Asia-Pacific Regional Workshop on Implementing Guidance on Inclusive CRVS Systems with a Focus on Forced Displacement, Statelessness and Children on the Move

World Health Organization
REGIONAL OFFICE FOR South-East Asia

Sharing country experiences & perspectives

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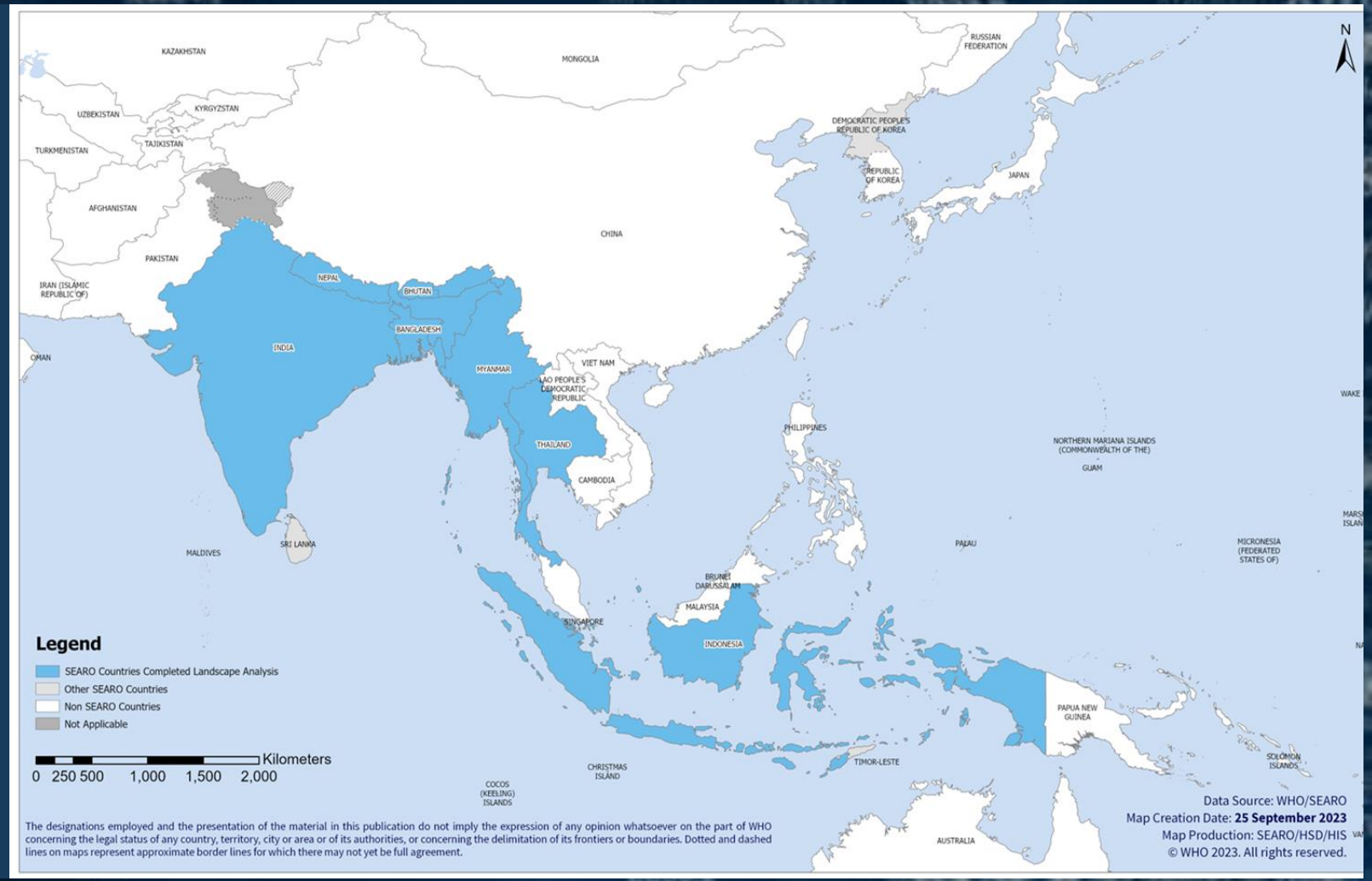


