MIGRANTS' RIGHT TO HEALTH

Legal and Policy Instruments Related to Migrants' Access to Health Care, Social Protection and Labour in Selected East African Countries

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UN MIGRATION

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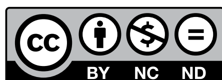

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Foreword

The protection of the right to health for all including migrants is a priority and paramount in the current environment where the free movement protocols in the region are advancing. Progress in the free movement protocols in the East and Horn of Africa (EHoA) will contribute to the economic, social and cultural developments of the countries, so health agenda shall progress. However, to date, many migrants in the region have no access to health care and have to negotiate their way between humanitarian relief programmes and other public and private service providers on their migration journeys from their country of origin, transit, and to the country of destination, or upon return to their country of origin. Furthermore, health policy and initiatives are not yet to the standard of Universal health coverage (UHC) even for nationals, and fragile health system is struggling with health financing to reach the set target of the Abuja declaration of 15 per cent of GDP to health.

In this scenario and far sighting the progressive inclusion of migrants into UHC and across countries, The aim of this report is twofold: (1) to provide a better understanding of the legislative barriers that could affect this vision and (2) to provide a rationale to advance the well-set recommendations of the African Union Migration Policy Framework for Africa and Plan of Action 2018–2030 where African Member States identified the health of migrants as cross-cutting issues. They committed, among others, for the inclusion of migrants into national health plans.

IOM is in the front line to advocate and assist its Member States to advance better the migration health agenda at the national level and across borders. During the COVID-19 pandemic, the migrant populations, including the most at-risk groups in the region were excluded from preparedness and response plans and the COVID-19 vaccine. It is only with the advocacy and support of development partners that we could directly assist and include them in the vaccination deployment in most countries. However, migrants' inclusion in health plans should not be a project-based or emergency issue. Instead, it should be considered part of population health.

We hope that this report could stimulate discussions around this area and prompt action to revise better national legislation to be more inclusive for a region and continent aspiring to reach the African Agenda in 2063.

Michela Martini
Senior regional migration health specialist
IOM Regional office for East and Horn of Africa

Drug administration to a migrant.
Sango Bay. ©IOM Uganda 2013

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Acronyms and abbreviations

ACHPR	African Charter on Human and Peoples' Rights
ACHPR-PW	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)
AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention to Eliminate All Forms of Discrimination against Women, as well as Committee on the Elimination of Discrimination against Women
CEDAW-OP	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
DSD	Diaspora Services Department
EAC	East African Community
FGM	Female Genital Mutilation
HIV	Human Immuno-Deficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICRMW	International Convention on the Protection of the Rights of Migrant Workers
IDP	internally displaced person
IGAD	Intergovernmental Authority on Development
ILO	International Labour Organization/Office
IOM	International Organization for Migration
OHCHR	Office of the High Commissioner for Human Rights
SDG	Sustainable Development Goal(s)
UNAIDS	United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHA	World Health Assembly
WHO	World Health Organization

Executive Summary

A. Background

Over the past century, international migration reached historical levels globally, with over 281 million people living outside their countries of birth or citizenship at mid-year 2020 (IOM, 2020). Around the same time, 21 million Africans were living in another African country other than their country of origin compared to 18 million Africans in 2015 (IOM 2022). International migration remains a complex phenomenon that touches on a multiplicity of economic, social and security aspects and if the current global trends persist, it is a fair estimate that migratory populations will continue to increase in the coming years. Eastern and the Horn of Africa remains one of the most dynamic regions of the world in terms of migrations caused by an evolving complex of economic, social and security interplay. The East African region covers ten countries including Burundi, Djibouti, Ethiopia, Eritrea, Kenya, Rwanda, Somalia, South Sudan, Uganda and the United Republic of Tanzania. The dynamic situation portends a radical increase in the number of migrants both regionally and globally.

Migrants and mobile populations continue to face many obstacles in accessing essential health-care services including migration status, language barriers, lack of migrant-inclusive health-care laws and policies, inaccessibility of services, and the inability of the receiving country to afford addressing their welfare. The COVID-19 pandemic serves as a key reminder of how vulnerable migrants are in such emergency situations. High morbidity and mortality among migrants, especially in irregular, forced, or exploitative migration situations is a critical health concern that deserves international attention. This underscores a global fact that countries receiving migrants need to frequently review and adopt their legal frameworks to regional policies, international treaties, human rights laws, and social assistance in order to address migration issues on access to health-care services and treatment as part of a renewed commitment to the 2030 Agenda for Sustainable Development (United Nations General Assembly, 2021).

B. Objectives

This report aims at reviewing the domestication of international legal instruments (such as laws, international treaties, public policies on social, labour and health protection) aimed at ensuring migrants' and refugees' access to health-care services and treatment. Legal frameworks for four East African countries: Burundi, Rwanda, Kenya and Uganda were reviewed in this report.

C. Methods

Desk review of national legislations was conducted on online databases for legal instruments containing national jurisdiction on migrants that included direct terminologies such as: immigrants, migrant groups, seasonal labourers, migrant workers, and people living in congested environments, refugees, IDP camps, Mobile populations, and nomads; health treatments; migration rights/services; and social protection and labour rights. Findings were summarized in three main thematic areas: Health law, regulation and policies; Migration law regulation and policy; and Social protection and labour laws, regulation and policy legislation. The comparative analysis assessed whether national legislations guaranteed health and social service access to migrant populations as ratified in the international and regional agreements. Findings were listed in tables to demonstrate identified gaps in these legal frameworks.

D. Key findings and recommendations

- Major gaps were identified in the domestication of international human rights recommendations for migrants including a limited direct reference to migrants, refugees, and displaced persons in the respective countries' legal texts.
- Most of the national legal instruments had insufficient coverage on the four key migration-related themes (migration, health, social protection and labour) in international and regional instruments, which also varied widely among the four countries.
- The national instruments lacked direct obligatory language in stipulating benefits for migrant populations on access to the health-care services, labour systems, social security systems and social assistance at the local country levels.
- Revision and strengthening of national legal instruments to align with regional and international framework on social protection and health-care access for migrants is recommended.
- Well-monitored national implementation roadmaps ensuring enforcement and conformity to these legal frameworks for migrants are urgently needed in these countries.

Table 1. Summary of access to services by migrants

Country	Right to health care and life	Family planning services	Vaccination	Basic health-care services	Psychosocial follow-up	Access to universal health care (regular)	Access to universal health care (irregular)	Government financial health scheme	Receive help through IOM	Access to emergency health care	Access to maternal health care	Access to HIV treatment
Burundi	Yes	No	No	Yes	Yes	Not clear	Not clear	No	Yes	Yes	No	No
Kenya	Yes	Yes	Yes	Yes	No	Yes	Not clear	Not clear	Yes	Yes	No	No
Rwanda	Yes	No	No	No	No	Yes	Not clear	Yes	Yes	Yes	Yes	Yes
Uganda	Yes	No	No	Yes	No	Yes	Not clear	No	Yes	Yes	Yes	Yes

Country	Right to social security	Right to social protection	Right to work	Protect pregnant women (workplace)	Protect pregnant women (generally)	Migrants benefit from cash transfers	Injury benefits/ sick leave	Annual leave	Pension	Equal pay for equal work	Equal opportunities	Allowed entry with vaccination certificate
Burundi	Yes	Yes	Yes	Yes	Not clear	Yes	Not clear	Not clear	Not clear	Not clear	Not clear	Yes
Kenya	Yes	Yes	Not clear	Yes	Not clear	Not clear	Yes	Not clear	Not clear	Not clear	Not clear	Yes
Rwanda	Yes	Yes	Yes	Yes	Not clear	No	Yes	Yes	Yes	Yes	Yes	Not clear
Uganda	Yes	Yes	Yes	Yes	Not clear	Not clear	Yes	Not clear	Not clear	Not clear	Not clear	Not clear

Country	Allowed if mentally disturbed or with contagious disease	Temporary work permit	EAC free movement	Long-term work permit	Persecution of illegal migrant
Burundi	No	Yes	Yes	Yes	Not clear
Kenya	Not clear	Not clear	Yes	Not clear	No
Rwanda	Not clear	Not clear	Yes	Yes	Not clear
Uganda	Not clear	Not clear	Yes	Not clear	Not clear

Key

(teal)	Yes
(yellow)	No
(orange)	Not clear

Source: Authors own elaboration.

Medical screening at an IOM Resettlement Clinic. ©IOM Kenya

Part I

Introduction

At mid-year 2020, Africa had over 25 million international migrants (IOM, 2020). Eastern Africa region accounted for 7.7 million international migrants, and 12 million emigrants. The top three countries with the highest number of migrants in this region included Uganda (1.7 million), Ethiopia (1.1 million) and Kenya (1.1 million) (IOM 2021). Access to the highest attainable standard of health is a fundamental human right and a prerequisite for sustainable development. Migration as a process can increase people's vulnerability to a variety of health risks, particularly in the country of transit and destination where migrants may live and work in unfavourable and unsafe conditions (Greenaway and Castelli, 2019; Abbas et al., 2018; Gushulak et al., 2010). The situation is amplified when immigrants do not have equal access to health-care services, treatment, and financial protection. Even though health and social protection go hand in hand, their connection is often overlooked in migration governance, and migrants therefore frequently face health-care access challenges. These challenges gravitate around existing state laws or administrative regulations restricting eligibility, registration with social protection schemes that finance health care, and policies that are not inclusive of migrants on health matters. Discrimination, language and cultural differences, and lack of information about health entitlements constitute additional hurdles to the migrants seeking health care. Such barriers often exist in the context of generally weak health and social protection systems and high burdens of both communicable and non-communicable diseases, which continues to be a significant challenge for many countries (Derose et al., 2007; Buttigieg, 2016). In addition to barriers of accessing health-care services, these factors surrounding the migration process act as social determinants of migrants' ill health.

The East Africa region experiences significant migratory flows from within and without. This is due to a multiplicity of drivers such as work, study, and conflict. High levels of intraregional labour migration exist particularly among members of the East African Community (EAC), facilitated by the East African Common Market Protocol. East African Community members are also major transit countries for irregular migrants travelling to the Middle East, Europe and Southern Africa. These countries host significant numbers of refugees, most of whom are from the region. Concurrently, internal rural–urban migration remains an important trend within countries in the EAC resulting from effect of climate change on livelihood. Given the complexity and intensity of migration in the region and the important link between migration and health, an understanding of the status of migrants' health rights is imperative to inform and improve migration governance frameworks in the region.

COVID-19 Risk Communication and Community Engagement sensitization to beneficiaries by a community health volunteer in Burundi. © IOM 2020

A. Understanding Migration health governance

United Nations continues to play an important role in debates about migration in the world today. The milestones are represented by the introduction of Migration as Sustainable Development Goal (SDG) target 10.7' *Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies'* complemented by the United Nations General Assembly resolution 73/195 of 19 December 2018 which establishes the Global Compact For Safe, Orderly And Regular Migration with particular reference to activities of the United Nations system as well as the functioning of the relevant institutional arrangements (United Nations General Assembly, 2021). The Global Compact for Migration, as a first of its kind, is a unique global framework providing guidance on how to better manage migration with a whole-of-society and whole-of government approaches. Health is reflected directly in Objective 15 and has interlinkages with other objectives as highlighted below in green:

- 01 – Data
- 02 – Adverse drivers
- 03 – Information
- 04 – Legal identity
- 05 – Regular pathways
- 06 – Ethical recruitment
- 07 – Reduce vulnerabilities
- 08 – Save lives
- 09 – Counter smuggling
- 10 – Eradicate trafficking
- 11 – Manage borders
- 12 – Migration procedures
- 13 – Detention as a last resort
- 14 – Consular protection
- 15 – Access to basic services
- 16 – Inclusion and social cohesion
- 17 – Eliminate discrimination
- 18 – Skills recognition
- 19 – Migrant and diaspora contributions
- 20 – Remittances
- 21 – Return and reintegration
- 22 – Social protection
- 23 – International Cooperation

Source: IOM/MHD, 2018.

