter into multilateral agreements with adjacent countries to establish a referral system across borders that ensures continuous and consistent treatment for cross-border migrants.
- A coordination mechanism is needed to gather and document information and best practices for meeting migrants' health needs.

Section 6:

COVID-19 AND MIGRATION IN ASEAN

6.1 Introduction

The coronavirus disease 2019 (COVID-19) pandemic has had catastrophic effects on all countries within ASEAN, with migrants being amongst those who have been most disproportionately harmed and affected (UNESCAP, 2020). Within ASEAN, the first confirmed case of COVID-19 was detected in January 2020 in Thailand. Since then, despite the region's strong, early and robust efforts to contain the spread of COVID-19 through travel bans, widespread testing programmes, economic stimulus measures, curfews, nationwide lockdown measures and mandatory isolation at State-approved quarantine facilities throughout 2020, (Djalante et al., 2020) the rapid surge of the Beta (B.1.351) and Delta variants (B.1.617.2) during early 2021, alongside a limited vaccine rollout, has presented constant challenges and dramatically overwhelmed ASEAN health-care systems (Chookajorn et al., 2021). The lasting impacts and strains on health-care systems have made it significantly more difficult to reach the most vulnerable subpopulations within society.

Migrant subpopulations who are uniquely vulnerable to and have been most impacted by COVID-19 include internally displaced persons, irregular migrants, migrant workers, migrant women and children, migrants living with HIV/AIDs, elderly migrants, migrants with disabilities and trafficked migrants. The vulnerability that migrant populations within ASEAN already experience, due to pre-existing social and structural determinants – which result in xenophobia, social exclusion, labour exploitation, racism, poor sanitary and living conditions, societal discrimination, and limited health-care access – have been compounded by COVID-19. Specifically, the exclusion of migrants in their countries of destination may dissuade them from using health-care services, which largely contributes to their poorer health outcomes. Additionally, while some ASEAN Member States have included migrant workers within national economic stimulus packages and income support programmes only a limited number of migrants have been able to successfully access this financial support. Nevertheless, migrants continue to play a fundamental role during the COVID-19 recovery phase as essential workers within the informal and formal care economy, food supply chain and health sector. Thus, the invaluable contributions of migrants in destination countries should be recognized and rewarded through inclusion and equitable treatment (UNESCAP, 2020).

6.2 Migration and movement during the COVID-19 Pandemic

Due to strict entry and exit barriers applied by origin and destination countries within ASEAN during 2020, outflows of migrant workers significantly decreased. In **Viet Nam**, the total deployment of migrants during 2020 was only 41 per cent of the 2019 figure; in **Indonesia**, outflows of migrant workers in April 2020 were approximately 90 per cent lower than the April 2019 figure; in **Thailand**, the total deployment of migrant workers in the first six months of 2020 decreased by 60.9 per cent of the 2019 figure (OECD/ABDI/ILO, 2021). Throughout ASEAN, most destination countries have been hesitant to reopen their borders, in an attempt to contain the spread of COVID-19. ASEAN Member States were quick to act when WHO declared COVID-19 a global pandemic in March 2020 through suspending international and domestic travel, closing borders and imposing mandatory internal lockdowns. This disruption of movement greatly impacted migrant workers during the onset of the pandemic, as thousands were left stranded in destination countries or border points, which often left them in precarious and vulnerable situations (UNESCAP, 2020). Moreover, governments' lack of preparation to readily accept vast numbers of returnees and the lack or cancellation of international flights significantly contributed to the number of migrants who were stranded. Repatriation services were later implemented in 2020. **Indonesia** had received 162,000 migrant returnees by 28 June 2020; **Lao People's Democratic Republic** received 119,401 documented migrant returnees by 17 June 2021; by 15 August 2020, the **Philippines** had received 147,000 migrant returnees who benefited from cash assistance from a government-issued repatriation fund; **Viet Nam** received approximately 20,000 migrants between April and July 2020; by mid-April 2020, approximately 260,000 migrant returnees who had mostly been working in **Thailand** had returned to Myanmar, Cambodia and Lao People's Democratic Republic (OECD/ABDI/ILO, 2021).

Migrant workers have often been the first to be sacked during times of global economic and financial crises due to the nature of their fixed-term or temporary contracts. Thus, the continued lockdowns and economic restrictions implemented in destination countries resulted in the rapid return of migrant workers back to their home countries. Many migrant workers also reported that the fear of contracting COVID-19, not having access to health-care services, poor sanitary living conditions, expected job losses and the expiration or cancellation of work visas motivated their reasons for return (UNESCAP, 2020). Measures that ASEAN countries passed to support low-income workers, workers who were made redundant or soon to be made redundant due to COVID-19 were not always wholly inclusive of migrant workers either (OECD/ABDI/ILO, 2021).

6.3 COVID-19's impacts and access to health services

Within ASEAN, migrant workers have been disproportionately impacted by COVID-19, as evidenced by the fact that they have been infected with COVID-19 at significantly higher rates compared to their respective host communities. For example, while migrant workers in **Singapore** only make up 38 per cent of the workforce, the vast majority of Singapore's initial wave of COVID-19 cases early in the pandemic occurred in migrant worker dormitories. Similarly, while migrant workers make up 15 per cent of the workforce in **Malaysia**, around 30 per cent of Malaysia's total COVID-19 cases were attributed to migrant workers (OECD/ABDI/ILO, 2021). A major reason for migrant workers' overrepresentation amongst those infected with COVID-19 within ASEAN includes poor and inadequate housing. Most migrant workers live in overcrowded accommodations that have been provided by their employers. Living in these tight and cramped conditions makes it difficult and almost impossible for migrants to adhere to appropriate social distancing measures. Thus, dense living conditions within migrant worker dormitories have significantly contributed to the rise of infections amongst migrant populations. In **Singapore**, the COVID-19 virus spread quickly due to their cramped communal living arrangements, despite health and safe distancing measures that had previously been implemented.

Similarly, in **Malaysia**, mass clusters of COVID-19 were detected in migrant housing sites, which highlights how inadequate and poor housing is a major risk factor for migrant workers (OECD/ABDI/ILO, 2021).

Box 1. Malaysia's Response to COVID-19 outbreaks in migrant housing sites

In response to the mass clusters of COVID-19 infections detected specifically in migrant housing sites nationally in Malaysia throughout 2020, the Emergency (Employees' Minimum Standards of Housing, Accommodations and Amenities) (Amendment) Ordinance 2021 was passed as part of Emergency Ordinance under the Proclamation of Emergency that was issued by the Yang di-Pertuan Agong Malaysia under the Employees' Minimum Standards on Housing, Accommodation and Amenities Act 1990 [Act 446] which was enforced on 26 February 2021.

This Emergency Ordinance also meant that Act 466 would also be enforced in Sabah and Sarawak, where any employer who fails to report any of their unregistered foreign workers may be fined up to RM 200,000 (around USD 48,000) or jailed up to three years or both under Act 446.

The implementation of this Emergency Ordinance has been effective in ensuring employers provide safer and conducive accommodations to workers to curb the COVID-19 transmission in the country considering the overcrowded and non-standard accommodation of foreign migrant workers.

(Commissioner of Law Revision Malaysia, 2021)

Moreover, another major reason for the disproportionate burden of COVID-19 infections is due to the nature of the work conducted by many migrant workers throughout ASEAN, as they work in sectors that have been classified as "essential services" (OECD/ABDI/ILO, 2021). Migrants who were working as essential personnel – in health care, transport, construction or logistics – throughout ASEAN were more likely to be required to physically report to work, even during the strictest of lockdown mandates, which naturally resulted in increased exposure to COVID-19. Many workers working in these essential sectors did not have adequate or equitable access to personal protective equipment (PPE) such as masks, alcohol hand sanitizer gels, face shields, rubber gloves, and were not able to distance themselves as per government guidelines both during their transit to and at work. Moreover, they also were unable to wash their hands frequently, due to a lack of access to appropriate sanitation facilities (ILO, 2020).

Health impacts

The physical impacts of COVID-19, which include muscle aches, hypoxia, cough, high fever and fatigue (Dai et al., 2021), alongside the exhaustion of health-care resources due to national health-care systems being stretched to the limit during the height of COVID-19, resulted in inequitable access to COVID-19 treatment for migrant workers. This is because national emergencies such as pandemics result in the exacerbation of pre-existing health-care access issues for migrants and highlight the difficulties they experience, as migrants are usually the first subpopulation to be triaged out of national health emergency and preparedness plans. Additionally, subpopulations who are more likely to experience social exclusion and be socioeconomically disadvantaged – which include migrant workers in ASEAN – are also more likely to suffer from non-communicable and chronic diseases, which heightens their vulnerability of co-morbidity within the context of COVID-19 (OECD, 2020).

In addition to the disproportionate impact of COVID-19 infections on migrant workers, increased xenophobia and racism due to the perceived external threat of irregular migrants, refugees and internally displaced persons, as well as strict border controls throughout ASEAN has resulted in detrimental impacts to migrants' mental health and well-being (Hennebry and KC, 2020). Specifically, the xenophobia and racism that migrant workers experience has dramatically manifested in multiple, intersecting forms of discrimination at the individual, community, and structural level. At the individual level, overt examples of racism and xenophobia against migrant workers include them being the targets of physical abuse (such as spitting, pushing or hitting), hate speech and hateful behaviour. Moreover, at the structural level, xenophobia and racism have been historically built into labour migration governance and health-care service provision for migrant workers. For example, migrant workers globally, and specifically within ASEAN, have been subjected to increased levels of COVID-19 testing, movement and mobility restrictions or quarantined in poorly ventilated, unhygienic, and substandard accommodations away from host communities, while still being overwhelmingly excluded in pandemic support programmes and targeted in mass immigrant deportations (Hennebry and KC, 2020).

Specifically, a rapid assessment survey with 309 ASEAN migrant workers in 2020 conducted by ILO uncovered that 23 per cent of the survey participants who were quarantined experienced shortages of food, due to being overlooked by authorities. Moreover, while in these quarantine facilities, migrant workers reported struggling with severe social exclusion and isolation, depression and insomnia (ILO, 2020). Overall, the weaponization of fear against migrant workers and structural-level messaging that they pose a significant and dangerous health risk to host communities has been used under the guise of containing and controlling the spread of COVID-19 (Hennebry and KC, 2020). The perceived external threat of unscreened irregular migrants, as well as strict border controls throughout ASEAN, leads to more irregular movement and heightened dangerous conditions of travel for migrant workers.

In May 2020, António Guterres, the UN Secretary-General, called for collective and coordinated global action to address the “tsunami of hate and xenophobia, scapegoating and scare-mongering” that migrant workers were subjected to, in lieu of the pandemic (Jones, Mudaliar and Piper, 2020).

Box 2. Xenophobia and Racism experienced by migrant workers in Thailand during COVID-19 outbreaks

In the province of Samut Sakhon in Thailand, approximately 400,000 migrant workers, many of whom are from Myanmar, work in the fishing and seafood processing sector. Samut Sakhon is home to the largest community of Myanmar nationals within Thailand, and it is estimated that around 50 per cent of these workers are undocumented. These workers are often provided with overcrowded and poor housing by their employers, and are not able to understand Thai well, which leads to a lack of social cohesion, social exclusion and exclusion from participating in Thailand's national health-care system (Vandergeest, Marschke and Duker, 2021).

In December 2020, a cluster of migrant workers in Samut Sakhon working in the central wholesale shrimp market tested positive for COVID-19. Further targeted 'contact and trace' COVID-19 testing unveiled thousands more positive COVID-19 infections. Approximately 12,000 cases were discovered through targeted testing in Samut Sakhon's seafood factories, the majority of which were detected within the province's factories that mostly employ Myanmar national migrant workers. While Samut Sakhon's provincial hospitals retained a good level of outreach during the outbreak towards migrant workers, for example, by employing migrant volunteers to work in the field hospitals that Thailand temporarily created and set up for persons infected with COVID-19, these efforts were unfortunately deterred and undermined by national discriminatory policies and top-level messaging towards Thailand's migrant workers. For example, top government officials in a televised address stated that the clusters were due to Myanmar nationals and migrant workers illegally sneaking past the Myanmar-Thailand border. This kind of rhetoric highlights how migrant workers were and continue to be scapegoated and blamed for "spreading" COVID-19, which has provoked increased racism towards migrant workers from Myanmar – who have historically been systemically discriminated against (Vandergeest, Marschke and Duker, 2021).

Furthermore, additional policies were introduced to curb the COVID-19 outbreak in December 2020. The government forced migrant workers who worked near Samut Sakhon's wholesale shrimp market to quarantine in their congested, overcrowded and cramped dormitories by placing both infected and uninfected COVID-19 workers together. Additionally, their dormitories were fenced off with barbed wire, a policy that no other subpopulation in Thailand was subjected to. The government also imposed an interprovincial travel ban in Samut Sakhon. However, this ban only applied to migrant workers, which added to the narrative that migrant workers were the sole carriers and transmitters of the virus. This was still able to travel inside and outside of Samut Sakhon if they pre-applied for a travel permit, which is yet another example of discriminatory COVID-19 health and travel policy against migrant workers in Thailand (Vandergeest, Marschke and Duker, 2021).

In addition to the xenophobia and racism experienced by migrant workers in their host countries, those who returned or were repatriated home increasingly found themselves to be feared by or subjected to discrimination by their former neighbours, as due to the nature of their work and travel, their home communities also viewed them as being carriers for COVID-19, despite returnee migrant workers being required to go through rigorous testing and quarantine requirements. In **Myanmar**, some returnee migrant workers felt that extra quarantine procedures singled them out negatively as sources of COVID-19 infection; however, others welcomed these extra quarantine procedures as a method of reassuring their former neighbours and home communities (Jones, Mudaliar and Piper, 2020).

