A Regional Research on Universal Health Coverage (UHC) for Labor Migrants in Four South Asian Countries

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INTRODUCTION

According to the World Health Organization (WHO), Universal Health Coverage (UHC) means that "All individuals and communities should receive health services without suffering financial hardship." UHC is an approach not only toward the provision of comprehensive health services but also to its funding, management, and administration. Hence, robust health financing structures are important to achieving UHC. In simpler words, UHC is a guide on financing and managing the health sector.

Universal Health Coverage ensures that every person can access health services regardless of the circumstances, i.e., socioeconomic status and background. UHC includes essential services such as health promotion and prevention, as well as rehabilitation, treatment, and palliative care. When people's health is taken care of by UHC, this means that their health and or medical expenses are paid for by the government. However, this may only hold true for some countries. Some countries ensure that patients' medical bills are completely paid, while others only ensure that the medical bills are affordable for the patient and that the remaining balance will be paid out of the patient's pockets. Each country's extent of coverage can be different from the rest, with some countries incorporating oral care in their health care policies, as is the case in countries like Austria and Spain, while other countries do not include it, such as Canada, among others.

According to WHO's data, at least half of the human population does not receive the necessary health services. Additionally, about 100 million people are pushed into extreme poverty every year due to the amount of money they spend on health. It is believed that about a good chunk of these people that do not receive the health services they need are migrant workers.

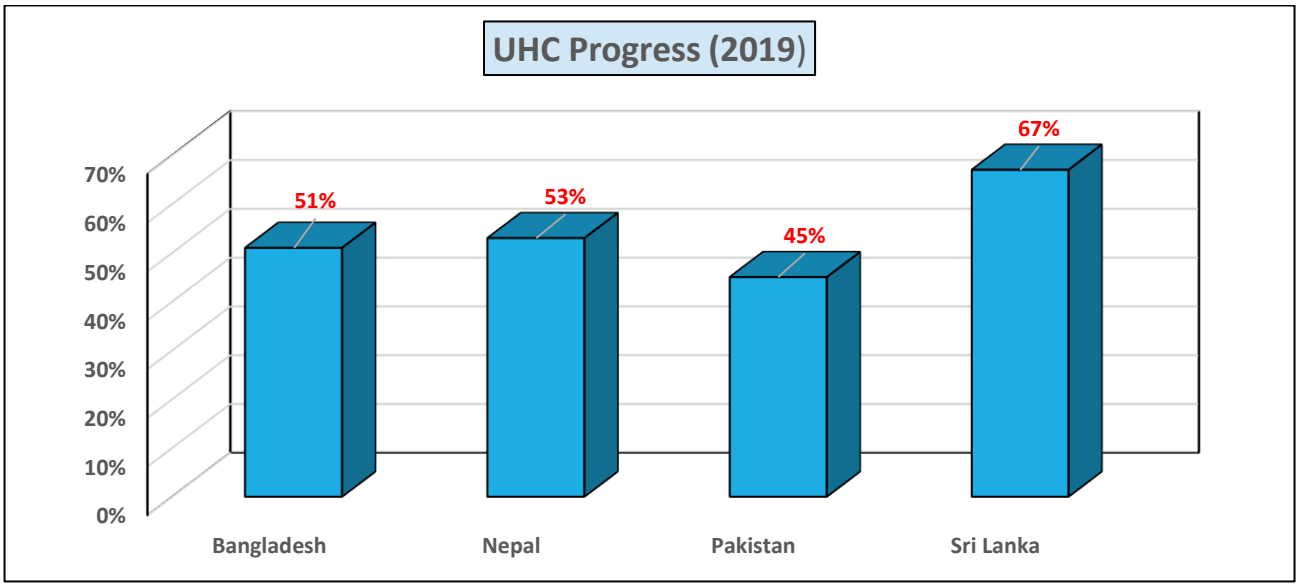
Migrant workers are known to be a vulnerable group in the sense that they have not only been away from their homes for an extended period but are also treated unfairly due to the lenient enforcement of worker's rights in receiving countries that makes it easy for employers to force the workers to work more hours, get paid less, or worse, not get paid at all. This predicament forces them to work in hazardous conditions, which in turn exposes them to various occupational diseases such as cancer, asbestosis, silicosis, and Chronic Obstructive Pulmonary Disease (COPD). (Hach & Rose, 2022). Moreover, the criminalization of migrant workers in receiving countries is a stigma that many of them suffer from. This normally is the case when MWs get infected with HIV and other sexually-transmitted diseases, where as a consequence, they get outrightly arrested, detained, and deported. It has been validated and reported by a number of research studies that migrant workers from South Asian countries get to experience this unjust treatment from their receiving countries that are part of the GCC and of the Middle East in general. In particular, SPEAK (Pakistan) has done multiple case studies/analyses of international and national laws to prove discrimination, detention, and deportation of migrant workers concomitant to their HIV positive and other STD diagnosis. POURAKHI (Nepal) also confirms that this dreary reality is the fate of Nepalese migrant workers who have been diagnosed with HIV and or other STDs. In most, if not all cases, there is not even a referral for proper health

services once they are back home, and the absence of a mechanism for sending countries to check the health status of returnees who got deported for health reasons further aggravates the matter.

In the four countries where the research was conducted (Bangladesh, Nepal, Pakistan, and Sri Lanka), all except Sri Lanka have not properly addressed the health needs of their labor migrants in past bilateral and Memorandum of Understanding (MoU) agreements, which delay the migrants' health policies from progressing. All labor migrants in the aforementioned four countries are facing inequities in terms of healthcare access, i.e., more financially capable citizens being able to afford better health services while limited financial resources constrain migrant workers and working-class citizens. This is a major barrier in achieving UHC.

Below is a table that shows the progress in Universal Health Coverage in the four countries for 2019; the figure is in percent.

Figure 1: UHC Progress in the Four Countries (2019)



Source: https://www.who.int/data/gho

The chart presents UHC progress/coverage as of 2019, expressed in percent, and this is for the general population, including migrant workers. It can be gleaned from the chart that Pakistan, among the four countries, failed to reach half of the target full coverage or 100% coverage. Sri Lanka registered the highest progress, which is 67%, while Bangladesh and Nepal attained a little over 50% progress in UHC.

The four countries' governments have generally allocated very little to improve the quality of life of their labor migrants due to poor planning, and implementation, which impact progress towards UHC, and in the case of Sri Lanka and Pakistan, additional contributory factors would be sociopolitical strive

and natural calamities, respectively, thereby resulting in socioeconomic crises. Additionally, HIV positive labor migrants are worse off and remain to be an underrepresented group in policymaking.

In line with the objectives of the research that are presented in the succeeding section, the study only focused on the migrant workers each of the four countries exports. It must be noted that Pakistan's report is the only one that mentions 'imported' migrants benefiting from health services within its borders, as these imported migrants are refugees. The report also mentioned that the nation's health benefits that are provided for migrants could only be availed if the labor migrant is within Pakistani borders. Below is a table that displays the labor migrant statistics in the four countries.

Table 1: Estimated Annual Number of Migrant Workers from Sending Countries

Country	Total Population (2021)	Estimated Annual Labor Migration Flow (*in 1,000s*)						
		2014	2015	2016	2017	2018	2019	2020
Bangladesh	169,356,251	426	556	756	1,009	734	12,000 (*as of 2019*)	217
Nepal	30,034,989	520	500	404	383	354	3,210 (*as of 2019*)	
Pakistan	231,402,117	754	752	622	496	382	625	
Sri Lanka	22,156,000	301	263	243	212	211		

Table 1 presents the estimated annual labor migration flow covering at least five years, from each of the four countries. Additionally, for 2019, a couple of data presented pertain to the cumulative number of migrant workers as of the year mentioned. As can be seen in the table, the figures were on a downward trend from 2014 to 2018, except for Bangladesh whose numbers increased steadily over a four-year period and dropped quite significantly on the following year. Relevant annual statistics for 2019 and 2020 are only available for Pakistan and Bangladesh respectively. The close to 30% drop in the annual number of labor migrants from 2018 to 2020 in Bangladesh can be attributed to the COVID-19 pandemic that brought lockdowns in most countries around the world, thereby affecting labor migration flow in many countries and regions. In this regard, the annual labor migration flow statistics for the other three countries for the years 2020, 2021, and 2022 are expected to have significantly dropped as well.

Finally, this regional research project was funded by Global Health Council and was undertaken by CARAM Asia in collaboration with Ovibashi Karmi Unnayan Program (OKUP) Bangladesh, POURAKHI Nepal, SPEAK trust (Pakistan), and Community Development Services (CDS) for Sri Lanka. In particular, the research included these four countries in South Asia not only for their geographical location but also because they are countries that are keen on exporting labor whose foreign remittances help put funds in the government's coffers. This research is a review of the government's current state of healthcare, particularly healthcare policies for labor migrants.

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METHODOLOGY

All four countries utilized a qualitative research design. Primary and secondary data were both used to formulate the reports. The primary data were gathered from in-depth interviews, focus group discussions, and questionnaires. Meanwhile, the secondary data came from government documents, published scholarly research, relevant government surveys, and studies from Ovibashi Karmi Unnayan Program (OKUP) Bangladesh, and POURAKHI Nepal, which are Non-Government Organizations (NGOs).

The research conducted in Pakistan and Nepal referred to the eight focus areas in attaining Universal Health Coverage from the UN's Sustainable Development Goals. Pakistan also utilized a qualitative data analysis technique, particularly cluster/thematic analysis using NVivo software, while Nepal utilized mapping of its stakeholders and institutions to identify gaps in legislation. All four countries interviewed stakeholders, key informants, politicians, and government workers in relevant NGOs, institutions, and government facilities.

OBJECTIVES

The following are the specific research objectives:

- Focus on migrant workers' health rights
- Identify urgent needs related to migrant workers' health issues at the national level
- Identify the focused areas for immediate funding

Ultimately, the research findings will pave the way for exploring potential action areas in the health system to increase the capacity and competency of stakeholders in reducing inequities through collaborative actions and demand to increase the health budget.

Regional Analysis

Constitutional and Legal Basis of Health Rights and the Current State of Healthcare in Participating Countries

Taking care of one's health is a matter of personal responsibility, and while proper nutrition and exercise are proven means of ensuring and maintaining our well-being, healthcare and access to the same, are just as important. Access to healthcare is also a fundamental human right, and leaders worldwide have made efforts to create a future where health services are easily accessible and to improve the overall state of all humans living on this planet. One such strategy meant to help attain this aspiration is the worldwide implementation of Universal Health Coverage.

Universal Health Coverage, or UHC, is one of the United Nations' (UN) Sustainable Development Goals (SDG). The SDG is a shared blueprint made by the UN in hopes of attaining peace and prosperity worldwide, with these goals hoping to be reached by all countries by 2030. UHC makes it so that most health services are cheap enough for people living in poverty, that it becomes affordable to them. Moreover, in some countries, UHC provides free medical services. When people have access to UHC, the government pays for most, if not all, services residents' avail. Since it is also affected by legislation, current events, culture, and politics, each country has diverse healthcare policies.

One of the government's responsibilities is to provide affordable healthcare services to its people, with no exceptions. In many countries worldwide, the right to affordable and quality healthcare as a basic right of every citizen is stipulated in the country's constitution. The status of healthcare in a country is impacted by a combination of factors, i.e., government leadership, legislative agenda priorities, economy, budget allocations subject to legislation, political parties, or politicians in power, etc.

The right to health and social equality is enshrined in the constitution of Bangladesh. Article 15 of its Constitution envisages that it is the fundamental responsibility of the State to attain a steady improvement in the standard of living of the people, by providing the basic equipment, including food, clothing, shelter, education, and medical care. The country is also committed to addressing inequalities in access to health and the country joined the global community in committing to achieve Universal Health Coverage (UHC) by 2030 under the Sustainable Development Goals (SDG). Being indicted in the list of 'Least Developed Countries by the UN in the 1970s, Bangladesh has been making strides to graduate from the list; this includes improving its healthcare system. Healthcare has been improving since the early 2010s, with policies such as the National Health Policy being implemented as they lay the foundation for attaining these improvements.

The country has a pluralistic healthcare system, which means that healthcare is shared between traditional and modern medicine. This, along with a mix of NGOs, for-profit organizations, and

government and international welfare organizations making decisions for the country's healthcare, can cause issues. One big issue is the unequal treatment of people, as they are being discriminated against by their caste and social class. Poorer individuals may have a hard time getting the help they need, and may resort to unconventional medical practices, while wealthy people can easily afford what modern medicine/treatment can offer.