The development of health aspects of the Global Compact for Migration were further elaborated by WHO with the "a five-year 2019–2023: Global Action Plan (GAP) to Promote the Health of Refugees and Migrants" adopted in 2019 at the World Health Assembly and renewed (WHO, 2019). The GAP provides guidance to Member States on how advance this agenda and strengthen health system for all with six priorities for actions as follows:

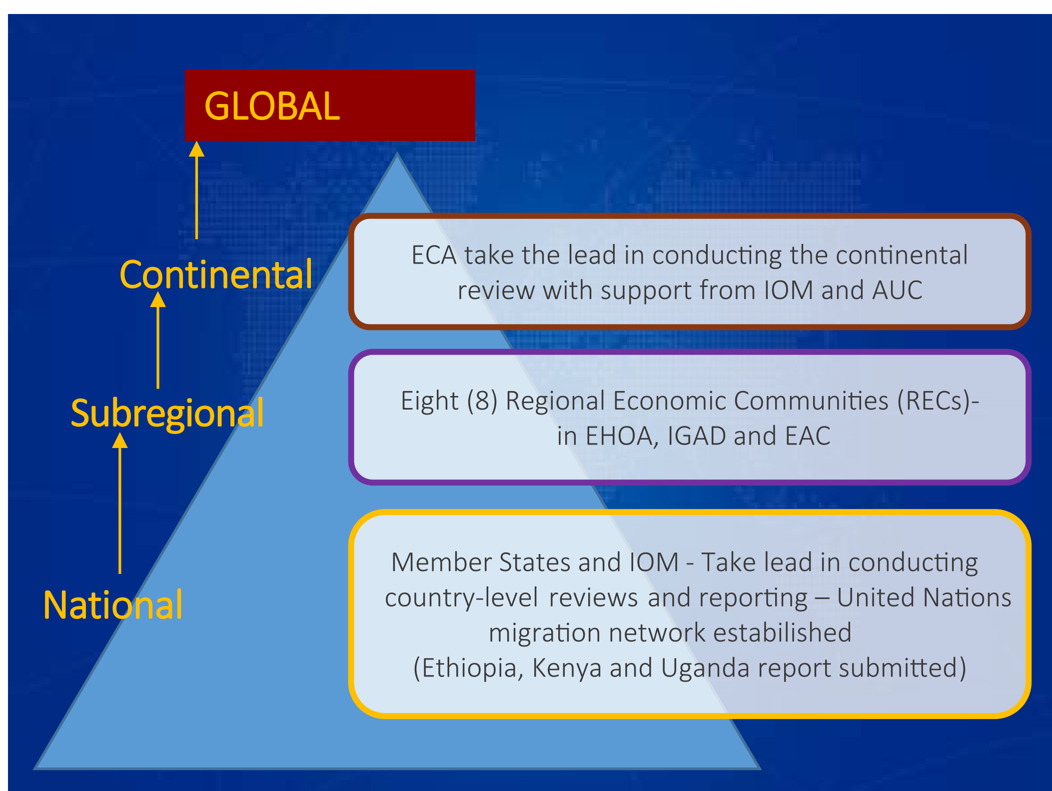
- Priority 1: Advocate mainstreaming refugee and migrant health in the global, regional and country agendas
- Priority 2: Promote refugee- and migrant-sensitive health policies, legal and social protection and programme interventions
- Priority 3: Enhance capacity to address the social determinants of health
- Priority 4: Strengthen health monitoring and health information systems
- Priority 5: Accelerate progress towards achieving the SDGs, including universal health coverage
- Priority 6: Reduce mortality and morbidity among refugees and migrants through short- and long-term public health interventions

Member States of the WHO had previously committed to ensure the right to health for all migrants as articulated in two World Health Assembly (WHA) Resolutions[1] where inclusion of migrants into national services and revision of health policies and laws to be more migrants-inclusive are clearly stated.

These relatively recent, global governance processes such as the Global Compact and GAP, are important strategic opportunities for supporting Countries in ensuring protection of the rights of health for all including migrants and that access to health-care services and policies more broadly are progressively migration aware.

The Global Compact, with its dedicated objective 15, is a concrete platform to integrate the right to health into migration coordination forum and decision-making platforms. Three-tier arrangement: continental, regional and country levels are let respectively by African Union Commission (AUC), Economic Commission for Africa (ECA); the Regional Economic Commissions (RECs), and States for conducting the reviews, for the Global Compact for Migration implementation. The establishment of a Regional Consultative Process (RCP) led by RECs are the important platform to identify regional priorities and guidance of health aspects the context of migration in harmonized and coherent manner while country level coordination is the foundation for the actual implementation.

Figure 1. Architecture of Global Compact for Migration implementation in Africa

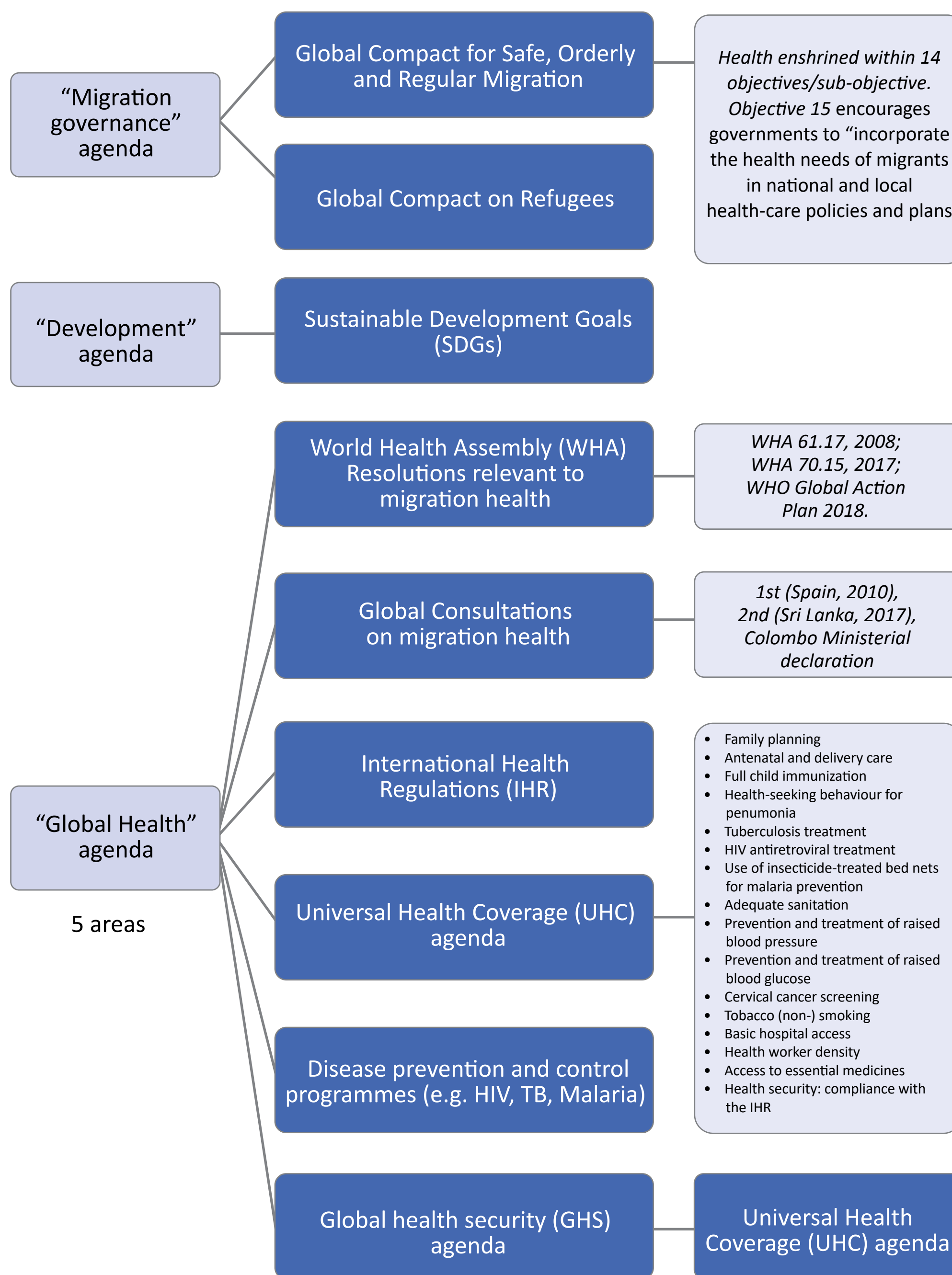


Source: Author own elaboration.

1 World Health Assembly, "WHA61.17," 2008; Assembly, WHA Resolution 70.15 Promoting the Health of Refugees and Migrants'.

The architecture of migration and health is complex and embraces principle of public health, development, and health security. Its complexity has been represented by authors as follows:

Figure 2. Architecture of migration health



Source: Adapted from Vearey et al., 2019.

Table 2. Sustainable Development Goals (SDGs) target 3.8 and 10.7 and the Global Compact for safe, orderly and regular migration Objectives 7, 15 and 16

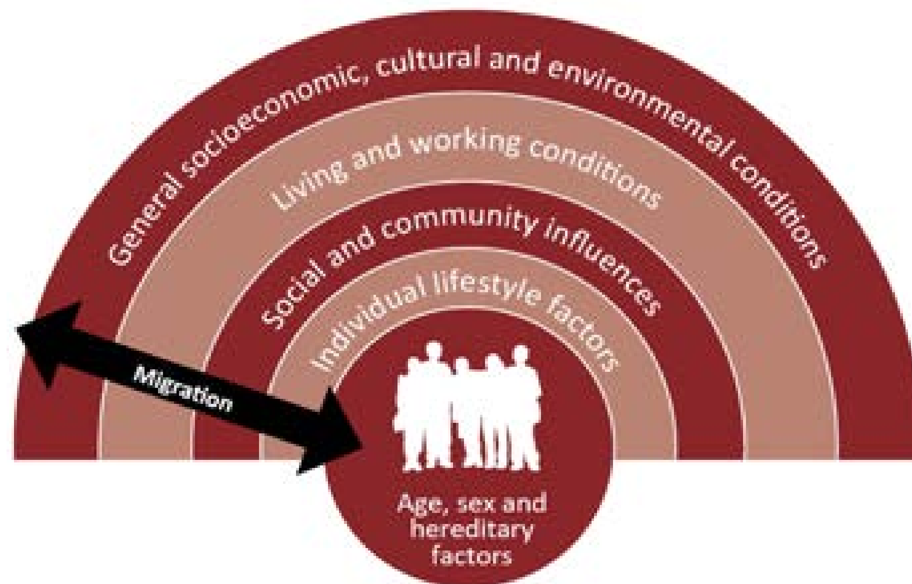
Item	Statement
Sustainable Development Goals (SDG)Target 3.8	"Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"
Sustainable Development Goals (SDG) Target 10.7	"facilitate orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies"
Global Compact for Migration Objective 7	"calling for addressing and reducing vulnerabilities in migration including health"
Global Compact for Migration Objective 15	"access to basic services for migrants, which encourages states to include migrants in national and local health policies and strategic plans"
Global Compact for Migration Objective 16	calling for the inclusion of migrants in societies, including health

B. Understanding the right to health in the context of migration

As clearly stated in relevant international instruments, the right to health, which implies the right to the highest attainable standard of health, is not limited to access to health care but all conditions that can impact health outcomes, the so called social determinant of health (OHCHR and WHO, 2008) including safe drinking water, adequate sanitation and housing, education, health related information, work, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. Furthermore, States obligations of the right to health include to ensure access to care to everyone, including migrants and health care should be AVAILABLE in sufficient quantity, ACCESSIBLE (physical, economic and information accessibility) to everyone without discrimination, ACCEPTABLE (respectful of medical ethics and cultural appropriateness), scientifically and medically appropriate and of GOOD QUALITY (OHCHR, 2000).