Socioeconomic impacts

The devastating socioeconomic impacts on migrant workers in ASEAN cannot be overstated, as COVID-19 has severely disrupted the flow of remittances. Across low-income countries nations around the world, as well as the Asia-Pacific, migrant remittances have famously served as an important source of income for many families and households. Families dependent on migrant remittances often solely depend on these remittances to successfully use public services such as health care or education. Thus, if there is a massive drop in remittance flows, it would very likely force families dependent on migrant remittances below the poverty line of their respective countries (Ernst, 2021). Migrant workers' socioeconomic situations have not been fully considered either, as they have been repatriated by their home nations without any consideration for their current or future situation. Repatriation has brought along debt, as migrant workers will still be obliged to continue to pay off their labour recruitment fees and all associated costs, even though they might have been unsuccessful at earning an income (Subramaniam, 2020).

All in all, COVID-19 and its impacts have forced and encouraged countries around the world, including within ASEAN, to think inclusively of their populations – including migrant workers – when it comes to outreach health programmes, national COVID-19 vaccine campaigns, and COVID-19 related health treatments.

6.4 COVID-19 related policies implemented across ASEAN (as of April 2022)

Table 42. COVID-19 related policies implemented across ASEAN (as of April 2022)

ASEAN Member State	Mandatory Social Distancing (1.5 meters apart)	Mandatory Mask	Mandatory Quarantine Measures if Fully Wearing Vaccinated (when travelling inbound)	Inclusion of Migrants in National Vaccine Plans
Brunei	✓	✓	✓	✓
Cambodia	✓	✓	✗	✓
Indonesia	✓	✓	✓	✓
Lao PDR	✓	✓	✓	✓
Malaysia	✓	✓	✗	✓
Myanmar	✓	✓	✓	✓
Philippines	✗	✓	✗	✓
Singapore	✗	✓	✗	✓
Thailand	✓	✓	✓	✓
Viet Nam	✓	✓	✓	✓

6.5 Conclusion

The wide-reaching impacts of COVID-19 since January 2020 have dramatically underscored the need for ASEAN Member States to adopt an inclusive, people-centered and migrant-friendly COVID-19 response at all levels. While everyone globally has been impacted by the pandemic in some shape or form, migrants have remained uniquely vulnerable as governments have left migrant workers in precarious situations. Migrants are excluded from public health policies, which has severely impacted their physical, mental and socioeconomic well-being. For COVID-19 to be successfully mitigated and managed, Mercy Barends, an Indonesian Member of Parliament has stated that “government policies must ensure that they [migrant workers] have equal access to immediate aid, testing, treatment and vaccinations, without fear” (APHR, 2021).

As critically stated in the ASEAN Post-2015 Health Development Agenda’s overall mission, ensuring a healthy, caring and sustainable ASEAN Community by promoting healthy lifestyles, responding to all hazards and emerging threats, strengthening health systems and access to care, and ensuring food safety is important. Thus, applying this objective to migrant health within ASEAN, it is crucial to respond to COVID-19 through strengthening health systems by making them migrant-sensitive and friendly. This could include targeted COVID-19 vaccine outreach programmes, tailored to specific migrant subpopulations’ native languages.

Migrants should and must be included in national social protection measures in their host countries.

Specifically, the ASEAN Comprehensive Recovery Framework, which serves as the consolidated exit strategy from the COVID-19 pandemic as ASEAN plans to enter the post COVID-19 recovery phase, stresses that the development of occupational safety and health standards, as well as improvements to the living facilities of workers whose work cannot be conducted remotely, are extremely important to mitigate the risk of future COVID-19 infections. Moreover, labour migration policies that could critically safeguard migrant workers during COVID-19, and in other pandemics or future crises must be further pursued by ASEAN Member States, to protect community-wide health and health systems overall.

The ASEAN Parliamentarians for Human Rights state that governments in ASEAN should ensure that any human being attempting to access essential services during COVID-19 should not be barred based on their nationality, citizenship or immigration status, and that migrants who have tested positive for COVID-19 should receive health-care attention immediately and must be allowed to receive the COVID-19 vaccination at the same time as national citizens. The APHR also emphasize that ASEAN Member States have an obligation to improve social protection and implement labour reforms for migrant workers, in line with their previous binding commitments made in the “ASEAN Declaration on Strengthening Social Protection” (APHR, 2021). Furthermore, as new variants have emerged and will continue to arise, health services must ensure inclusivity of all peoples, which include refugees, internally displaced persons, stateless individuals and migrants, if nations are to achieve universal healthcare for all, and to build robust systems that successfully protect entire populations (UNHCR UK, 2020).

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ANNEX

Photo by Sol on Unsplash

Annex A: Definition of terms

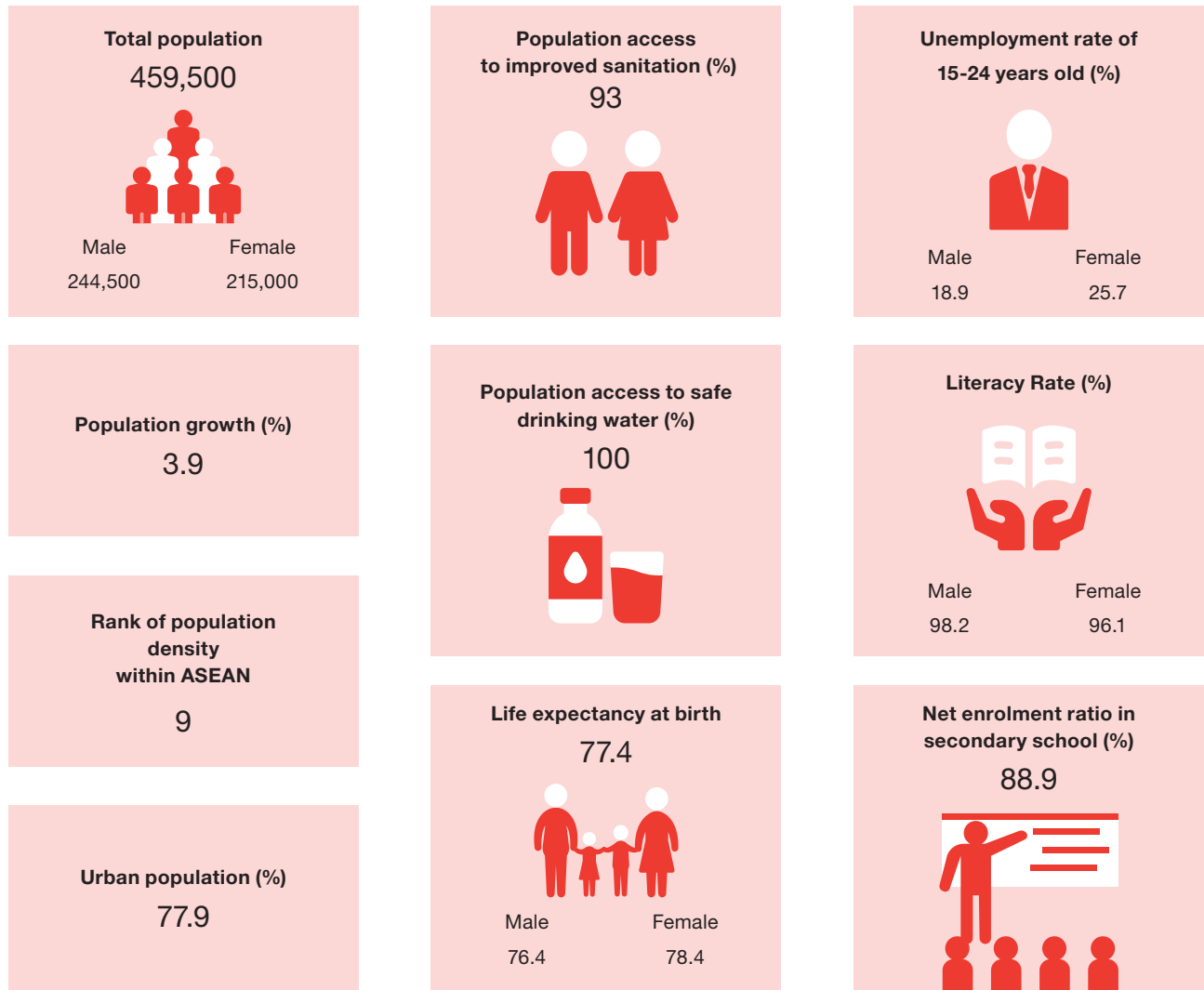
Terminology	Definition
Complementary and alternative medicine (CAM)	Medical products and practices that are not part of standard medical care. Complementary medicine is treatments that are used along with standard medical treatments but are not considered to be standard treatments. One example is using acupuncture to help lessen some side effects of cancer treatment. Alternative medicine is treatments that are used instead of standard medical treatments. One example is using a special diet to treat cancer instead of anticancer drugs that are prescribed by an oncologist.
Emergency care	Emergency medical attention given to an individual who needs it; includes those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.
Emigration	The act of departing or exiting from one State with a view to settling in another.
Fair treatment	The just and reasonable treatment applied to migrant workers in the workplace with respect to working conditions, safety, and access to recourse in the event of employment subject to the prevailing national laws, regulations and policies of the Receiving State.
Health Insurance	A form of financing and managing health care based on risk pooling; social health insurance pools both the health risks of the people on one hand, and the contributions of individuals, households, enterprises, and the government on the other.
Health maintenance organization	A medical insurance group that provides health services for a fixed annual fee. An organization that provides or arranges managed care for health insurance, self-funded healthcare benefit plans, individuals, and other entities, acting as a liaison with healthcare providers (hospitals, doctors, etc.) on a prepaid basis.
Hospitalization	Admission to a hospital or health facility for treatment.
Immigration	A process by which non-nationals move into a country for the purpose of settlement.
Immunization	The process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine.
Inpatient care	The care of patients whose condition requires admission to a hospital.
Migrant worker	A person who is to be engaged or employed, is engaged or employed, or has recently been engaged or employed in a remunerated activity in a State of which he or she is not a national.
Out-of-pocket expense	The share of the expenses that the insured party must pay directly to the healthcare provider, without a third-party (insurer, or government).
Premium	The amount of money that an individual or business must pay for an insurance policy; Income for the insurance company, once it is earned, and also represents a liability in that the insurer must provide coverage for claims being made against the policy.
Primary care	The first point of contact for healthcare for most people. Mainly provided by general practitioners, but community pharmacists, opticians and dentists are also primary health-care providers.
Ratification	The international act in which a state indicates its consent to be bound to a treaty if the parties intended to show their consent by such an act. In the case of bilateral treaties, ratification is usually accomplished by exchanging the requisite instruments, and in the case of multilateral treaties, the usual procedure is for the depositary to collect the ratifications of all states, keeping all parties informed of the situation.
Receiving state	The ASEAN Member State which hosts a migrant worker.
Refugee	A person who has been forced to flee his or her country because of persecution, war or violence. A person has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group.
Sending state	The ASEAN Member State of which the migrant worker is a national.
Tax-based financing	Those in which more than half of public expenditure is financed through revenues other than earmarked payroll taxes (i.e. to distinguish it from social security or social health insurance), and in which access to publicly-financed services is, at least formally, open to all citizens.
Undocumented migrant worker	A person who fails to comply with the conditions provided for him or her to legally enter the Receiving State and to stay legally for the duration of employment pursuant to the applicable laws, regulations, and policies of the Receiving State. This definition includes a migrant worker who has recently been in employment but is no longer legally employed in a remunerated activity.

Annex B: Country Indicators

1. Brunei Darussalam

1.1 General indicators

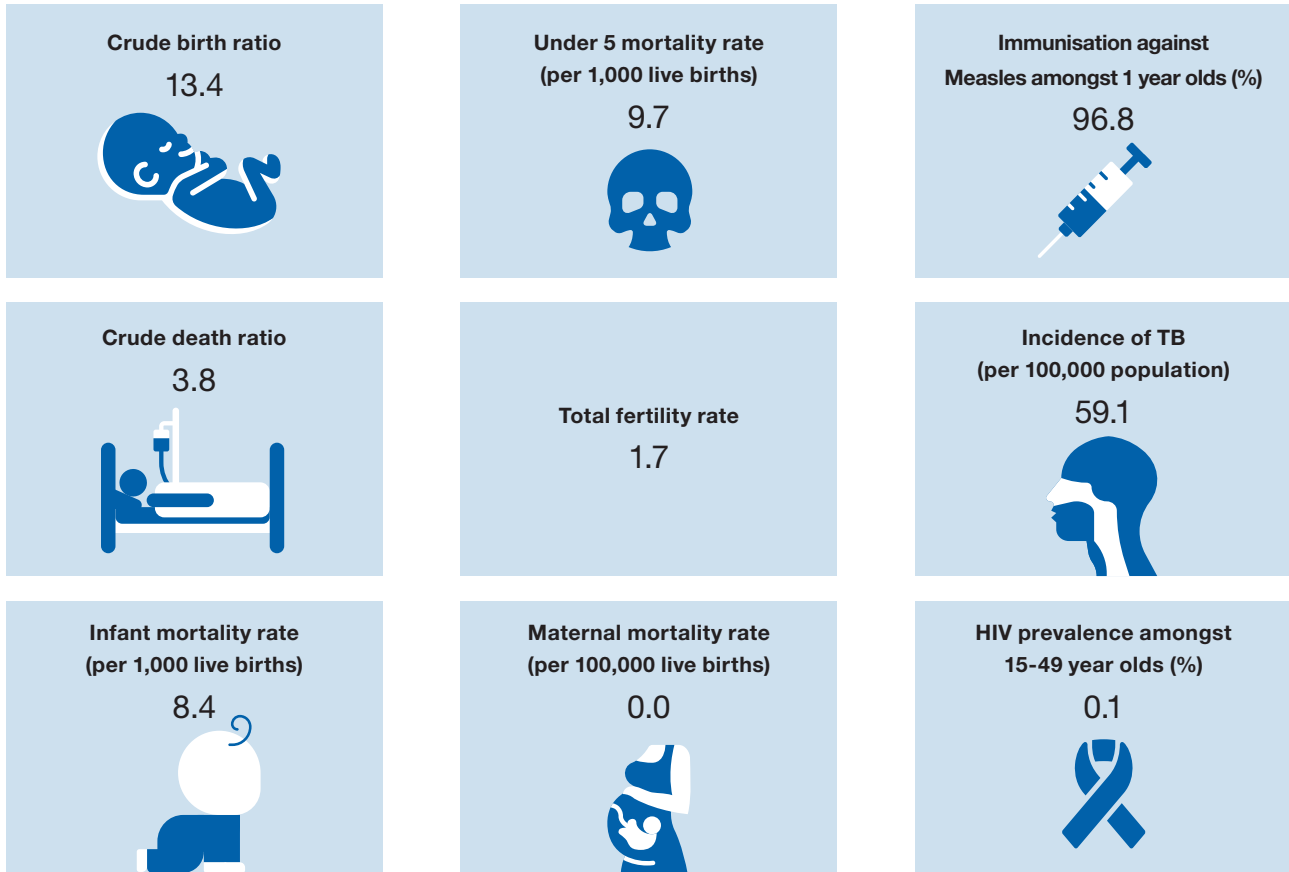
Figure 7. General indicators of Brunei Darussalam