The Constitution of Nepal has established basic health care as a fundamental right of its citizens. As the country has moved to a federal governance system, it has become the responsibility of the state to ensure access to quality health services for all citizens based on contextual norms of the federal system. Article 35 of the Constitution states, "Every citizen shall have the right to free basic health services from the State, and every citizen shall have equal access to health services." others. Over the years, a large number of public health programs have been implemented to increase access to healthcare services in Nepal. Notably, the Free Health Care Programme (FHCP) was introduced through the Free Health Care Policy between 2006 and 2009, which has 4 phases: targeted free care, universal free care, free primary health care, and free hospital care. Basic free health care services are provided through FHCP in all public facilities. Vulnerable persons receive free essential health care services through not only FHCP but also emergency services and inpatient and outpatient treatment in public facilities. On the other hand, supplementary services are covered by 'social health protection arrangements,' namely Social Security Fund, Employee Provident Fund, and Health Insurance Board. The Employee Provident Fund (EPF) medical scheme for civil servants was later established in 2013, in line with the Employee Provident Fund Act 2019 (1962).

While the country's Constitutional provisions, global support, progress on the health insurance act, decentralization of health service to the grass root level, and positive trends of increasing service coverage are seen as notable progress, existing volunteer types of health insurance, the misleading role of trade unions, and a high proportion of population outside the country are regarded as major challenges. Another issue the Nepalese healthcare system is facing is the indirect effects of the caste system, as the current "out-of-pocket system" makes it more favorable for those in higher castes as they can afford better care and therefore, have better health outcomes than those that receive it for free. Nevertheless, the political commitment under the changing political context, a sense of national priority, and international support were identified as the facilitating factors towards UHC. Lastly, the National Health Policy has served as the basis to lead interventions toward UHC and develop a national health insurance system (Dahal et al., 2017). The Public Health Service Act was later implemented in 2018, through which the right of every citizen to receive high-quality health care was emphasized.

In the case of Pakistan, Article 38 of its Constitution says that "Anyone who goes to a hospital will be given treatment irrespective of their sect, caste, or economic status." However, it needs to be clearly stated in the Preamble that healthcare for its people is a responsibility of the government. Instead, it indirectly connects healthcare to the social pillar as the government believes that the social sector is responsible for the health of the citizens. Hence, while the desk review did not indicate any specific

information on the importance of healthcare being part of a constitutional provision, it was noted however that the country is advancing in some areas of UHC. The research stressed that it is the first country to invest in the Essential Package of Health Services (EPHS), which is a comprehensive package developed not based on population density but on the burden of diseases. And similar to Bangladesh, the country is using the Sustainable Development Goal (SDG), in its case, tapping its indicator 3.8.1 in monitoring UHC progress. However, the man-made natural calamities that hit the country recently, i.e., deadly floods caused by torrential rains, melting ice caps and subsequent heat waves, severe water scarcity instigated by climate change, pollution, and overpopulation, have all put the country in financial disarray and have put plans on improving the health sector on hold, thereby stalling efforts and initiatives to move a step closer to attaining UHC.

For Sri Lanka, since its independence from the British in 1948, the country continued to strengthen the health sector that the British left behind by ensuring there are sufficient budgets available for the improvement and enhancement of health services. However, the researchers noted how healthcare rights are in the Constitution of Sri Lanka. In more concrete terms, while the right to healthcare is not explicitly articulated in the constitution, such a right as mentioned in relation to Articles 12, 13(1), and 13(2), can be restricted in the interest of public health. Further, the research stressed that even under the 'Directive Principles of State Policy and Fundamental Duties,' which are not enforceable in a court of law, there is no mention of health standards. Notwithstanding this scenario, significant investments were made toward the health infrastructure at the national and district levels. Hence, Sri Lanka has been lauded by many multilateral agencies and multi-sectoral bodies for its health sector achievements despite having a modest per capita income. To date, some notable health indicators for the country are as follows: achieving child immunization status with 99% coverage, eradicating polio, eradicating measles, an excellent family planning record, maintaining Sri Lanka as a low prevalence country in HIV and bringing perinatal transmission down to zero, ensuring ARVs are given immediately on detection, excellent pregnancy care of 99% with very high levels of pre and post-natal care, extremely low levels of under 5 years of the age mortality rate of 9.4%, and a 94% access to basic sanitation across the country.

Finally, results and findings from Sri Lanka's 2018 Health Sustainable Development Goals further solidify its efforts in improving its health sector while also revealing lapses in the current health system that can be fixed. As of 2018, Sri Lanka has a UHC coverage of 68% and the country was reported to have focused on enacting health interventions to prevent diabetes, cardiovascular and respiratory diseases, and cancer. However, in the same year, reports of high tobacco usage among men, as well as high suicide rates, and the lack of sex education among teenagers prove that Sri Lanka's health sector's efforts in information dissemination leave a lot to be desired. Moreover, in more recent times, there has not been any concrete policy on key health indicators, although cases of citizens with non-communicable diseases (NCD) are rapidly growing in the country. In addition, policymakers have not developed strong awareness, prevention, and management strategies to curtail the growth of diseases like diabetes, high cholesterol, cancer, cardiovascular diseases, and respiratory diseases. Sexual and reproductive health education among adolescents and young people has failed to penetrate and address

needs because of political and religious influence and interference. To cite a case in point, a good education program has been completely abolished as a result of these powerful groups interfering and blocking the right of the people to be informed about these matters.

At present, the country's priority is focused on rebuilding the economy that plummeted last year, hence, the intent of improving health services has been relegated to the side. Further, the global economic crisis caused foreign aid for drugs and health supplies to stop coming into the country, and worse, the health sector in the country is currently being used as a political tool to gain support and power.

Overall, the four participating countries have considered health rights a fundamental human right, and two have explicitly stipulated it in their constitution. In contrast, the other two have constitutional provisions that stress the importance of affordable public healthcare at the very least. As health rights are important to these nations, they all have made measures to achieve UHC by using SDGs. In the case of Bangladesh, its healthcare system has been shaped by circumstances. Bangladesh has experienced various health crises due to hazardous working conditions, man-made pollution, overpopulation, and widespread poverty. In 2013, Rana Plaza, an eight-story garment factory in Dhaka collapsed, killing 1,132 people, and injured more than 2,500 people. Several large cracks appeared on the vaulting just one day before the collapse, however, all garment workers were still ordered to come back to work the next day, leading the workers of the Rana Plaza to their deaths. While not all hazardous working conditions can lead to fatalities such as the tragedy that took place in 2013, lack of proper ventilation, poor sanitation, constant exposures to harmful chemicals and carcinogens, among others, can cause health issues that can be severe and eventually lead to death. Worse is, until this time, healthcare inequities are a reality that citizens grapple with. To deal with prevailing healthcare inequities and the expenses of medical care, the country's healthcare system has become pluralistic: which means that the country utilizes both western medicine and alternative medicine.

The Nepalese National Health Policy served as the basis to improve the nation's current healthcare system, followed up by the Public Health Service Act, which emphasizes that citizens have the right to high-quality health and hospital care. Additionally, Nepal introduced the Free Health Care Programme which aims to provide basic health services, emergency services, as well as inpatient/outpatient treatment in public facilities. However, the country still lacks a concrete and accessible health insurance scheme, and medical services are mostly paid out of the patient's pockets. Nepal also has a shortage of medical professionals, especially doctors.

As previously stated, Article 38 of the Pakistani constitution clearly stipulates that treatment will be accorded without exception to anyone who is hospitalized. Yet, the provision did not elaborate what needs to be done to realize it. The desk review from the Pakistani research team has found that the country only focused on 6 out of 8 areas of commitment to UHC. It is revealed that they were the first country that utilized EPHS, which are health packages that are customized to deal with what Pakistan is most struggling with healthcare-wise. Though, in 2022, it is proven that EPHS is not enough, as the

most recent monsoon season crippled Pakistan's healthcare system; this also proves that disaster preparedness, which is one of the two areas of commitment that Pakistan chose to ignore, was dismal. Lastly, Sri Lanka's healthcare system had been celebrated for its history of lowering rates of preventable diseases since its independence in 1948. However, its suicide and tobacco consumption rates, as well as the lack of sex education among teenagers were a major cause of concern for the Sri Lankan health sector. Diseases are also stigmatized around the country due to misinformation and the aforementioned lack of sex education. Recently, with the 2022 economic crisis closing down hospitals and forcing unemployment and violence around the nation, the current state of health has declined in all population groups.

The current state of healthcare in the participating countries paints a picture of a sub region that remains optimistic for a better and healthier future. However, these four countries still need to deal with other issues that negatively affect the health of their citizens to properly see and calibrate the progress these countries have made over the years.

The Four Countries' Commitment to and Accomplishments in UHC

Bangladesh

In terms of a country's commitment to UHC, Bangladesh appears to have a strong political will to do so. The Health Economics Unit and the Ministry of Health and Family Welfare (MOHFW) of Bangladesh have developed UHC monitoring tools with some key indicators in place, such as health workforce, infrastructure, medicine and reagents, health information, and research, service access, and readiness, service quality and safety, service delivery/coverage of intervention, risk factors and behaviors, improved health status, health care financing, and health protection. Yet, in most cases, the government has focused on maternal and child health care more than the other issues in the health sector. Migrants' health has not been properly addressed. There are delays in the publication of survey reports and in compiling routine data, which are the common barriers to monitoring universal health coverage in Bangladesh.

Notwithstanding those aforementioned hiccups, the Government of Bangladesh is committed to moving progressively towards universal health coverage by 2032, which is documented by the Health

Care Financing Strategy of 2012. The country's seemingly strong political will to commit and comply with UHC's ideals and standards for healthcare is seen through the involvement and commitment of relevant government agencies and entities in developing UHC monitoring tools to ensure that complete coverage and effective compliance take place. It envisions strengthening financial protection, extending health services, and providing population coverage.

This means everyone who needs health services will be able to get them without undue financial hardship. To achieve this, three strategic objectives were proposed: generate more resources for health, improve equity (by pooling resources and equitably allocating them), and enhance efficiency. Nevertheless, there is a dearth of information on specific and concrete steps the country is taking or intends to take to attain UHC based on key indicators but instead, it has set a target to reach UHC by 2030 as part of its Sustainable Development Goal (SDG).

Nepal

For its part, Nepal gears towards addressing equity gaps and focuses on making health services accessible via the introduction of free health care programs targeted health package schemes, and a safe delivery incentive scheme. The Nepal Health Sector Strategy 2015-2020 provides a roadmap toward Universal Health Coverage (UHC) and prioritizes health system improvement in human resources for health, public financial management, infrastructure, procurement, and health governance. Both health policy and health strategy are in line with the Sustainable Development Goals (SDG). Since 2018, the UHC Partnership (UHC-P) has been supportive of the finalization of basic healthcare service packages and has been strengthening capacity building regarding health service delivery at all levels. The development of a health financing strategy and technical support regarding the strengthened health management information system is also part of the cooperation with the UHC-P. The national health system of Nepal ensures that health coverage covers all types of health services and financially covers all citizens who suffer from illness, and in so doing, aligns its priorities with that of the UHC. In more concrete terms, Nepal has been able to attain notable progress in terms of public financing for health. Yet, as emphasized in the research, "Between 2017 and 2019, Nepal's Universal Health Coverage (UHC) service coverage index increased from 48% to 53%, less than 50% of the required rate to attain the Sustainable Development Goals (SDGs)."

Nevertheless, besides highlighting notable progress in terms of public financing for health, Nepal's research was able to identify a few more concrete accomplishments of the country in the health sector. Health and Education have been prioritized to increase the Human Development Index (HDI) to 0.65,

which is 0.602 at present. The cases of COVID-19 have dropped as well. However, up to this point, the government of Nepal has been highly relying on patient fees/OOP payments to fund the health system. Hence, the UHC plans included some action to abolish patient fees/OOP payments such as free medicine and free health check and eliminate out-of-pocket costs on insulin and other critical drugs.

Pakistan

One thing about Pakistan's healthcare is that the country is implementing Primary Health Care (PHC) as UHC, yet, while PHC is a component of UHC, many quarters believe that its implementation is less likely to ensure UHC coverage. Previously, Assembly discussions around UHC were made under the terminology of Sehat Sahulat Program (SSP), which is a successful public health insurance initiative falling under the 'Prime Minister's National Health Programme.' There is also the Essential Package of Health Services (EPHS), which is a comprehensive package developed not based on population density but on the burden of diseases. Pakistan is the first country in the world to invest in such a package, which is being implemented on a pilot basis for 5 years and is funded by the World Bank.

