SAARC Regional Strategic Plan on Cross Border, Migration & Health

towards Region free of AIDS & TB by 2030

2018-2023

SAARC TB and HIV/AIDS Centre
Thimi, Bhaktapur

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Printed in Nepal

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Preface

Cross-border migration poses a big challenge for many countries, both in terms of the magnitude and variety of migration patterns and processes. If appropriately managed, migration can greatly benefit the individual as well as his/her source and destination communities. In contrast, poorly managed migration can result in various social, cultural, and economic difficulties, including public health problems such as HIV/AIDs and TB. The South-East Asia Region carries the highest burden of TB and the second highest burden of HIV in the world. Four Member States, out of eight in the SAARC region, namely India, Bangladesh, Pakistan and Afghanistan are among the 22 high burden countries.

Tuberculosis (TB) and HIV/AIDS are the two dominant public health problems in the SAARC region and the problem is further aggravated by high mobility of both inter and intra-regional migrants. Many countries within the region share long stretch of porous border within the region, for instance India has a 4,097-km border with Bangladesh, similarly India also shares almost 1900 Km of porous border with Nepal and 450 Km stretch porous border with Bhutan. Further to this the countries like Maldives, Sri Lanka and Bhutan are migrant receiving country both from the region and other continents. Therefore, there is high likelihood of public health catastrophy if migrants are deprived of basic health care services in the destination country. The effect of internal or international migration on migrants' health is complex and much variation exists between the migrant groups.

Considering the magnitude of the migration pattern in the South Asian Region, the SAARC is deemed to undertake this agenda to ensure public health safety in the region. This regional strategic plan on migrant health and cross border issues related to HIV/ AIDS & TB is expected to guide the regional iniaitives towards promotion of healthy living conditions for the migrants and at the same time facilitate the Member States in prirotizing migrant health as key component under the national health policies and programmes.

Dr. Ramesh Kumar Kharel
Director
December 2019

Acknowledgement

We would like to acknowledge Dr. Rajendra Prasad Pant, Dr. R. P. Bichha, Former Directors (STAC) and Dr. A. P. Weerakoon, Former Epidemiologist (STAC), Dr. Rabeya Sultana, Research Officer (STAC) for their contribution in bringing out this document.

Special thanks to Mrs. Meena Kumari Dhakal, STAC for her hard work and dedication to produce this strategy. Also thanks to Mr. Y. B. Mahata and Mr. D. Subba, STAC for designing, layout.

December 2019

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CBOs	Community Based Organizations
CSOs	Civil Society Organizations
DoI	Department of Immigaration
GFATM	Global Fund to Fight AIDS, Tuberculosis & Malaria
HIV	Human Immuno Virus
IBBS	Integrated bio-behavioral surveillance survey
ILO	International Labour Organization
INGO	International Non-Governmental Organization
IOM	International Organizaiton for Migration
LGBTI	Lesbian, Gay, Bisexual, Transgender & Intersex
LTBI	Latent TB Infection
NGO	Non-Governmental Organization
PLHIV	People Living with HIV/AIDS
SAARC	South Asian Association for Regional Cooperation
SDG	Sustainable Deveolopment Goal
STAC	SAARC TB & HIV/AIDS Centre
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	The joint United Nations Programme on HIV/AIDS
UNCHR	United Nations High Commissioner for Refugee
UNFPA	United Nations Fund for Population Activities
UNGASS	UN General Assembly Special Sessions
WHO	World Health Organization

CHAPTER 1

BACKGROUND

1.1 Introduction

South Asian Association for Regional Cooperation (SAARC) is an association for manifestation of the determination of the people of South Asia to work together towards finding solutions to their common problems in a spirit of friendship, trust and understanding and to create an order based on mutual respect, equity and shared benefits. The SAARC comprises of Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

SAARC Tuberculosis and HIV/AIDS Centre (STAC) is a Regional Centre of SAARC, located in Kathmandu, Nepal. The Centre was established in 1992. The initial mandate of the centre was to work for prevention and control of TB in the Region by coordinating the efforts of the National Tuberculosis Control Programs of the Member States. Later on its mandate has been extended to work for prevention & control of HIV/AIDS and TB/HIV Co- infection in the Region. Accordingly, the centre has been functioning as the regional coordination body for the prevention and control of HIV/AIDS and TB in the SAARC Member States. The first regional programme Manager's meeting on cross border held in Thimphu Bhutan in 2017 proposed the centre (STAC) to be upgraded to the 'SAARC Centre for Communicable Diseases'. The proposal was made in lieu of the important role played by SAARC in the region.

A number of regional initiatives exist that are important to issues of cross-border mobility and HIV. The South Asia Association for Regional Cooperation (SAARC), established in 1985, was initially dedicated to economic, technological, social, and cultural development, emphasizing collective self-reliance. As Member States faced common emerging health-related issues, health became a part of SAARC's work.

In 2004, SAARC signed a Memorandum of Understanding with UNAIDS to help Member States work toward the goals of HIV prevention and appropriate care and support for PLHIV. In the same year, the SAARC Regional Strategy on HIV and AIDS (2006-2010) was formulated, which emphasized regional-level coordination, collaboration, and partnership with organizations and national programmes and also stressed promotion of regional dialogue on cross-border issues relevant to HIV and AIDS.

Considering the mandate of the SAARC, it has become imperative for the SAARC secretariat to take up the agenda to secure the health and well being of every individuals in the region, therefore, migration and health related to cross border is being recognized at top most priority, as it intersects both health and social well being in the region. Therefore, STAC is emphaisizing on the promotion of regional harmony through promotion of health for all including the migrants.