Source: ASEAN Statistical Yearbook 2020

1.2 Demographic and health indicators

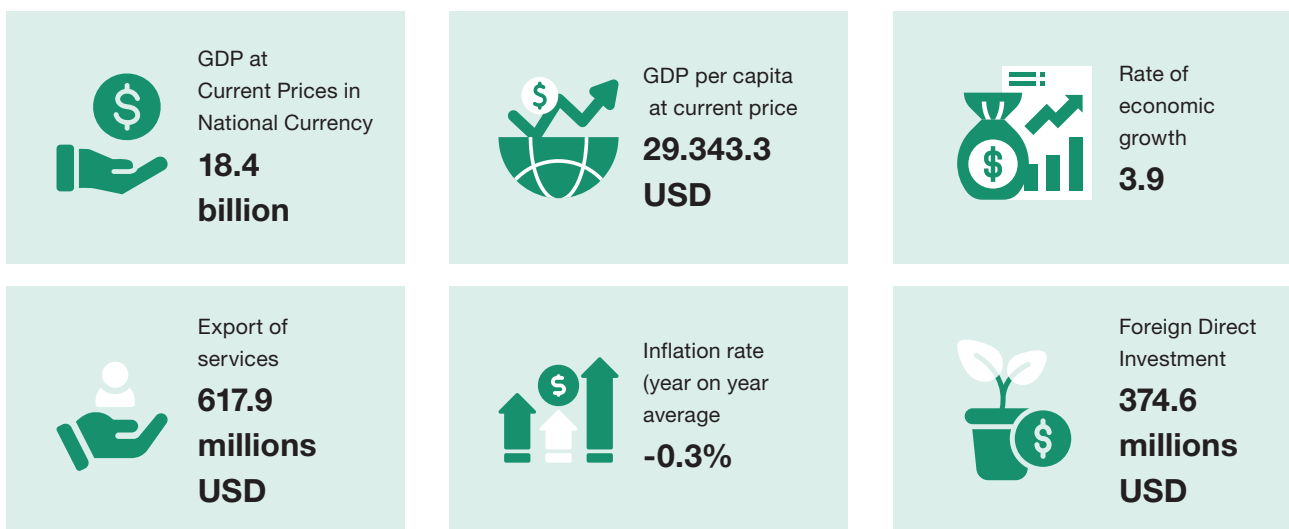
Figure 8. Demographic and Health indicators of Brunei Darussalam



Source: ASEAN Statistical Yearbook 2020

1.3 Macroeconomic Indicators

Figure 9. Macroeconomic Indicators of Brunei Darussalam



Source: ASEAN Statistical Yearbook 2020

2. Cambodia

2.1 General indicators

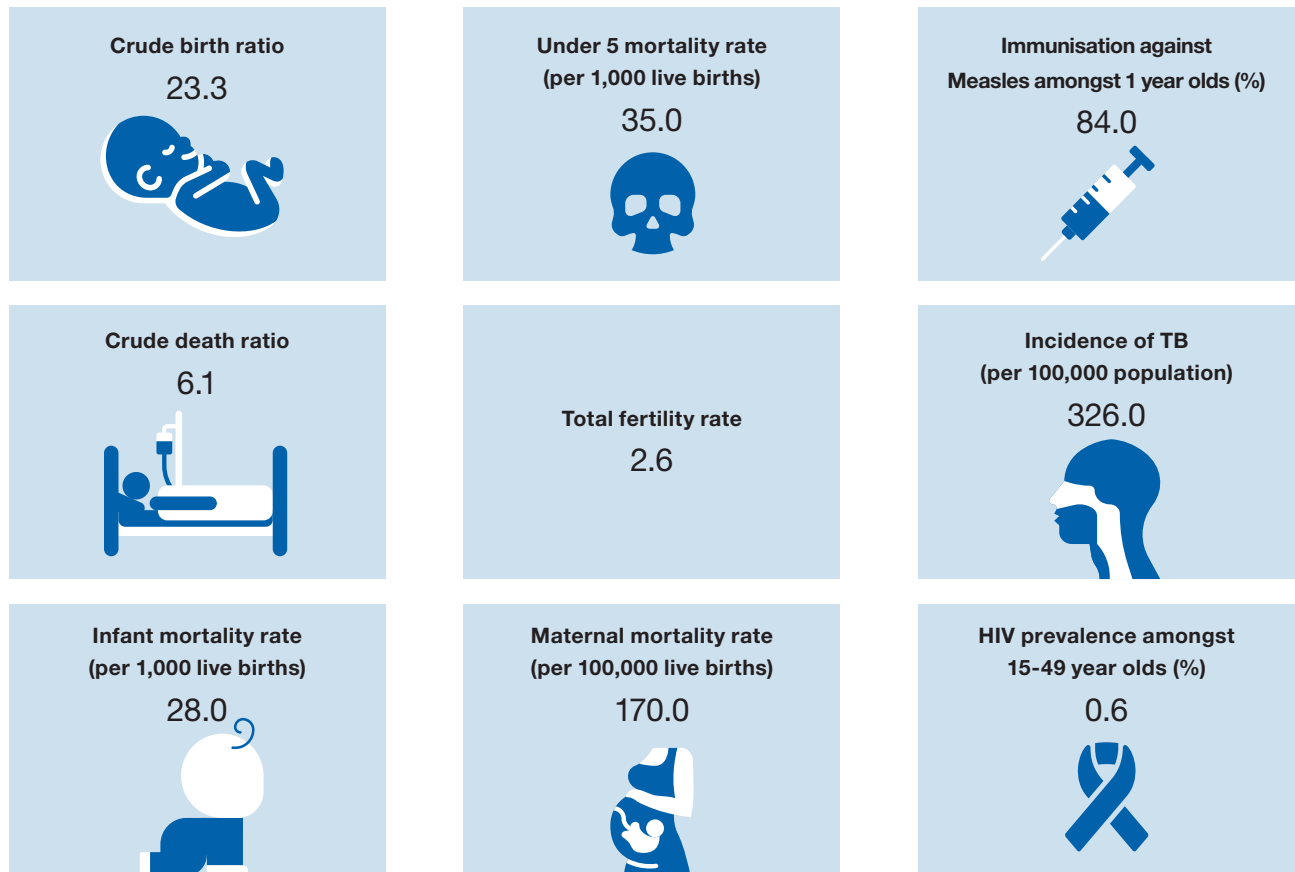
Figure 10. General indicators of Cambodia



Source: ASEAN Statistical Yearbook 2020

2.2 Demographic and health indicators

Figure 11. Demographic and Health indicators of Cambodia



Source: ASEAN Statistical Yearbook 2020

2.3 Macroeconomic indicators

Figure 12. Macroeconomic indicators of Cambodia



Source: ASEAN Statistical Yearbook 2020

3. Indonesia

3.1 General indicators

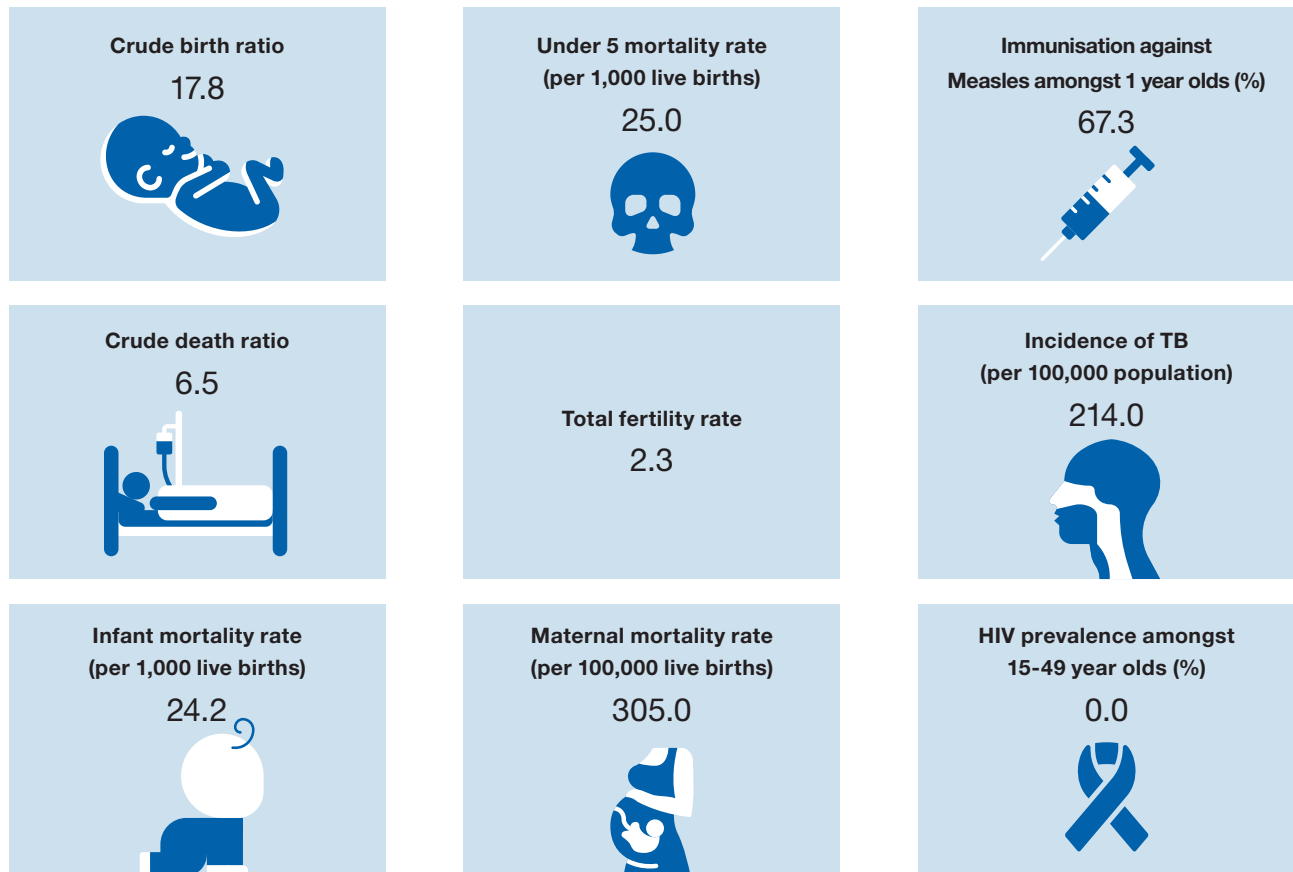
Figure 13. General Indicators of Indonesia



Source: ASEAN Statistical Yearbook 2020

3.2 Demographic and health indicators

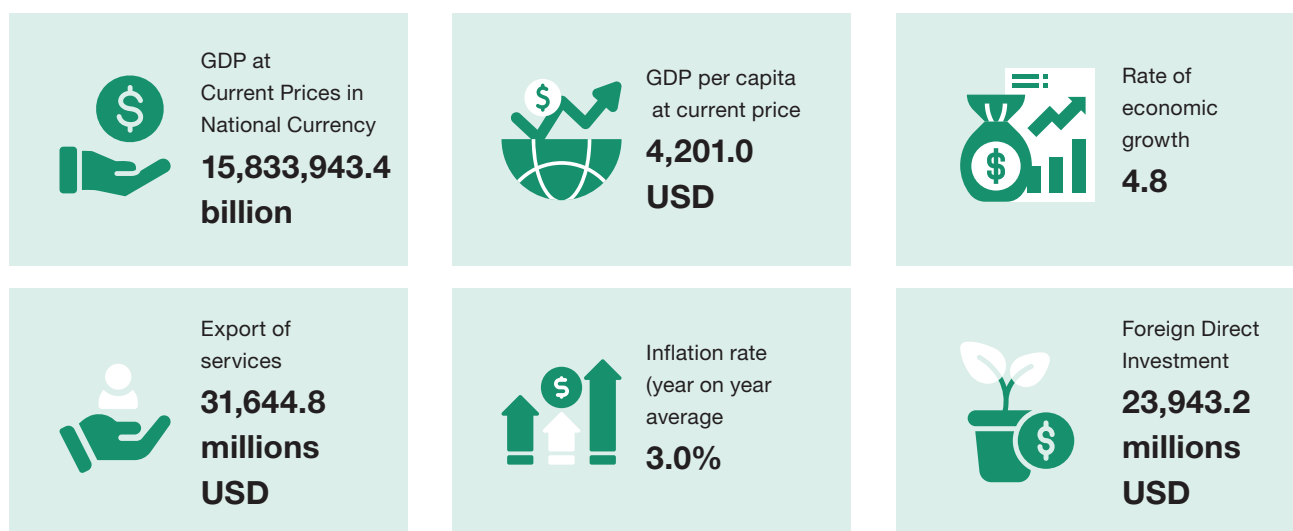
Figure 14. Demographic and health indicators of Indonesia