It was gathered from the research respondents that there is no UHC legislation in the country on the national level, yet, many of the respondents believe that Pakistan does not need another legislation on health, but instead, regulation of existing health legislation would be adequate in achieving UHC. Many of the respondents also claim that Pakistan's decision-making is mostly political, which can be seen with the UHC KP Act 2022. UHC KP Act 2022 is the closest to provincial legislation but majorly pertains to health emergencies and SSP (Sehat Sahulat Program). The study also reported that Pakistan has been implementing PHC since the 70s, but the results remain unfruitful. Further, the respondents articulated that Pakistan has a detailed and thought-out planning process in place with the Inter-Sectoral Coordination (ISC) of ministries yet the problem is the lack of sustainability in the planning process.

The research respondents identified eight areas that can be regarded as obstacles to advancing UHC in the country. From the most fundamental aspect, understanding of the UHC varies among stakeholders, thereby necessitating a standard definition that will pave the way for a common understanding, especially among policymakers. Some quarters are insisting that UHC legislation is not required since there are existing provisions in the constitution, and would prefer not having new legislation as legislation is used for political purposes. However, those from the other end of the spectrum counter that there is a need for UHC legislation to outline the roles of the stakeholders, which will subsequently ensure the effective implementation of interventions. Another obstacle is that there

is no national or provincial roadmap for UHC in Pakistan. Hence, the country is using the Sustainable Development Goal (SDG) indicator 3.8.1 to monitor UHC progress.

At the same time, it was also noted that the country is advancing in some areas or facets of the UHC, yet, for each gain attained, there appears to be a corresponding glitch that is spotted. While there is no UHC legislation in the country on the national level, this can be attributed to the fact that the country has been implementing Primary Healthcare (PHC) as Universal Health Care (UHC). This situation has stood in the way of providing UHC legislation as several policymakers think that the country does not need another legislation on health, but what it needs is regulation of existing health legislation believing that doing so would pave the way for the attainment of UHC's mission. And as stressed earlier, while the country has been implementing PHC since the 70s, it has always been regarded as unsuccessful. It is for this reason that many believe that while PHC is a component of UHC, its implementation is less likely to ensure UHC coverage. It was also noted that the country has been regularly and consistently working on increasing budget allocation for health. Its latest budgetary target/commitment for health, which it intends to attain by 2023 is that of 3% of the GDP. However, this target budget has been seen and labeled as 'ambitious and unrealistic' due to issues with the economy and the lack of resources for the health sector.

Sri Lanka

As gathered from the research conducted in Sri Lanka, the country's 2018 UHC Policy aims to ensure free universal coverage to all its citizens. Sri Lanka has been following a free healthcare policy since 1952, which subsidizes the costs of healthcare services and medications. They highlighted that the main piece of legislature was the 1952 Health Act, even though numerous policies have emerged over the years. As a country that is part of the United Nations, the policies are aimed towards achieving the Sustainable Development Goals. The small island nation had also made agreements and projects with Asian Development Bank and the World Health Organization. Hence, for its sufficient budget provision on healthcare and the achievements of the health sector, despite the country having a modest per capita income, Sri Lanka has been lauded by many multilateral agencies and multi-sectoral bodies.

Despite Sri Lanka's long-standing and pioneering efforts in public health services in the sub-region and its quite numerous accomplishments in health services to date, many believe that it has a long way to go to achieve universal coverage. As pointed out by one participant, free access to healthcare is not absolute as it is restricted by limited resources, i.e., availability of medicine, among others. In such a case, a poor patient is less likely to secure medication from outside as he cannot afford it. It also

highlighted how political instability and the changing of governments affect policies since those policies that get proposed are discarded when a new government takes over.

Before the political turmoil that took place in the current year, the nation's economy suffered tremendously due to the pandemic, which precipitated the protests that took place. And now, with the depletion of the country's foreign reserves, it was unable to supply drugs and other essential products to the health sector, so it was very likely that some vital health indicators must have been affected. Further, the health sector has been used by leading political parties as pawns to destabilize the very vital healthcare services in the country. Unions and even some of the professional health sector bodies were politicized to gain political mileage. These events must have had a setback in the overall health sector and its indicators and achievements. Further, as stressed by the research participants, it has to be acknowledged that getting back to the laudable indicators will not only take time but will also require genuine political commitment and resolve.

Finally, as can be gleaned from the contents presented in this subsection, each of the four countries' commitment to UHC differs from that of the other. Adherence to the vision of UHC, commitment to its principles and cause, and implementation of policies and guidelines that would facilitate the attainment of UHC's goals are significantly impacted by several factors, many of which are also determinants of healthcare status in a country and more so of the level of commitment and magnitude of accomplishments in UHC, i.e., the current country's leadership, the political will of sitting leaders, priorities of politicians tasked with the legislature, the current state of the country's economy and monetary resources, the socio-political predicament that besets the country at present, among others.

The International Organization for Migration (IOM) recognizes that health outcomes can be influenced by the multiple dimensions of migration. Risks to migrants' health vary according to their individual characteristics, i.e., gender, age, educational attainment, and disability, among others, and, more notably, their legal status. Additionally, in the migration cycle, MWs are vulnerable to infections, especially sexually transmittable infections (STIs) and HIV, due to lack of knowledge and information about them as well as their corresponding preventive measures. Given their predicament, irregular migrants especially face higher risks of exploitation and marginalization, including a lack of access to health services. In addition, even if migrants have access to health services, they generally choose to avoid them because of fear of deportation and possible xenophobic and discriminatory attitudes of healthcare staff as well as linguistic and cultural barriers, i.e., values and norms, stereotypes, and religious beliefs, among others. Sri Lankans are predominantly Buddhists while receiving countries in the Middle East, which are popular destinations of Sri Lankan migrant workers, are Islamic countries. While this is not exactly a cause for concern, awareness of such differences can be intimidating or threatening to migrants, which can impact on their decision to seek medical care.

Being a vulnerable population, migrant workers suffer from health-related issues and concerns, which can be attributed to precipitating factors such as the rigors of the migration process, being away from home and their loved ones, the predicament and conditions relevant to employment, plus natural and man-made calamities.

In Bangladesh, in 2020-2021, it was revealed that about a couple of hundred returning migrants with ailments received medical treatment, but there was no detail on the number of migrants that applied for medical assistance and on what basis those who were assisted were selected. Most likely, a good number of cases were also unaccounted for. It was reported that a significant number of Bangladeshi migrants suffer from diseases including diabetes, dermatological problems, physical pain and weakness, eye and ear problems, heart disease, liver, lung, and kidney problems, ulcers, tumors, Hepatitis B, HIV, and cancer. Besides medical treatment for physiological ailments, health support for returnee migrants with issues relevant to psychological well-being was also provided from the years 2019 to 2021, in the form of psychosocial counseling. Symptoms such as lack of interest, a feeling of callousness, sleeplessness, aggressive behaviors, and depression were triggered by sad memories about life abroad, frustration at work or in a career, etc.

In a study conducted by IOM, it was revealed that 38% of the respondent's encountered discrimination in the hospitals because they were returnee migrants, which is a reflection of the pervading exclusionary nature of Bangladesh' health system. There would also be incidents when critical cases

are declined to minimize the risks and complexities. The prevalence of corruption, mismanagement, and administrative subjugation, especially in government hospitals, outweighs the benefits of providing affordable health services to the underprivileged population. Bangladeshi returnee or vacationing migrant workers face difficulties in access to health care services once they undergo mandatory health testing. Additionally, even in the pre-departure orientation protocol, there is hardly a discussion or orientation on the potential health risks that migrant workers may face as well as information on access to healthcare and treatment as stipulated in the job contract. Lastly, there is no health insurance yet provided by the government for migrant workers. At present, most health insurances cover merely primary health care or only accidents rather than any disease like SRH, dental, mental, and chronic ailments. On the other hand, undocumented migrants are in a worse predicament because given their status, they are completely deprived of universal access to health care both in their countries of origin and in their destination countries.

The Constitution of Nepal contains provisions for labor migration and various migration policies and legal frameworks have been framed to govern foreign labor migration. However, the existing labor migration policies and guidelines are meant to ensure that foreign employment is safe and free from any type of exploitation and regulate economic interests and benefits instead of focusing on the health needs of migrant workers. Nevertheless, Nepal has been keen on addressing equity gaps and is increasingly focused on making services accessible to the population in need. It has introduced free health care programs, targeted health package schemes, and a safe delivery incentive scheme to minimize the equity gap. However, despite this, the country still faces many health challenges. Even if the country has defined marginalized and vulnerable groups in a quite comprehensive manner, it does not specify people who use drugs, sex workers, prisoners, and migrants as part of the cluster, and also ignores the health insurance schemes for these groups. Additionally, there are no specific laws and policy frameworks that explicitly support the vulnerable groups to access health services or quotas or earmarked services, and existing health policies and plans do not seem to address the social and environmental determinants of health. The UHC policies, plans, and reports include a focus on investing in the health workforce yet not much focus on Migrant Workers' (MW's) health rights.

The state of UHC coverage is structured around eight 'commitment areas' in its declaration, which serves as bases for every country in aligning their health sector with UHC. However, the desk review that was done in the research in Pakistan uncovered that the country has only made commitments in six of the areas, excluding gender equality and emergency preparedness. Of the six commitment areas that the country has made commitments in, no specific mention was made about migrant workers in two of them, Political Leadership and Moving Together (synergy).

Commitment Area 2 is 'Leave no one behind equity, yet, ironically, migrant workers are left behind in Pakistan's commitments. The results gathered correlate with the information provided by the UHC country portal stating that impoverished people, women and girls, People Living with HIV (PLHIV), and migrants are the populations that are left behind in Pakistan's UHC commitment. The migrant

workers' health needs have been ignored by the government when in fact, in the 2007-2012 'National HIV and AIDS Strategic framework', MWs were first identified as the 'most at risk and bridge group' for Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) transmission and were also identified as a 'vulnerable group' by the 'Pakistan AIDS Strategy III' by National AIDS Control Programme.

In Commitment Area 3, which is 'Regulate and Legislate', migrant workers are scarcely included in any policy frameworks developed under the National Health Vision 2016-2025, both at national and provincial levels. In particular, while Pakistan AIDS Strategy 3 (2015-2021) enumerates key strategies to address MWs' HIV needs, no implementation was seen taking place within the specified time frame (2015-2021). Concerning Commitment Area 4 (Upholding the Quality of Care), in Pakistan, since HIV, being a sexually transmitted disease, is not included in the schemes, it leaves MWs vulnerabilities to this disease unattended. Commitment Area 5 is all about 'Investing more in better programs. The desk review conducted revealed that there is no budget allocation for MWs health needs from national or provincial governments even though they contribute a larger share to Pakistan's economy in terms of remittances. In August 2022 alone, MWs remitted 2.7 billion dollars to the country.

Sri Lanka stands out to date as the only country in the sub-region that has its own migrant workers' health policy that was developed in October 2013. It covers the following: develop and implement a comprehensive and standardized Health Assessment, ensure health protection for migrant workers by entering into bilateral and MoUs with destination countries, offer voluntary Health Assessments for returnee migrants to be effectively reintegrated into society, adopt and implement a coordinated local response that will address mental and physical health services and social welfare support to migrant workers and the families left behind by migrants, develop and implement a coordinated child Health Protection Plan including nutrition programs for vulnerable children of migrant workers, develop and implement a system of information generation and dissemination among migrants and their families left behind to raise awareness on special situations such as health emergencies and death of a migrant worker, among others.

Meanwhile, as gathered by the research, lately, there has been an increase among migrant workers who are complaining about skin rashes, migraine, back, and joint aches, respiratory issues, diabetes, and cardiovascular conditions due to the harsh climatic conditions in the Gulf states and the strenuous workload they have to perform over long hours every day. The research stressed that sadly, the government has not addressed the needs of this population group that is increasingly becoming a health burden in the country.

Moreover, there are medical expenses that are incurred before the migration that are not covered by the policy, such as the mandatory medical examination, which is carried out by the Gulf Approved Medical Centers Association (GAMCA) and not by the government medical testing services. This is

very costly, and it has to be borne out by the migrant workers, in particular, the males. The data relevant to the tests are not shared with the government health system. Finally, while the research has confidently ascertained that the only investment the country has made for the migrant workers' population is that of providing pre-departure orientation programs, it has failed to determine if voluntary health screening for returnee migrants is carried out and if the families left behind get any preferential treatment by the state health sector apparatuses and devices. The absence of any research done on the migrant community makes it difficult to understand their health needs and their current health status.