1.2 Migration and Health as Global Agenda

Countries in different regions of the world have promoted a health equity agenda for migrants and displaced populations regardless of their legal status. A common factor seems to be an understanding that the realization of national health goals cannot be achieved without the inclusion of migrants and that health represents a fundamental aspect of human rights that extends beyond issues of nationality. Few countries, however, have scaled up their capacity and invested in their response to new or prospective health needs related to migration flows; nor have many countries put in place mechanisms to enhance multisectoral collaboration, cross-sector policy coherence and multi-stakeholder partnership, which are fundamental to the ability to consistently address migrants' health needs and determinants of health. In most instances, this has been due to the presence of political sensitivities and lack of readiness to commit financial resources, as well as a general political climate in which migration has catalysed divisive elements of society.

The issue of migrant health can no longer be ignored. It must take its place within the global health agenda, as well as within the global migration and socio economic development agenda, owing to its relevance in an increasingly interconnected world where, from a purely public health point of view, individual health security and global health security are interdependent. Furthermore, being and staying healthy is a fundamental prerequisite for successful integration and the ability of migrants to contribute to the prosperity of societies of origin and destination. This is in everyone's interest, as migration and human mobility are indisputably megatrends of the twentyfirst century.

1.3 Cross Border Migration in the SAARC Region

According to a UN Department of Economic and Social Affairs report (2009), India was projected to rank ninth in terms of number of international migrants in 2010 and to account for 2.5 percent of all international migrants. As per India's National Sample Survey Organization (2010), there were 326 million internal migrants in 2007–08 (28.5 percent of the population). India shares a common border with Bangladesh, Bhutan, China, Myanmar, Nepal, and Pakistan and thus is one of the most sought-after destinations by immigrants, evident from the huge influx of people from neighboring countries such as Bangladesh and Nepal.

According to Behra (2011), the nature of migration from Bangladesh and Nepal to India has been dissimilar because of their different historical backgrounds, geographical variants, ethno-religious affinities, political systems, and bilateral arrangements with India. Behra illustrates that geographical contiguity, sociocultural affinity, the kinship factor, and historical reasons have left the Indo-Bangladesh and Indo-Nepal borders vulnerable to migration.

India has a 4,097-km border with Bangladesh along the states of Assam, Meghalaya, Tripura, and West Bengal. Of this, only around 1,500 km is fenced, leaving a major portion of the border porous and easy for illegal migration. Bangladeshi migrants are therefore mostly concentrated in Assam and West Bengal. A study by Siddigui and Abrar (2002) highlighted that most Bangladeshi migrants, irrespective of their country of destination, migrated between the ages of 25 and 35 years and spent about half their lives in the host country before returning to their native country.

Similarly, India and Nepal share an open and porous 1,900-km border that runs along the states of Bihar, Sikkim, Uttar Pradesh, and West Bengal. Migration between Nepal and India has been easy because of the open, porous border and strong familial links. As a result of a bilateral friendship treaty signed between India and Nepal in 1950, citizens of both countries can travel and work freely across the border. Their concentration is in the northeastern states, Uttar Pradesh and West Bengal, with scattered presences over the remainder of the country (Behra 2011). According to recent estimates, there are approximately one million Nepalese working in India (GoN 2004), and they mostly work as unskilled permanent or seasonal labourers. The 2001 census shows that more than 762,000 individuals—or 3.3 percent of Nepal's total population of just over 23 million—were out of the country, with more than 77 percent of those in India. Most Nepalese respondents migrated for the first time between the ages of 16 and 20 years (Samuels et al. 2012). Several studies have shown that the choice of destination for most Nepali migrants was Mumbai (Samuels et al. 2012; Bam et al. 2013; Poudel et al. 2003; Poudel et al. 2004).

Unlike the migration from Nepal, movement from Bangladesh to India needs approval from the relevant authorities and most migrants to India are unauthorized (Samuels and Wagle 2011). Although exact figures are unknown, the 2001 India census documented that there were approximately 3 million Bangladeshi migrants in India, representing 60 percent of total migrants in India. People from India and Bangladesh regularly cross the porous borders through many unofficial transit points (Samuels et al. 2012).

Singh (2009) highlight that illegal migration is extremely difficult to measure, and in the Indian context, it is far more complex in view of the ethnic ties the migrants share with the native population. Efforts to control illegal cross-border immigration remain highly inadequate in India. Unabated cross-border immigration for the last several decades is particularly worrisome in North-East India. Bangladeshi immigrants in the region are actually "settlers" and thereby competitors for space: land, water, services, and jobs. Hence, their presence is perceived as a potential threat, capable of creating tensions and conflict between the immigrants and the natives, and capable of altering the demographic and political profile of the region (Singh 2009).

In Nepal, more men migrated with their peers. In contrast, most women migrating to India have come with their spouse and children. While most Nepalese migrants moved on their own or with peers, migration among Bangladeshis is arranged largely by brokers (Samuels et al. 2012).

1.4 Cross border Migration coupled with issues of HIV/AIDS & TB

The effect of internal or international migration on migrants' health is complex and much variation exists between the migrant groups. The disease patterns of immigrants are influenced by the environments of the origin and destination countries and by the process of migration itself (McKay et al. 2003). Therefore, the effect of migration on a particular health outcome(s) varies according to who is migrating, when they migrate, where they migrate from, where they migrate to, and what health outcome is measured (McKay et al. 2003). Thus, migration as an "exposure" is complex, involving a wide range of socioeconomic, behavioural, and environmental changes (Ebrahim et al. 2010).