Migration is also considered a social determinant of health considering that actions taken during migration might compromise health status of people on the move for several reasons including model of travel, access to information and proper care, linguistic barriers, lack of protection, migration restrictive policy. In this respect migrants have a double vulnerability requiring tailored protection and integration of health aspects into migration frameworks and vice versa integration of human mobility and migration component into the health plans.

Figure 3. Determinants of health in migration



Source: The Dahlgren-Whitehead rainbow model (1991) for determining health inequalities. Readapted from Dahlgren and Whitehead, 2006.

C. The goal and aims of this report

This report summarizes current status on domestication of and conformity to legal instruments ensuring migrants' access to health-care services and Treatment in four East African countries. This will assist Member States to reenergize their strategies for achieving global commitments particularly the SDGs target 3.8 and 10.7, as well as implementing the Global Compact for safe, orderly, and regular migration particularly with references to Objectives 7, 15 and 16 on global commitments (Table 2 above). The aims are as follows:

- Assess national frameworks and the extent to which they conformed to international and regional instruments establishing health-related rights and obligations;
- Evaluate the national framework on the right of migrants to access health-care services and treatment in East African countries of Burundi, Kenya, Rwanda and Uganda;
- Examine the extent to which the legal and policy frameworks of the said countries enabled or restricted migrants' access to health care;

- To provide recommendations on how to better protect and promote migrants' health rights in the East Africa region in accordance with these instruments.

D. Research questions

- What legal frameworks exist in East African countries regarding migrants' access to health care?
- Do the existing national legal frameworks conform to international and regional instruments on the right of migrant's access to health care and how effective are they?

IOM's Dr. Youssouf treats the injured foot of a migrant found in the desert during a Mobile Unit patrol.
©IOM Djibouti 2020/Ali

Part II

Methodology

The review was conducted in multiple steps:

(1) **Defining the scope and methodology.** The scope of the research was defined and agreed upon by the research team. The review was focused on access to health-care services and treatment and the interlinked enabling legal and policy environment for health, migration, social protection, and labour. Diverse categories of migrants were targeted including regular and irregular migrants, labour migrants, asylum-seekers, refugees, and internally displaced persons (IDPs). Data summary tools matrices were completed and used in this report. Available international and regional human rights instruments provided a background against which national frameworks were selected and assessed. At country level, the research team agreed to focus on national legal frameworks to allow for a more expedient comparison across countries with emphasis on the attributes and structure of legal systems, the discretionary power of governments to apply the law, and public policy choices that often can differ substantially from country to country. From the 10 countries in East Africa, Burundi, Rwanda, Kenya and Uganda were purposively selected for this review.

(2) **Mapping exercise.** The legal and policy frameworks of Burundi, Kenya, Rwanda and Uganda were mapped through online desk research, with a focus on constitutional laws, infra-constitutional legislative acts, and public policies that were most relevant to the areas of health, migration, social protection and labour. The study utilized only available online documents.

(3) **Desk review process.** For the case selection of national legislations, the following criteria was employed:

(i) The legal instrument with national jurisdiction with effect on migrants.

(ii) Legal instrument with direct terminologies such as immigrants, emigrants, migrant groups, seasonal labourers, migrant workers, and people living in congested environments, refugees, IDP camps, mobile populations and nomads

(iii) Legal instrument with terminologies relating to health treatments

(iv) Legal instrument with terminologies relating to migration rights/services

(v) Legal instrument with terminologies relating to social protection and labour rights

Using these criteria, databases were searched for legal instruments that corresponded to migrant issues as highlighted above. The study searched databases for keywords in English or French depending on the official language of the country. Comparative analysis was based on whether the national legislations employed and guaranteed health and social service access to migrant population while putting in practice what was ratified in the international and regional agreements.

(4) **Review and conformity assessment with international standard.** An in-depth review and conformity assessment was conducted to identify how the national legal frameworks on the health of migrants complied with global and regional migration legal frameworks, standards, and policies. The study gathered information relating to the selected relevant legal instruments in each of the four countries, the main

findings were listed in analysis matrices and through examination enabled the identification of gaps on the legal framework, for each specific area. The comparison was again mapped to the three main thematic areas:

(i) health law, regulation, and policies

(ii) migration law regulation and policy

(iii) social protection and labour laws, regulations and policies.

(5) **Consultation and final recommendations.** Preliminary findings were shared with competent authorities in each country for revision and consensus. Final recommendations were finalized through national consultations with authorities and stakeholders. The report concluded with recommendations for strengthening inter-agency coordination, networking and information-sharing for better policy development and migration governance.

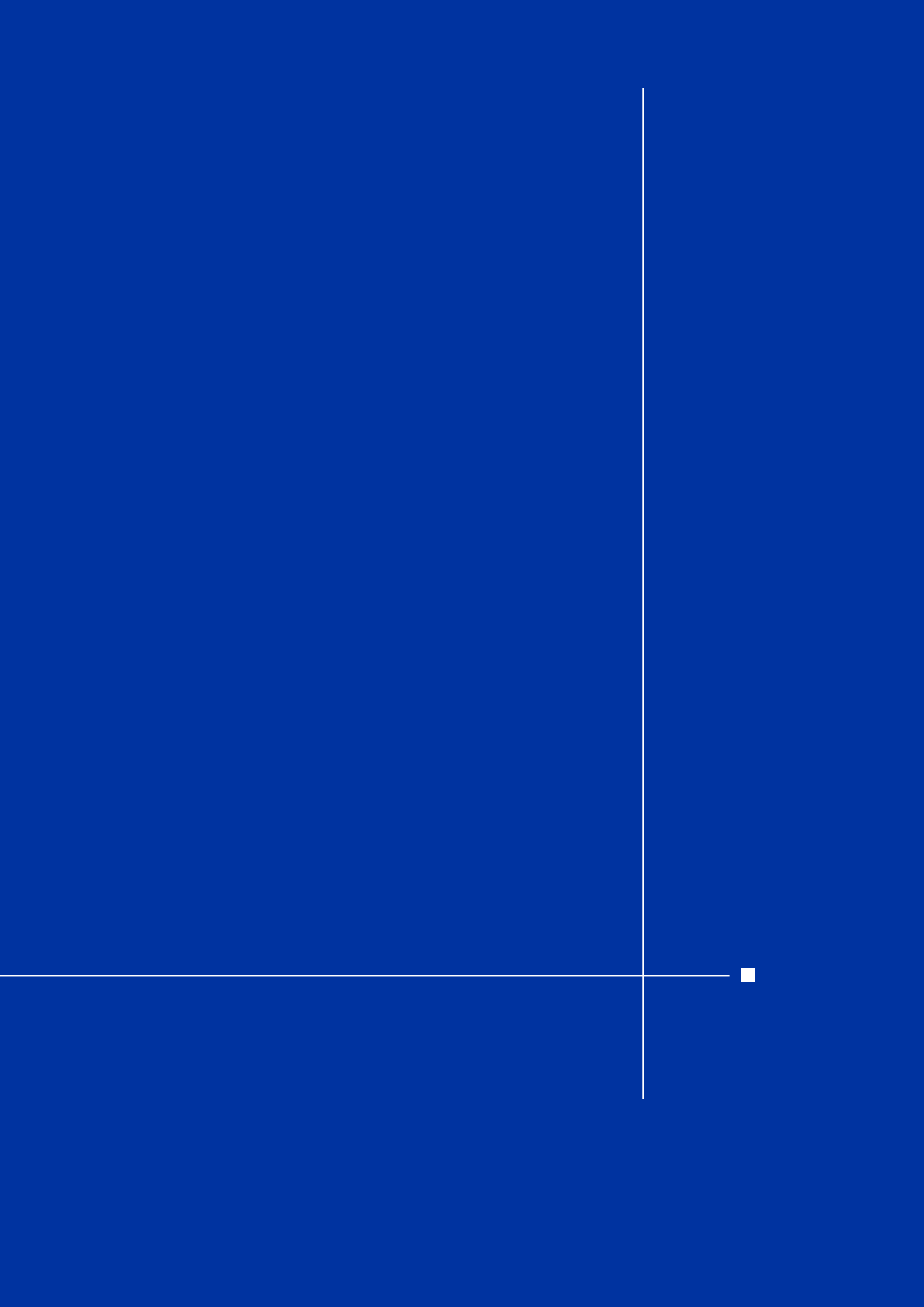
Limitations

In this review, the study relied on available online information on laws, regulations, policies, international treaties, conventions, plans and programmes, which may not have been exhaustive or representative of actual national-level practices. Legal instruments used varying generic and unclear reference to migrants, some with an inclusive language, some with a more direct reference (mentioning one term such as "refugee" indistinctly) and some with very specific definition (referring to "internally displaced person (IDP)"; "immigrants"; "migrants"; "refugees", etc.). Table 3 summarizes how the study dealt with this issue.

Table 3. Categorization of instruments on reference to migrants

	Reference to	Categorisation as
1	Unclear reference to migrants	Unknown
2	Language with no reference to migrants but intended to be inclusive	Inclusive language
3	Direct reference to migrants	Reference was quoted
4	Specific definition of migrants	Group and reference quoted

The existence of laws and policies in the national legislative frameworks did not necessarily guarantee access to health services and social/labour protection by immigrant and refugee populations and vice versa.



Covid 19 training to improve prevention strategies. ©IOM Uganda

Part III

COVID-19 training to improve prevention strategies. © IOM Uganda

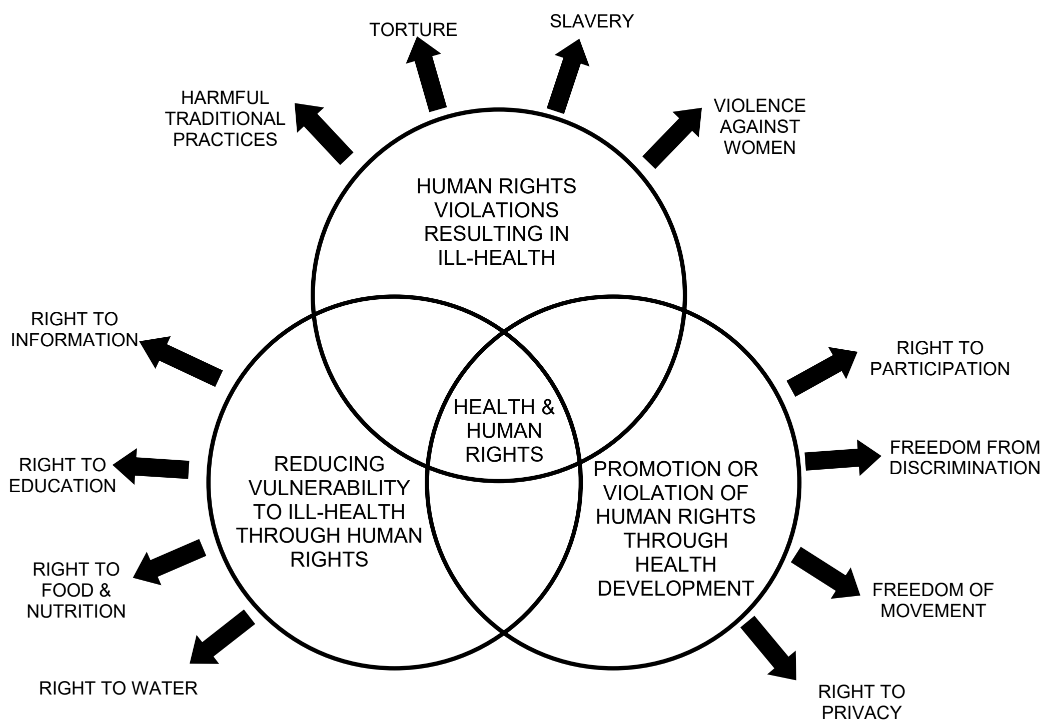
Right to health in international and regional standards and domestication in EAC countries

This section presents a review of international and regional instruments on migration, access to health and social protection and the analysis of national domestication of the international and regional instruments.

A. International instruments on migration, right to health and social protection

The right to health is not an independent branch of law, however it is considered a fundamental human right and it is based on the different branches of law that apply to health problems. The right to health is closely related to and dependent upon the realization of other human rights as showed in Figure 7.