In summary, to date, the Bangladesh government has not provided any health insurance to migrant workers. For the general population, health insurance would merely cover primary health care or accidents rather than those that pertain to SRH, dental, mental, or chronic illnesses. Nepal has been keen on addressing health equity gaps and is cognizant of the vulnerability of high-risk groups and has specified what comprises the same, yet, it has failed to include the migrant workers as part of it. It is probably for this reason that the UHC policies, plans, and reports include a focus on investing in the health workforce yet not much focus on MW's health rights. Similarly, while the research in Pakistan is quite articulate in presenting strategies to combat obstacles in fulfilling UHC's vision as well as in tackling the Commitment Areas that the country has addressed, the desk review revealed that there is no budget allocation on MWs health needs from national or provincial governments even though they contribute a larger share to Pakistan's economy in terms of remittances. And while close to 20-25% of Sri Lanka's workforce are migrant workers, hence they are considered an important sector due to their enormous contribution to the national economy by generating about 8-10% of the country's GDP by way of remittances, no research has been done on the migrant workers that would provide information that would be indicative of their current health status and would facilitate understanding of their health needs. Lastly, for the four countries included in this research, undocumented migrants are completely deprived of universal access to health care both in their countries of origin and in their destination countries.

The Human Immunodeficiency Virus (HIV), which is responsible for causing an immunodeficiency syndrome that significantly weakens the immune system of its host, if left untreated, can progress into AIDS. Migrants are prone to get infected with HIV for a myriad of reasons. The lack of sex education endangers migrant workers as their lack of knowledge in contraception and transmission can put them at risk not only for unwanted pregnancies but for getting infected with an STD like HIV and chlamydia. Migrant workers who are financially handicapped if not desperate for money, may resort to commercial sex work as a means of earning extra income. This, bundled with the lack of sex education, can make them engage in behaviors that would put them at high risk of getting sexually transmitted diseases. Lastly, migrant workers, regardless of sex, can be victims of sexual abuse, which in some if not most cases, is unprotected sexual contact.

Statistics would show that South Asian migrant workers are mostly situated in Gulf countries, where homosexuality is a criminal offense. While statistics would reveal that the majority of people infected with HIV are homosexuals, the reality is that the virus and the infection are not discriminatory or selective when it comes to sexual preference. Each Gulf country has its policies for preventing HIV and AIDS, but these policies are exclusively for its citizens. It has to be stressed as well that Gulf countries deny entry to any migrant who has been found to be or is open about his or her HIV positive status. South Asian countries that import migrant workers mostly to Gulf Countries do not have HIV policies that protect their own migrant workers, and hence it is common practice in these countries to stereotype them to be disease carriers when they return home to their country of origin, it appears to be a case of double jeopardy for them.

Bangladesh has a low prevalence in terms of HIV cases. Only 1% of the most vulnerable population groups are known to be HIV positive. Data gathered by Ovibashi Karmi Unnayan Program (OKUP) suggest that the prevalence among Bangladeshi migrants is higher when compared to the general population of Bangladesh. OKUP also states that the rise in cases may be due to unprotected sex practices as well as sexual assault and rape of female migrant workers. UNAIDS and the IOM office in Dhaka worked together on a study on the HIV vulnerability of female migrant workers that found that there are inadequacies in HIV information and health services in both the country of origin and the countries they are working in. Relevant to this, it was revealed by migrant workers participating in the research that there is little to no orientation done about STD transmission during their pre-departure phase which can be detrimental to those who have little to no knowledge of the concept of safe sex practices. They are heavily vulnerable to contracting the disease due to a lack of regulations and protection rights, as well as to the low wages that drive them to consider doing commercial sex work. There is a lack of information on the exact number of Bangladesh' migrants who have HIV,

however, migrant workers are stigmatized to be carriers of the disease and are discriminated against. Life insurance policy for overseas workers excludes HIV/AIDS from their health coverage and undocumented migrant workers have no health coverage at all.

The 2009 and 2015 constitutions of Nepal have laid the foundations of the country's path towards Universal Health Coverage (UHC), intending to institutionalize UHC through the Health Sector Strategy (2015−2020), which emphasizes the importance of supporting vulnerable groups. For this goal to be achieved, the Free Health Care Program (FHCP) was created and subsequently implemented. Additionally, three social health insurance schemes, namely the Health Insurance Board (HIB), the Social Security Fund (SSF), and the Employee Provident Fund (EPF) were introduced and institutionalized, all with the intent of fulfilling the vision of UHC. Moreover, Nepal has a National Health Insurance scheme, and in line with this, the National Health Insurance Policy was passed by the Government of Nepal in 2014 and on the 9th of February 2015, the ordinance for the formation of the Social Health Security Development Committee was passed by the Government of Nepal and published in the Nepal Gazette.

However, the HIV & AIDS policy in South Asian countries that send MWs does not recognize migrants either as a key population or a vulnerable group, thus, their health vulnerabilities are neglected. Thus, despite all those initiatives mentioned above that the country has taken, Nepal's labor migrants' health rights continue to be neglected, thereby rendering the migrants and their families to be vulnerable to infectious diseases, i.e., STDs like HIV/AIDS, and opportunistic illnesses and communicable diseases such as Covid-19.

In Pakistan, while migrant workers are considered a 'vulnerable group' in the current AIDS strategy being implemented, i.e., "AIDS Strategy Pakistan IV 2021-2025", and are officially recognized as 'most at risk and bridge group' in National HIV and AIDS Strategic Framework (2007 – 2012), data available on HIV among migrants are limited, hence health initiatives leave Migrants Living with HIV (MLHIV) behind. The country does not have HIV policies that protect its migrant workers but have HIV policies exclusively for those within Pakistani borders. On the other hand, migrant workers in Sri Lanka have been identified as a vulnerable group yet they are not listed as a 'key population' or are not considered in general as a population at risk for HIV, hence, government policies on HIV do not cover migrant workers. Nevertheless, it has to be mentioned that in some cases, migrants get referral for health services from the host country to the home country. The government follows the internationally accepted key affected population, such as commercial sex workers, MSM, and injecting drug users. The rationale offered for this is that HIV testing was only done for outgoing migrants. Inbound migrants, which include migrant workers going back to their country of origin, do not go through the same mandatory testing procedure, hence, relevant data are not gathered which could pinpoint or indicate that they are a population at risk. Furthermore, migrant workers are not even documented when they come back, thus, there is no statistical basis to state that there is a continuous increase in the number of migrant workers who are HIV positive.

Sri Lanka appears to be somehow adequately responsive and manifestly proactive in dealing with SRHR-related needs and concerns of its migrant workers. Its National Labour Migration Policy, which came into being in 2008 and went through an extensive review in 2019, covers in particular migrant workers' sexual and reproductive health, HIV, and STDs. The health-related feature of the policy offers assistance to migrant workers in vulnerable situations under the strategic framework "Protection and Empowerment of Migrant Workers and their Families". Some of the key strategies outlined in the framework are to have a comprehensive HIV awareness orientation including an understanding of STDs, to understand the vulnerabilities associated among female workers and domestic workers, in particular, to recommend HIV testing along with another medical testing at reintegration, and to engage with spouse/partner and other family members. However, it was observed that while this policy has been widely accepted in the sub region, its implementation could have been a lot better. As articulated in the research, the National Labour Migrants Health Policy failed to link and acknowledge the values of the National Labour Migration Policy, as both are fiercely independent.

The healthcare policies of each of the four countries pertinent to HIV positive migrants differ from each other, although they also share some common features. Not all four countries consider migrant workers as a vulnerable population, and yet it does not necessarily follow that even if a country has done so, the health needs of its HIV positive migrants are addressed, if at all. Bangladesh ensures that all relevant policies would facilitate proper health care services for all, especially for the most disadvantaged and vulnerable populations, yet, at this point, while Bangladeshi migrant workers are recognized as a vulnerable group, they remain unrecognized as 'most at risk population'. And as for the general population, the existing life insurance policy for overseas workers excludes HIV/AIDS and self-harm from the coverage, which is seen as a violation of human rights. Besides the fact that migrant workers' insurance policy does not cover HIV/AIDS cases, they also suffer from stigma upon their return to their home countries as they are seen to be carriers of HIV, thereby a case of double jeopardy.

Currently, the Constitution of Nepal contains provisions for labor migration and various migration policies that are only meant to ensure that foreign employment is safe and free from any type of exploitation and to regulate economic interests and benefits instead of focusing on the health needs of migrant workers. Despite the efforts expended to define marginalized and vulnerable groups, it was not comprehensive enough to clearly specify people who use drugs, sex workers, prisoners, and migrants as part of the cluster, and also ignores the health insurance schemes for these groups. Further, as of the present time, there has been no existing evidence yet that indicates that the Nepal government has formally recognized them as the 'most at risk population'. Insurance policies in the country do not cover life insurance for PLHIV. However, the government of Nepal has a Social Health Security Program (SHSP) that aims to enable citizens to access quality healthcare services without placing a financial burden on them. This program attempts to address barriers in health service utilization and ensure equity and access for poor and disadvantaged groups as a means to achieve Universal Health Coverage. In particular, it grants 100% subsidy to families of ultra-poor HIV, MDR-TB, Leprosy, or severe disability patients, etc. Nonetheless, the research also reported that HIV and AIDS-related

stigma and discrimination exist in all levels of Nepalese society, and in the case of health service delivery, rejection, isolation, avoidance, denial, and participation restrictions are common manifestations of discrimination faced by migrant workers with HIV.

On the other hand, Pakistan has officially declared migrant workers as a vulnerable population and a population 'most at risk'. However, it has no HIV policies to protect its migrant workers as its policies are only applicable to those inside its borders, which include returnee migrant workers who are either deported or on vacation leave. In the country, health insurance for PLHIV is not a concern as HIV treatments and medications are provided free of cost by the National and Provincial AIDS Programmes of Pakistan, yet, this is not enjoyed by migrant workers once they are outside of its borders. Additionally, in the country, PLHIV encounters discrimination while accessing HIV treatment, regardless of their status, migrant workers or not.

Like Pakistan, Sri Lanka recognizes migrant workers as a vulnerable population but unlike the former, it does not recognize them as 'most at risk population'. Even so, it appears to be responsive in addressing HIV related needs of migrant workers. Further, some of their relevant policies appear to consider migrant workers a vulnerable group. For instance, its National Labour Migration Policy covers SRHR, HIV, and STD-related health needs of migrant workers, which all fall under the strategic framework "Protection and Empowerment of Migrant Workers and their Families". However, as commonly observed, the loophole is in its implementation. Similar to the other three countries, insurance policies in Sri Lanka do not cover HIV, and the same is true with the insurance program offered by the government. HIV is a reason for a person to be rejected for a job that he or she may be qualified for, and it is for this reason that an HIV test for pre-employment purposes is mandated. However, the current policy is to offer free ARVs on detection to any person, including migrant PLHIV when they are inside the borders.

NATIONAL REPORTS

1 Bangladesh

The Current State of Healthcare in the Country

Bangladesh is a South Asian country located in the east of India. With its inclusion in the Least Developed Country list of the United Nations in 1975, it aspires to be an upper-middle-income country and is heavily reliant on migrant workers to achieve that goal. As a currently developing nation, Bangladesh is notorious for the lack of protection rights for its local workers. With fabric and clothing being their main export, the pollution that comes from fast fashion factories poses a major health risk as it can contaminate water reservoirs and food supply. The lack of protection rights, pollution, and high poverty rates make Bangladeshi people prone to accidents and disease. According to Thelwell (2020), the country's 3.5 million local workers are composed of 85% women. They are paid low wages and are working in cramped, dangerous conditions without any financial compensation. An incident that highlights the dangers local workers were put through is the Dhaka garment factory collapse on April 24, 2013. BBC News (2013) reported that the Rana Plaza Building, which housed 5 fabric factories collapsed and killed 1,132 people and injured 2,500 more. It remains to be Bangladesh's worst industrial disaster. The Bangladeshi government was criticized by the UN for the lack of worker safety regulations that brought about the collapse.