1.4.1 HIV/AIDS

Several studies have documented that a more mobile global population brings increased potential for the spread of diseases such as HIV. Migration and migrants specifically have had a significant role in the history of the global HIV pandemic. In 2008, the Joint United Nations Program on HIV/AIDS identified migrants as one of the groups most vulnerable to HIV infection and its consequences (UNAIDS 2008). International and internal migrants are among the 12 groups it identified as most-at-

risk of HIV transmission and facing barriers to treatment. The report outlines some of the social, economic and political factors in origin and destination countries which influence the risk of HIV infection of international labour migrants and contribute to their heightened vulnerability. These include separation from spouses, families and familiar social and cultural norms, language barriers, substandard living conditions, and exploitative working conditions, including sexual violence. The resulting isolation and stress may lead migrant workers to engage in behaviours, e.g. unsafe casual or commercial sex, which increase HIV risk. This risk is exacerbated by inadequate access to HIV services and fear of being stigmatized for seeking HIV-related information or support. Female migrant workers may be particularly vulnerable to HIV as many are employed in relatively unskilled jobs within the manufacturing, domestic service or entertainment sectors, often without legal status and little access to health services. They are often susceptible to exploitation and/or physical and sexual violence, in some cases by their employer, and have few alternative employment opportunities.

High prevalence of sexual-risk behavior has been found among work migrants in many countries, and the major role this plays in HIV transmission is well established (Anarfi, UNFPA Expert Group Meeting, 2005). Not only does migration facilitate the rapid spread of a virus along so-called "corridors of migration", but also causes behaviours and situations that facilitate transmission (Brokerhoff and Biddlecom 1998). Migration is a dynamic process, and the role of migration in HIV transmission is a nonlinear function of individual, dyadic, and network features regardless of context (Cassels et al. 2013). Migrant labourers account for almost 40 percent of all new HIV infections (UNGASS 2010). Seasonal migrant laborers have been identified as a "bridge population" that transmits HIV in the general population. A study among Nepalese migrant labourers traveling to Indian cities (a common destination) found 32.8 percent of men (up from 27 percent in 2006 and 22 percent in 2008) engaged in unprotected sex in India, often with sex workers (IBBS 2010). In examining the role of population mobility in spreading HIV across the Indo-Nepal border, several studies have highlighted that migrants not only exhibit a higher risk for acquisition of HIV and other sexually transmitted infections (STIs) than non-migrants, but disproportionately transmit those infections to others (IBBS 2010; FHI 2002; Population Council 2011; SmithEstelle and Gruskin 2003; Mercer et al. 2007; Poudel et al. 2003; Thapa et al. 2014; Bam et al. 2013).

Despite low HIV prevalence in Bangladesh (1 percent), the population is vulnerable to HIV epidemic. Cases of HIV and active syphilis have been found in successive rounds of sero-surveillance among vulnerable populations, including female sex workers, injecting drug users, and men who have sex with men. (Government of Bangladesh 2003). Annual behavioural surveillance has found that risk behaviour among vulnerable populations is at least as prevalent as in Asian countries having a concentrated epidemic.

1.4.2 Tuberculosis (TB)

Among the 22 high-burden countries that account for more than 80 percent of the worldwide incident cases of TB, 19 territories are in tropical areas (Zammarchi et al. 2014). South East Asia carries about 40 percent of the global TB burden, and India is the highest TB burden country in the world and accounts for more than 25 percent of the world's incident cases (WHO 2012).

Migrants currently play an important role in determining the current epidemiology of TB in countries where they are settled. The incidence in the countries of origin is the strongest predictor of TB incidence in migrants according to some authors (Watkins and Plant 2002). Migrants have a high risk of acquiring TB before migration as they are exposed in their country of origin to several risk factors for TB infection and progression. TB may occur in migrants as a consequence of a reactivation of a Latent TB Infection (LTBI) acquired in the country of origin, but may also occur because of a new infection acquired in the host country after resettlement or during travel in the country of origin (Zammarchi et al. 2014). Moreover, after migration, migrants are exposed to additional risk factors for acquiring or reactivating TB infection, such as poverty, stressful living conditions, social inequalities, overcrowded housing, malnutrition, substance abuse, and limited access to health care. An increased risk of TB is still present in second-generation migrants, in whom a link to endemic countries persists after migration through social networks or travel in the country of origin (Health Protection Agency, UK, 2010).

Access to the health system, including TB diagnostic and treatment services is lower in migrant populations compared with native subjects (Zammarchi et al. 2014). Migrants have a longer patient diagnostic delay for TB (defined as the time elapsed from the onset of symptoms and the first medical consultation), while natives have a longer health care diagnostic delay (defined as the time elapsed between the first medical consultation and the initiation of treatment) (Mor et al. 2013; Gagliotti et al. 2006). The increased patient delay is possibly due to a combination of reasons such as language barriers, possible lack of medical insurance, fear of deportation (for illegal migrants), or discontinuation of their employment and competing socio-economic priorities may prevail over health issues (Mor et al. 2013; Gagliotti et al. 2006; Zammarchi et al. 2014.

CHAPTER 2

VISION, MISSION, GOAL AND STRATEGIC DIRECTIONS

2.1 Vision Health for migrants without borders in SAARC Region.

2.2 Mission To ensure better access to HIV/AIDS & TB prevention and treatment services through improved coordination and collaboration between the SAARC Member States.