Figure 4. Linkages between health and other human rights



Source: OHCHR, 2000.

The institutional arrangements constitute of numerous international and national legal instruments relevant to migration that recognize and refer to interactions between nations, their citizens, and businesses. These instruments create rights and obligations between parties as exemplified by the right to health and the related "non-discrimination principle". Table 4 highlights these international instruments and health aspects for migrants:

Table 4. International instruments providing protection mandate for various thematic areas

	Instrument	Protection thematic area for migrants health
1	Universal Declaration on Human Rights (United Nations General Assembly, 1948) articles 22 and article 25	Article 22 mentions the right to health and social security. Article 25 "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services" and specifies "motherhood and childhood are entitled to special care and assistance", for children born both in and out of wedlock.
2	International Covenant on Economic, Social and Cultural Rights - ICESCR (United Nations General Assembly, 1966, Article 12 and Article 9)	Article 12. States parties to ensure the provision of prevention, treatment, and control of diseases. Everyone's right to enjoy the highest attainable standard of physical and mental health without discrimination of any kind. In addition article 12.2 enumerates, by way of illustration, a number of clear "steps to be taken by the States parties ... to achieve the full realization of this right". Article 9. States parties are obligated to respect, protect, and fulfil the right to health by ensuring health services, goods and facilities are available, accessible, acceptable, and of good quality, and provided to all without discrimination. Social security that includes social insurance.
3	Committee on Economic, Social and Cultural Rights- (CESCR) (United Nations Economic and Social Council, 2000)	State parties have the obligation to respect, protect and fulfill the right to health, including by ensuring that health services, goods, and facilities are Available, Accessible, Acceptable, and of good quality, and are provided to all without any discrimination. With this instrument the access to health is recognized in a broad manner with 3 aspects of availability, accessibility and acceptability.
4	International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (United Nations General Assembly, 1965) article 5	Article 5. States must prohibit and eliminate racial discrimination as they guarantee the right of everyone to public health, medical care, and social security and social services. ICERD and CESCR both stress that State parties should respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative, and palliative health services.
5	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (United Nations, 1988), Articles 10, 11, 12 and14	Article 10. Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning. Article 11. The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction. Article 12. Countries must guarantee equal access to health care and ensure women and girls are not discriminated against in health care, particularly on sexual reproductive health. Article 14. Focused on rural women to have access to adequate health-care facilities, including information, counselling and services in family planning.

6	Convention on the Rights of the Child (CRC) (United Nations Commission on Human Rights, 1990) at articles 23, 24 and 25.	Article 23 on the right of disabled children to enjoy a full and decent life, and to have access to the necessary services, including health services. Article 24 on the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. Article 25 on the right of social security and insurance.
7	Convention on the Rights of Persons with Disabilities (CRPD) (United Nations General Assembly, 2007) at articles 25 and 28	Human rights for persons with disability
8 9 10	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) (United Nations General Assembly, 1990, Articles 27, 28, 43[e] and 45[c])	Provides a case of direct mandate to the migrant health care and social welfare. ICRMW advocates for the right to equal treatment in accessing social and health services for documented (regular) migrants and their families. However, the ICRMW fails to provide that irregular migrants should benefit from disease prevention measures such as early diagnosis and medical follow-up. Article 27. With respect to social security, migrant workers and members of their families shall enjoy in the State of employment the same treatment granted to nationals. Article 28. It also recognizes the right to emergency medical treatment for all migrant workers and their families, regardless of their status even if they are irregularly living or employed in the country. Article 43[e] ensures equal access to social and health services for regular migrants and states shall ensure migrant workers equality of treatment with nationals for access to social and health services, provided that the requirements for participation in the respective schemes are met. Article 45[c] extend this benefit to family members.
12	Convention on the Status of Refugees (United Nations General Assembly, 1951)	Protection of refugees. Article 23 states that refugees are entitled to the same treatment as nationals of their host State as regards public relief, which includes health care. This entitlement is interpreted to include asylum-seekers.
13	Status of Stateless Persons (United Nations General Assembly, 1954)	Protection of stateless persons

B. Regional instruments on migration, right to health and social protection

At the regional level, the rights of migrants to health and social security are articulated in a way that reflects regional domestication of the international instruments in Table 5.

Table 5. Regional instruments providing protection mandate for various thematic areas

	Instrument	Protection thematic area
1	African human rights system under the African Charter on Human and Peoples' Rights (ACHPR) (Organization of African Unity, 1981, Article 16)	… that establishes the right to enjoy the best attainable state of physical and mental health, and calls on State parties to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.
2	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (ACHPR-PW) (African Union, 2003, Articles 14 and 13)	Provides for the right to health under international human rights law and the importance of social protection.
3	African Charter on the Rights and Welfare of the Child (ACRC) (Organization of African Unity, 1990, Article 14)	Protection provisions related to health
4	African Youth Charter (AYC) (African Union, 2006, Articles 14 and 16).	… recognizes the right to "enjoy the best attainable state of physical, mental and spiritual health" and to "benefit from social security, including social insurance".
5	Migration Policy Framework for Africa and Plan of Action (2018–2030)	"Provide migrants' access to social services, and the nutritional needs of infants and children of migrants in line with international law, standards and norms un-restricted on the basis of migration status…", builds on the first African Union Migration Policy Framework for Africa (MPFA), adopted in Banjul, the Gambia, in 2006: 'Ensure that migrants have adequate access to health-care services by granting access to national health-care systems and programmes…" "Ensure the minimal healthcare service package for refugees and displaced persons, including prevention, treatment and health education, with special regard for the needs of vulnerable groups, and mobilise resources needed, by inter alia enhancing collaboration with UNHCR, IOM, WHO, ICRC, IFRC, UNFPA, UNAIDS and other relevant agencies".

C. Status ratification and domestication in East African countries of international and regional instruments'

Table 6. Status of ratifications of international and regional human rights instruments by EAC countries

	International Instruments	Burundi	Kenya	Rwanda	Uganda
1	Universal Declaration on Human Rights (United Nations General Assembly, 1948, Article 22)	_	Ratified: 1990	Ratified: 1975	Ratified: 1985
2	International Covenant on Economic, Social and Cultural Rights - ICESCR (United Nations General Assembly, 1966, Article 12)	Ratifed: 1990	Ratifed: 1972	Ratifed: 1975	Ratifed: 1987
3	International Covenant on Economic, Social and Cultural Rights - ICESCR (United Nations General Assembly, 1966, Article 9)	Ratifed: 1990	Ratifed: 1990	Ratifed: 1975	Ratifed: 1987
4	Committee on Economic, Social and Cultural Rights - (CESCR) (United Nations Economic and Social Council, 2000)	Ratifed: 1990	Ratifed: 1990	Ratifed: 1975	Ratifed: 1987
5	International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (United Nations General Assembly, 1965), Article 5	Signed: 1967 Ratified: 1977	Ratified: 2001	Ratified: 1975	Ratified: 1980
6	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (United Nations, 1988, Articles 11, 12 and 14)	Signed: 1980 Ratified: 1992	Ratified: 1984	Signed: 1980 Ratified: 1981	Signed: 1980 Ratified: 1985
7	Convention on the Rights of the Child (CRC) (United Nations Commission on Human Rights, 1990), Articles 24 and 26)	Signed: 1990 Ratified: 1990	Signed: 1990 Ratified: 1990	Signed: 1990 Ratified: 1991	Signed: 1990 Ratified: 1990
8	Convention on the Rights of Persons with Disabilities (CRPD) (United Nations General Assembly, 2007, Articles 25 and 28)	Signed: 2007 Ratified: 2014	Signed: 2007 Ratified: 2008	Ratified: 2008	Signed: 2007 Ratified: 2008

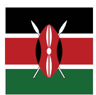
9	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) (United Nations General Assembly, 1990) (United Nations General Assembly, 1990, Articles 43[e] and 45[c])	Ratified: N/A	Ratified: N/A	Ratified: 2008	Ratified: 1995
10	ICRMW (United Nations General Assembly, 1990, Article 27)	N/A	N/A	Ratified: 2008	Ratified: 1995
11	ICRMW (United Nations General Assembly, 1990, Article 28)	N/A	N/A	Ratified: 2008	Ratified: 1995
12	Convention on the Status of Refugees (United Nations General Assembly, 1951)	Signed: 1967 Ratified: 1977	Ratified: 2001	N/A	N/A
13	Status of Stateless Persons (United Nations General Assembly, 1954)	N/A	N/A	N/A	N/A
Regional Instruments					
African human rights system under the African Charter on Human and Peoples' Rights (ACHPR) (Organization of African Unity, 1981, Article 16)		Ratified: 1989	Ratified: 1992	Signed: 1981 Ratified: 1983	Signed: 1986 Ratified:1986
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (ACHPR-PW) (African Union, 2003, Articles 14 and 13)		Signed: 2003	Signed: 2003 Ratified: 2010	Signed: 2003 Ratified: 2004	Signed: 2003 Ratified: 2010
African Charter on the Rights and Welfare of the Child (ACRC) (Organization of African Unity, 1990, Article 14)		Signed: 2004 Ratified: 2004	Ratified: 2000	Signed: 1991 Ratified: 2001	Signed: 1992 Ratified: 1994
African Youth Charter (AYC) (African Union, 2006, Articles 14 and 16)		Signed: 2006	Signed: 2008 Ratified: 2014	Signed: 2007 Ratified: 2007	Signed: 2017 Ratified: 2008
Migration Policy Framework for Africa and Plan of Action (2018–2030)		N/A	N/A	N/A	N/A

In addition to the ratification of international standards, each country has national laws and policies such as the constitution that refer to the obligations of international standards.

BURUNDI: Status of domesticating international and regional instruments

Burundi has several health-related national laws and policies that include references to the International standards as follows:

- The Offer of Health Care and Services Code and the Public Health Code, the Millennial Development Goals (MDGs) or Sustainable Development Goals (SDGs), and to international treaties, declarations and commitments relevant to health subscribed to by Burundi as evident in the current health policy statement (National Health Policy, 2016–2025).
- Burundi is signatory to numerous International and regional instruments that are directly or indirectly applicable in the country's constitution. Constitution of Burundi (Constitution de Burundi, 2018) was adopted by a referendum on 17 May 2018 and reflects both monists approach in Article 279, and dualist approaches in Article 277 in the integration of international and regional treaties (Barakamfitiye, et al., 2017).



KENYA: Status of domesticating international and regional instruments

International laws have gained more prominence in the Kenyan legal system since the country adopted a new constitution in 2010.

- The Constitution of Kenya (2010) recognizes that "every person has the right to life" (Constitution of Kenya, 2010, Article 26) and "the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care" (Constitution of Kenya, 2010, Article 43(1[a]).
- The Constitution of Kenya (2010) also provides for the specific application of rights to particular groups: in terms of health rights specifically, it provides for affirmative action programmes for minority and marginalized groups to ensure reasonable access to health services among others (Constitution of Kenya, 2010, Article 56[e]).
- The 2010 Constitution (as it is known) also provides for a devolved government in which powers and responsibilities are shared between the national government and 47 county governments including the responsibility to ensure "reasonable access to services in all parts of the Republic" (Constitution of Kenya, 2010, Article 6(3)).
- The Constitution states that "a person shall not be denied emergency medical treatment" (Constitution of Kenya, 2010, Article 43(2)) and recognizes the right to determinants of health (Constitution of Kenya, 2010, Article 43(1)).
- The Constitution also provides for the specific application of rights to particular groups: in terms of health rights specifically, it provides for affirmative action programmes for minority and marginalized groups to ensure reasonable access to health services among others (Constitution of Kenya, 2010, Article 56[e]), It

reiterates that children have the right "to basic nutrition, shelter and health care" (Constitution of Kenya, 2010, Article 53), and provides for measures to ensure the rights of older persons to receive reasonable care and assistance from their family and the State are fulfilled (Constitution of Kenya, 2010, Article 57[d]).