Fortunately, Bangladesh' healthcare system has been improving since it implemented new health-related policies in the early 2010s. This included a couple of laws and policies relevant to the general population with some policies being relevant to the health of migrant workers. The National Health Policy of 2011 ensures equitable health services, gender equality, and healthcare for people with disabilities and marginalized groups by trying to achieve Universal Health coverage in the country, which means they are gearing towards healthcare that also targets migrant workers. Bangladesh' Perspective Plan of 2021-2041 plans to increase public healthcare spending from 0.7% of their GDP to at least 1.5% of GDP by 2031, and 2.0% of GDP by 2041, which will be useful as a bigger budget makes more room for the government to invest on healthcare. Currently, most hospital care is paid out-of-pocket or paid for by private organizations, however, the government seeks to change this as

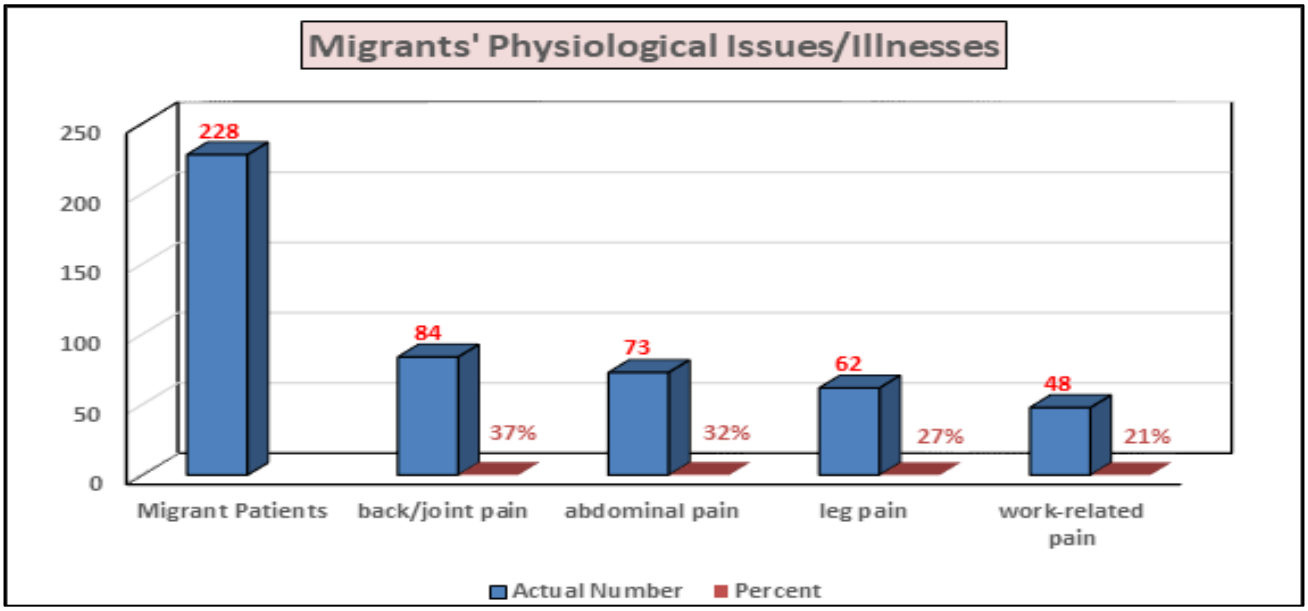
the 8th five-year plan for July 2020 to June 2025 was formed to ensure that all citizens will receive health benefits and improve the general population's well-being by expanding access to quality and equitable health care.

Policies and Challenges of Universal Healthcare Coverage for Migrant Workers

Bangladeshi migrant workers, like the local workers, are exposed to various health risks. They are prone to extreme stress that could lead to chronic conditions such as diabetes and heart disease. Some workplaces also make them prone to cancer. The construction sector, a popular profession among male Bangladeshi migrants, has the largest burden of occupational cancers compared to other work sectors, with 40% of occupational cancer deaths and cancer registrations. According to the Ministry of Expatriates Welfare and Overseas Employment of Bangladesh, 207 migrant patients received medical treatments from 2020 to 2021. However, it was unclear how many migrants applied to their programs, and there was no information on what criteria were used in shortlisting those seeking assistance. There is no comprehensive data on how many migrant workers return to the country with ailments. However, The Ovibashi Karmi Unnayan Program (OKUP) has provided health support to 228 returnee migrants, which includes basic psychological counseling from 2019 to 2021.

The chart below shows the statistics regarding absolute and relative values pertinent to the physiological issues or illnesses that returnee migrants sought medical assistance for. The data cover the years 2019 to 2021.

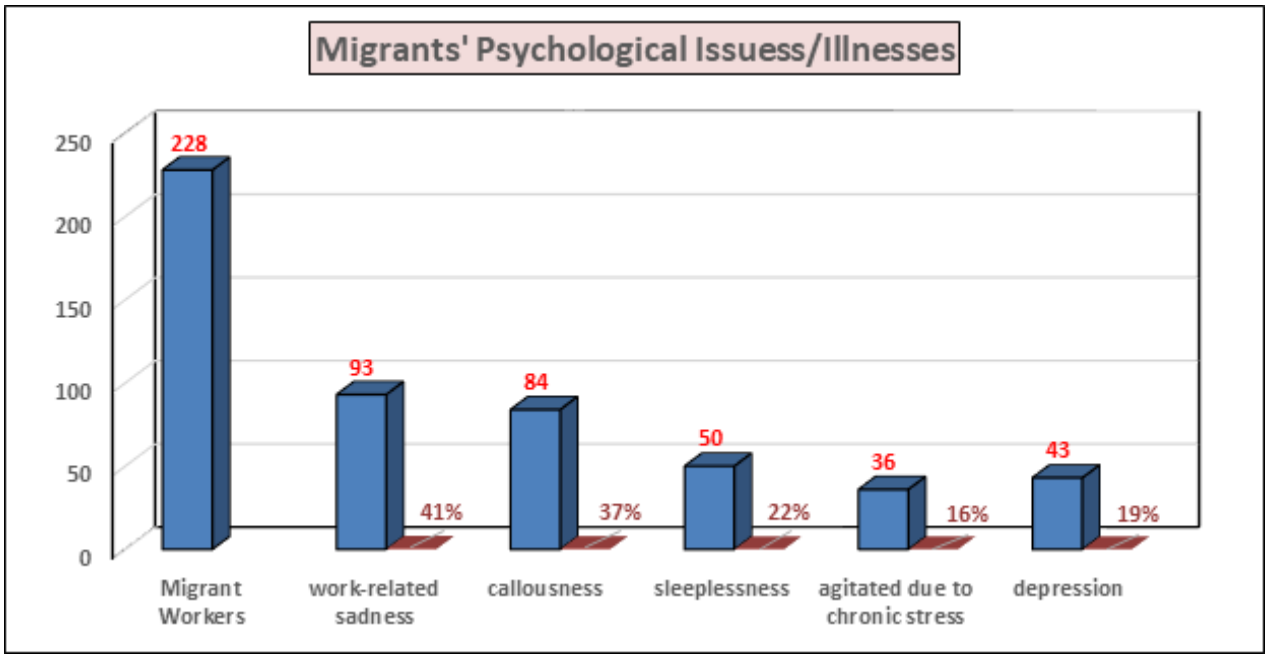
Figure 2: Data on Returnee Migrants' Physiological Issues/Illnesses (2019-2021)



OKUP's data (2019-2021) on the physiological aspect of the patients show that 84 of 228 or 37% of the migrants were treated for pain in their back and joints, a common bodily spot or area for labor workers to feel pain due to heavy lifting. Data also show that 73 (32%) of patients were given health support for abdominal pain, 62 or 27% were for leg pain that was regarded as "unbearable" by respondents, and 48 (21%) were for work-related injuries. Other instances that led these migrants to seek assistance were mostly due to chronic diseases such as diabetes and cancer. Some sought help for headaches and vision problems.

As mentioned earlier, OKUP also performed psychosocial consultations on the returnees. Figure 2 displays the pertinent data.

Figure 3: Data on Returnee Migrants' Psychological Issues/Illnesses from 2019-2021



It was gathered from the consultation sessions that 93 of 228 (41%) of the migrants expressed feelings of work-related sadness and frustrations, while 84 or 37% expressed a lack of interest or callousness regarding their jobs. Additionally, it was found that 50 or 22% remained sleepless, 36 (16%) were aggressive when talking with the counselor, which may be rooted in the chronic stress the patient experienced in their work, and lastly, 43 or 19% of the respondents were diagnosed with depression.

The International Organization for Migrants (IOM) recognizes that health outcomes are influenced by multiple things, and health risks for migrants vary from person to person, most importantly, their legal status. Illegal migrants face higher risks for exploitation and marginalization compared to their legal counterparts. They also lack access to health services as they can be reported by hospital staff for being illegal migrants, which could lead to them being deported. The migrant's sex also affects their vulnerability to health hazards. Bangladeshi female workers, either local or migrant, are highly

vulnerable to health hazards. Female workers dominate the population in the fabric and clothing industry in Bangladesh, while migrant workers work primarily in the hospitality sectors as Domestic Workers (DWs). DWs are excluded from many labor laws, and considering that most south Asians work in the Middle East, they are being treated as secondary citizens and are expected to follow their master's orders. They are at risk of contracting STDs from rape or sex work and are also prone to abuse and extortion, regardless of their job.

Returnee migrants face some issues when visiting hospitals in their own country. The IOM states that about 38% of returnee migrants had expressed facing discriminatory behaviors from hospital staff due to their status as returnee migrants. Bangladeshi hospitals also exhibit an exclusionary attitude toward their migrant laborers. This cannot only dishearten other migrant workers but also dissuade future migrant patients from seeking the help they need in fear of being excluded or discriminated against. Despite this, the law mandates migrants to go through health testing–this procedure is barely covered by the government and is paid for by the migrant workers themselves.

There is no government health insurance made exclusively for migrants as of 2022, and some health insurance policies for migrant workers usually only cover primary health care services or accidents and do not cover chronic diseases, oral care, and mental health services. Undocumented migrants are worse off, being completely deprived of any semblance of health care not only in their country of origin but in their country of employment as well.

According to the Wage Earner's Welfare Board (WEWB), Bangladesh received 3,652 dead bodies of migrant workers in 2021, which is a 25% increase when compared to 2020. Most of the deaths are due to cardiovascular diseases such as heart attacks and strokes, but some died due to accidents, murder, and suicide. According to OKUP Chairman, Shakirul Islam, the root cause of cardiovascular issues among migrant workers is excess workload and poor living conditions that their migrant workers have been placed under.

A few of Bangladesh's health policies mentioned and included migrants. One such is the Action Plan for the Implementation of the Expatriates' Welfare and Overseas Employment Policy of 2016, which was put in place to offer education, health facilities, and services for children and family members of migrant workers. Another policy that aims to improve the quality of health among migrants is the Overseas Employment and Migrant Act of 2013, which was implemented to promote opportunities for overseas employment and to establish a safe and fair system of migration. It also ensures the rights and welfare of migrant workers, and they are extended to their family members. This Act restricts any migration to countries that infringes the rights of Bangladeshi migrants, and this includes their right to health. Lastly, the Overseas Workers Insurance Policy and the 2008 Policy on Providing Special Citizenship Benefits to Expatriates of Bangladesh who send remittances to encourage the migrant to continue working as they are insured to be compensated financially, and those that continually send remittances legally ensure the migrant worker's family is given the benefit of gaining access to proper hospital care in case of emergencies.

Healthcare for HIV Positive Migrant Workers

Bangladesh remains to be a country with low HIV cases. Only 1% of the 'most at-risk population groups' are known to be infected with HIV. However, these numbers can be different when compared with migrants and are expected to be higher when compared with the general population. As established, HIV can be contracted primarily from unprotected sex, as well as sharing needles and blood transfusions. Bangladeshi migrants lack the education required to understand that the aforementioned methods are key factors in contracting STDs and HIV/AIDS. This was evidenced by the fact that there is little to no orientation held in preventing contracting STDs before the migrants depart, and therefore can cause the migrant to remain ignorant on the issue. There is also a study in two rural areas in Bangladesh that revealed that sex work was more common among men who had worked abroad. The lack of education and the presence of returnee migrant workers caused migrants to be stereotyped as disease carriers.

Bangladesh has made measures to prevent and limit the spread of HIV in their country as well as aid in limiting the spread of HIV among their migrant population. The Bangladesh Population Policy of 2012 aims to develop the country with planned development and population control. The policy also aims to ensure prevention and care for migrants that were infected with STDs and HIV/AIDS. More specifically, the 4th National Strategic Plan for HIV and AIDS response 2018- 2022 was enforced to minimize the spread of HIV. The program aims to eradicate AIDS by 2030 by giving HIV-infected individuals antiretrovirals to prevent them from spreading the disease as well as prevent the virus from progressing to AIDS. Despite these efforts, life insurance policies for overseas workers continue to exclude HIV/AIDS and can be considered an infringement on the migrant's rights to health.