2.3 Goal To Reduce the burden of HIV/AIDS & TB in SAARC Region while promoting access to basic preventon and treatment services for all migrants.

2.4 Objectives The key objectives for the Regional Strategy includes;

a) To improve the health of the migrants in SAARC Region through improved access to basic public health services both within and across the border.

b) Strengthen cross border collaboration between the SAARC Member States in the prevention and control of HIV/AIDS & TB.

c) To gear towards ending HIV/AIDS & TB by 2030, in line with the Sustainable Development Goal', UNAIDS vision of 'Fast tracking the national response to ending AIDS' and Stop TB goal of ending TB.

d) To reduce the risk and vulnerabilities associated with TB and HIV/AIDS infection among the migrants,

e) To develop resilient regional public health system through improved migrant's health outcome.

f) To promote the global public health safety.

2.5 Strategic Directions

With the aim of improving the health of the migrant in South Asia Region, the first round of Regional Programme Manager's meeting on cross border in Thimphu, Bhutan recommended the need for a Regional Strategic document to guide the implementation of the regional and country specific interventions to address the migrant's health issues in the region. The SAARC Regional Strategy on cross border Migrant Health is built on the principle of 'respect for human rights,' 'promoting regional public health safety', 'evidence based interventions' and 'inter-country collaboration and partnership'. The Regional Strategic plan will form the basis for the SAARC Member States to priotitize the need for country specific policy on migrant health and promote the rights and protection of all the migrants to basic public health services with emphasis on TB & HIV/AIDS. The Regional Strategic Plan is built on six core strategic directions and these strategic directions will guide the Member States and the STAC in harmonizing the regional initiaitves towards promotion of migrant's health.

Strategic Direction 1: Fostering political commitment of the Member States through advocacy and dialogues;

This strategic direction aims to seek political commitment of the SAARC Member States to recognize the health needs of all the migrant workers incorporate migrant health component into national policies and strategies. The STAC will undertake the advocacy with the Member States during the larger SAARC forums including the policy makers and parliamentarians.

Strategic Objectives: To institutionalize migrant's health policy into the core national health agenda of the Member States.

Strategic Output: SAARC Member States have adopted national migrant health policy.

Strategic Focus;

- High level regional advocacy programme initiated by the STAC engaging parliamentarians and policy makers.
- Regional Health Minister's meeting on cross border migration and health issues in South Asia Region.
- Annual Regional Programme Manager's meeting to discuss the modalities towards improving migrant's health issues.

Strategic Direction 2: Public Health surveillance and events/interventions along the international borders;

The Public Health interventions (with focus on HIV/AIDS & TB) along the international borders aim to assess the trend of HIV/AIDS & TB among the inbound migrants and empower the migrants with the basic information on disease prevention and precautions. Further this interventions will also guide both the regional and national programmes to strategically focus the interventions for maximum impact, however this intervention is no means to determine the eligibility for visa or work permit.

Strategic Objective: To enhance evidence informed public health programming along the international borders in the SAARC region.

Strategic Output: Evidenced based public health interventions implemented focusing all types of migrants.

Strategic Focus:

- Establishing partnership linkage with priority sectors like Department of Immigration (DoI), Law enforcement agencies (Police), Ministry of Labor and private institutions including NGOS and CBOs.
- Developing institutional capacity.
- Sharing of the best experiences and lessons learnt between the Member States.
- Estbalihsing Regional surveillance sites in selected Member States.

Strategic Direction 3: Establishing Referral Linkages across the border for continuum of care.

Establishing referral linkage across the border is often seen as a challenge in the bigger countries like India and Bangladesh, where private sector dominates the public sector in terms of catering health services (mostly curative). Therfore, establishing linkage between the health facilities between the countries is crucial in terms of achieving better health outcome of the migrants as well for public health safety in both home and the host country. Linking people living with HIV on ART and TB patient on anti-TB medication are the practical problems worldwide, hence this regional strategy aims to establish referral points across the border through identification and designation of referral points in each Member States.

Strategic Objectives: to provide uninterrupted health care services for better health outcome of the migrants and as well as for regional public health safety.

Strategic Output: Designated cross referral links and centres established in all the Member States.

Strategic Focus:

- Mapping & Identification of referral sites across the border in SAARC Member States
- Regional & In-country coordination meeting among the designated referral sites
- Regional technical seminars on migrant health
- Joint monitoring mission led by STAC.

Strategic Direction 4: Partnership development and collaboration with key sectors including the Inetrnational bilateral and multilateral organization, INGOs and NGOs.

Developing close partnership and collaboration with relevant sector is key to success of addressing the health needs of the migrants. The issue on migration and health is cross sectoral agenda and the relevant sectors should take equal ownership considering the positive impact of the migration on local economy. This strategic direction also outlines the need for closer partnership with other international organizations like World Health Organization (WHO), International Orgnaization for Migration (IOM), International Labor Organization (ILO) etc.

Strategic Objectives: to foster closer partnership with key sectors within the country and also with international development agencies to cater better health access for all migrants.

Strategic Output: Partnership and collaboration formalized both at regional and country level.

Strategic Focus:

- Development of national/regional collaboration strategy
- Partnership forums.
- Collaborative research activities
- Joint review forums

Strategic Direction 5: Developing strategic information for evidence based public health programming and results based management of cross border activities.

Evidence through research findings is key to impactful public health interventions, therefore, developing strategic information shall remain the centre of priority for the success and sustainability of the cross border public health activities. This strategic direction therefore calls for building robust strategic information to guide the planning, implementation and monitoring of both regional and country based cross border public health activities.