Source: ASEAN Statistical Yearbook 2020

3.3 Macroeconomic indicators

Figure 15. Macroeconomic Indicators of Indonesia

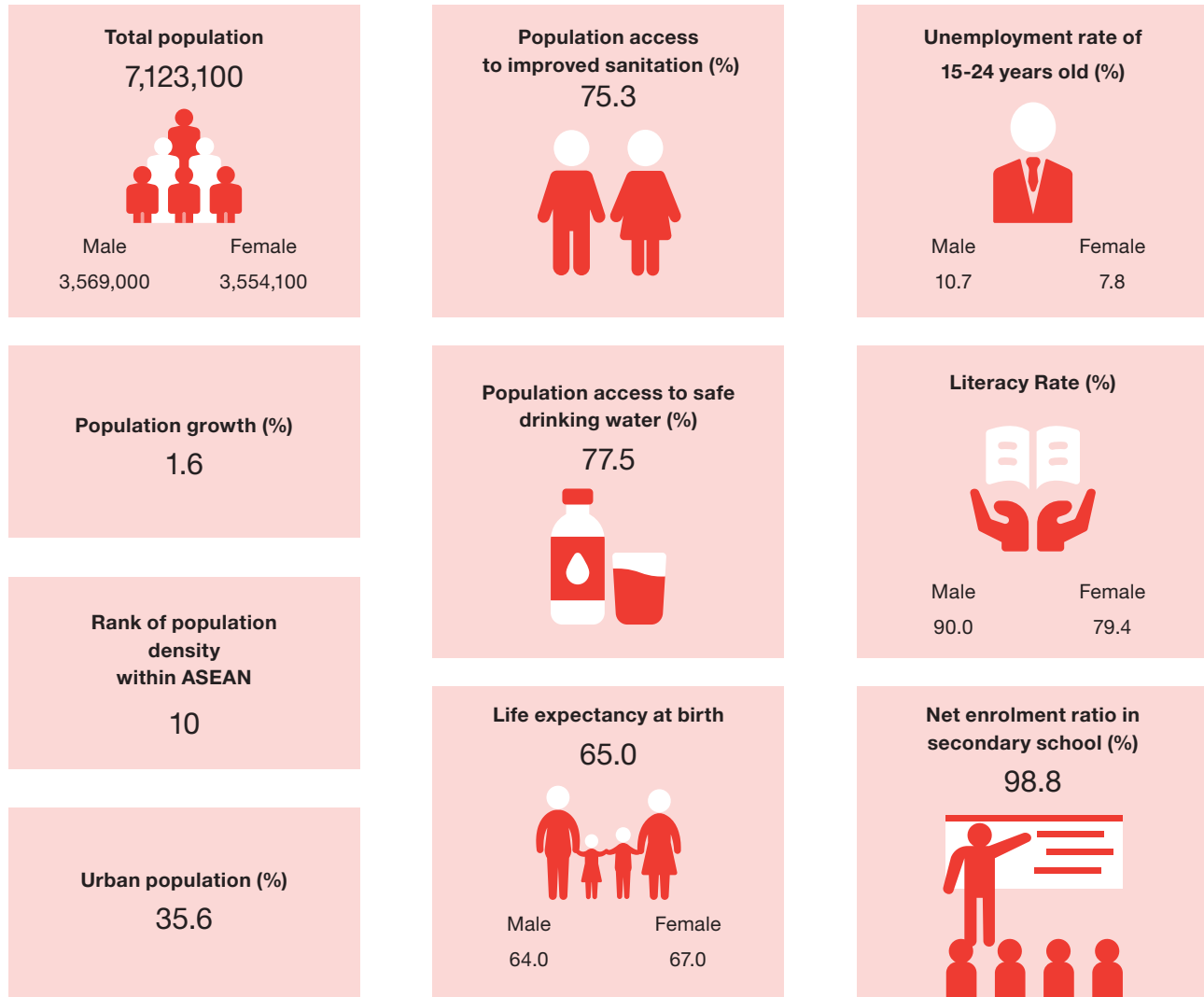


Source: ASEAN Statistical Yearbook 2020

4. Lao People's Democratic Republic

4.1 General indicators

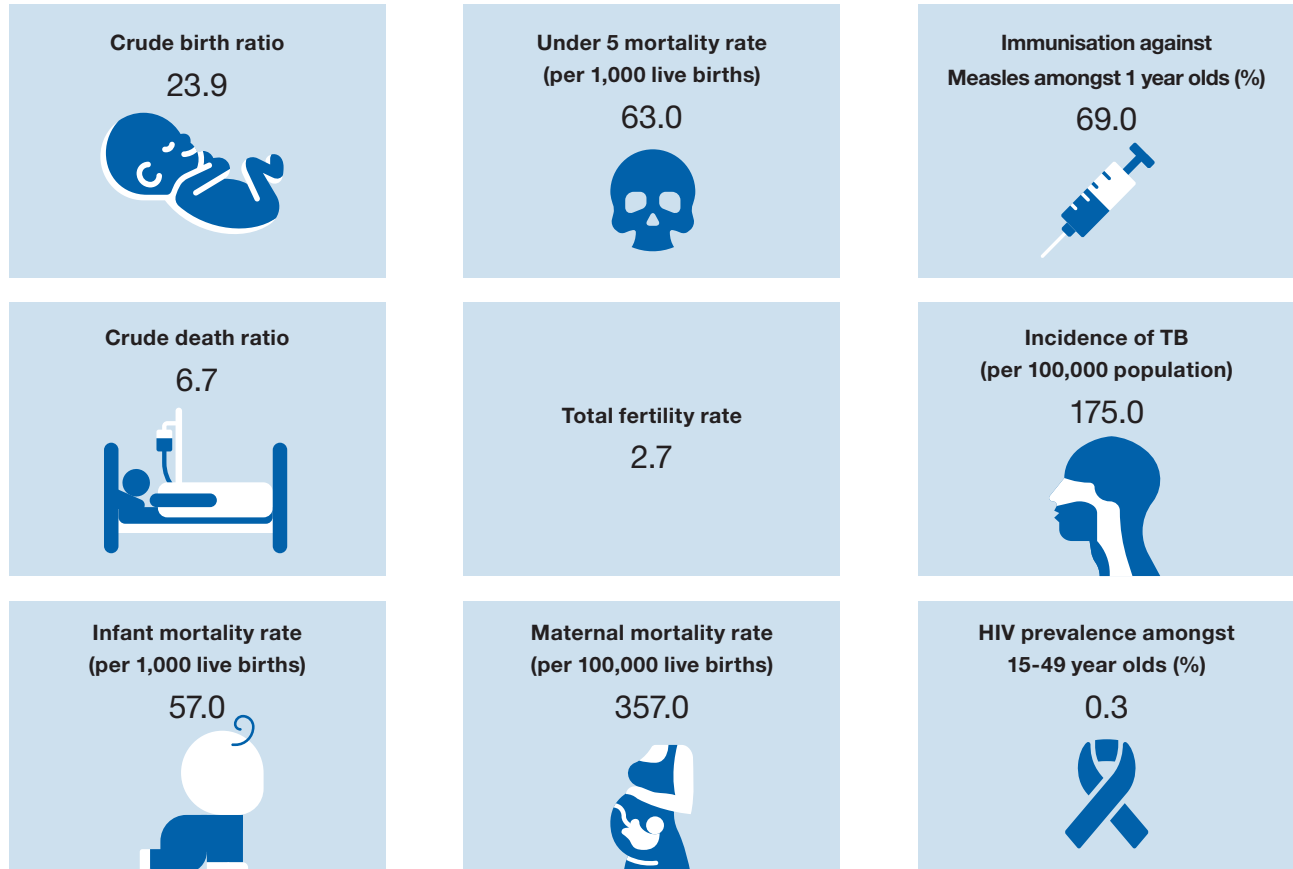
Figure 16. General indicators of Lao People's Democratic Republic



Source: ASEAN Statistical Yearbook 2020

4.2 Demographic and health indicators

Figure 17. Demographic and health indicators of Lao People's Democratic Republic



Source: ASEAN Statistical Yearbook 2020

4.3 Macroeconomic indicators

Figure 18 Macroeconomic Indicators of Lao People's Democratic Republic



Source: ASEAN Statistical Yearbook 2020

5. Malaysia

5.1 General indicators

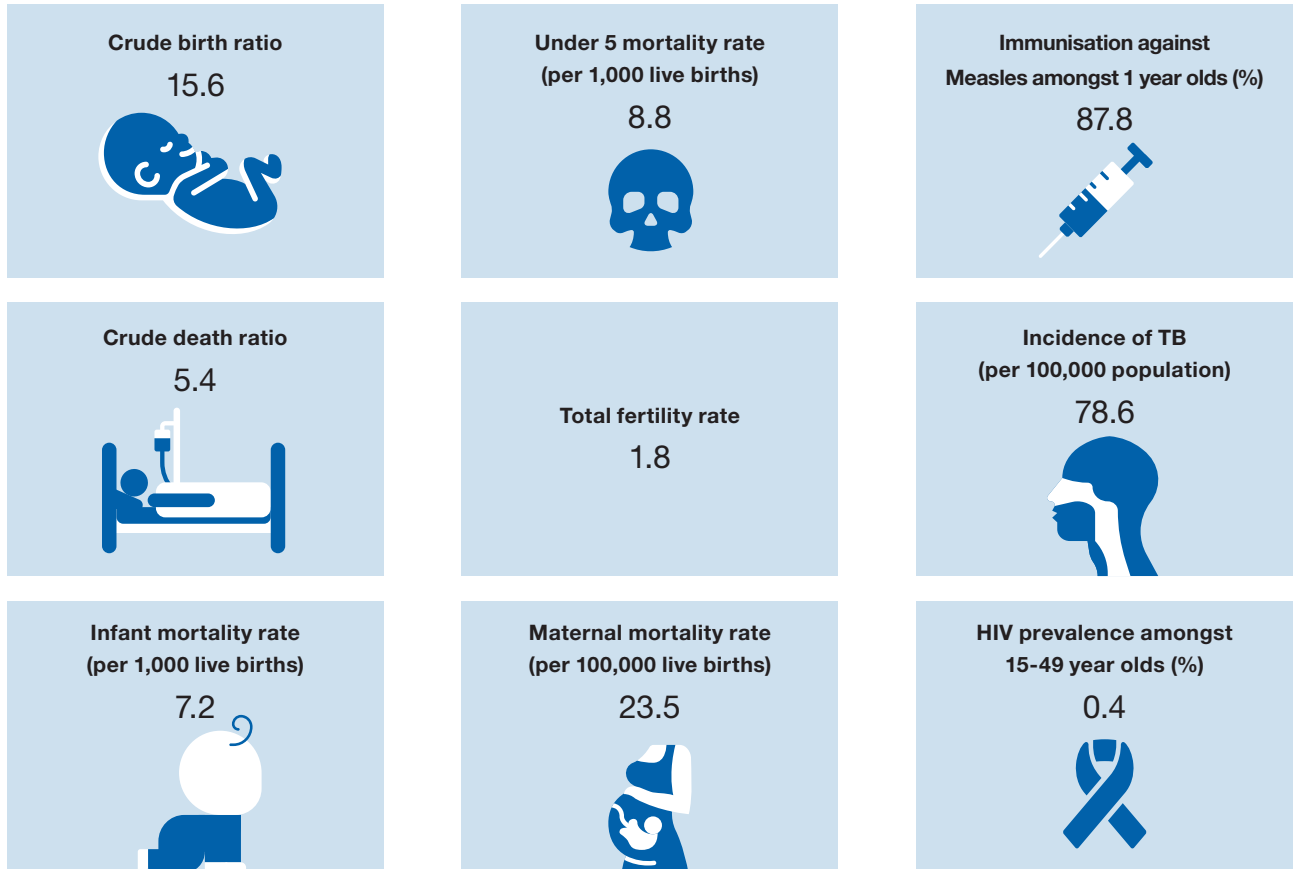
Figure 19. General indicators of Malaysia