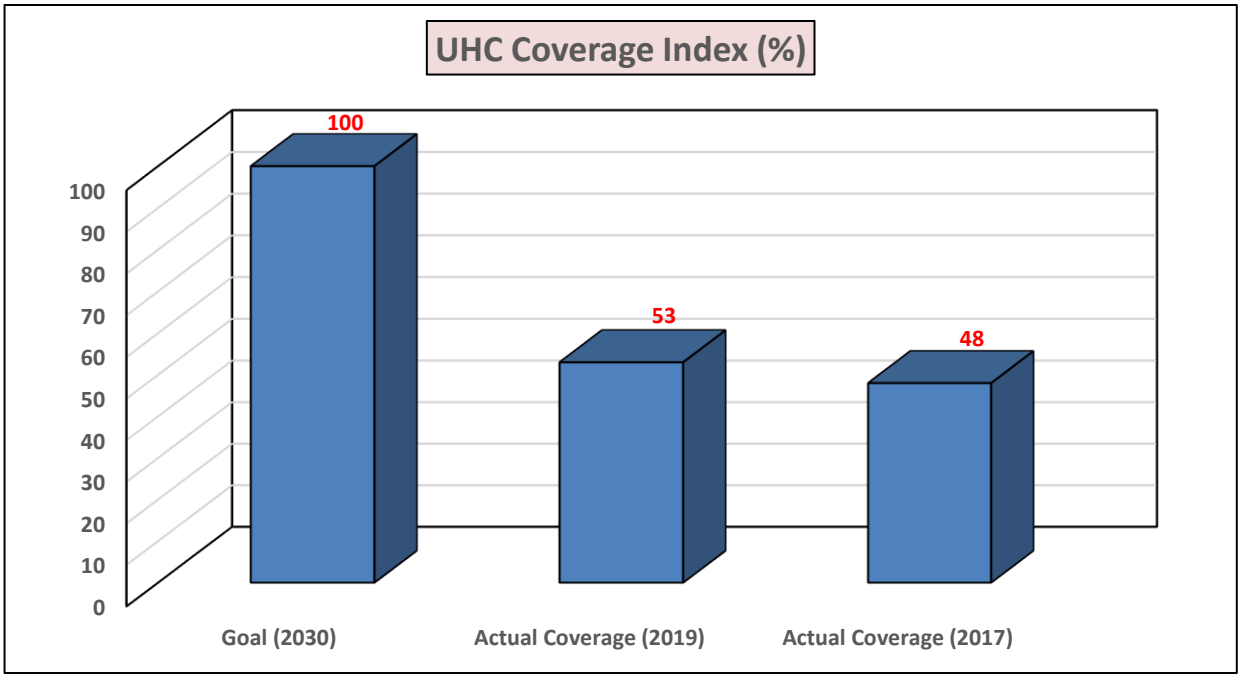
2 Nepal

The Current State of Healthcare in the Country

Nepal is a landlocked country in South Asia with a population of 28 million people. The current life expectancy in Nepal is 69 years for men and 72 years for women. The Nepalese constitution mentioned health rights in Article 35. It states that (1) Every citizen shall have the right to free basic health services from the State, and no one shall be deprived of emergency health services, (2) Every person shall have the right to get information about his or her medical treatment, (3) Every citizen shall have equal access to health services, and, (4) Every citizen shall have the right of access to clean drinking water and sanitation. Therefore, ever since its conception, Nepal has been striving to improve the state of health and wellness among its citizens.

To improve the state of health in the country, Nepal strives to reach the SDG goals set by the UN, which aim to improve the state of living and promote peace in every nation and must be met by the year 2030.

Figure 4: UHC Coverage Index



SDG goal number 3 emphasizes Universal Health Care as a vital part of health promotion. In the case of Nepal, as displayed in the chart immediately above, the UHC coverage index for 2019 is 53%, which means that the government has met its goal halfway, and for 2017, 48% of the general population was able to access UHC. This suggests a 5% increment in coverage index in two years.

The government prioritizes health data available to support and deliver more health services, especially to vulnerable populations. They currently have cost-free Basic Health Care Packages (BHCP) which they give to local governments as one of their actions to achieve UHC in the country. They also implemented the Health Sector Strategy (2015-2020) that emphasizes the importance of supporting vulnerable groups. Lastly, the government has collaborated with the Health Insurance Board (HIB), the Social Security Fund (SSF), and the Employee Provident Fund (EPF) to create and implement a free Basic Health Care Program as another means of achieving UHC. Despite these implementations, there are currently various coexisting health schemes that have led to fragmentation and inefficiencies in the health sector, which then leads to subsidized health care being barely used. Currently, Out-of-Pocket payments remain to be the norm in Nepal, which means that although the implementation of helpful policies was made, there is a lapse in enforcing these programs and policies.

More policies were mentioned in the report that can provide a better picture of the current state of healthcare in Nepal. One of these policies is the National Health Policy. Formulated in 2019, which was made based on the lists of exclusive and concurrent powers and functions of federal, state, and local levels as per the constitution. This policy has served as the basis to lead interventions toward UHC and develop a national health insurance system (Dahal et al. 2017). Another policy is the Public Health Service Act of 2018 which emphasizes that every citizen has a right to receive high quality healthcare for every citizen, and it is inferred that migrant workers are included here. These helped create public health programs that increased the accessibility of healthcare in the country. The Employee Provident Fund (EPF) medical scheme for civil servants, established in 2013, was formed in line with the Employee Provident Fund Act of 2019.

Vulnerable populations are prioritized in Nepal's healthcare system as they are provided with basic free healthcare services in all public healthcare facilities. These vulnerable groups also receive emergency services, as well as inpatient and outpatient treatments. But for the majority of the population, supplementary services are covered by 'social health protection arrangements', namely the HIB, SSF, and EPF. The government of Nepal defines vulnerable groups as communities that are "made politically, economically, and socially backward, are unable to enjoy services and facilities because of discrimination, and oppression, and of geographical remoteness or deprived thereof and are in lower status than the human development standards mentioned in Federal law". It also includes highly marginalized groups and groups on the verge of extinction, such as remote tribes. Despite this definition, the government does not consider migrant workers as a vulnerable group.

There are political debates formed on the issue of UHC and public health recently. And in 2020, Nepal

allocated a budget of NPR 90.69 billion for public health, which was, unfortunately, lower than the budget allocated the year before. And as of 2023, the budget proposal from the Ministry of Health and Population (MoHP) was submitted to the Ministry of Finance (MoF) and National Planning commission (NPC) for discussion and finalization. The budget must be divided under economic expenditure heads and must be based on the approved "integrated code for revenue and expenditure for all three tiers of governments".

There are still issues that hinder the progress in reaching UHC. Firstly, there is a lack of proper enforcement of its current health policies, despite its importance being emphasized by the government, and the amount of international support the nation receives. The Nepal Health Sector Strategy (2015-2020) is the current roadmap the health sector uses to help reach their goals of meeting UHC by 2030 and has been successful to some extent as its implementation led to multiple successful public health programs and gave birth to more health programs and international support. Such a program is the National Health Insurance Scheme, which was formed by the Social Health Security Development Committee. The insurance covers the following:

- PR 3,500 (35 USD) per year for a family of up to 5 members.
- NPR 700 (7 USD) for every additional family member.
- 2% payroll contribution for the formal sector.
- 100% subsidy for indigent families, HIV, MDR-TB, Leprosy, severe disability patient
- 100% subsidy for the elderly population above 70 years.

As of now, there are no alternatives in the current healthcare policies, and those that want more options will have to opt for health insurance from expensive private insurance companies.

Another issue the Nepalese healthcare system is facing is the indirect effects of the caste system. The caste system, though mostly frowned upon or even abolished in other south Asian countries, remains intact in Nepal today. Though laws were made to make it illegal to discriminate against other people in lower castes, the current 'out-of-pocket system' makes it more favorable for those in higher castes as they can afford better care, and therefore, have better health outcomes than those that receive it for free. This problem can be mitigated with policies that abolish patient fees and remove out-of-pocket payments for items such as medicine and basic protective gear, and services such as checkups and laboratories.

Lastly, there are internal issues in the current healthcare system in Nepal. There is a lack of healthcare workers that are working in Nepal as current salaries have been considered low relative to its grueling workload. There is also a gender disparity in hospitals as even though 70% of the workers are female, only ¼ of females work in senior roles in the hospital. The government is training health workers to support the needs of marginalized groups; however, these training programs are regarded as

'inadequately' paid for by the government. There was no mention of the issues of Nepali healthcare workers that moved abroad, which may be a cause of concern.

Policies and Challenges of Universal Healthcare Coverage for Migrant Workers

One of Nepal's main exports is migrant workers. These workers commonly work in India, Malaysia, and the Middle East. Migrant workers are an important player in Nepal's economic growth. However, labor migrants' rights, particularly their health rights, are not being properly addressed and are not being acknowledged by the Nepali government. This lack of acknowledgment can be detrimental to migrant workers, as well as their families. As an example, POURAKHI Nepal noted that migrant workers were severely affected by the COVID-19 pandemic, as they have been hit by unemployment, delayed payments, bankruptcies, and illness. There is also inequity in the access to healthcare for migrant workers due to health policies that exclude migrant workers, fragmented health systems, and insufficient resources from both their home country and the country they work in. Laborers are hardest hit by this inequity due to their work environments that make healthcare harder to access.

According to IOM Nepal Chief of Mission Paul Norton, "We cannot achieve Sustainable Development Goal 3.8 on universal health coverage unless the health needs of migrants and refugees are met. The access of refugees and migrants to quality health services is of paramount importance to rights-based health systems, global health security, and to public efforts aimed at reducing health inequities. This policy will provide an opportunity to promote a more coherent and integrated approach to health, beyond the treatment of specific diseases for all populations, including migrants, irrespective of their legal and migratory status." The National Health Policy of 2019 was created as a roadmap for attaining UHC. The roadmap includes healthcare coverage for Nepal's Migrant Workers as one of their major goals. This policy paved the way for many projects geared toward attaining UHC and was responsible for the development of a natural health insurance system. The Public Health Service Act in 2018 also emphasized the importance of providing high-quality healthcare for every citizen, and it is inferred that migrant workers are included here. However, outside of these, there is a lack of policies made for the benefit of migrant workers, as well as their health rights.

Lastly, although patients from vulnerable groups are given priority by the government, migrant workers are not included in Nepal's definition of a 'vulnerable group.' The government focuses more on local refugees, indigent populations, marginalized groups, and groups on the verge of extinction such as tribes, and does not include migrant workers and sex workers, unlike other countries. This then solidifies that the main issue of the healthcare policies for migrant workers is the lack of policies, Migrants remain neglected in their health rights, which makes them susceptible to disease and financial ruin.

Healthcare for HIV Positive Migrant Workers

Though the constitution emphasizes health rights as a fundamental human right, migrant workers' health rights are not being discussed, nor is its current state being properly addressed. As migrant workers' health rights are being neglected, HIV positive migrant workers are also being neglected. There is a lack of information on the number of Nepalese migrants infected with HIV. There is also a lack of policies enumerated in the report that mentioned HIV. This can be attributed to Nepal being a low HIV prevalence country. According to the United Nations Office on Drugs and Crime, about 64,000 citizens are living with HIV, with most of these populations being sex workers. The only policy where HIV positive migrant workers are included is the Nepal Health Insurance Policy in 2014, which includes a 100% subsidy for HIV positive Nepalese individuals, which should include HIV positive Nepalese migrant workers. All the aforementioned issues from the previous subheading (Policies and Challenges of Universal Healthcare Coverage for Migrant Workers) also apply when it comes to the healthcare of Nepali migrants that are positive for HIV.

Unfortunately, there is a lack of communication between the government and other private groups that can aid migrants with HIV, which means that there are no programs and interventions in the works in the near future. This lack of health intervention can be dangerous due to the nature of the disease. HIV, being an immunity disorder, gets worse when left untreated, which can progress into AIDS, and eventually death from its complications.

3 Pakistan

The Current State of Healthcare in the Country

Pakistan is a country located in South Asia. In 2018, Pakistan signed the UHC Global Compact, which made the country commit to achieving Universal Health Coverage by 2030. In 2010, Pakistan was also one of the signatories of the International Health Partnership (IHP positive) which aims to improve the health sectors that are signed under it by collaborating with other signatories. However, there are no UHC legislations implemented as of 2022 and the goal of achieving UHC by 2030 was regarded to be an 'ambitious' commitment.