Strategic Objectives: To generate robust data on migration and health for evidence based public health programming both at national and country level.

Strategic Output: Evidence based public health programmes designed and implemented targeting the migrants.

Strategic Focus:

- Identify critical research topics
- Develop the institutional capacities through trainings
- Promotion of research activities through provision of small scale research scholarships.
- Dissemination workshops at regional level/ Regional Conference on migration and health.

Strategic Direction 6: Promotion of equity and empowerment of Migrants for accessing basic health care services across the border.

Most often owing to undocumented status of the migrants or simply due to lack of required documentation proof, cross border migrants are often denied of social entitlements resulting in the lack of access to any social institutions like hospitals, educational institutions and even banks. Social exclusion, lack of basic amenities and necessities puts the cross border migrants and their families at a higher level of risk and deteriorates their quality of life (Singh et al. 2017). Therefore, this strategic intervention aims to promote equity and empower migrants to seek timely health care services without prejudice, however this requires better understanding among the stakeholders on the nature of migration and their contribution towards developing local economy.

Strategic Objectives: To promote timely health interventions for all migrants without discrimination.

Strategic Output: Morbidity and mortality due to treatable medical conditions reduced in migrant population.

Strategic Focus:

- Sensitization programme targeting health care providers
- Joint technical seminars
- Partnership building with service providers including CSOs
- Migrant's health information

Strategic Direction 7: Financing and Resource Mobilization for sustainability

Allocation of adequate resorouces and ensuring future sustainability is core element for effective implementation of the regional strategy. The Member States needs to pour in resources to address the issues pertaining to migrant's health in line with the Regional

Strategic Plan. The STAC as regional coordination body will also ensure allocation of adequate resoruces to materialize the regional iniaitives on cross border and migrant health. The STAC may also laise-up with international donors to support the regional initiatives.

Strategic Objectives; To sustain the regional intervention on cross border and migrant health with emphasis on HIV/AIDS & TB in SAARC Region.

Strategic Output; adequate resource mobilized for implementation of regional strategy both at national and regional level.

Strategic Focus;

- Donor advocacy
- Development of realistic regional and country specific action plans
- Publication of annual success stories (annual publications & journals)
- Active community engagement (involving INGOs and NGOs

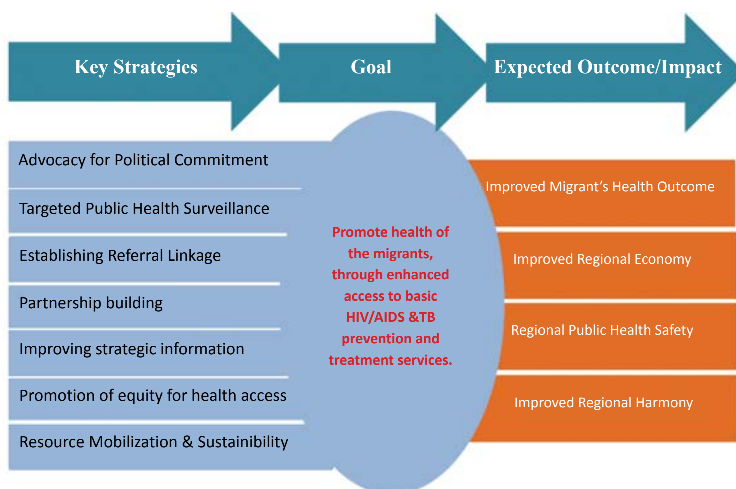

Fig. 1; Regional Strategic Framework

CHAPTER 3

INSTITUTIONAL ARRANGEMENTS

The SAARC TB and HIV/AIDS Centre is the lead implementing body for the SAARC Cross Border Strategy on Migrant Health. The SAARC Secretariat, which deals all SAARC-related policy matters, gives policy guidance and coordination support. The Member Countries have a role to play in supporting the STAC to ensure technical cooperation and inputs. The STAC as the regional coordination body will facilitate the Member States to adopt national policy on migrant health and implement public health interventions to promote the health of the migrant population in the region. The Member States will develop the national policy in line with the regional guidance document (SAARC regional strategic Plan on migrant health and cross border). Through the implementation of this strategy, STAC and the SAARC Secretariat will work on developing close partnership with technical agencies, international organizations, civil society groups, academia and others, which will support the implementation of the cross border activities in years to come. The STAC will work in close collaboration with the Member States in the implementation of the cross border activities with equal emphasis on all the Member States in SAARC region. The SAARC secretariat / STAC will take lead role in disseminatin the regional strategic plan to all its Member States.

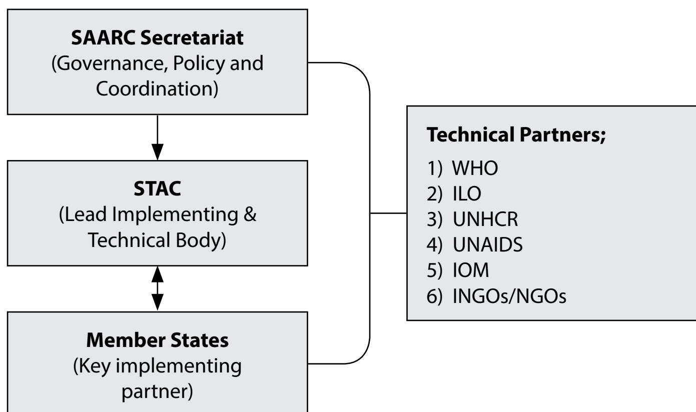

Fig. 2; Implementation Map

The Implementation of SAARC Regional Cross Border Strategy on Migrant Health demands intersectoral and cross sectoral collaboration and it cuts across other humanitarian issues related to the health and social security of the migrant workers. Therefore, the STAC as lead implementing body needs to develop closer collaboration with International Labor Organization (ILO), World Health Organization (WHO), International Organization on Migration (IOM) and other International and National Non-Governmental Organizations to facilitate the implementation of the regional strategy. However, the Member States remains the key implementing partner at the country level. The Member States will report to STAC on the status of the policy implementation at the national level.