Source: ASEAN Statistical Yearbook 2020

5.2 Demographic and health indicators

Figure 20. Demographic and health indicators of Malaysia



Source: ASEAN Statistical Yearbook 2020

5.3 Macroeconomic indicators

Figure 21. Macroeconomic indicators of Malaysia

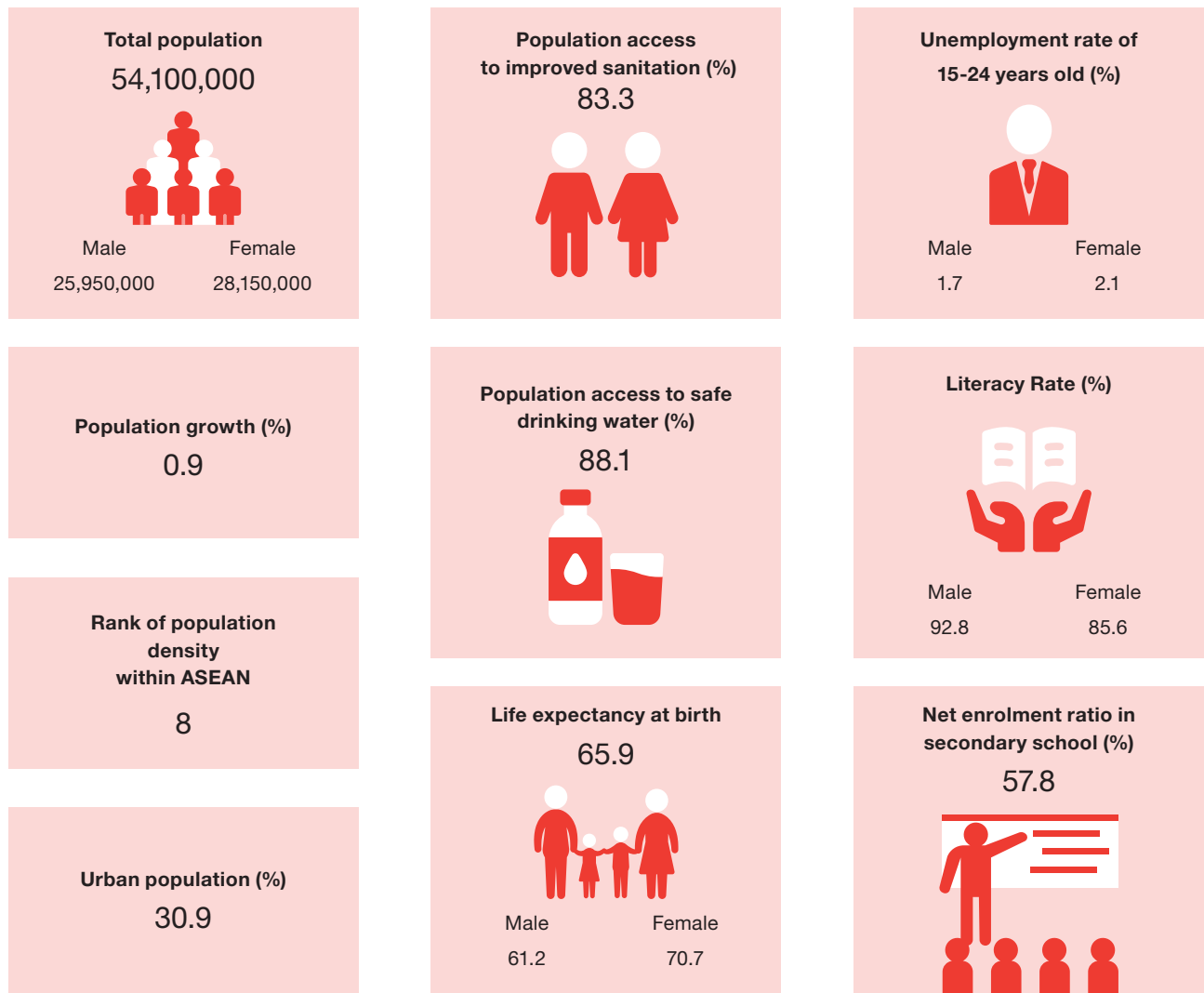


Source: ASEAN Statistical Yearbook 2020

6. Myanmar

6.1 General indicators

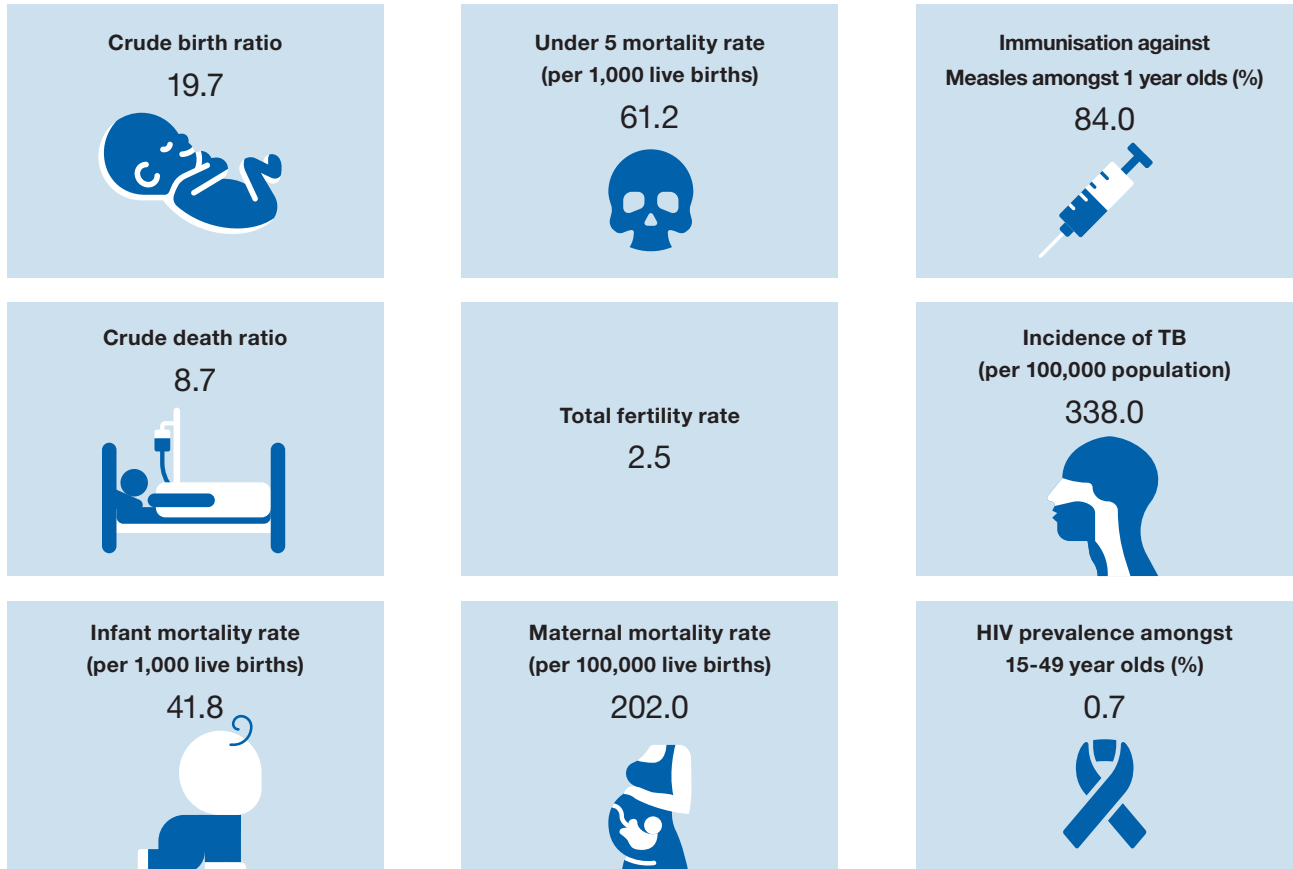
Figure 22. General indicators of Myanmar



Source: ASEAN Statistical Yearbook 2020

6.2 Demographic and health indicators

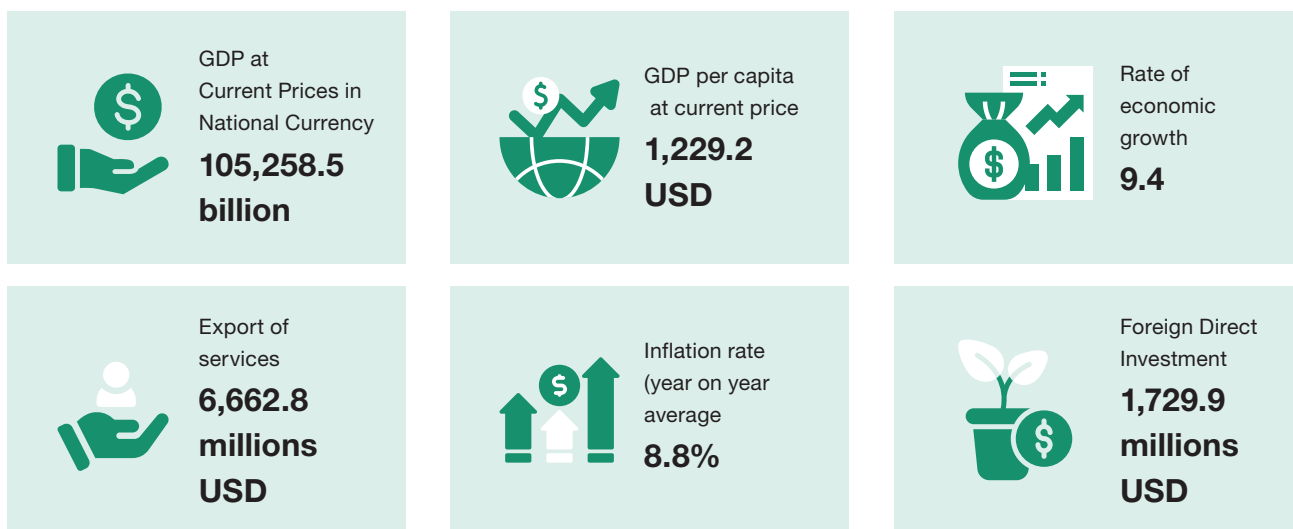
Figure 23. Demographic and health indicators of Myanmar



Source: ASEAN Statistical Yearbook 2020

6.3 Macroeconomic indicators

Figure 24. Macroeconomic indicators of Myanmar



Source: ASEAN Statistical Yearbook 2020

7. Philippines

7.1 General indicators

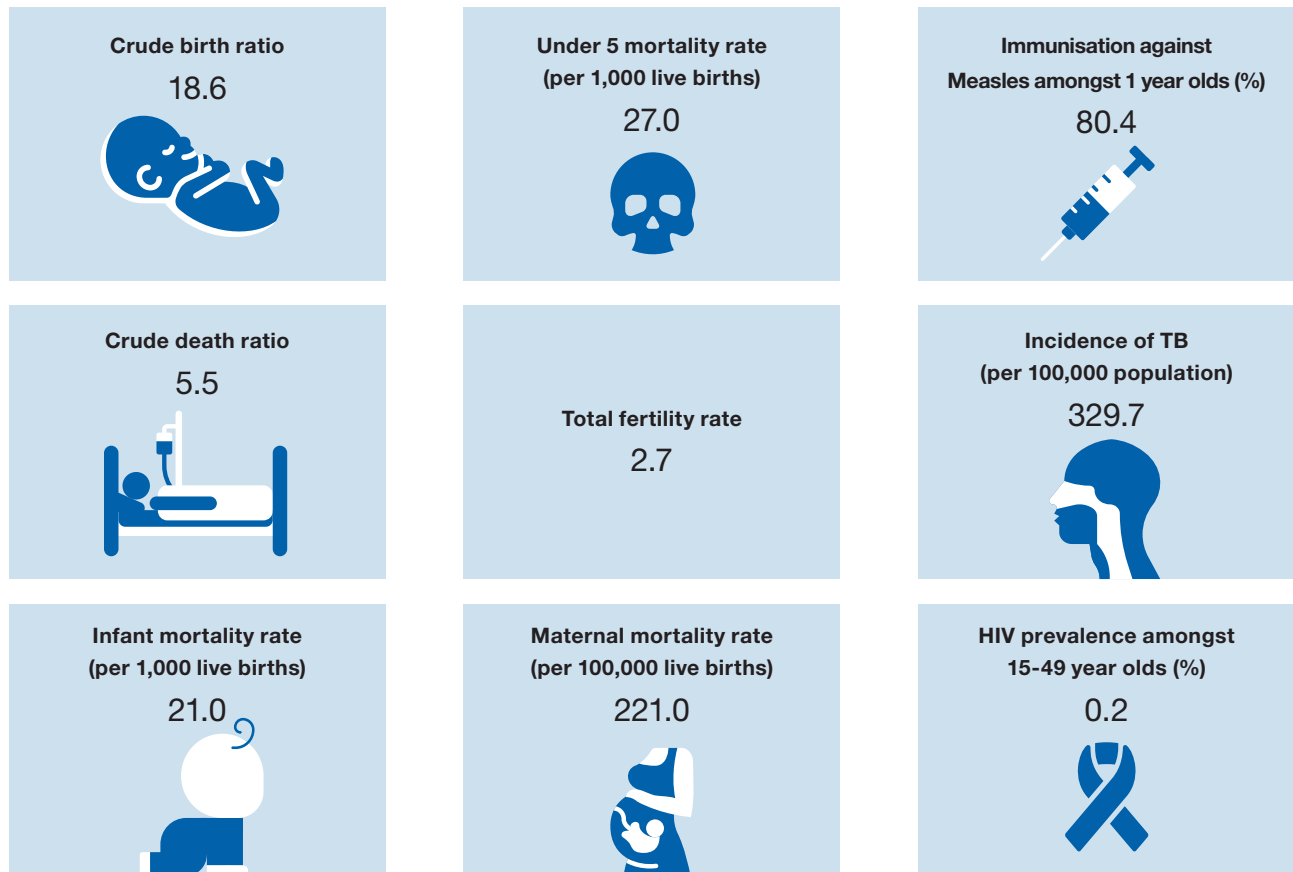
Figure 25. General indicators of the Philippines



Source: ASEAN Statistical Yearbook 2020

7.2 Demographic and health indicators

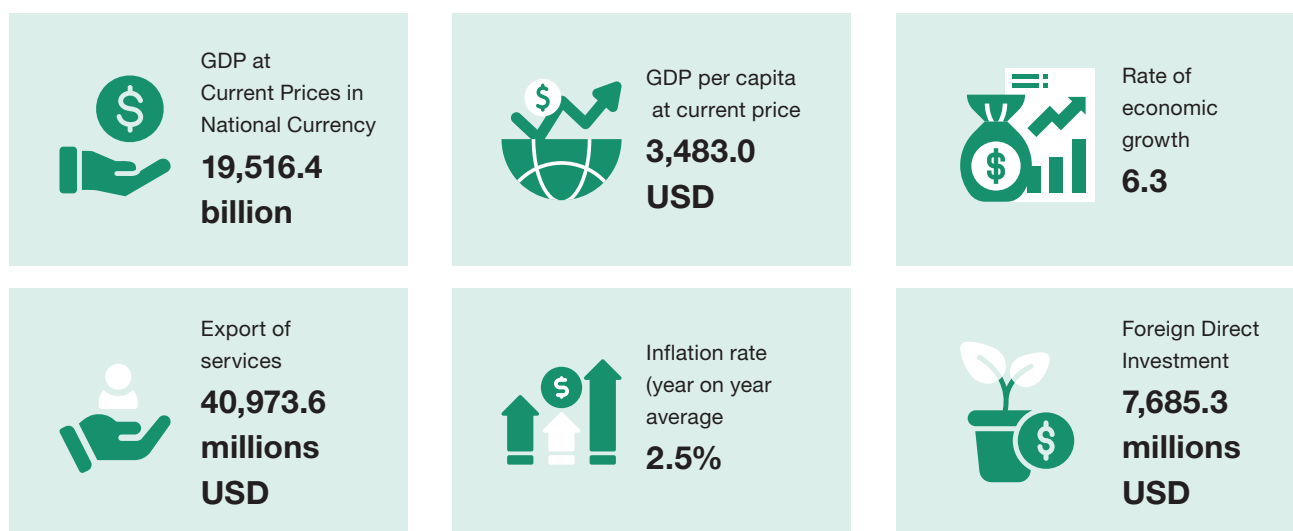
Figure 26. Demographic and health indicators of the Philippines