- The Health Act, of 2017 emphasizes the collaboration between national and county governments to address the health needs of vulnerable groups. It mandates the provision of emergency and specialized care including the provision of free maternity care, vaccinations for children under age five, and workplace breastfeeding facilities.

RWANDA: Status of domesticating international and regional instruments

The Constitution of the Republic of Rwanda (2003) was adopted in 2003 and revised in 2015. It emphasizes human rights, freedom, and on the principle of equality before the law, and equality between men and women (Constitution of the Republic of Rwanda, 2003). In Rwanda, international treaties take effect when regularly ratified, with the president having the power to ratify international treaties and agreements. However, international treaties and agreements concerning armistice, peace, commerce, accession to international organisations, commitment of state finances, modification of national legislation or those relating to the status of persons can only be ratified after approval by Parliament (Constitution of the Republic of Rwanda, 2003, Article 167). Either way, the Parliament is notified of treaties and agreements following their conclusion.

Some of the health-related national laws and policies in Rwanda are those that refer to the International Health Regulations and OAU Plan of Action on HIV/AIDS. Such include:

- Health Sector Policy (2015)
- Rwanda's fourth health sector strategic plan (2018-2024)
- National Policy on HIV /AIDS, Vision 2050 "The Rwanda We Want" and EAC Vision 2050 & SDGs. Law number (48/2015) of 23/11/2015, pronounces itself on the establishment, organisation, functioning and management of Health Insurance Schemes in Rwanda where health insurance is mandatory.
- Article 3 of the Constitution of the Republic of Rwanda (2003) demands that any person, whether a Rwandese or a foreign national who is on the Rwandan territory must have health insurance. Consequently, any person entering the Rwandan territory without any form of health insurance must subscribe to health insurance with an insurance regime of choice within a period not exceeding thirty (30) days.
- Among labour-related national laws in Rwanda include reference made to ILO conventions and standards in general as seen in Law number (13/2009) of 27/05/2009.
- Even though Rwanda is yet to ratify the Social Security (Minimum Standards) Convention (ILO, 1952) number 102, the existence of national legal instrument on Social Security system is pointed out by Law number (06/2003) of 22/03/2003 that modifies and completes the Decree Law of August 22, 1974, concerning Organization of Social Security.

UGANDA: Status of domesticating international and regional instruments

The Constitution of the Republic of Uganda (1995) was adopted in 1995, and among its objectives was the protection and promotion of fundamental human rights and freedoms. According to this Constitution, treaties take effect when regularly ratified (Constitution of the Republic of Uganda, 1995). The president, or a person authorised by the President can make treaties, conventions, and agreements, however, the parliament makes laws to ratify them and insert them in the legal system (Constitution of the Republic of Uganda, 1995, Article 123).

Some of the health-related national laws and policies of Uganda analysed in this study include:

- The International Health Regulations
- OAU Plan of Action on HIV/AIDS such as the HIV and Aids Prevention and Control (Uganda: HIV and Aids Prevention and Control Act, 2014).
- The National Integrated Prevention of Mother to Child Transmission of HIV (PMTCT) Policy Guidelines (2011), is also relevant as it employs direct reference to terminologies such as "all persons", "persons with HIV" and "without discrimination based on HIV status."
- Regarding labour-related national laws, reference is made to ILO conventions and standards in general as mirrored by Employment Act, (2006) in Uganda.
- Even though Uganda, like many of its East African neighbours is yet to ratify the Social Security (Minimum Standards) Convention (ILO, 1952) number 102, it still mirrors its aspects in the national legal instruments. Highlighted in this respect is the existence of Social Security system as indicated by national laws such as the National Social Security Fund Act (1985), Retirements Benefits Regulatory Authority Act (2011), Workers Compensation Act (2000), and the bilateral agreements between the United Kingdom of Great Britain and Northern Ireland, and East African Community (Kenya, United Republic of Tanzania and Uganda) concerning public officers' pensions 1978 (McGillivray, 2010).

D. Inclusion of reference to human rights and principle of universality in national instruments

Reference to the general human rights principles

The Constitutions of the East African countries of Burundi, Kenya, Rwanda and Uganda refer to general human rights principles such as equality, non-discrimination and to the concept of human dignity. For example, the Constitution of Kenya (2010) widely prohibits discrimination on all grounds, including pregnancy, race, sex, marital status, health, ethnicity or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language, or birth (Constitution of Kenya, 2010, Article 27(4)). Most health-related laws, including the Health Act (2017) use inclusive language (e.g. "all persons" or "every person") or specify whether the laws apply to people who are "ordinarily resident" in Kenya (which would

include internal migrants, regular migrants and refugees, which would exclude irregular migrants). The Constitution of Kenya in this respect can be interpreted as being inclusive of migrants. Annex 2 provides all-inclusive health services in Kenya. The Kenyan Constitution generally is in line with the interpretation of the right to health in international and regional instruments as evident in CRC Article 24 (United Nations Commission on Human Rights,1990), CRPD Article 25 (United Nations General Assembly, 2007), ICESCR Article 12(1) (United Nations General Assembly,1966), ACHPR Article 16 (Organization of African Unity,1981), and ACRWC Article 14 (Organization of African Unity, 1990). It also states that "a person shall not be denied emergency medical treatment" (Constitution of Kenya, 2010, Article 43(2)) and recognizes the right to determinants of health (Constitution of Kenya, 2010, Article 43(1)).

In Burundi, the application of the principle of non-discrimination is particularly wide-ranging, as "no one" may be the target of discrimination, notably on the basis of "origin, race, ethnicity, sex, colour, language, social situation, religious, philosophical, or political belief, physical or mental handicap, HIV/AIDS status or having any other incurable illness" (Constitution de Burundi, 2018, Article 22).

In Rwanda, article 10 of the Constitution of the Republic of Rwanda (2003) establishes the application of the principle of non-discrimination, social welfare, equal opportunities, social justice, and other fundamental principles such as the right to life and freedom. This constitution in this respect refers to equal access to health and social rights when it notes that, "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control," (Constitution of the Republic of Rwanda, 2003, Article 25).

The Ugandan Constitution (1995) maintains that all persons are equal before and under the law in all spheres of political, economic, social, and cultural life and in every other respect and shall enjoy equal protection of the law (Constitution of the Republic of Uganda,1995, Article 21). This constitution also alludes to community protection where no person shall be deprived of personal liberty. Under the Ugandan constitution, all are assured of the right to life, right of the child, and gender equality among others (Constitution of the Republic of Uganda, 1995, Articles 22, 23 and 34).

Reference to the principle of universality

The principle of universality is implied in various constitutions for these East African countries. In Kenya, the principle of universality is reflected in the use of terms like "every person" and "any persons" as used in the Bill of Rights (Chapter 4) of the Constitution of Kenya (2010). This aligns with international and regional instruments regarding civil, political, economic, cultural, and social rights (Constitution of Kenya, 2010, Articles 22 and 23). The Constitution also establishes the State's fundamental duty to "observe, respect, protect, promote and fulfil the rights and fundamental freedoms in the Bill of Rights"

(Constitution of Kenya, 2010, Article 21(1)). The language used in the Constitution of Kenya (2010) can therefore be interpreted as being generally inclusive of migrants even though not explicitly. In particular, the Constitution of Kenya allows for dual citizenship (Constitution of Kenya, 2010, Article 16). It also directs the State to address the needs of vulnerable groups, comprising members of minority or marginalised communities, and members of particular ethnic, religious, or cultural communities e.g., pastoralists, including through affirmative action to ensure reasonable access to health services among others (Constitution of Kenya, 2010, Articles 21(3), 56[e] and Article 260[d]). This is in line with the interpretation of the right to health in international and regional instruments as evident in CRC Article 24 (United Nations Commission on Human Rights,1990), CRPD Article 25 (United Nations General Assembly, 2007), ICESCR Article 12(1) (United Nations General Assembly, 1966), ACHPR Article 16 (Organization of African Unity, 1981), and ACRWC Article 14 (Organization of African Unity, 1990).

Burundi Constitution (Constitution de Burundi, 2018) uses terms like "all human beings", "all persons", "every person" and "no one". Burundi's constitution refers to the Charter of the United Nations, the Charter of the Organization of the African Union and to the Treaty establishing the East Africa Community, in its preamble. However, these instruments must be submitted obligatorily for constitutional review by the Constitutional Court before being subjected to a vote by the Assemblies as contained in the Constitution of Burundi (Constitution de Burundi, 2018, Article 234).[2]

The Constitution of Rwanda (2003) uses terms like "all persons", "every person"; "all individuals"; "everyone" and "no one" and are "equal before the law," "have the right to live in a clean and healthy environment," "have the right of equal pay," "has the right to life," (Constitution of the Republic of Rwanda, 2003, Articles 15, 22, 30 and 12). Therefore, the principle of universality in the Constitution of the Republic of Uganda (1995) is implied by use of terms like "all persons", "every person", "all individuals"; "everyone" and "no one."

However, some sections of Burundi, Rwanda, and Uganda constitutions refer exclusively to "Burundians," "Rwandans" and "Ugandans" respectively or to "citizens", which would exclude many categories of migrant populations. The rights of migrants having Burundian, Rwandan and Ugandan nationality or citizenship are therefore much more clearly stated in the constitutions than the rights of foreign migrants. For example, the Migration Law Number (57/2018) of 13/08/2018 on Immigration and Emigration in Rwanda, the Organic Law Number (30/2008) of 25/07/2008 relating to Rwandan Nationality, and Presidential Order Number (21/01) of 27/05/2009 establish the procedures for the application and acquisition of Rwandan Nationality. The only exception with reference to human rights is the case of Burundi where foreigners benefit from the protection accorded to people and goods in the limits stipulated by the law (Constitution de Burundi, 2018, Article 59). Safety as implied here has a health dimension by extension that is potentially inclusive of migrants.

2 Domestication of the international and regional instruments in Burundi, takes effect through either regular ratification or the fulfilment of conditions for their enactment (Constitution de Burundi, 2018, Article 279).

PART IV

Medical screening at migrants response centre. Hargeisa, Somalia.

Analysis and conformity assessment

This section explored to what extent the national frameworks conformed to international and regional instruments in three main perspectives: Health rights in migration laws and policies; health system and access to health care by migrants; social protection coverage and labour rights as per SDGs.

A. Health rights in migration laws and policies

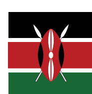
In Burundi, the Constitution sets out "every person" has a right to access health care (Constitution de Burundi, 2018, Article 55) and to satisfy the economic, social, and cultural rights indispensable to the dignity and free development of one's person (Constitution de Burundi, 2018, Article 52). It also establishes that all "human beings" have the right to life (Constitution de Burundi, 2018, Article 24) and freedom of their own person, notably in their physical and psychic integrity (Constitution de Burundi, 2018, Article 25). Article 24 (Constitution de Burundi, 2018) could be interpreted favourably as mandating at the very least life-saving emergency services to all people (thus including irregular migrants). Additionally, application of the non-discrimination principle provides coverage for all migrants (Constitution de Burundi, 2018, Article 22). Nevertheless, the Offer of Health Care and Services Code (2018) is slightly different from the Constitution, in that it does contain the expanded definition of the right to the highest attainable standard of health (Constitution de Burundi, 2018, Article 3(55)) as well as specific measures for women and children with reference to reproductive health care, family planning services, and vaccination as captured in Title I, Chapter V, Section 1 (the Offer of Health Care and Services Code, 2018).