CHAPTER 4

MONITORING & EVALUATION

Articles V and VI of the SAARC Charter clearly lay out the roles and responsibilities of the Standing Committee and Technical Committee, respectively, which are responsible for the implementation, coordination and monitoring of the programmes in their respective areas of cooperation. While monitoring and evaluation are complementary, they are two distinct processes. Monitoring follows a management model with a focus on improving day to day operations evaluation uses a research model to assess the extent to which project objectives have been met or surpassed. However, monitoring and evaluation are most effective as interwoven activities.

Monitoring of the implementation framework for the SAARC Regional Cross Border Strategy on Migrant Health is built based on three distinct measuring parameters; Input-Process-Output/Outcome and impact, similarly the evaluation shall be carried out through joint reviews, monitoring reports and progress updates. The monitoring and evaluation framework shall consist of set of key indicators to measure the progress in the implementation of the Regional Strategy. The overall progress of the regional strategy is measured using impact indicator, measured at the end of the strategy time frame; similarly the set of outcome indicator will be drawn in line with impact target, the outcome indicators and targets will be used as basis for mid-term review of the regional strategic plan document, and coverage indicator will be used to assess annual performance against the annual targets set. These three level of monitoring indicators are interlinked to ensure consistency in the implementation of the regional strategy. These set of indicators are key towards fulfilling the overall vision of ending AIDS & TB by 2030. The impact and outcome targets will be measured at the regional level, however all the Member States under SAARC region will contribute towards fulfillment of the coverage targets, which will be reported to STAC on annual basis.

The following performance framework will be used as monitoring and evaluation tool to assess the overall performance and impact of the regional cross border strategy on migrant's health;

STAC has prepared Country Reporting Form which is annexure 2

Table 1; Performance Framework

(1) Impact Indicators					
Indicator #	**Indicator Description**	Baseline		Target	
		Value	*Year*	*Value*	*Year*
1.1	Proportion of inbound migrant workers assessed for HIV/AIDS & TB while entering the destination country (indicator to be reported by low prevalent country, Afghanistan, Bhutan, Maldives & Sri Lanka).				
1.2	Proportion of outbound migrant workers completing health screening check-ups before departing to the destination country (indicator to be reported by sending countries like Nepal, India, Bangladesh and Pakistan)				
(2) Outcome Indicators;					
Indicator #	**Indicator Description**	Baseline		Target	
		Value	*Year*	*Value*	*Year*
2.1	Number of countries in SAARC region having migrant health policy in place.				
2.2	Number of countries in SAARC region having designated health facilities for migrant workers.				
2.3	Number of countries in SAARC region, who have included migrant health in national health policy or national strategic plan.				
(3) Coverage/Process Indicators					
Indicator #	**Indicator Description**	Baseline		Target	
		Value	*Year*	*Value*	*Year*
3.1	Number of countries in SAARC region having targeted public health interventions targeting migrants.				
3.2	Number of countries providing free ARV and anti-TB treatment to all inbound migrants.				
3.3	Number of countries in SAARC region where migrants report easy access to basic health care services.				
3.4	Number of HIV/AIDS positive cases referred across the border for continuum of care by host country to their respective home country.				
3.4	Number of cross border collaboration meeting held between Member States.				
3.5	Number of coordination meeting held with technical partners, especially with WHO.				

CHAPTER 5

FINANCING OF REGIONAL STRATEGY IMPLEMENTATION

The implementation of the Regional Strategy will be financed by the national level of SAARC Member States, for the country specific interventions with regard to the migrant health, respective Member States are encouraged to take full ownership. The SAARC TB & HIV/AIDS Centre with consensus from the Member States will help to explore the donor funds for the regional activities and for this the regional proposal will be developed in line with the regional strategic plan document.

Following diagram shows the financing modility of the Regional Strategic Plan;