The 18th amendment in the national constitution recently made Primary Health Care the main strategy for detecting diseases early and ensuring early intervention/treatment. It was planned that PHC would be strengthened first for UHC to take effect. Once UHC is established, it aims to include comprehensive health services and multi-sectoral policies and to help encourage its citizens to become more empowered and self-reliant in ensuring their health and well-being. However, these aspirations failed to translate into reality. Below is a graphical representation of the accessibility of PHC services by the country's population.

Figure 5: Accessibility of PHC by the Country's Population (2022)

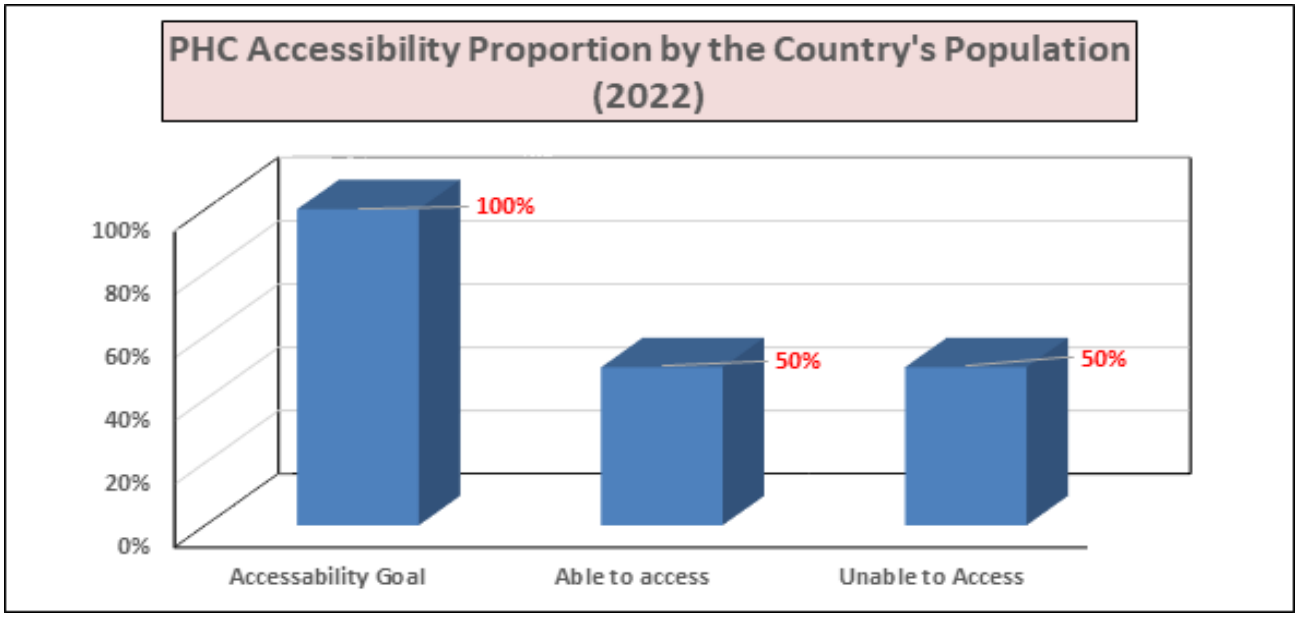


Figure 4 shows that 50% of Pakistan's population do not have proper access to these PHC services, which is a problem as PHC is supposed to be for everyone. Logically, the other half (50%) of the population were able to access PHC's health services. This also suggests that the program is only halfway through achieving its goal, which is 100% accessibility of PHC's health services, in line with the primordial objective of the program.

In 2016, Pakistan launched a health insurance program called the 'Sehat Sahulat Program' (SSP) which, along with the Ehsaas Tahaffuz Program, ensures accessible medical healthcare to citizens below the poverty line. The addition of the SSP's Insaf Card and the Naya Pakistan Quami Sehat Card is also a welcome development as these cards cover multiple districts throughout Pakistan and are believed to cover a total of 70 million people. Sadly, these developments, along with Primary Health Care, do not include migrant workers as they are 'excluded' from Pakistan's UHC commitments.

The desk review from SPEAK Trust found that Pakistan only focused on 6 out of 8 areas for the commitment to attaining Universal Health Coverage and does not include gender equality and emergency preparedness. It also identified 7 things that hinder achieving UHC. One of the more glaring issues is the lack of a standard understanding of UHC among stakeholders. For example, some stakeholders believe that legislation is necessary to outline their roles in ensuring effective implementation, while others do not think it is necessary as their current constitution is enough, and that legislation is purely political. Another issue is the dependency on Primary Health Care to ensure UHC coverage. Primary Health Care is only a tiny part of Universal Health Coverage, and there is more to it than primary health interventions. This may be remedied by the Essential Package of Health Services (EPHS) being currently piloted by foreign aid, as this package is created to deal with Pakistan's challenges in health. However, EPHS is developed to deal with the challenges a nation currently faces and lacks the versatility UHC has. One of the 7 issues that hinder the nation from achieving UHC is its lack of budget allocation. Pakistan's commitment to making their health budget take up 3% of the GDP in 2023 was called 'ambitious and unrealistic. This, along with the fact that Pakistan has not allocated a budget for the health of any Pakistanis outside of their borders only proves that their goal to achieve UHC in 2030 is unlikely.

Recently, Pakistan has been hit with various natural disasters that endanger the health of its citizens. Karachi, the nation's financial capital, had been experiencing periods of water shortages since 2005. According to Rizvi (2022), more than 80% of the country's population is experiencing "severe water scarcity", and by 2025, the country will be in absolute scarcity of water as water levels decrease over time due to climate change, man-made pollution, and overpopulation. Additionally, torrential rains and melting ice caps, followed by a severe heat wave caused one of the deadliest floods in Pakistan's history (Rascoe, 2022). The 2022 Pakistan floods killed 1,717 people. These events put plans on improving the health sector on hold, as well as put the country in financial disarray. Ironically, this also highlights how the exclusion of disaster preparedness in their UHC commitments is a lapse of judgment.

Policies and Challenges of Universal Healthcare Coverage for Migrant Workers

Similar to other South Asian migrants, Pakistani migrant workers primarily work on labor- intensive jobs. These jobs are not only physically exhausting but are mentally distressing and are prone to work-related accidents and deaths. These workers are mostly underpaid, and live in cramped, cheaper spaces, and some even work with very little to eat, causing malnutrition and disease.

Currently, the health of migrant workers is being neglected by the government. There is no budget allocated for migrants' health, and they are also not included in social protection services. Additionally, there are no bilateral agreements formed between the Pakistani government and the destination countries. The main reason why this is the case is Pakistan's current policies focusing only on the wellness of those inside its borders.

One more glaring issue is the stakeholders' misconception about migrant health rights being preserved when within Pakistani borders. The nation's primary healthcare unit can only be accessed by 50% of the Pakistani population, and there is a chance that a migrant cannot access health services due to a lack of healthcare coverage. Additionally, when migrant workers are in their country of employment, their hospital fees are paid for with their own money, which can be expensive and financially draining.

Healthcare for HIV Positive Migrant Workers

HIV is a sexually transmitted disease that attacks the immune system of its host, and advances to AIDS once left untreated, which can cause death. The disease is of low prevalence in Pakistan. However, there is an epidemic in small, vulnerable groups which take up 0.01% of the nation's population that needs to be addressed.

As migrant workers' health and wellness continue to be neglected by the Pakistani government, HIV-infected migrant workers are also neglected. When migrants return to Pakistan however, the Pakistan AIDS Strategy 3 2015-2021 makes sure that vulnerable populations such as migrants are given the resources they need. The report did not explain the AIDS strategy, but it can be assumed that prevention and treatments are given to vulnerable groups as they are the ones most affected.

HIV statistics among migrant workers, as well as HIV tests are not provided. This can act as a hurdle to health initiatives and programs that want to help HIV positive migrants as they lack sufficient data.

4 Sri Lanka

The Current State of Healthcare in the Country

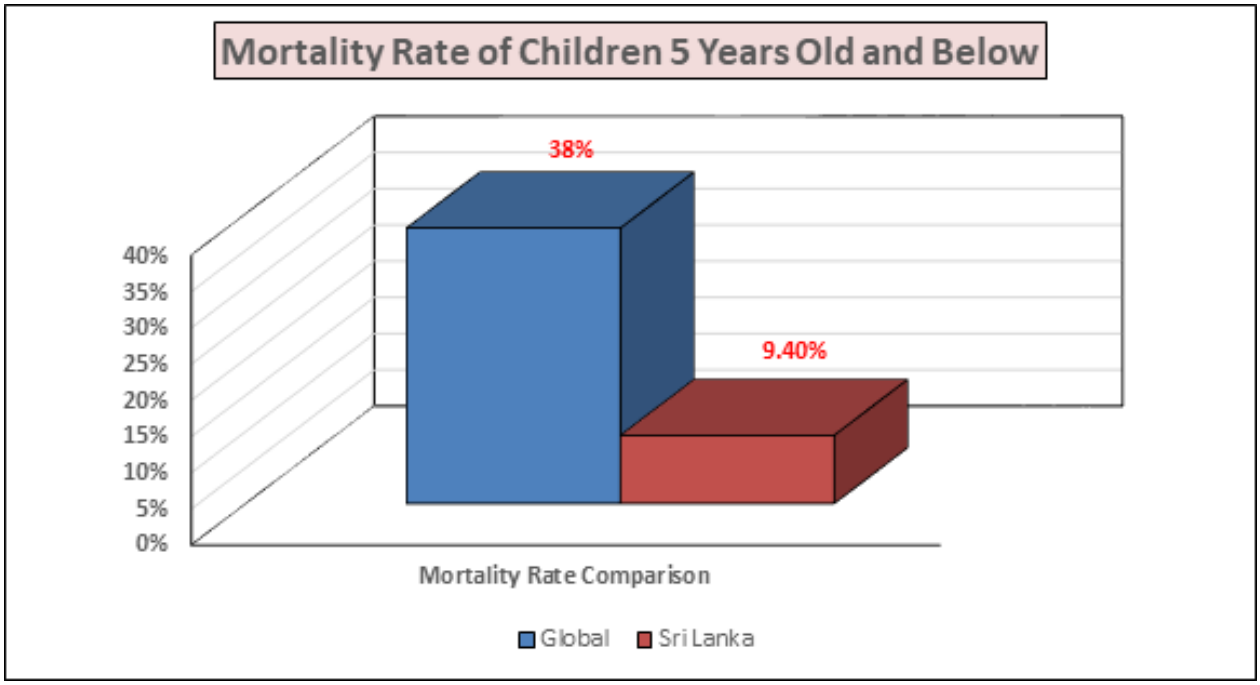
Sri Lanka is a small island nation located in South Asia. Since its independence in 1948, Sri Lanka has been striving to strengthen its health sector into what it is today. The nation's healthcare is well-celebrated despite the nation's modest income per capita. Table 1 below highlights the country's accomplishments over the years in different health areas in terms of either quantitative or qualitative indicators.

Table 2: Cumulative Accomplishment in Healthcare Services Since Independence in 1948

Areas	Accomplishment	
	Quantitative Indicator (%)	Qualitative Indicators
Prenatal and postnatal care	99	
Coverage in child immunization	99	
Population access to basic sanitation	94	
HIV perinatal transmission	0	
Polio and measles		Eradicated
Family planning		Excellent
HIV cases		Low prevalence
HIV infected citizens		Given ART immediately

As shown in the table, the county attained a prenatal and postnatal rating of 99%, one of the highest in Asia. It managed to have a 99% coverage in child immunization, provided 94% of the population access to basic sanitation, and controlled its HIV cases low enough to maintain its "low-prevalence" status. Additionally, the country managed to eradicate polio and measles, was regarded to have an "excellent" family planning record, was able to control its HIV cases low enough to maintain its "low-prevalence" status, and provided immediate ART treatment to those infected with HIV.

Figure 6: Mortality Rate of Children Five Years Old and Below



Relevant to child immunization, which was reported in the previous table to be 99%, the country's coverage aided in lowering the mortality rates of children aged five years old and below, which was only 9.4%, compared to the global 'under five' mortality that was 38%.

Results and findings from Sri Lanka's 2018 Health Sustainable Development Goals further solidify its efforts in improving its health sector while also revealing lapses in the current health system that can be fixed. As of 2018, Sri Lanka has a UHC coverage of 68%, and the country was reported to have focused on enacting health interventions to prevent diabetes, cardiovascular and respiratory diseases, and cancer. However, in the same year, reports of high tobacco usage among men, as well as high suicide rates and the lack of sex education among teenagers prove that Sri Lanka's health sector leaves a lot to be desired.