Contrary to certain regional and international treaties to which Burundi is a party, Burundi's Constitution falls short of provisions for the specific application of health rights for particular groups, except for children (who have the "right to particular measures to assure or improve the necessary cares for their well-being, health, physical security, and for being protected from poor treatment, extortions, or exploitation" (Constitution de Burundi, 2018, Article 44). Article 55 of the Burundi Constitution (Constitution de Burundi, 2018) even though indirectly addressing vulnerable groups, also falls short of the "right to the highest attainable standard of health" set out in regional and international instruments such as CRC Article 24 (United Nations Commission on Human Rights, 1990), CRPD Article 25 (United Nations General Assembly, 2007), ICESCR Article 12(1) (United Nations General Assembly, 1966), ACHPR Article 16 (Organization of African Occupational Safety and Health Convention, 1981), and ACRWC Article 14 (Organization of African, 1990). The specific coverage of migrants in the Burundi Constitution is unclear, as there is incongruence between the principle of non-discrimination (Constitution de Burundi, 2018, Article 9), the stated right of "every citizen" (not every person) to access basic health care services (Constitution de Burundi, 2018, Article 8), and the right of sick persons to quality, conscientious and diligent health care, for which health care providers must use available means for the benefit of "all persons" (Constitution de Burundi, 2018, Article 10). Most other health-related laws and policies either do not mention health rights for migrants at all as is evident in the Public Health Code or use general inclusive language

that is not specific to migrants. This is the case with Law number 1/018 (2005) on the Legal Protection for People Infected with HIV and for People with AIDS, Law number 1/03 (2018) on the Promotion and Protection of the Rights of Persons with Disabilities in Burundi, and the National Health Policy, 2016–2025.

The decree-law number 11/007 (1989) in Burundi regulates the Access, Stay and Establishment of Foreigners in Burundian territory by setting out requirements such as entry visa, internationally recognized vaccination certificates to enter the country as well as the condition that the Government of Burundi reserves the right to refuse access to people who are not in full mental health or who have contagious or communicable diseases (see also Constitution of Burundi; 2018, Art. 7). Burundi, unlike other East African Community country, presents a case where migration-related law clearly addresses the health rights of foreigners with particular reference to refugees, stipulating that people recognized as such are entitled to receive the same treatment as Burundians with regard to health care as contained in Law number 1/32 (2008) on Asylum and the Protection of Refugees in Burundi.

The only law in Burundi granting access to health care which does apply specifically to migrants is Law number 1/28 (2014) on the Prevention and Suppression of Trafficking in Persons and the Protection of Victims of Trafficking. It specifies that foreign victims of trafficking benefit from aid and assistance, which includes at the very least the provision of safe and suitable accommodation as well as, in a language which is accessible to them, basic medical care and psychological follow-up guaranteeing confidentiality. In addition, particular attention must be paid to the needs of all vulnerable people, especially women and children (Constitution de Burundi, 2018, Article 23).



In Kenya, the Constitution exhibits a variance with other health-related laws surveyed, by either showing a disparity with the right to health care (focusing instead on control measures, such as the Malaria Prevention Act, 1983; Public Health Act, 1986; and Prohibition of FGM Act, 2011) or fell short of international standards and Constitutional provisions. These laws appeared to employ a less comprehensive interpretation than the "right to the highest attainable standard of health" as the case of the Children Act (2001) and Persons with Disabilities Act (2003) portend when it omits specific applications of the right to health to particular groups. In Kenya the laws providing for the health-related entitlements of victims (of a range of offenses), use inclusive language and are very well-developed, providing for medical assistance provided by the State (the Sexual Offences Act, 2006, Counter Trafficking in Persons Act, 2010, Victim Protection Act, 2014, Protection Against Domestic Violence Act, 2015, and the Prevention of Torture Act, 2017). The assistance provided by the state includes psychological or psychosocial assistance, compensation for personal injury and the cost of medical or psychological treatment from the offender (the Victim Protection Act, 2014), and culturally sensitive services for persons and members of ethno-cultural and religious minorities (ibid.). Just a few laws explicitly identify the category of migrants, which are most often very restricted definitions, such as victims of trafficking, IDPs, or "aliens" in detention (Persons Deprived of Liberty Act, 2014).

Kenya's existing national laws on migration do not expressly focus on the health rights of migrants. In general, the related laws focus more on defining categories of prohibited immigrants and inadmissible persons, registration requirements, and establishing eligibility for the application for permanent residence and citizenship. Similarly, the Kenya Citizenship and Immigration Act (2011) establishes the duties and rights of permanent residents, which include "the right to access and enjoy social services and facilities in Kenya" (Section 38) and can be understood to comprise access to health-care services as a right of permanent residents. The only migration-related policy that currently exists, the Kenya Diaspora Policy (2014), is relevant to outbound migrants only and does not address health rights (although it does feature health as a subject in terms of retaining health workers and promoting medical tourism to Kenya). The laws and regulations pertaining to refugees are not very explicit when it comes to health rights, preferring instead to the rights "contained in the international conventions to which Kenya is a party. Mentioned in this regard is the requirement to provide overall safety, protection, and assistance to refugees, to maintain refugee and transit camps in an environmentally sound manner; and the possibility of accelerating asylum procedures in medical emergencies (Refugees Act, 2006 and Refugees (Reception, Registration and Adjudication) Regulations 2009).

It is an interesting feature in Kenya that although the constitution and the laws appear to be migrant-inclusive with reference to access to health care at the operationalization level, language is more mixed up where the terms "Kenyans", "citizens", and "all people" are sometimes used interchangeably, in addition to broad and ill-defined terms such as "vulnerable", "marginalized", "hard-to-reach" or "at risk" populations, therefore, compromising on migrant inclusivity.

In Uganda, the constitution ensures the provision of basic medical services to the population and establishes that "No person shall be deprived of life" (Constitution of the Republic of Uganda, 1995, Article 22). However, the Ugandan Constitution also sets that "all Ugandans have the right to "healthy environment" or "access to health services but does not mention any provisions for the specific application of health rights for particular groups, except for children when it stipulates that no child shall be deprived by any person of medical treatment, education or any other social or economic benefit (Constitution of the Republic of Uganda, 1995, Article 34).

In Rwanda, the Constitution sets out that all Rwandese have the right to "good health", with specific application of health rights for children (Constitution of the Republic of Rwanda (2003)). This reference on "Rwandese" therefore excludes migrants living in Rwanda. The compulsory health insurance to all people in Rwanda however balances this in favour of migrants. Although the Labour Law No. 66/2018 of 30/08/2018 Regulating Labour in Rwanda (Rwanda Labour Law 2018) obligates employers to ensure occupational health and safety for private and contractual workers including legal migrants, there are however no provisions for other types of migrants who may not have legal documentation to enable employers to make remittances to medical insurance/benefit schemes in Rwanda.

Table 7. Health care within migration laws and policy

Country	Vaccination Certificate	Mentally Disturbed/ Contagious Diseases Allowed	Right to Health Care by Migrants	Temporary Work Permit	EAC Free Movement	Long-term Work Permit	Persecution of Irregular Migrant
Burundi	Allowed	Not allowed	Allowed	Allowed	Allowed	Allowed	Not clear
Kenya	Allowed	Not clear	Not clear	Not clear	Allowed	Not clear	Not allowed
Rwanda	Not clear	Not clear	Allowed	Not clear	Allowed	Allowed	Not clear
Uganda	Not clear	Not clear	Allowed	Not clear	Allowed	Not clear	Not clear

Key

(teal)	Allowed
(yellow)	Not clear
(orange)	Not allowed

Source: Authors own elaboration.

Table 8. National Health laws and rights on general migrant population

Country	National Health Laws and Policies	Right to Health Care and Life	Family Planning Services	Vaccination	Basic Health-care Services	Psychosocial Follow up	Health-Related Laws Specific to Migrants
Burundi	Existent	Existent	Non existent	Non existent	Existent	Existent	Non existent
Kenya	Existent	Existent	Existent	Existent	Existent	Non existent	Existent
Rwanda	Existent	Existent	Non existent	Non existent	Non existent	Non existent	Non existent
Uganda	Existent	Existent	Non existent	Non existent	Existent	Non existent	Non existent

Key

(teal)	Existent
(orange)	Non existent

Source: Authors own elaboration.

B. Health system and access to health care by migrants

The Health Systems in Burundi are decentralized subject to Law number 1/07 (2020) providing for health services comprising of 45 health districts spread over 17 health provinces constituting the operational level of the health system each with an administrative base, a district hospital, and a network of approved public and private health centres (including community health facilities). Universal Health Care (UHC) is a stated objective of Burundi's Government, although it is unclear whether migrants have been part of UHC discussions and there is a general lack of data about it (UHC Burundi (2017)). The National Health Policy (2016–2025) defines UHC as being made up of two components: necessary health services (preventive, curative, promotional and rehabilitation) and protection from financial risk for every individual. There do not appear to be any government health schemes that address the needs of migrants only with reference to health care.

Table 9. Health services in Burundi and migrant inclusion

Service	Inclusive of migrants
Burundi National Health policy, 2016–2025	Free medical assistance for "those in need", under the responsibility of the MSNDPHG, however eligibility criteria are unclear. The MSNDPHG caters to the needs of displaced persons and returnees, as well as people living in extreme poverty and other vulnerable groups (such as the Batwa and persons with disabilities). Likely not open to non-Burundians (MFPTSS, 2015). Gratuité-FBP (targeted free health care linked to Performance Based Funding): free health care for pregnant women and children under five years old (since 2006) (National Health Policy, 2019). Patients have to produce an ID card and, in the case of children, a birth certificate and a vaccination card (Hodges, 2014). Children: only children under the age of 5 whose parents are not employed in the formal sector, are of Burundian nationality, and are residing in Burundi are 100 per cent subsidized (provided that services take place in public health-care facilities) (MSPLS, 2019).
Expanded Vaccination Programme [Programme Élargi de Vaccination] (PEV) (MSPLS, 2020) to protect "all children" from preventable diseases by vaccination (measles, tuberculosis, polio, diphtheria, tetanus, pertussis (whooping cough), hepatitis B and Haemophilus influenzae type b [DTP-hepB-Hib])	Unclear. However, a WHO report notes that an action plan was developed for MSPLS in 2019 and that, with the help of GAVI, universal access to vaccination was granted to all children living in districts which had lower vaccination rates from 2016 to 2018, and which reached children in the suburbs of Bujumbura, as well as refugees, displaced people and returnees (WHO, 2010).
National Integrated Programme for the Fight Against Malaria [Programme National Intègre de Lutte Contre le Paludisme] (PNILP) (MSPLS, 2021)	Unknown
National Programme for the Fight Against AIDS [Programme National de Lutte Contre le Sida] (PNLS) (MSPLS, 2021)	Unknown
National Programme for Leprosy and Tuberculosis [Programme National Lèpre et Tuberculose] (PNLT) (MSPLS, 2021).	Unknown
National Integrated Programme for the Fight Against Chronic Non-Communicable Diseases [Programme National Intégré de Lutte Contre les Maladies Chroniques Non Transmissibles] (PNILMCNT) (MSPLS, 2021)	Unknown

National Programme for the Fight Against Neglected Tropical Diseases and Blindness [Programme National de Lutte Contre les Maladies Tropicales Négligées et la Cécité] (PNIMTNC) (MSLPS, 2021)	Possibly refugees and displaced people (in particular with regard to urinary schistomiasis) (MSPLS, 2021)
National Programme for the Development of Health Informatics [Programme National de Développement de l'Informatique Sanitaire] (PNDIS) (National Development Plan, 2018–2027)	Unknown
National Integrated Programme for Food and Nutrition [Programme National Intégré de l'Alimentation et de la Nutrition] (PRONIANUT)	Unknown

The health system in Kenya is organized around six levels. Level 1 is a community unit focused on promotive health, while Levels 2 and 3 offer primary health-care services; Levels 4 and 5 are county-level secondary referral facilities for curative services and Level 6 is national tertiary referral facilities for curative and specialized medical care. Regular migrants (whether temporarily or permanently resident) can access public health services, while the situation is less clear for irregular migrants. Research conducted during COVID-19 by IOM and its partners found that migrant women seeking free antenatal, delivery, and postpartum services in local hospitals were not attended to by health-care workers as they were considered ineligible to free schemes of maternity care (Lusambili and Martini et al., 2020). As a result, many migrant women are unable to pay for maternity care, delivered in their homes with the help of traditional birth attendants increasing their vulnerabilities.

While the Health Act (2017) has a broad definition of health and takes into account specific groups, the measures it identifies such as free and compulsory vaccination for children under five years of age and free maternity care are not as extensive in scope when compared to those proposed by international and regional instruments as can be captured in CEDAW Article 12 (United Nations, 1988), ACHPR-PW Article 14 (African Union, 2003), or AYC Article 16 (African Union, 2006).