Bangkok, Thailand – 18-21 March 2024

In the 76th (2023) the World Health Assembly ***adopted a resolution to extend the WHO Global Action Plan on promoting the health of refugees and migrants until 2030, which requests governments, stakeholders, and networks, in collaboration with WHO to continue to improve the health of refugees and migrants worldwide.***

To prepare for this talk, I have asked my HIS counterparts in WHO Country offices to give me some information on how ***forcibly displaced and stateless people*** *are managed in terms of their health needs and their service utilization measured and monitored by the health system.*

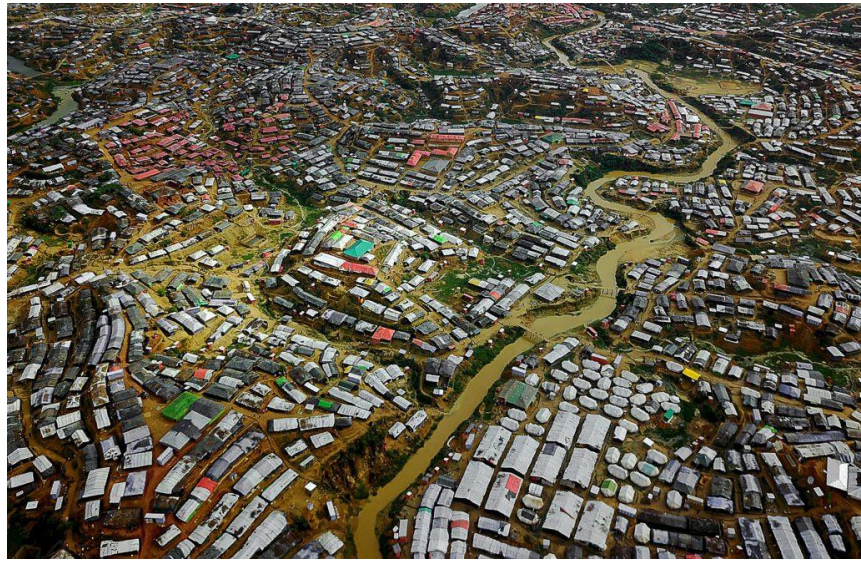
1) Within the context of your countries health system, are these key population group **clearly identified in any official health data or statistics** (e.g. in the annual health statistics bulletin; in the most recent household-based health survey,…etc)?
2) Are there **any specific health service delivery provisions levelled** at their health care needs?
3) Are there **any specific provisions or mechanisms to monitor their access to services and service utilization?**
4) Are there any specific health policy interventions (e.g. in financing, outreach programmes,…etc) targeting improvements of their health conditions?

Bangladesh (WHO Country Office → Cox's Bazar)

1) Within the context of your countries health system, are these key population group clearly identified in any official health data or statistics (e.g. in the annual health statistics bulletin; in the most recent household-based health survey,…etc)?

Annual Health bulletin (sub-chapter 4.10 - Health Interventions for the forcibly displaced Myanmar nationals (FDMNs)

Link: old.dghs.gov.bd/images/docs/vpr/LHB_2022_6_2_2024.pdf)



2) Are there any specific health service delivery provisions levelled at their health care needs?

Under the guidance of Civil Surgeon's office in Cox's Bazar, WHO, along with the health sector partners developed an ESP for FDMN camps in 2017 to ensure the quality health service among the FDMNs. 45 health facilities (11 primary health centers, 13 health posts, 10 community clinics, 5 family welfare centers, 4 union sub-centers, and 2 upazila health complexes) are established and maintained for the FDMNs to ensure primary health care with focus on MNCAH services, family planning services and EPI. Referral SOP has been drafted with a view to providing possible health services inside the FDMN camps but whenever there is a need for referral services, it should follow referral pathway.

Bangladesh (WHO Country Office → Cox's Bazar)

3) Are there any specific provisions or mechanisms to monitor their access to services and service utilization?

a. With the aim of better coordination and monitoring, the Government of Bangladesh established the DGHS coordination center. This coordination Center regularly arranges coordination meetings with partners at the office of Coordination Center and/or Civil Surgeon's office.
b. **DHIS2 based reporting system** established for FDMN health service information.

4) Are there any specific health policy interventions (e.g. in financing, outreach programmes,…etc) targeting improvements of their health conditions?