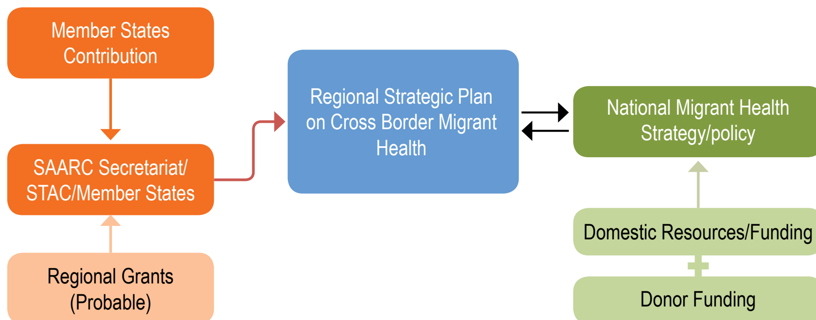

Fig. 3; Finacing modality for Regional Strategic Plan on Migrant Health

ANNEXURE-1
REGIONAL OPERATIONAL PLAN

No.	Strategic Direction	Strategic Objective	Strategic Focus	Activities	Lead Role	Key partnerships	Time Line
1	Fostering political commitment through advocacy and dialogues.	To institutionalize migrant's health policy in to the core national health agenda of the Member States.	(1.1) High level regional advocacy programme initiated by STAC engaging parliamentarians and policy makers.	Parliamentarian meeting on Migration and Health.	SAARC/ STAC	STAC/IOM/WHO/ Member States	
				(1.1.2) Regional dissemination workshops focusing the policy makers.	STAC	STAC/WHO/IOM/ Member States	
				(1.1.3) High level exposure visit to Maldives and Bangladesh.	STAC	STAC/Member States	
			(1.2) Regional Health Minister's meeting on cross border migration and health issues in South Asia Region.	(1.2.1) Development & circulation of meeting concept note.	STAC	STAC/SAARC	
				(1.2.2) Liasing with host member state for the SAARC Health Minister's meeting.	STAC	Member States	
				(1.2.3) Preparation and finalization of meeting agenda/programme.	STAC	WHO/IOM/ UNAIDS	
			(1.3) Regional Programme Manager's meeting to discuss the modalities towards improving migrant's health issues.	1.3.1) Regional programme Manager's meeting held on annual basis.	STAC/SAARC	Member States	

No.	Strategic Direction	Strategic Objective	Strategic Focus	Activities	Lead Role	Key partnerships	Time Line
2	Public Health surveillance and events/ interventions along the international borders.	To enhance evidence informed public health programming along the international borders in SAARC region.	(2.1) Establishing partnership linkage with priority sectors like Department of Immigration (DoI), Law enforcement agencies (Police), Ministry of Labor and private institutions including NGOS and CBOs.	(2.1.1) Develop inter-sectoral collaboration framework on migrant health.	Member States	STAC/IOM/WHO	
				(2.1.2) Organize quarterly collaboration meeting with stakeholders.	Member States	STAC/WHO/IOM	
			(2.1) Developing institutional capacity.	(2.2.1) Training of health workers at the point of entries and exit.	STAC/SAARC	WHO/IOM/ Member States	
				(2.2.2) Identificstion and mapping of surveillance sites.	Member States	STAC/WHO/ UNAIDS/IOM	
				(2.2.3) Development of surveillance tools.	Member States	STAC/WHO/ UNAIDS/IOM	
			(2.2) Sharing of the best experiences and lessons learnt between the Member States.	(2.3.1) Regional study tour programmes for state/district health workers.	STAC/SAARC	Member States	
				(2.3.2) Regional technical seminars to disseminate the research findings on cross border issues related to TB & HIV/AIDS.	STAC/SAARC	Member States	
				(2.3.4) Publication of reports on the best practices in SAARC Member States.	STAC	Member States/ WHO	

No.	Strategic Direction	Strategic Objective	Strategic Focus	Activities	Lead Role	Key partnerships	Time Line
3	Establishing Referral Linkage across the border for continuum of care.	To provide uninterrupted health care services for better health outcome of the migrants.	(3.1) Mapping & Identification of referral sites across the border.	(3.1.1) Identifying and designation of referral sites across the border in all eight Member States.	Member States/STAC	Member States	
				(3.1.2) In-country based sensitization and training of health workers from designated health centres on migration and health issues.	Member States	STAC/IOM/WHO	
				(3.1.3) Inter country dialogue and meeting between the Member States sharing porous border.	STAC	Member States/ IOM/WHO	
			(3.2) Regional & in-country coordination meeting among the designated referral sites.	(3.2.1) Regional Coordination meeting on cross border migrant health issues (meeting among local public health officials along the international borders).	STAC	Member States	
				(3.2.2) In country state/district level coordination meeting among the state/district level public health programme managers.	Member States	STAC/IOM/WHO	
				(3.2.3) Regional technical seminars and workshops on migrant health.	STAC/SAARC	WHO/IOM/ UNAIDS/UNHCR	
			(3.3) STAC oversight visit in Member States to monitor the referral activities.	(3.3.1) Formation of 'Task Force' team to carry out oversight visits.	STAC	Member States	
				(3.3.2) STAC's participation in country's joint monitoring missions.	STAC	Member States	

No.	Strategic Direction	Strategic Objective	Strategic Focus	Activities	Lead Role	Key partnerships	Time Line
4.	Partnership development and collaboration with key sectors including the Inetrnational bilateral and multilateral organization, INGOs and NGOs.	To foster closer partnership with key sectors within the country and also with international development agencies to cater better health access for all migrants.	(4.1) Development of national/regional collaboration strategy/ MoU.	(4.1.1) Development of national level collaboration strategy to strengthen collaboration with priority sectors.	Member States	WHO/STAC	
				(4.1.2) Meeting with international organizations to develop partnership in area of cross border, migration and health.	STAC	WHO/IOM	
			(4.2) Memorandum of understanding (MoU) with developmental partners, especially with WHO & UNAIDS.	(4.2.1) Conduct advocacy forum targeting the developmental partners especially WHO, UNAIDS, IOM and GFATM, to sensitize the role of SAARC & STAC at regional level.	STAC/SAARC	WHO/IOM/ UNAIDS/GFATM	
				(4.2.2) Signing of the MoU with international developmental partners.	STAC	WHO/IOM/ UNAIDS	
			(4.3) Joint regional programme review on cross border activities.	(4.1.1) Conduct Joint monitoring missions (JMM) together with WHO, UNAIDS & IOM on migration and health in SAARC region (in selected Member States).	STAC	WHO/IOM/ UNAIDS/Member States	
				(4.1.2) Draft and dessminate JMM report to Member States.	STAC	WHO/IOM/ UNAIDS	