The National Health Insurance Fund (NHIF) is a state corporation and Kenya's primary health insurance scheme, originally created in 1966 for employees in the formal sector (NHIF, 1998). An insurance subsidy programme was introduced in 2014 to cover certain people on social assistance as evidenced in Kenya Social Protection Sector Review, (2017) and in 2018 a medical insurance scheme called Edu Afya was introduced to cover all students in public secondary schools (as long as they are registered in the National Education Information System [NEMIS]) (Tuvuti Editorial Team, 2019). NHIF is open to members who are "ordinarily resident in Kenya" and above the age of 18 years, covering their spouse and children. Regular migrants and internal migrants are therefore able to become members of the NHIF for the length of time they are allowed to be in Kenya,

as determined by their permit. The documents required for foreign nationals to apply for NHIF membership are passport and alien card (including of the spouse, if applicable), birth notification or certificate (also of dependent children), and for employees, their work permit (including of the spouse, if applicable) and appointment/introduction letter from employer. Kenya is in the process of scaling up Universal Health Coverage (UHC). It is unclear to what extent UHC would be accessible to migrants, even if regular migrants have the right to access public health services. No policy or plan related to UHC mentions migrants explicitly, and often the language used refers to "Kenyans" or to "citizens". Where reference is made to migrants and migration in health-related policies, it is more often in terms of risks than rights or measures to facilitate access to health care. For example, the Health Policy (2014–2030) recognizes increased cross-border movements of people as an "influence on national health risks and priorities" and that the migration from rural to urban areas poses "health risks mostly affecting the urban informal settlements. There do not seem to be any national-level health schemes specifically for migrants (regular or irregular). However, Kenya has made progress in recognizing some current gaps through two National consultations on migration health and is committed to ensuring that migration health is mainstreamed in health and development legislation, policies, programmes, and strategies and integrated within the National Health Sector Strategic Plan. (IOM, 2011; WHO, 2011)

Table 10. Health services in Kenya and migrant inclusion

Service	Inclusive of migrants
Linda Mama programme: free maternity care at public health facilities. Flagship programme of the Big Four Agenda.	The Health Act 2017 uses inclusive language. However, according to the NHIF website this scheme is for Kenyan citizens only.
Free and compulsory vaccination for children under five years of age.	The Health Act 2017 uses inclusive language.
Emergency medical treatment in public and private facilities.	The Constitution 2010 and the Health Act 2017 use inclusive language.
Free rehabilitation and medical services in public and privately owned health institutions; affordable essential health services; and provision of "assistive devices, appliances and other equipment" for persons with disabilities to be provided by the National Council for Persons with disabilities.	The Persons with Disabilities Act 2003 uses inclusive language.
"Beyond Zero" free county-specific health services through "medical safaris" and delivery of mobile clinic to every county. Flagship programme of the Big Four Agenda.	Unknown
The Kenya Health Sector Strategic Plan 2014–2018 states that "improvements in financial access will focus on ensuring the following services are available for free at the point of use: maternity, primary care, emergency, services for HIV, TB, Malaria and neglected tropical diseases (MOH- KHSSP; 2014 -2018).	It is unclear whether inbound migrants (regular and irregular) would have access to these free services. Currently, the majority of these services (except for maternity care and emergency services) seem to be available only to persons with health insurance (namely through the NHIF).

The health system in Rwanda is more elaborate and operational due to a strong political and governance system. At the central level, technical working groups (TWG) have been established to facilitate dialogue with the main stakeholders (national institutions, representatives of civil society, and development partners) involved in different programmatic areas. At the district level, the coordination of actors from different sectors is ensured by the Joint Action Development Forum (JADF) where all important development issues are discussed, and inter-sectoral collaborative interventions are designed and monitored. District Health Units (DHU) have recently been put in place to coordinate the different actors of the health sector at the decentralized level (DH, HC, NGOs, DPs and community-based interventions), to clarify and allocate the tasks of the different actors and ensure an adequate integration of the multidimensional determinants of the health status of the population. Health personnel and financial resources have been decentralized to the district level. Health insurance covers all medical services available and described under primary health care for all people including migrants. Secondary and tertiary level services can be covered based on the medical referral system applicable in all public health facilities. Under the scheme, registered refugees enjoy the same rights as native Rwandese. Contributory health insurance schemes are offered by two public institutions, the MFP and MSP, as well as several private/micro-insurance schemes and community Mutuelle. A subsidized contributory health-care scheme called the Medical Assistance Card was also available to independent workers and their dependents until 2020. The Civil Service Mutuelle (Mutuelle de la fonction publique – MFP) was created in 1980 as a health insurance scheme for public officials and equivalents. It is also open to persons designated as beneficiaries by an international agreement, international officials of technical cooperation (unless they are covered by a social security system in their country of origin or from their organization), students enrolled in higher education, and members of associations or staff engaged in public service. The health insurance scheme managed by the MFP covers all medical care (curative and preventative) with a co-payment of 20 per cent. Undocumented migrants are least likely to access these contributory health insurance schemes.

Table 11. Health services in Rwanda and migrant inclusion

Service	Inclusive of migrants
Civil Service Mutuelle (Mutuelle de la fonction publique - MFP)	Inclusive of migrants Benefits high school and refugees living in urban areas. covers all medical care (curative and preventative) with a co-payment of 20 per cent. It's open to persons designated as beneficiaries by an international agreement, and international officials of technical cooperation unless they are covered by a social security system in their country of origin or from their organization.
Rwanda's fourth health sector strategic plan (2018–2024)	Unknown

National Programme for the Fight Against AIDS [Programme National de Lutte Contre le Sida] (PNLS) (MSPLS, 2021)	Uses inclusive language Mentions refugees and immigrant traders
National Programme for Leprosy and Tuberculosis [Programme National Lèpre et Tuberculose] (PNLT) (MSPLS, 2021).	Unknown
Community-Based Health Insurance (CBHI) since 1999/2000 “mutuelles de santé”	Inclusive of urban refugees and student refugees
Rwanda’s Health Sector Policy (2015)	Makes no reference to migrants
Constitution of the Republic of Rwanda (2003)	Language is not inclusive of migrants. However, Article 3 uses terms such as “any person,” must have health insurance and must subscribe to health insurance with an insurance regime of choice within a period not exceeding thirty (30) days.

Health system in Uganda is divided into national and district-based levels. At the national level, there are: the national referral hospitals, regional referral hospitals, and semi-autonomous institutions including the Uganda Blood Transfusion Services, the Uganda National Medical Stores, the Uganda Public Health Laboratories and the Uganda National Health Research Organization (UNHRO, 2009). At the district level there are the Village Health Teams (VHTs) which are teams of volunteer health workers responsible for health education, preventive services and simple curative services. Health Centre II is an outpatient service run by a nurse and serves up to 5000 people while Health Centre III (HCIII) offers simple diagnostic and maternal health services serving up to 10,000 people. Health Centre IV, has medical doctors and provides emergency and obstetric care including surgical services. Uganda provides free universal access to state health facilities and therefore is migrant inclusive by implication. One of the biggest challenges for Uganda to increase access to health service is the lack of professionals such as medical doctors, especially in rural areas. The health policies in Uganda however are more recent and address the problem of inclusivity. These policies employ migrant-inclusive references such as “migrants”, “refugees”, “internally displaced persons” and other vulnerable groups. Uganda’s Health Sector Integrated Refugee Response Plan. This aligns refugees’ health response to Uganda’s National Health Policy and Health Sector Development Plan, which is rooted in values and principles of integration, equity, universal coverage, government leadership, mutual respect, and efficiency. According to the Second National Health Policy (2010) the universal access to quality and Minimum Health-Care Package is guaranteed to all people in Uganda, with emphasis on vulnerable populations.

Table 12. Analysis of health services in Uganda and migrant inclusion

Service	Inclusive of migrants
Uganda National Minimum Health-Care Package "UNMHCP" (2000)	Inclusive of refugee and asylum-seekers It is a cost-effective venture established by the government to guarantee free access for its population to a set of health services. Packages include preventive services, i.e. childhood immunization and health promotion and education and treatment and control of common and infectious diseases such as malaria, HIV, and Tuberculosis.
National Integrated Prevention of Mother to Child Transmission of HIV (PMTCT) (2011)	Does not use inclusive language However, it employs direct reference to terminologies such as "all persons", "persons with HIV" and "without discrimination based on HIV status."
Health Sector Refugee Response Plan 2019-2024, (HSIRRP 2019–2024).	Uses language Inclusive of refugees It is intended to address the needs of the host communities including refugees and ensure access to quality health services for both through the improvement of staffing of refugee-hosting districts to 95 per cent of the public staffing norms.
Uganda Health Sector Development Plan (HSDP) 2016–2020	Does not use inclusive language, however, it includes measures to better the health of refugees and post-conflict communities. Measures taken by the government include immunization and registration of refugee children, community health outreach programmes, training of village health teams to support communities with managing minor medical needs and ensuring refugees' access to COVID-19 vaccination.
Constitution of the Republic of Uganda (1995)	The language is not inclusive of migrants

C. Social protection and labour rights as a facilitator to accessing health care

Social protection constitutes policies and actions, including legislative measures. It aims at enhancing the capacity of and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods, and welfare to enable them and their dependents to maintain reasonable levels of income through decent work. This facilitates access to affordable health care, social security, and social assistance (National Social Protection Policy, 2020).

Burundi social protection: A direct reference to social security as a basic right to be fulfilled by the State is lacking in the Burundi Constitution except for Articles 94 and 158 in reference to the president, vice-president, prime minister, and legislators (Constitution de Burundi, 2018). Social protection is indirectly referred to through the duty of every

Burundian “to respect their parents at every moment, and to nourish and assist them in necessary cases” (Constitution de Burundi, 2018, Article 66), and taking a broad interpretation of the right to access health care could provide a constitutional basis for the right to health insurance. Social protection coverage in Burundi was reserved for salaried workers in the formal sector for a long time but was extended by the Social Security Code (1999). It importantly states that “everyone, as a member of society, has the right to social security for the fulfillment of economic rights and development of the person, through national effort and international cooperation” (Constitution de Burundi, 2018, Article 1). It recognizes that “motherhood and childhood are entitled to special care and assistance” and further specifies the “right to security in the event of illness, disability, widowhood, old age or in other cases of loss of livelihood due to circumstances beyond their control” (Constitution de Burundi, 2018, Article 2). The Code covers all workers who are under a contract of employment (Constitution de Burundi 2018, Article, 14[e]), with provisions for Burundian workers employed abroad and migrant workers employed in Burundi based on reciprocity agreements, international conventions, or specific conventions between social security organizations (Constitution de Burundi; 2018, Article 12). Therefore, it only provides cover to regularly employed migrants.

The social protection system in Burundi is composed of public, private and community entities, and consists of both contributory and non-contributory mechanisms (National Social Protection Policy, 2011). According to Burundi Labour Code, a female employee who has given birth is entitled to a maternity leave of at least twelve (12) consecutive weeks and at least two (2) weeks before delivery. An employer cannot give a female employee who has given birth a notice of dismissal which is a condition included in her maternity leave. The worker is entitled to sick leave of up to 6 months if certified by the doctor, where the first three months are paid while the last three months are unpaid. There is a provision for annual leave to all workers on completion of one year of service and workers can enjoy the annual leave within two years of its qualification.