At 4th sector plan (HPNSP), **an additional (fourth) component was added** with additional financing to provide health services delivery to the FDMNs and Host Communities in Cox's Bazar district under Chattogram division. The MOHFW will continue to deliver humanitarian aid directly and through the agencies of the United Nations (UN) and local/international NGOs for supply of food, HNP services, sanitation, water and other essential services to the FDMNs.

a. Joint healthcare plan 2018 for FDMN and host community drafted.
b. A Standardized Protocol for Infection Prevention and Control (IPC) was developed for the Health Facilities of the FDMN camp and endorsed by the Civil Surgeon and RRRC. This helped significantly during theCOVID-19 response.
c. A referral SOP was developed and approved in September 2022, endorsed by both the Civil Surgeon and the Refugee Relief and Repatriation Commissioner (RRRC) with a view to decreasing unnecessary referrals and a rationalized use of health facilities. Now the approval processes to permit displaced Rohingyas out of the camps have become coordinated and accountability for refugees who did not return to the camps have decreased. This SOP is therefore useful to guide an objective prioritization process to ensure universal coverage for referral health care for those most in need.
d. **A unique health card was piloted in various camps and distributed in all camps for implementation. The unique health card will minimize medicine shopping behaviors and the use of resources will be rationalized**.

Indonesia (WHO Country Office)

1) Within the context of your countries health system, are these key population grou
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In the annual health profile from the MoH and the statistics from the Indonesian Statistics Bureau (BPS),
there is no data available regarding forcibly displaced and stateless people.
The information provided is only about internal displacement persons/domestic refugees resulting from disasters, etc or within country migration. *However, there is data in the UNHCR Indonesia website : Fact Sheets – UNHCR Indonesia*

1) Are there any specific health service delivery provisions levelled at their health care needs?

For medical assistance, UNHCR collaborates with IOM to provide healthcare services. ***IOM takes the lead in providing necessary medical care for refugees and migrants, with support from local NGOs.*** *This is in line with presidential decree number 125 of 2016, which delegates healthcare provision for refugees to local governments. In practice, IOM also collaborates with local health departments and community health centers. However, due to Indonesia's non-ratification of the two international agreements, it is difficult for the central government to be fully involved.*

In the UNHCR Indonesia website, there are several information regarding the access of health care, available services, etc:
- At the Puskesmas level: Information for refugees and asylum seekers – UNHCR Indonesia
- Assistance and support for health (PHC, Emergency & Advance Health care, mental health, and vaccination: Assistance and Support - UNHCR Indonesia

Indonesia (WHO Country Office)

1) Are there any specific provisions or mechanisms to monitor their access to services and service utilization?

Through IOM (which has comprehensive data on medical care for migrants, but confirmation is needed for transit) *and UNHCR (which usually possesses basic segregation data), access in Indonesia can be facilitated through immigration detention officers under the coordination of the Directorate General of Immigration. The attached presidential decree of 2016 on handling foreign refugees provides further details.*

1) Are there any specific health policy interventions (e.g. in financing, outreach programmes,…etc) targeting improvements of their health conditions?

Only resources provided in this decree are available from the government. ***The Ministry of Health does not have a specific budget for this purpose.***

According to the presidential decree No 125/2016, the authority to determine refugee status still lies with UNHCR as the UN High Commissioner for Refugees for international refugees. The prolonged process of determining refugee status has led to increased human rights violations and requires coordination with local authorities for refugee management.