No.	Strategic Direction	Strategic Objective	Strategic Focus	Activities	Lead Role	Key partnerships	Time Line
5.	Strategic Information for evidence based programme planning.	To generate robust data on migration and health for evidence based public health programming both at national and country level.	(5.1) Identifying key research topics.	(5.1.1) Call for research agenda from Member States on cross border, migration and health.	STAC	Member States	
				(5.1.2) Selecting the critical research topics in close coordination with WHO & IOM.	STAC	IOM/WHO/ UNAIDS	
			(5.2) Developing institutional capacities through trainings.	(5.2.1) Regional training events on basic operation research, data analysis and report writing.	STAC	WHO/Member States	
				(5.2.2) Call for EoI from Member States for small scale research grants.	STAC	Member States	
			(5.3) Improving data recording and reporting on migration and health.	(5.3.1) develop standard recording and reporting templates for Member States.	STAC	Member States/ WHO	
				(5.3.2) Training of programme managers on reporting modalities.	STAC	Member States/ WHO	
6	Promotion of equity and empowerment of Migrants for accessing basic health care services across the border. migrant workers	To promote timely health interventions for all migrants without discrimination.	(6.1) Sensitization programme targeting health care providers.	(6.1.1) In-country Sensitization programmes for health workers.	Member States	STAC/IOM/WHO	
				(6.1.2) Migrant's Stigma reduction workshops (regional event) targeting health care providers from designated health facilities (mid-level health care providers)	STAC/SAARC	Member States/ WHO/IOM	
				(6.1.3) Media advocacy/ campaigns using both print and electronic media.	STAC	Member States	

No.	Strategic Direction	Strategic Objective	Strategic Focus	Activities	Lead Role	Key partnerships	Time Line
			(6.2) Partnership building with service providers including CSOs.	(6.2.1) Partnership forum with CSOs, NGOs and private medical care providers.	Member States	STAC/WHO/IOM	
				(6.2.2) develop cross referral forms between private medical care providers/CSOs and designated migrant health facility.	Member States	STAC/WHO/IOM	
			(6.3) Advocacy with policy makers and law enforcement agencies.	(6.3.1) conduct advocacy forums with policy makers and law enforcement agencies.	Member States/WHO/IOM	STAC	
7	Financing and Resource Mobilization for sustainability.	To sustain the regional intervention on cross border and migrant health with emphasis on HIV/AIDS & TB in SAARC region.	(7.1) Donor advocacy	(7.1.1) conduct systemic review of the cross border migration and health in South Asia.	STAC	WHO/IOM	

No.	Strategic Direction	Strategic Objective	Strategic Focus	Activities	Lead Role	Key partnerships	Time Line
				(7.1.2) circulate the review report to potential donors, ie; GFATM, Gates Foundation, PEPFAR, ADB etc. for regional support. (the report needs to be endorsed by Member States prior to circulation).	STAC	WHO/Member States	
				(7.1.3) Conduct donor forums with invitation to potential donors.	STAC	WHO/Member States	
			(7.2) Development of realistic regional and country specific action plans.	(7.2.1) Develop regional/national action plans for donor support.	STAC	Member States/ WHO	
			(7.3) Publication of annual success stories (annual publications & journals)	(7.3.1) develop and disseminate annual reports/publication on migration and health in SAARC region.	STAC	Member States/ WHO	
			(7.4) Active community engagement (involving INGOs and NGOs)	(7.3.1) Sensitization of migrants on migration and health issues.	Member States	STAC/WHO/IOM	
				(7.3.2) Active engagement of community representation in programme planning and implementation.	Member States	STAC	

ANNEXURE-2
COUNTRY REPORTING FORM

SAARC Tuberculosis and HIV/AIDS centre (STAC), Nepal
Regional Cross Border, Migration & Health Issue

INDICATORS	Outcome	Remarks
Country Name:		
Year:		
Documentation migration health policy in place Yes/No		
1. To address coverage indicator 3.1		
1.1 Total estimated number of migrant (in number)		
Documented:		
Undocumented:		
1.1 Total number of documented migrants (in number)		
1.2 Total number of documented migrants (in number)		
Male:		
Female:		
2. To address coverage indicator 3.2; 3.3 and 3.4		
2.1 Total number of designated health centers to provide health services for migrants (in number)		
With government facility:		
With private facility		
2.2 Total Number of newly diagnosed HIV/ AIDS cases in migrant population		
Male:		
Female:		
2.3 Number of newly diagnosed HIV/ AIDS cases received ART treatment in immigrated country		
Male:		
Female:		

INDICATORS	Outcome	Remarks
2.4 Number of diagnosed HIV/AIDS cases referred across the border for continuum of care Inbound		
Inbound		
Outbound		
2.5 Total number of newly diagnosed TB cases in migrant population		
Male:		
Female:		
2.6 Total number of treated TB cases in migrant population		
Male:		
Female:		
2.6 Number of diagnosed TB cases referred across the border for continuum of care		
Inbound		
Outbound		
2.8 Total number of linkages/referral across border		
For HIV/AIDS		
For TB		
3. To address coverage indicator 3.5 and 3.6		
3.1 Is there any cross border collaboration meeting held between the bordering countries? Yes/No		
3.2 If yes, number of cross border collaboration meeting held		
3.3 Any coordination meeting held with technical partners, especially with WHO? Yes/No		
3.4 If yes, Number of coordination meeting held with technical partners		

Authorized signature;
Signature:
Name:
Designation:
Date:

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