Currently, improving the health sector is not the main priority of the Sri Lankan government, as its economy plummeted the year before. In a recent World Bank report, it is estimated that 500,000 Sri Lankan citizens are considered to be living below the poverty line due to the hyperinflation, unemployment, and high costs of living brought about by the 2021 Sri Lankan economic crisis. The economic crisis caused foreign aid for drugs and health supplies to stop coming into the country, and the health sector in the country is currently being used as a political tool to gain support and power. The Sri Lankan protests are ongoing, and the nation remains in a state of emergency.

Other than economic and political issues, Sri Lankans also face environmental problems that put their

citizens at risk. People that work in agriculture are subjected to skin and respiratory diseases brought about by the lack of protective gear when handling agrochemicals, which are chemicals used in agriculture (ex: fertilizers and pesticides). Agrochemicals can also contaminate water sources which can cause kidney diseases among those that drink it, and when left untreated, can cause kidney failure and eventual death.

Policies and Challenges of Universal Healthcare Coverage for Migrant Workers

Sri Lankan migrants consist of about ¼ of Sri Lankan workers and are stationed mainly in Gulf countries such as Qatar and Kuwait. They generate 8-10% of the Sri Lankan economy. Migrant workers have complained about health issues from general discomforts such as rashes and body pain to chronic diseases such as heart disease and diabetes. The work culture migrants experience is believed to be the key factor to these problems, as most migrants work in blue-collar jobs such as construction, agriculture, and hotel management. MoU and bilateral agreements between the sending and receiving country were made in regards to Sri Lankan migrant health rights. The migrant workers' health policy of 2013 provides MWs with comprehensive health assessments and protection towards their health rights.

Healthcare inequity towards Sri Lankan migrants is a major problem and is caused by discriminatory policies and the lack of collaboration among sending and receiving countries. Corruption is also a huge factor in healthcare inequity, as the money that can be used for the improvement of healthcare can be pocketed by those in power. However, some policies try to mitigate these issues. The migrant worker health policy is formed to develop and implement a standardized health assessment of migrants. It ensures health protection for migrants by collaborating with its receiving nations. The policy plans in facilitating overall better health coverage for its migrant workers. The Sri Lanka National Health Policy identifies vulnerable groups as part of their priority lists, and this includes migrant workers.

There is no recorded instance of discrimination and stigmatization among returnee migrants, however, medical examinations for those that plan to immigrate are mandatory and are carried out by the Gulf Approved Medical Centers Association. Medical tests are paid for by the migrant themselves, which poses a problem to those with financial problems. There is also no known research done on Sri Lankan migrants to fully understand their health issues.

Healthcare for HIV Positive Migrant Workers

Sri Lanka is a country with a low number of HIV cases and is labeled as a “low-prevalence country”. This was due to commitments made by the government in the 1980s to minimize the rate of infection in the country to below 0.1%. Their efforts were a success and were celebrated by other countries. HIV infection among migrants is also low. To date, the country has not recognized migrant workers as a ‘vulnerable population group’.

Sri Lanka stands out to date as the only country in the sub-region that has its own migrant workers' health policy that was developed in October 2013. It covers the following: develop and implement a comprehensive and standardized Health Assessment, ensure health protection for migrant workers by entering into bilateral and MoUs with destination countries.

However, HIV is still a heavily stigmatized topic in Sri Lanka, and statistics for HIV test results among migrants are not provided as it is considered unethical. HIV positive individuals are also barred from migrating to other countries, regardless if they are workers or tourists, infringing their right to work and travel. HIV positive individuals are also discriminated against by their peers, regardless if they are a migrant or not, and this can cause dynamic changes within families and peers due to the lack of education and stigma on HIV.

CONCLUSION

In conclusion, the health sectors of the participating countries have made efforts on improving their country's state of health. All four countries regard the health rights of their citizens as fundamental human rights. They also have some form of health coverage scheme for their citizens, have used the UN's Sustainable Development Goals as a reference in their commitment to attaining UHC, and all countries have their general strategies for reaching this goal before 2030. Bangladesh has a rapidly improving health sector since implementation of new policies and investments in the early 2010s such as the Bangladesh Perspective Plan 2021-2041. Pakistan focuses on implementing Primary Health Care and Care Packages as the government thinks it could spread throughout their territories more easily. Nepal focuses more on improving the quality of care given the lack of healthcare workers in the country, and Sri Lanka was considered a country that has made strides in improving the state of health of its citizens since its independence despite its small land area and GDP. However, UHC calls for healthcare for migrant workers to be mandatory, and that governments must make health insurance more affordable for migrants– which has not been done by any of the participating countries.

There are more issues that all participating countries should address and focus on. Firstly, three of the participating countries (except Nepal) include migrant workers in their list of vulnerable groups, yet only Pakistan recognized them as 'most at risk population', indicating that the government wouldn't prioritize migrant workers despite their struggles and barriers being open to the public. Another issue worth mentioning is that all sending countries have not properly addressed the health rights of their migrant workers to the receiving countries, which delays developments in terms of policies meant to protect migrants– especially health rights. Lastly, HIV positive migrants were not mentioned in any of the current health policies in all four countries, indicating that this group is truly neglected.

RECOMMENDATION

This chapter will help identify the most pressing issues in each nation regarding their healthcare, their healthcare policies for migrants, as well as policies for migrants that are HIV positive. Afterwards, each problem will be given a recommendation to encourage future changes in policies or actions that are currently being done by their health sectors and governments.

Problems Common to the Four Countries and Corresponding Recommendations

- ***The Bangladeshi, Nepali, and Sri Lankan governments currently do not consider migrant workers to be a vulnerable group***

Although including migrant workers in their list of vulnerable groups does not necessarily guarantee an appropriate response from the government, it is a good first step to making positive changes in the migrant worker's quality of health. This is because the list serves as a priority list of what groups of people need the most help in terms of programs and policies, and any lack of action notwithstanding means negligence on the government's part.

- ***Healthcare inequity remains to be a pressing issue for all four countries***

Healthcare inequity is the economic disparity of healthcare services. The concept of UHC is that every person gets access to even the most expensive treatments and medications and attaining this can combat the issue of inequity. However, due to these four countries only making little progress in attaining UHC, their respective heads of the health sector must create better and clearer roadmaps that can aid in achieving UHC in the most efficient and effective manner.

- ***HIV-positive migrants from all four countries are being neglected***

Although HIV cases are low in these four countries, ignoring the issue can cause the cases to rise and spread widely to the general population. HIV-positive individuals, and especially migrants that have been deported due to their HIV diagnosis, must be provided with quality care and aid. HIV-positive people must be encouraged with taking antiretrovirals and HIV-positive deportees must be given financial allowances while out of work and counseling as ways to help them get back on track. The labor department can also help these deportees by helping them find a job in their home country.

- ***The Pakistani, Nepali and Bangladeshi governments have not properly addressed the health rights of their migrants in MoU and Bilateral agreements***

MoU and Bilateral agreements are formed between the sending and receiving countries to address the pressing issues that migrants face yet the health rights of the migrants have always been neglected. Addressing and highlighting pressing issues in migrant health rights such as inequities in the health sector, negligence towards certain migrant subgroups such as HIV-positive migrants, and current living and working conditions among labor migrants can be a good start for any positive and meaningful progress to happen.

Bangladesh

Problems

- There is a lack of specific policies that focus on migrant workers' health rights, and even more so for migrant workers with HIV.
- Teachings about HIV prevention and various STDs are not being done for migrants in their pre-migration period, making most migrants ignorant of the issue.
- The government's current policies on HIV and AIDS are lacking, with very little health coverage and policies that provide free check-ups, testing, and ARVs.
- Families of migrant families are being negatively affected by the lack of policies aimed at subsidizing their health.

Recommendations

- The government of Bangladesh should create more specific policies for migrant workers' health rights. Amendments to the existing policies must be made as well
- The government must formulate a pre-departure education program on HIV, AIDS, and STDs if there is none yet, and enforce its compliance.
- Both destination and origin countries must improve the health insurance of MWs and their families by enforcing full coverage for all illnesses, including STDs, HIV, and AIDS.
- Families of migrant workers must be given health benefits that are more substantial such as free treatments and checkups, as well as discounts on medications

Nepal

Problems

- The government's efforts of attaining UHC may not have been perfect, but there have been multiple efforts done by the health sector in recent years. However, there is a lack of awareness when it comes to the general population's knowledge of what health programs and policies are ongoing, this is especially the case for migrant workers.
- The current data that Nepal uses to obtain health information is proven to be fragmented due to the country's decentralized governance. These gaps in data may hinder showing the issues the country needs to address on a national level.
- Also due to Nepal's decentralized government, there is a lack of communication within the three levels of government, which means that there are little to no synergies in the policy each sector implements. There will be overlaps and gaps in policymaking.
- It is difficult for migrant workers to access the little health services given to them by the government. Destination countries also do not give Nepalese migrants substantial health coverage, putting their life in danger in the line of work, with little to no insurance.
- Migrant workers' health rights are not addressed by the Nepalese government and destination countries. There have not been any recent MoU or bilateral agreements formed between the aforementioned parties.

Recommendations

- Encourage the Ministry of Health to invest in advertising to promote their health programs in multiple forms of media i.e., television, radio, newspapers, posters, billboards, social media, etc.
- A research organization funded by the government that is dedicated to investigating the gaps in each data on public health available must be formed. This can help solve the issue of fragmentation in Nepal's fragmented health data. Alternatively, a centralized data management system has to be lodged either by the Ministry of Health or the Ministry of Manpower, depending on which is more relevant and what type of data sets are required, for the government to improve its data management.
- Devise a system that consolidates data at all levels allowing for more efficient data utilization for policy programming and improvement of services even in a decentralized system of governance.
- The government's health department should create new policies and create new health programs that aim to make healthcare for Nepalese migrant workers more accessible. The government should also make a more comprehensive health insurance policy for migrant workers as they are major contributors to the Nepalese GDP via remittances with 25% of the nation's GDP coming from the migrant worker industry alone.

Pakistan

Problems

- UHC legislation is recognized as an important part of reaching the nation's sustainable development goals, but the current interventions used to reach these goals have been proven insufficient.
- The provincial healthcare system is inadequate and can be a cause of concern as most Pakistanis live outside of urban areas and settle in rural communities.
- The quality of health equipment and services in Pakistan is poor, however, the Ministry of Health (MoH) chooses to fix the problem by investing in infrastructure instead, such as by making more health centers.
- The MoH does not have a comprehensive health plan for indigent populations, which can also include migrant workers. They also have no specialized health coverage.
- There is a lack of communication in the implementation of medical policies and laws between the federal and provincial health ministries, creating lapses and overlaps in policies, and reducing diversity in services.
- All health benefits that Pakistani residents can get can only be accessible within their borders. Migrants cannot access their healthcare benefits as they are outside the borders. Foreign refugees, however, can avail of these services when they are within Pakistani territory.

Recommendations

- UHC legislation must be prioritized by the governing federal and provincial levels and can be done by formulating discussion through various forms of media i.e., television, radio shows, and social media.
- The current health system of Pakistan at the provincial level needs to be reconstructed to create more health centers in rural centers as the majority of the Pakistani people live in rural areas.
- The Ministry of Health should prioritize investing in quality health equipment in their plans instead of infrastructure such as health centers because demand for health centers reduces if the quality of health care increases.
- The current health insurance system also needs to include a health insurance scheme for low-income families due to the current social determinants indigent populations face.
- The federal and provincial health ministries must ensure inclusivity in their initiatives such as encouraging collaboration and communication in implementing proper medical services plans for the diseased.
- The Pakistani government through its Ministry of Health should come up with health policies that mandate health coverage for all citizens whether inside or outside its borders. HIV positive

migrant workers that have been deported must be given additional benefits such as stipends, consultations, and therapy sessions. and for the migrants to be provided with free anti-retroviral medication and contraceptives.

Sri Lanka

Problems

- The current political climate and the subsequent events such as the 2022 riots had negatively affected the Sri Lankan healthcare system as it forced hospitals to close and health workers to be subsequently unemployed.
- HIV and AIDS remain a taboo topic for Sri Lankans as the general population openly discriminates against those infected with the disease to which migrant workers are notable targets.

Recommendations

- Mitigation efforts such as establishing connections with the UN and WHO to formulate and enact collaborative health missions to create makeshift health clinics must be made to respond to damages done by the crisis, particularly the damages that were done to the progress of the health sector.
- The Ministry of Health must allocate funds for educational health campaigns that educate the Sri Lankan public on HIV and AIDS to encourage conversation on the subject and remove the stigma. The Ministry of Education must also incorporate STD, HIV, and AIDS awareness in the current sex education curriculum.

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