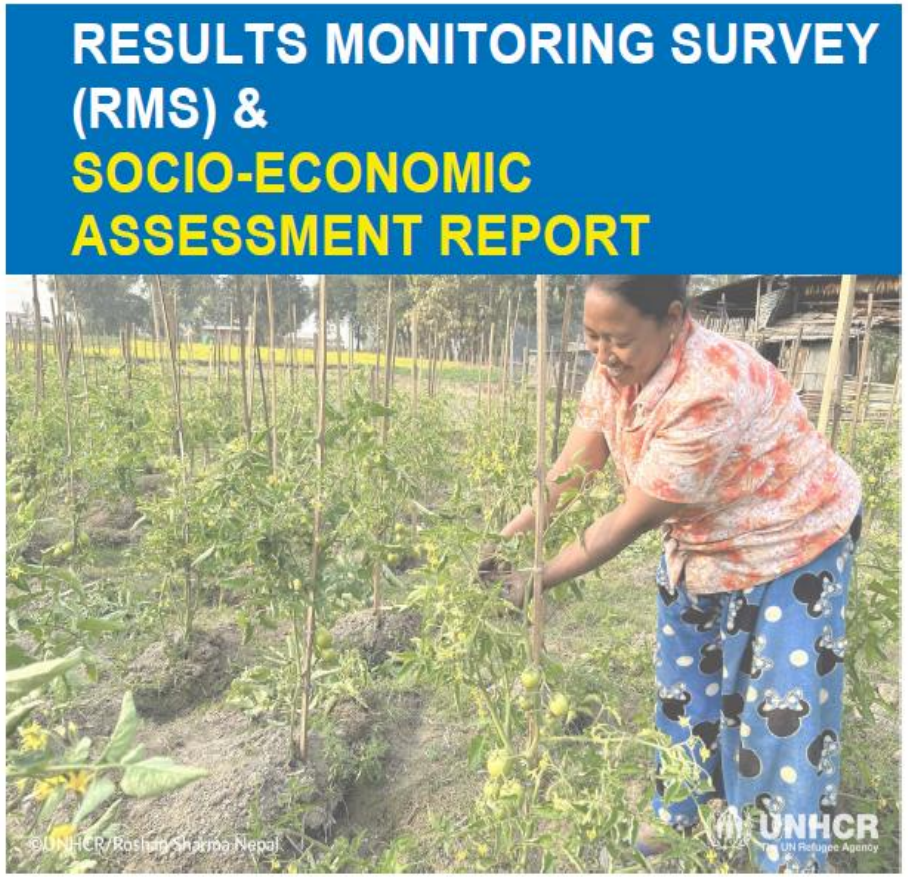
Nepal (WHO Country Office + UNHCR)

1) Within the context of your countries health system, are these key population group clearly identified in any official health data or statistics (e.g. in the annual health statistics bulletin; in the most recent household-based health survey,…etc)?

Refugees and people without legal identity documents mainly the citizenship certificate and birth registration have not been clearly identified in any official health data or statistics including annual health statistics bulletin, household-based health survey. **The Government of Nepal recognizes refugees from Bhutan and Tibet only.** In general, refugees and people without legal identity documents have access to the health care system except for subsidies provided by the Government of Nepal to citizens.

2) Are there any specific health service delivery provisions levelled at their health care needs?

Except inclusion in Health Insurance for Bhutanese refugees, no specific health service delivery provisions levelled at their health care needs. All individuals including refugees and people without legal identity documents have access to health services including immunization. Nepal also included refugees and people without legal identity documents in COVID-19 vaccination. Nepal was the first country in Asia to give access to COVID-19 vaccination to refugees.



UNHCR Nepal March 2023

Nepal (WHO Country Office + UNHCR)

3) Are there any specific provisions or mechanisms to monitor their access to services and service utilization?

No. However, when UNHCR conducted its Results Monitoring Survey in 2023 for Bhutanese and mandate refugees (from nationalities other than Bhutanese and Tibetan) the results show that 100% of those surveyed had access to healthcare.

4) Are there any specific health policy interventions (e.g. in financing, outreach programmes,…etc) targeting improvements of their health conditions?

Not through the Government. UNHCR partner AMDA carries out health screenings for the **Bhutanese** refugees annually.

Nepal (WHO Country Office) - **Other observations (provincial level)**

1) Refugee children are registered in the respective ward offices, birth registration is being done in local wards.
2) Official health reports/statistics are not seen covering health status of key population.
3) Basic health services utilization by displaced population is captured in local level HMIS data .
4) Displaced people are receiving basic health service(immunization, nutrition, maternal services, ect) from local health facilities under municipalities with out any discrimination.
5) UNHCR is affording premium of elderly and people living with disability to register under Nepal Health Insurance program.
6) UNHCR is also supporting mental health program and psychiatrist consultation services targeting to displaced people.
7) UNHCR is supporting to strengthen local health facilities/hospitals aiming better health service availability/accessibility for displace people .
8) AMDA hospital provides 20 percent discount in hospital service to displaced population.
9) There is a coordination committee chaired by Chief District officer of respective District that deals with over all issues of displaced people along with health. **Separate mechanism to monitor their access and service utilization is not found existing.**
10) **There is lack of policy and program targeting health of displaced population by the provincial government.**
11) Local government implements outreach campaign/program and health screening camps at displaces peoples' community supported by AMDA Nepal/UNHCR .