Source: ASEAN Statistical Yearbook 2020

7.3 Macroeconomic indicators

Figure 27. Macroeconomic indicators of the Philippines

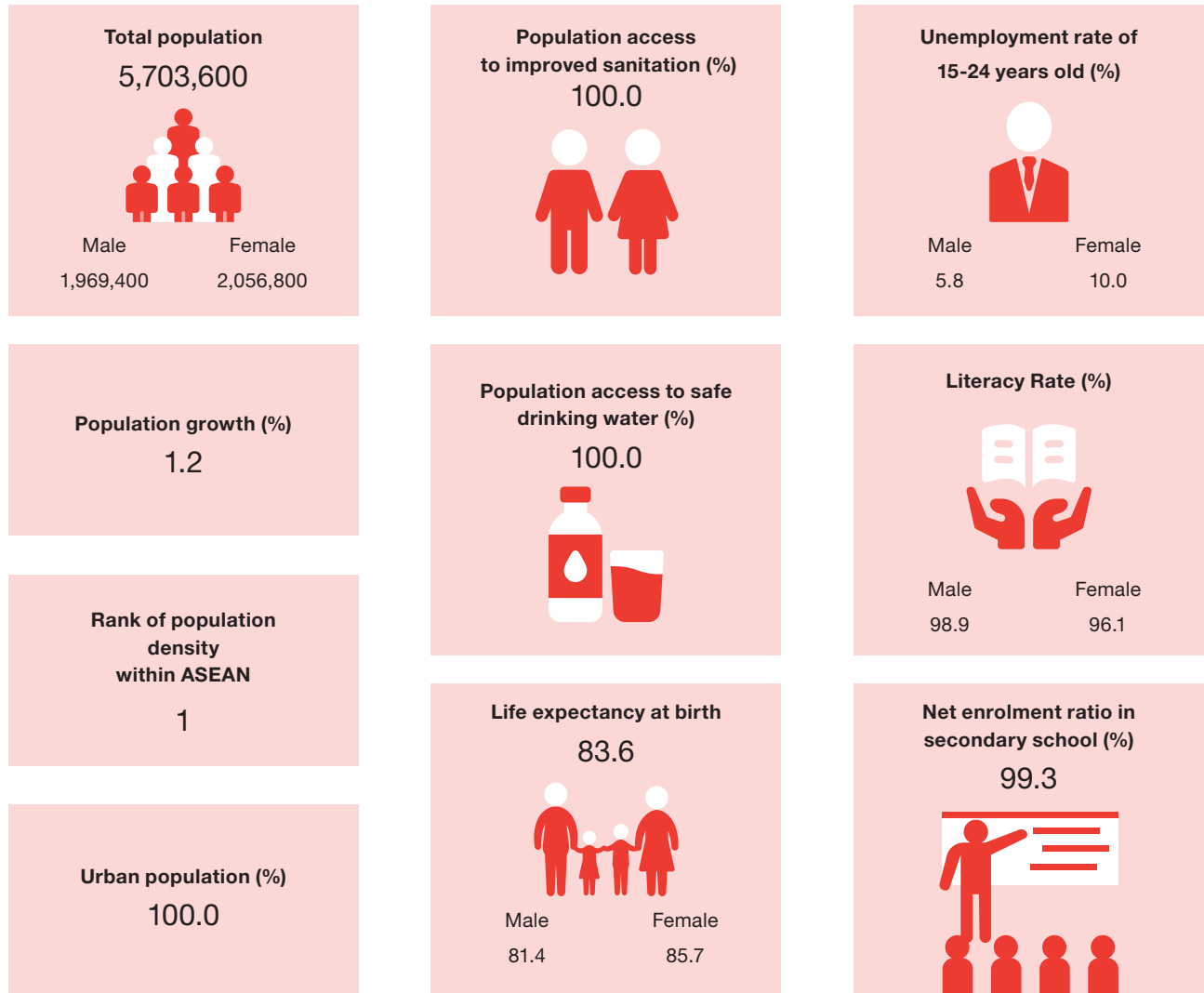


Source: ASEAN Statistical Yearbook 2020

8. Singapore

8.1 General indicators

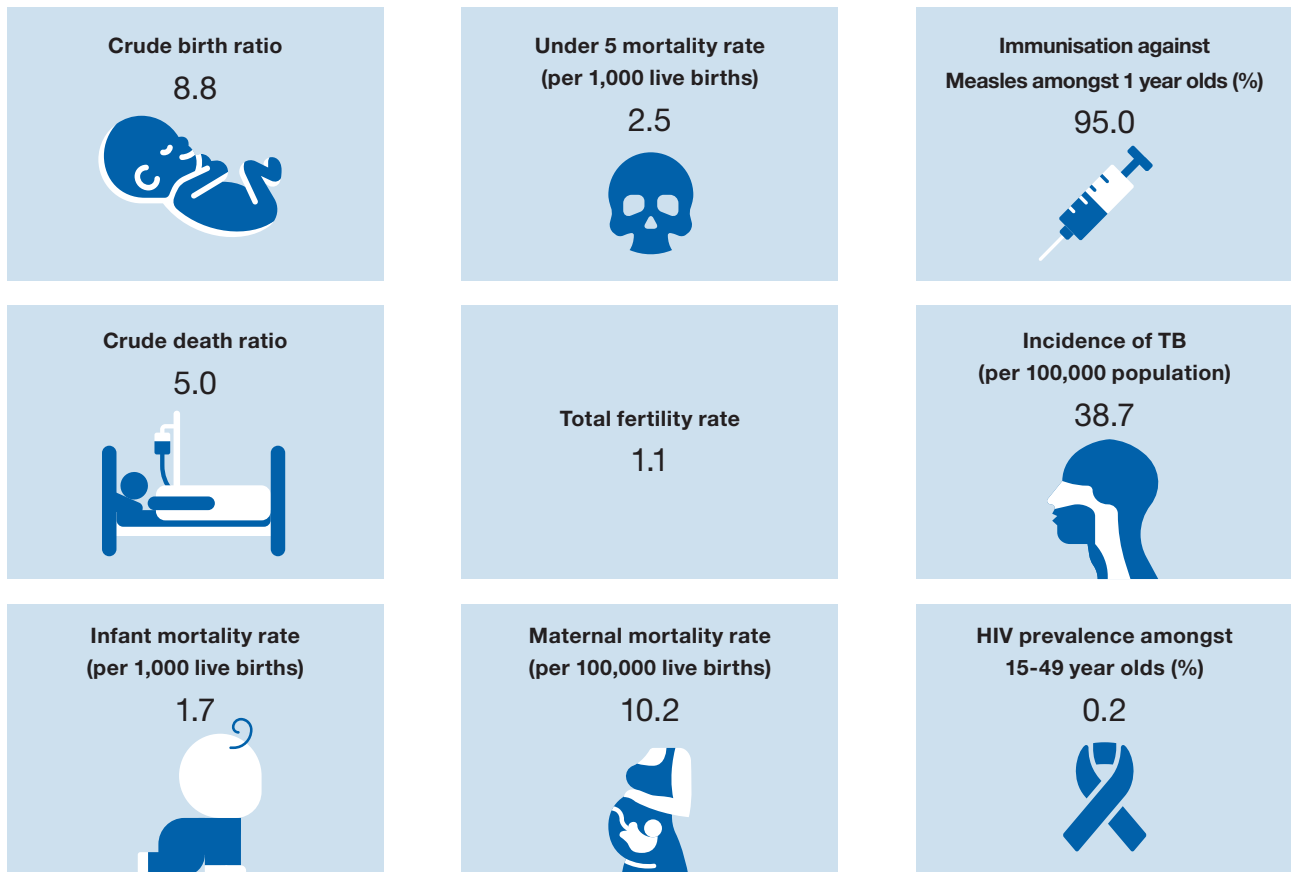
Figure 28. General indicators of Singapore



Source: ASEAN Statistical Yearbook 2020

8.2 Demographic and health indicators

Figure 29. Demographic and health indicators of Singapore



Source: ASEAN Statistical Yearbook 2020

8.3 Macroeconomic indicators

Figure 30 Macroeconomic indicators of Singapore

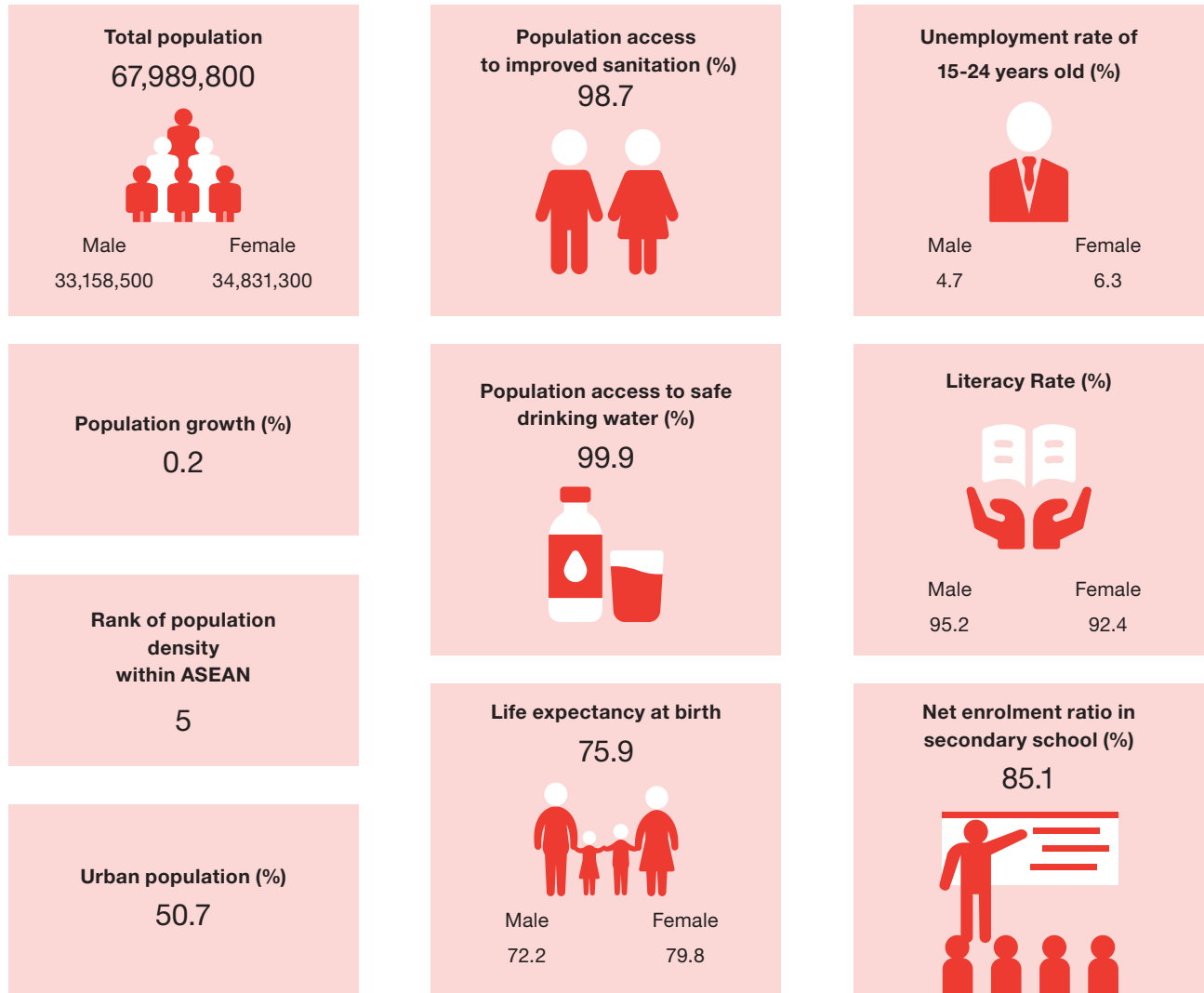


Source: ASEAN Statistical Yearbook 2020

9. Thailand

9.1 General indicators

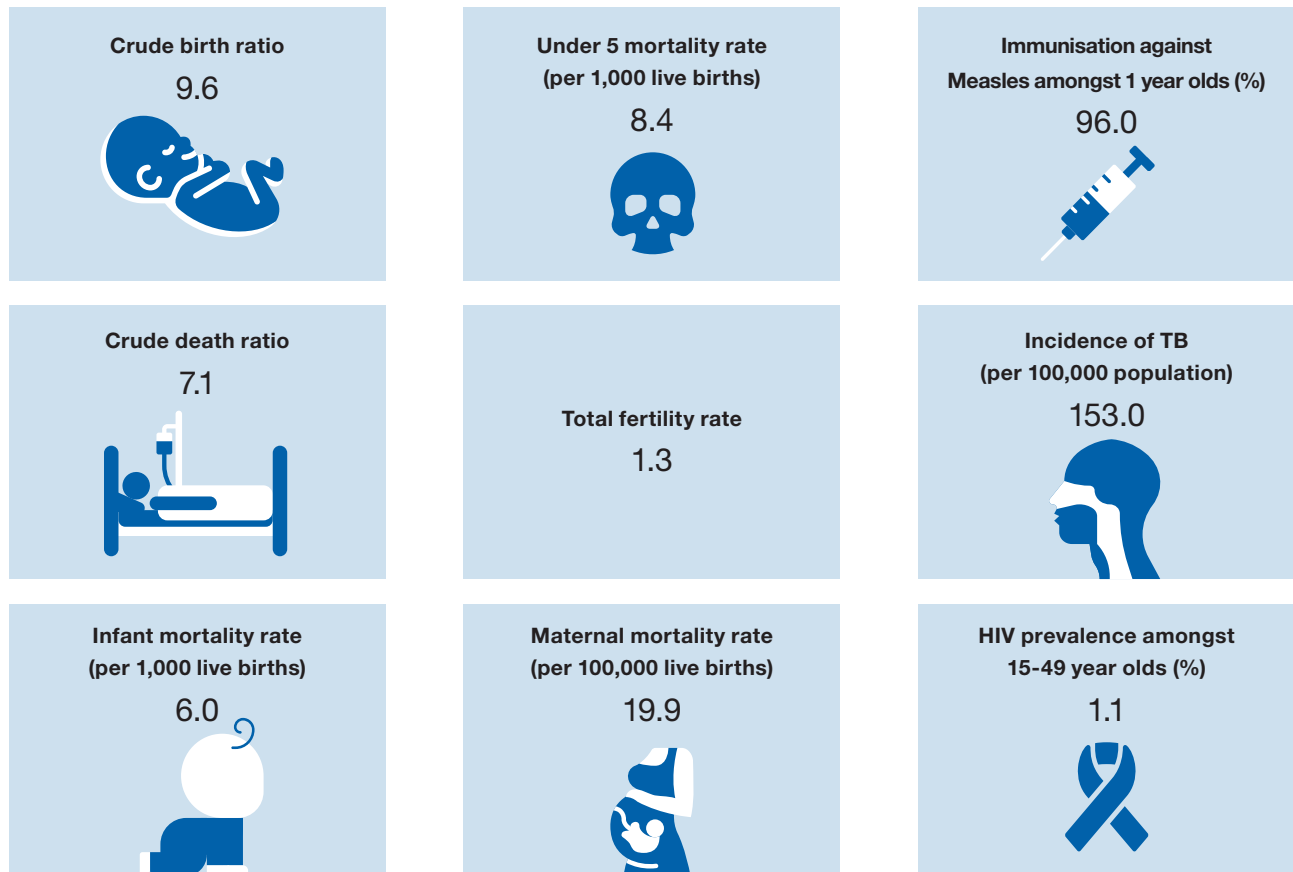
Figure 31. General indicators of Thailand