Sri Lanka: does not have forcibly displaced people (since the end of the civil war in 2009) and stateless people. However, there are instances where people are displaced for short periods of time (common scenario is flooding). Whenever there is a need for providing services for displaced people, the health system caters for them through special camps. At district level, **the public administrative system (through district secretaries and divisional secretaries) is responsible for addressing such issues**. Health services will be provided through the decentralized system as required directly to such persons. **However, as these events are short term, data will not be captured through the routine health information system (as the usual patient care processes go) except if they develop specific disease or outbreaks**.

https://news.navy.lk/index/search-and-rescue/?cultureKey=&page=9

Thailand

3 type of non-Thais population that match the definition below " forcibly displaced and stateless people" that health benefit packages are managed separately from Thai citizens.

World Health

	Estimated Number	Health Financing	Health Benefit package	Health Data (including health monitoring
Refugee*	97,601 (2022)	Free of charge	Basic health care need provided in the camps by INGOs funded by international donors,	Annual report produced separately by the consortium of NGOs called "CCSDPT" and shared to donors and interested parties
Stateless**	723,596 (Aug 2023)	Annual budget approved by the cabinet to MoPH to manage health care and reimbursement with health facilities	As same as Thais under UC scheme	Data is not regularly analyzed and shared widely
Migrant workers (economic forced)	2.5 million (Aug 2023)	MWs work in formal sector can enroll in social security scheme (like Thai workers) – tripartite scheme (Gov+ Employer+ Employee) (mange by MoL) MWs works in informal sector can enroll in MoPH Migrant Health Insurance Scheme (mange by MoPH)	As same as Thais under SSS scheme Similar to Thais under UC	Data is not regularly analyzed and shared widely
Undocumented migrants	???	Free of charge or small amount charge by NGOs M-Fund Insurance (NGO runs insurance)	Basic health care need provided by NGO i.e. Mae Tao clinic Basic Health care package defined by Insurance operator	Data is not regularly analyzed and shared widely

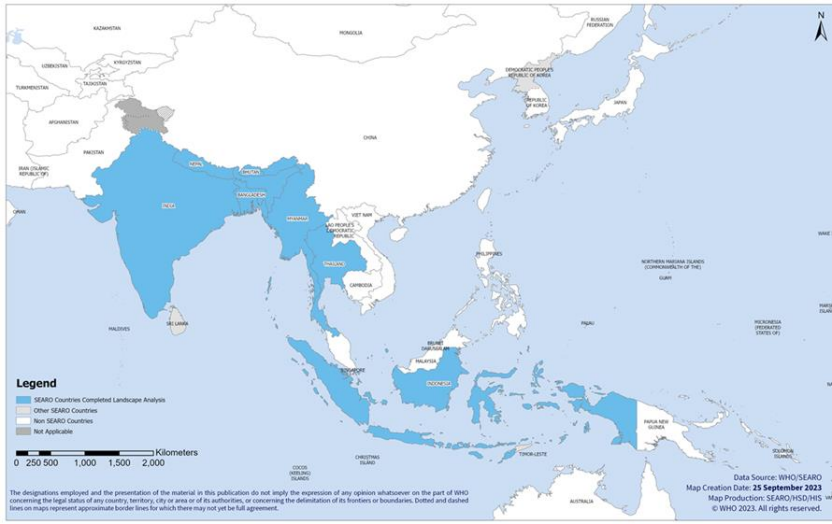
* Thailand did not sign the refugee convention, so Refugee is not an official term sued by Royal Thai Government. The Official term used by government is "displaced persons"
** Thailand does not the term stateless – the MoPH document used people with citizen and right problem

Finally monitoring the health status of these key populations remains a major gap…..

WHO established ***the Health and Migration Programme***, which led high-level advocacy efforts, developed a wide range of norms- and standard-setting technical products, set up a research agenda exercise to define global research priorities in health and migration,.

Also **initiated is a process to establish a Global Data Initiative on Refugee and Migrant Health and trained policymakers, health sector managers, and service providers in the field of health and migration.**

By extending the global action plan until 2030, Member States and WHO have renewed their firm commitment to work together **to close existing gaps in healthcare access so that all people, including refugees and migrants, have equitable access to quality health services anywhere, at any time, without financial hardship and regardless of their migratory status.**



https://www.who.int/health-topics/refugee-and-migrant-health#tab=tab_1

https://www.who.int/teams/health-and-migration-programme

https://openwho.org/courses/health-migration-programme

Thank You