Source: ASEAN Statistical Yearbook 2020

9.2 Demographic and health indicators

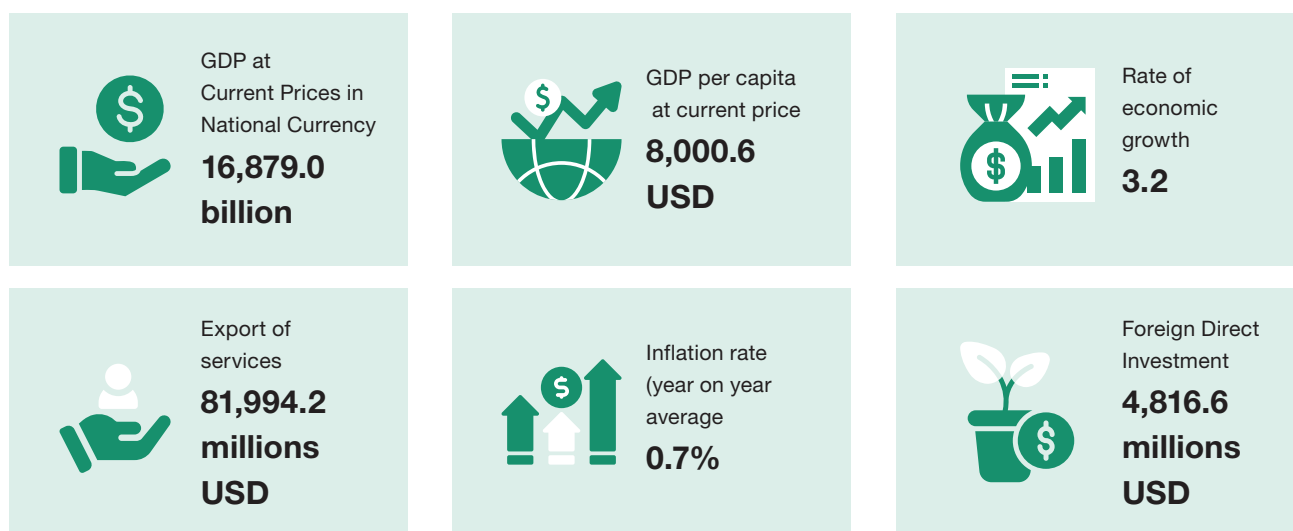
Figure 32. Demographic and health indicators of Thailand



Source: ASEAN Statistical Yearbook 2020

9.3 Macroeconomic indicators

Figure 33. Macroeconomic indicators of Thailand

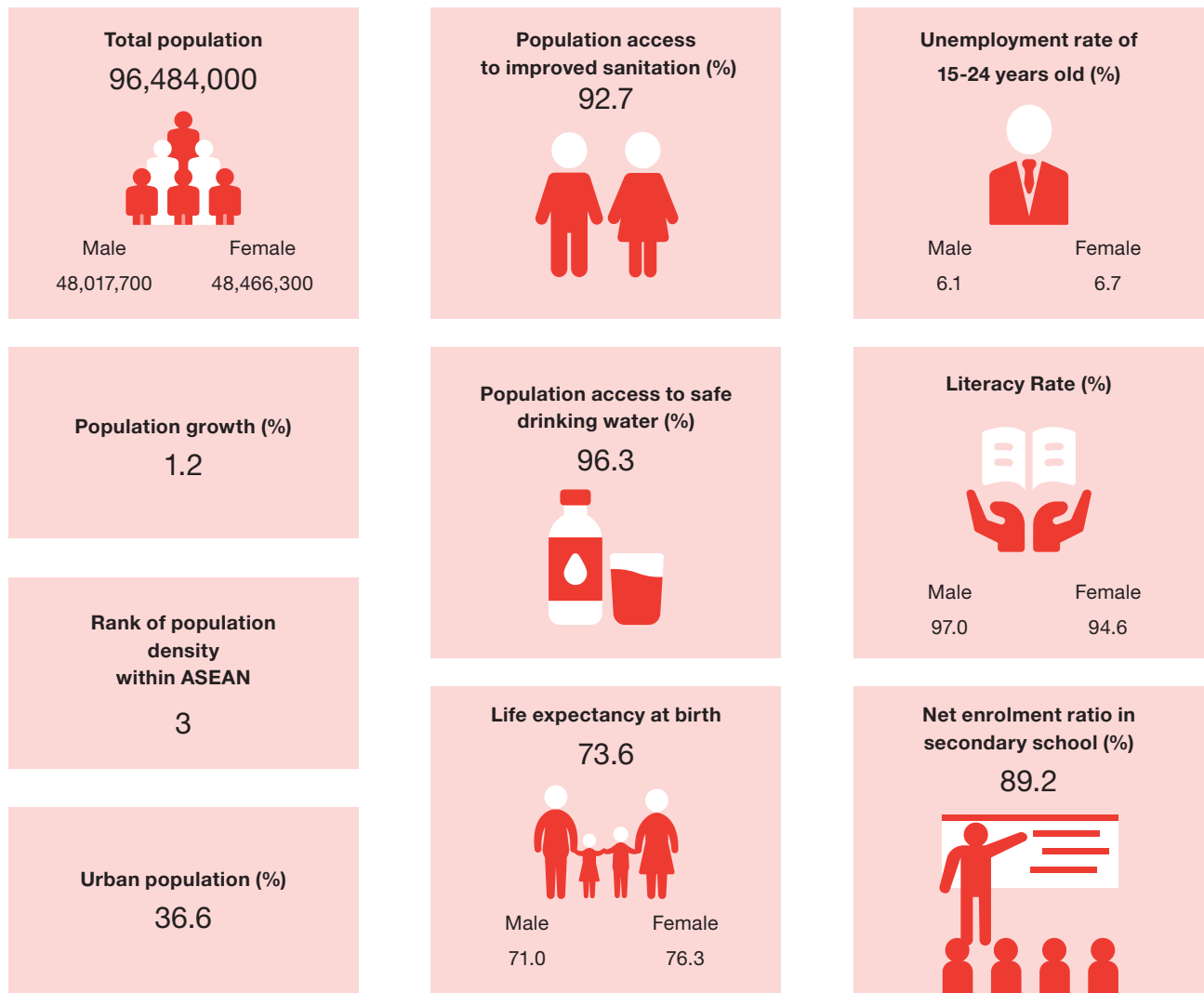


Source: ASEAN Statistical Yearbook 2020

10. Viet Nam

10.1 General indicators

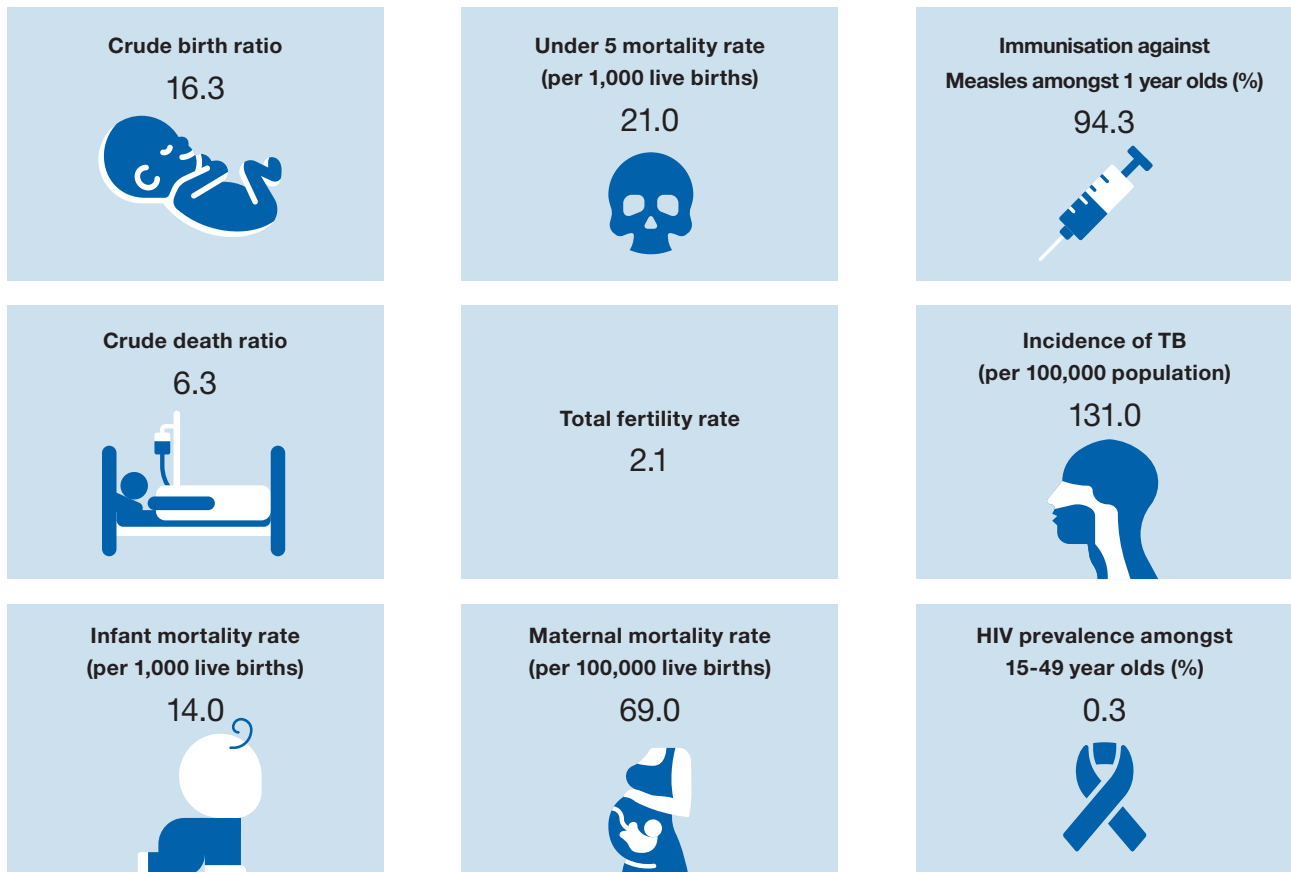
Figure 34. General indicators of Viet Nam



Source: ASEAN Statistical Yearbook 2020

10.2 Demographic and health indicators

Figure 35. Demographic and health indicators of Viet Nam



Source: ASEAN Statistical Yearbook 2020

10.3 Macroeconomic indicators

Figure 36. Macroeconomic indicators of Viet Nam



Source: ASEAN Statistical Yearbook 2020

Annex C: ASEAN Framework on Health Coverage for Documented Migrants including Migrant Workers and Special Populations

I. Background

1. As the Association of Southeast Asian Nations (ASEAN) works towards regional integration by building around its pillars on political-security, economy and socio-cultural communities, the cross-border mobility of workers and citizens is expected to further intensify. The relationship between migration and health will be more pronounced with the anticipated ASEAN economic integration. With the current push towards Universal Health Coverage (UHC) and in order to mitigate the risks and maximize the returns of this increased mobility, it is imperative for ASEAN Member States (AMS) to invest in the health of the documented migrants, including migrant workers and special population

2. Globally, agreements including the Sustainable Development Goals; World Health Assembly resolutions 61.17 and 70.15; and Global Compact on Safe, Orderly and Regular Migration focusing on the health of migrants and refugees call on all member states, including AMS, to work together to promote principles of UHC, shared responsibility, and to promote public health approaches towards improving the health of migrants and host communities.

3. The ASEAN Charter, entered into force on 15 December 2008, provides legal status and institutional framework to codify ASEAN norms, rules, and values. One of the purposes of ASEAN, as stated in the Article 1, is to enhance the well-being and livelihood of the peoples of ASEAN by providing them with equitable access to opportunities for human development, social welfare, and justice. This falls within the purview of the ASEAN Socio-Cultural Community (ASCC).

4. The ASCC is envisioned in the 2025 Blueprint to move towards a more inclusive community where there is the promotion of equitable access to opportunities for ASEAN people and protection of human rights including migrant workers. Further in the ASCC Blueprint, health is articulated in its strategic measures, particularly in the areas of social protection and UHC.

5. The ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers in 2007 followed by the signing of the ASEAN Consensus on the Protection and Promotion of the Rights of the Migrant Workers in 2017 highlighted the exigency for a framework including migrant workers. The ASEAN Human Rights Declaration which underscores the fundamental right to health was also adopted in 2012. Further, in 2013 the ASEAN Declaration on Strengthening Social Protection emphasized the need for UHC.

6. As a priority of the ASEAN Health Cooperation, migrants' health has been addressed in activities led by Senior Officials Meeting on Health Development (SOMHD) since 2010 under the ASEAN Health Strategic Framework 2010-2015. The workshop on Migrants' Health in ASEAN countries held in June 2012 in Bogor, Indonesia conceived a set of recommendations, Plan of Action, and Terms of Reference on migrants' health. The Workshop aimed to implement activities that will increase access to health services for ASEAN peoples. These were presented at the 8th SOMHD in August 2013 in Singapore.

7. Under the ASEAN Post-2015 Health Development Agenda, migrants' health was included as one of the health priorities under ASEAN Health Cluster 3 (AHC 3) on Strengthening Health Systems and Access to Care and is positioned to contribute to regional and global health through relevant regional activities.

8. Included in the 2016-2020 Work Programme of AHC 3, as endorsed by the SOMHD, is the development of the ASEAN Guideline on Health Coverage for Documented Migrants, including Migrant Workers and Special Population (e.g. mother and child), in which the definition of migrant workers is referred to in the ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers. This document was subsequently renamed as the ASEAN Framework on Health Coverage for Documented Migrants, including Migrant Workers and Special Population (e.g. mother and child), hereinafter referred to as "the Framework", in the workshop conducted in Manila, Philippines in December 2018 and in Surabaya, Indonesia in September 2019. Further, the ASEAN Situational Analysis on Migrants' Health was conducted to gather evidence-based findings to supplement the Framework.

9. This Framework contributes to the vision of the ASEAN Health Cooperation in order to provide a healthy and caring ASEAN Community by improving the quality of life of its people such that no ASEAN migrant is left behind.

II. The Status of Migrants' Health in ASEAN

10. According to United Nations Department of Economic and Social Affairs report in 2017, there are over 7 million ASEAN population work overseas in another ASEAN country, which highlights the crucial role that migration has played and continues to play in the political economy of the region. These intra-regional migrants account for two-thirds of the region's total international migrant stock.

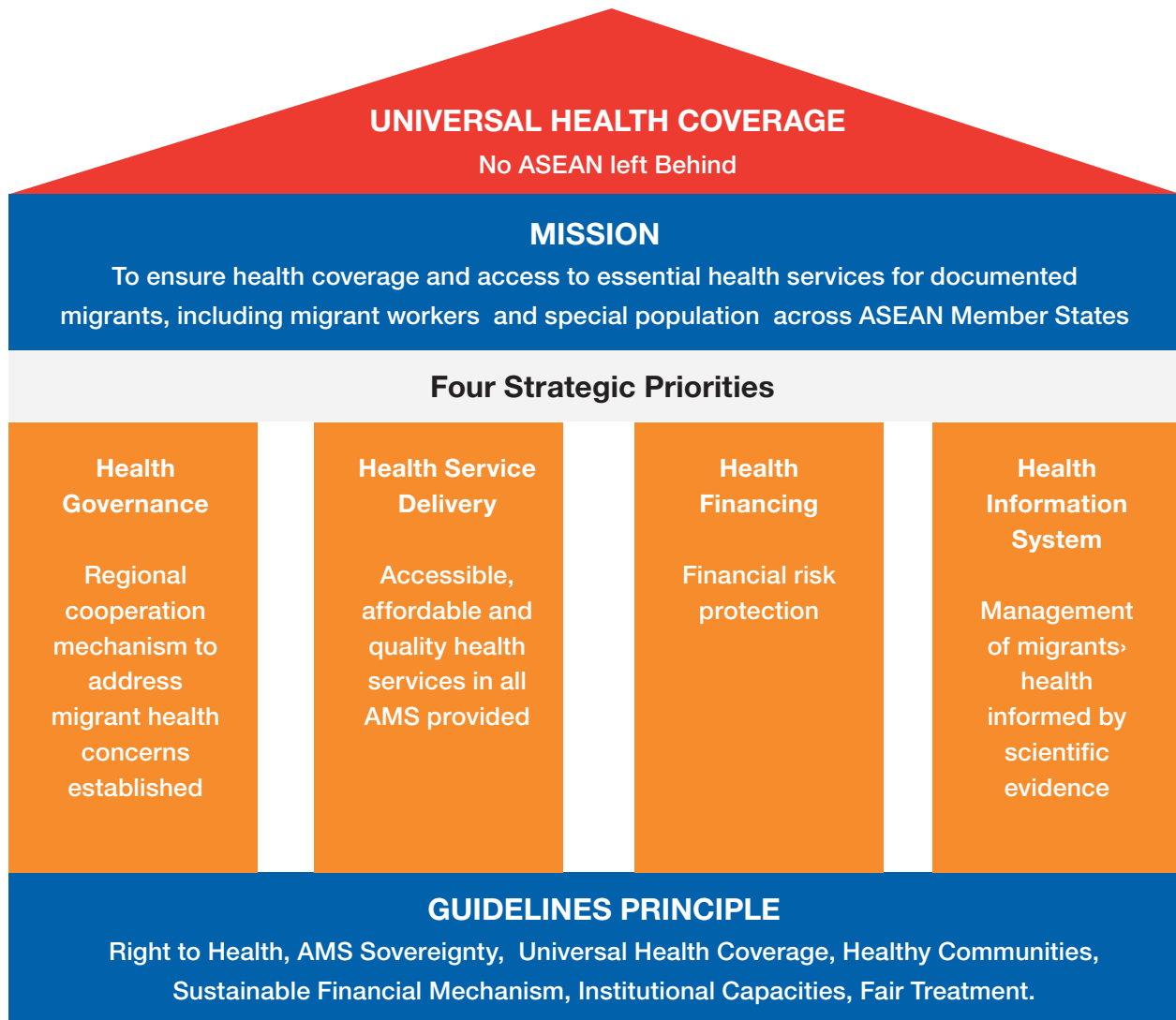
11. Despite this large-scale mobility of people within and out of ASEAN region, data on health issues of migration and migrants' access to health services are largely under recorded. The ASEAN Situational Analysis on Migrant's Health further verified these gaps on data and revealed that there is a scarcity in the pool of evidences, even on migrant stock and trends, that can be synchronized to derive meaningful policy or programme recommendations. There is a dissimilarity among the AMS' progress towards achieving UHC for migrants. It was also noted that there is a low uptake of health insurance schemes and acceptance by migrants.

12. In this context, it is important to highlight the need for further exploration and in-depth assessments at the country level to identify actual status and issues of documented migrants. It is also important to adopt a combined and multi-stakeholder approach in designing strategies to address health issues of migration within the ASEAN region.

III. Objectives

13. Recognizing the importance of achieving UHC, this Framework sets out the mutually agreed principles, strategies and priorities to guide AMS in their policy and regulatory approaches as well as in their pursuit of regional cooperation towards ensuring health coverage for documented migrants, including migrant workers and special populations.

Figure1: Summary of the Framework



IV. Scope

14. The scope of this Framework covers documented migrants including migrant workers and special population, mothers and children among them.

15. This framework shall adopt the definition of the migrant workers and special population under the ASEAN Consensus on the Protection and Promotion of Migrant Workers wherein migrant worker is defined as a person who is to be engaged or employed, is engaged or employed, or has recently been engaged or employed in a remunerated activity in a State of which he or she is not a national. This Framework covers migrant workers who are documented and those who become undocumented through no fault of their own, in reference to the ASEAN Consensus on the Protection and Promotion of Migrant Workers. Further to be utilized in the Framework is the operational definition of “special populations” included in the ASEAN Health

Cluster 3's Work Programme for 2021-2025 as adopted by the 15th ASEAN Health Ministers Meeting in May 2022. "Special populations" is referred to in the Work Programme "to comprise documented migrants including migrant workers, women/mothers and children and is in accordance with country context and prevailing national laws and regulations of AMS".

16. The Framework identifies four strategic priorities namely:

- a. Health Governance;
- b. Health Financing;
- c. Health Service Delivery; and
- d. Health Information System.

V. Guiding Principles

17. The Framework is guided by the following eight principles and in accordance to each AMS's country context and prevailing national laws and regulations:

- a. Ensuring migrants' right to health. Health is a fundamental right of all citizens, including migrants, thus, should enjoy highest attainable standard of physical, mental, and reproductive health, inclusive of basic health services and facilities.
- b. Respecting AMS sovereignty. Recognise that migrant workers have other fundamental rights as stipulated in the applicable international and regional treaties which AMS are a party to, in accordance with the prevailing national laws, regulations and policies of AMS.
- c. Working towards UHC. Ensure that all people including migrants have access to essential health services (including promotion, prevention, treatment, rehabilitation and palliative care) of sufficient quality to be effective while also ensuring that the use of these services does not expose the migrants from financial hardship.
- d. Promoting healthy communities. Promote a community that is healthy, caring, sustainable and productive, and one that practices healthy lifestyle, resilient to health threats, and has access to universal healthcare coverage.
- e. Supporting sustainable financing mechanism. Promote sustainable financing mechanism for social protection, through strategic partnerships with the private sector and other relevant stakeholders.
- f. Enhancing institutional capacities. Enhance institutional capacities to promote greater access to basic social services for all, particularly health services.
- g. Upholding fair treatment. Regardless of gender and nationality, fair treatment and the rights of migrants are upheld, promoted, and protected, in accordance with the obligations of AMS under appropriate international instruments to which they are parties.
- h. Pursuing sustainable development. The benefit of the present and future generations and to place the well-being, livelihood, and welfare of the peoples at the center of the ASEAN community building process.

VI. Strategic Priorities

18. To elaborate on the overall approach to achieve the objectives of this Framework, the following are the strategic of priorities to be undertaken:

- a. Health Governance: To establish appropriate regional cooperation mechanism to address migrant health concerns
 - i. Designate a focal unit on migrant health in each AMS;
 - ii. Establish networking mechanism for regular communication of migrant health concerns among AMS;
 - iii. Build the technical and management capacity of the focal unit;
- b. Health Service Delivery: To provide adequate, accessible, affordable, and quality medical and health services for documented migrants in all AMS
 - i. Promote coordination on pre-departure health requirements for migrants;
 - ii. Define essential health service packages for migrants, including emergency care
 - iii. Facilitate continuity of care through appropriate referral mechanism ;
 - iv. Increase health awareness and health literacy among migrants including occupational safety and health protection for migrant workers
- c. Health Financing: To ensure financial risk protection
 - i. Provide appropriate health coverage to migrants with consideration to the existing health financing schemes of the AMS;
 - ii. Explore mechanisms to achieve portability of health coverage ;
 - iii. Ensure access to affordable and quality health services for migrants through innovative financing mechanisms.
 - iv. Ensure that employment terms and conditions of migrant workers include health and safety benefits;
- d. Health Information System: To utilize scientific evidence to advocate and to improve management of migrants' health.
 - i. Establish a system for AMS information sharing, reporting, and monitoring of migrant health in the region with respect to confidentiality and protection of data;
 - ii. Identify commonly available data among AMS and the need for new data to enable standardization;
 - iii. Create a platform for the dissemination of lessons learned and best practices with stakeholders and partners through ASEAN Health Cooperation on migrant health.
 - iv. Develop appropriate consolidated information through a regional pocketbook and/or application that contains adequate information on occupational safety and health measures for migrants in AMS.

VII. Effect of the Framework

19. This Framework is a non-binding document and does not create rights or obligations under domestic or international law for the AMS.

VIII. Implementation of the Framework

20. AMS shall develop a plan of action and activities to support the operationalization of the Framework under the AHC 3 on Strengthening Health System and Access to Care.

21. AMS should endeavor to provide regular updates on the progress on the implementation of the Framework according to the ASEAN Health Governance and Implementation Mechanism. This will enable AMS to monitor their development with respect to this Framework.

IX. Amendments

22. The Framework shall serve as a living document to contribute to the ASEAN Health Cooperation goals as well as the ASCC vision that engages and benefits its people and is inclusive, sustainable, resilient and dynamic.

23. The Framework may be reviewed periodically and amended at any time through AHC 3 and SOMHD to incorporate new developments or changes, by mutual agreement amongst all AMS.

X. References

24. This ASEAN Framework on Health Coverage for Documented Migrants including Migrant Workers and Special Populations makes reference to the following relevant international and regional instruments:

- a. Relevant International Labour standards concerning all forms of forced and compulsory labour freedom of association and the effective recognition of the right to collective bargaining elimination of discrimination in respect of employment and occupation and abolition of child labour;
- b. Social Security and Migrant Labour;
- c. The Universal Declaration of Human Rights, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979);
- d. Convention on the Rights of the Child (CRC) (1989);
- e. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990);
- f. ASEAN Declaration on the Protection and Promotion of the Rights of Migrant Workers (2007);
- g. ASEAN Charter (2008)
- h. ASEAN Human Rights Declaration (2012);
- i. ASEAN Declaration on Strengthening Social Protection (2013)
- j. ASEAN Socio-Cultural Community Blueprint 2025 (2016)
- k. ASEAN Consensus on the Protection and Promotion of the Rights of Migrant Workers (2017);
- l. World Health Assembly Resolution No. 61.17 (2008) on Health of migrants and Resolution No. 70.15 (2017) on Promoting the health of refugees and migrants;
- m. Sustainable Development Goals (2015);
- n. Global Compact on Safe, Orderly and Regular Migration (2018)
- o. ASEAN Situational Analysis on Migrants' Health (2020); and
- p. ASEAN Post 2015 Health Development Agenda and its Work Programmes

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