In Burundi, some social assistance programmes with limited reach exist and are inclusive of migrants. Although not expressly mentioned in the decree that governs the mandate of such programmes, such support would include non-contributory schemes, although no major government-run cash transfer programmes exist (see United Nations Development Assistance Framework (UNDAF) Burundi, 2019–2023, 2018). NGOs reportedly implement cash transfer programmes for specific populations, including migrant and refugee women and women in humanitarian settings (Government of Burundi, 2019). The Social Security Code (1999) establishes the contributory social security schemes available in Burundi, which include basic occupational risk schemes (benefits in the event of work injury, an injury sustained while commuting to or from work, or an occupational disease) and basic sickness and maternity insurance schemes (medical care, sickness and maternity benefits). The National Institute for Social Security (Institut National de Sécurité Sociale - INSS) was created in 1962 and now manages the pension (old age, disability, and survivors’) and occupational risk schemes (work injuries and occupational disease) for workers (Law number 1/011, 2002). All employers who engage workers through a contract must declare

their employees and mandatorily affiliate them (INSS Burundi, date unknown). Workers covered by the INSS include those governed by the Labour Code and equivalents including public and political representatives previously under an employment contract, military personnel, state and local government employees, and trainees and apprentices bound by an employment or apprenticeship contract. Concerning labour mobility, Burundian workers employed by a company located in Burundi and who are posted to the territory of another country, if the foreseeable duration of the work does not exceed six months, then they are also eligible for coverage. Similarly, foreign workers employed by a foreign company who are posted to the territory of Burundi are also eligible, provided that the foreseeable duration of the work does not exceed six months. An independent worker may voluntarily register to the pensions branch only, provided they have been affiliated with the INSS's general social security system for at least six consecutive months, have submitted the request for coverage within 12 months following the date on which their compulsory membership ended, and will contribute for three consecutive years before turning 60 years. This option is therefore not conducive to foreign workers as the requisite form for voluntary registration does not allow for the applicant to record information related to their birth in a foreign country.

With attention to labour laws with a bearing on health, it is notable that Burundi is not a signatory to the Occupational Safety and Health Convention (ILO, 1981) number 155, however, the Labour Code (1993) does establish that all workers must benefit from satisfactory measures to protect their health and safety in the workplace and that the prevention of accidents at work is an obligation of the employer (which includes the compulsory organization of safety training for workers by every company) (Constitution of Burundi, 2018, Article 11). In addition, employers must consider the special working conditions required by pregnant women and young people (Constitution of Burundi, 2018, Article 146). Therefore, these provisions are believed to apply to all workers inclusive of migrant workers.

Kenya social protection: The Constitution of Kenya (2010) recognizes the right of every person to social security in Article 43[1[e]) and affirms that the State will provide "appropriate social security to persons who are unable to support themselves and their dependants" (Constitution of Kenya, 2010, Article 43(3)). While non-citizens are excluded from receiving social assistance according to the Social Assistance Act (2013), regular migrants are explicitly referred to in other national legislation relevant to social protection. The National Social Security Fund (NSSF) Act (2013) establishes compulsory membership of the National Social Security Fund for "any person who has attained the age of 18 years and who is employed in Kenya under a contract of service; or ordinarily resident in Kenya and is employed by an employer who resides in Kenya or employed on a ship or aircraft of which the owner resides in Kenya." The act also contains provisions for reciprocal agreements and coordination with East Africa Community and non-EAC countries regarding social security in Section 64. There are exemptions to compulsory membership under international conventions and for those not ordinarily resident in Kenya who are employed there for periods not exceeding three years at the first schedule of the National

Social Security Fund Act (2013), while leaving voluntary registration open to such exempt persons as well as those ordinarily resident in Kenya but employed abroad by a foreign employer; who are employed in Kenya by a person who is not an employer within the meaning of the Act; or who are citizens of Kenya who live and work outside Kenya (NSSF, 2014). Social security in Kenya is therefore inclusive of regular inbound migrant workers and outbound migrant workers. Despite this inclusive language, however, the National Social Protection Policy (2011) has insufficient provisions for non-citizens in terms of social security and health insurance, falling short of international and regional (EAC) standards (National Social Protection Policy, 2011). For example, the Work Injury Benefits Act (2007), which provides for compensation to employees for work-related injuries and diseases, is inclusive of regular migrant workers in the sense that it applies to "all employees" but it does not contain any provisions for the export of benefits, a crucial issue for migrants.

The Government of Kenya has chosen to build a lifecycle social protection system combining both contributory and non-contributory mechanisms. According to the National Social Protection Policy (2011) the three main pillars of this system are social assistance, social security, and health insurance, while the new Kenya Social Protection Policy (2019) is reportedly structured around four pillars: income security, health protection, shock responsive social protection and complementary initiatives (National Social Protection Policy, 2011). Four basic social protection guarantees that are to be established in law include income security for children, persons of active age, older persons, and access to essential health care and maternity care (Kenya Social Protection Sector Annual Report (2020)). According to Section 29 of the Kenya Employment Act (2007), female employees are entitled to three months (90 days) of fully paid maternity leave. The social protection schemes delivered at the national level are the focus of this analysis, although county governments have also initiated their own strategies and programmes (Kenya Social Protection Sector Annual Report (2020)). The extent to which migrants are covered by social protection measures depends on their status and the instrument.

Social assistance schemes encompass cash transfer programmes, school feeding programmes, general food distribution in emergencies, food for assets, access to agricultural inputs, health voucher schemes, and HIV and AIDS nutrition schemes. According to the Social Assistance Act (2013) of Kenya, only citizens meeting certain vulnerability criteria are eligible to receive social assistance. Naturalized citizens and internal migrants with Kenyan citizenship, therefore, have access to these schemes; one study noted that households in arid lands, which are predominantly pastoral, are three times more likely to receive social assistance compared with the rest of the country (Kenya Social Protection Sector Review, 2017). Social protection schemes in Kenya include pension schemes and employer-based occupational risk schemes. Current pension schemes consist of the National Social Security Fund (NSSF), which is a State contributory scheme mandatory for all employers and employees in the formal sector and open to voluntary membership. A member of the NSSF is entitled to an emigration benefit if they migrate from Kenya to another country without any intention of returning to reside in Kenya. If the country is one with which a reciprocal agreement has been made, the emigration is governed by such an agreement

(specific reference is made to East African Community (EAC) countries in the National Social Security Fund Act, 2013). In addition, there exists in Kenya the Civil Servants Pension Scheme, which is a non-contributory scheme administered by the Treasury for retired civil servants (and therefore likely excludes all non-citizens); and numerous private pension schemes (Kenya Social Protection Sector Annual Report, 2020).

Regarding labour rights in Kenya, the Constitution ensures protection from slavery, servitude and forced labour (Constitution of Kenya, 2010, Article 30). Freedom from slavery and servitude is also recognized as a non-derogable right and so is the reiteration that "every person has the right to fair labour practices" and that every worker has the right to "reasonable working conditions," (Constitution of Kenya, 2010, Articles 25 and 41 respectively). The principle of fair labour practices is reaffirmed in the Employment Act (2007) of Kenya. The act defines a "migrant worker" as "a person who migrates to Kenya with a view to being employed by an employer and includes any person regularly admitted as a migrant worker", states that the Act is applicable to these workers insofar as they are "employees", and prohibits discrimination on grounds of nationality, ethnic or social origin in matters of employment (including recruitment, terms and conditions, and termination as in Section 5(3)). The Employment (General) Rules (2014) further direct employers to put in place "policies which promote and guarantee equal opportunity in employment for all employees including migrant workers lawfully employed in Kenya" at regulation 4(b). While Kenya has not ratified ILO Convention no. 155 on Occupational Health and Safety, the Occupational Safety and Health Act (2007) establishes the duty of the occupier of a workplace to ensure the safety, health, and welfare at work of all persons working in their workplace. According to the Employment (General) Rules (2014), all employers must make medicine for the treatment of malaria, epsom salts, a solution of a recognized antiseptic and a first aid kit available at the workplace. As these provisions apply to all workplaces ("any land, premises, location, vessel or thing, at, in, upon, or near which, a worker is, in the course of employment"), regular and internal migrant workers are covered. However, it is less clear to what extent this duty is enforced.

Rwanda social protection: The Rwanda Labour Law No. 66/2018 (2018) was ratified to comply with ILO convention. It obligates employers to legalize foreign workers to contribute to a social security benefits body in Rwanda, and Articles 56 to 61 provide entitlement to 12 weeks of paid maternity leave to female employees. However, the situation of social security for other types of migrants is not clear. While refugees in Rwanda enjoy a generally favourable protection environment, the poor situation of the refugee camps and lack of livelihood opportunities mean that most refugees are still highly dependent on humanitarian assistance to meet their basic needs like shelter, food, health, education, nutrition, and energy for cooking. Access to core protection services such as registration, legal assistance, community-based protection, child protection, and support to persons with specific needs, including persons with disabilities, are the key protection priorities of the inter-agency response. The refugee response is based on a comprehensive approach to solutions, including socioeconomic integration, highlighting that refugees can contribute to the local economy, as well as complementary pathways and resettlement (Rwanda Country Refugee Response Plan, 2019–2020).

Refugees in Rwanda are granted the right to work, and the government has a policy of progressively integrating refugees into national systems for health and education. However, primary health care is provided in the camps by humanitarian staff, and refugees are sent to local health facilities for secondary and tertiary referrals. Rwanda Social Security Board is responsible to administer social security in the country. The branches currently managed include pension (old-age benefit; invalidity benefit – temporary or permanent incapacity; survivor's benefit – widow or children), occupational risks (work injury and occupational disease), health insurance (medical care; sickness benefit; maternity) and community-based health insurance (Mutuelle).

In terms of labour, the Constitution of the Republic of Rwanda guarantees the right of everyone, to free choice of employment and right "without any discrimination, to an equal pay for equal work" (Constitution of the Republic of Rwanda 2003, Article 30). The labour laws in Rwanda primarily use the term "employee"; "workers", referring to all workers. Most recent policies, such as the National Employment Policy and the National Youth Policy refer to migrants. Job creation as an aspiration is at the core of the transformation of Rwanda from a poor agrarian economy to a modern, prosperous, and skilled society. The recently Revised National Employment Policy (2019) has direct reference to: migrants; immigrants and emigrants, promoting employment of youth; women and persons with disabilities among others. This policy is in line with international, continental, and East African frameworks and commitments on labour.

Uganda social protection. The social protection in Uganda, in the form of pension sector comprises of; Public Service Pension Scheme (PSPS) which covers public servants (police, civil servants, the army, and local government employees), and the Uganda National Social Security Fund (1985) for private sector workers in companies with more than five employees. There also exist a few voluntary occupational schemes. The retirement benefits scheme in Uganda only offers basic mandatory benefits to members aged 50–55 years, deceased member's surviving family (spouse and children), invalidity (who can no longer be gainfully employed because of physical or mental incapacitation), and a minimum health-care insurance which are mainly accessible after retirement, death, loss of employment due to invalidity, and permanent emigration to another country. The situation of social security in Uganda in the specific case of migrants is not clear. According to Uganda Employment Act (2006), female employees are entitled to 60 working days of fully paid maternity leave. The compulsory leave is four weeks after childbirth or miscarriage. It includes at least four weeks after childbirth or miscarriage and may be extended by 20 working days under special circumstances. The pay during the leave period is financed by the employer as per section 56 of the Employment Act (2006) of Uganda. A male employee, after the birth of a child or miscarriage of a wife, is entitled to fully paid 4 working days of paternity leave in a year as per section 57 of the Employment Act (2006). Employers are also individually liable for the payment of compensation for the first month if the employee is incapable of work because of sickness or injury. The employee must provide a certificate of incapacity to work and duration of incapacity, signed by a qualified medical practitioner in section 55 of

the Uganda Employment Act (2006). However, if a worker's sickness continues after two months of sick leave, the employer is entitled to terminate the contract of the worker as per section 55 of the Employment Act (2006).

In relation to labour, the labour laws in Uganda like in Rwanda are migrant inclusive due to the primary use of the terms, "employee"; "workers", referring to all workers, etc. For example, most recent policies, such as the National Employment Policy (2019) for Uganda and the National Youth Policy (2001) refer to migrants in their advocacy for the creation of a supportive sociocultural, economic, and political environment that enables employment creation and socioeconomic development. Furthermore, Uganda regulations permit refugees to work cultivate land and move around freely; a right rarely granted to that extent in other countries of the first asylum, where the arrivals are typically viewed as competition for jobs and scarce resources. Table 13 summarizes the dynamics of social protection with reference to migrants in the four specified countries of East Africa.

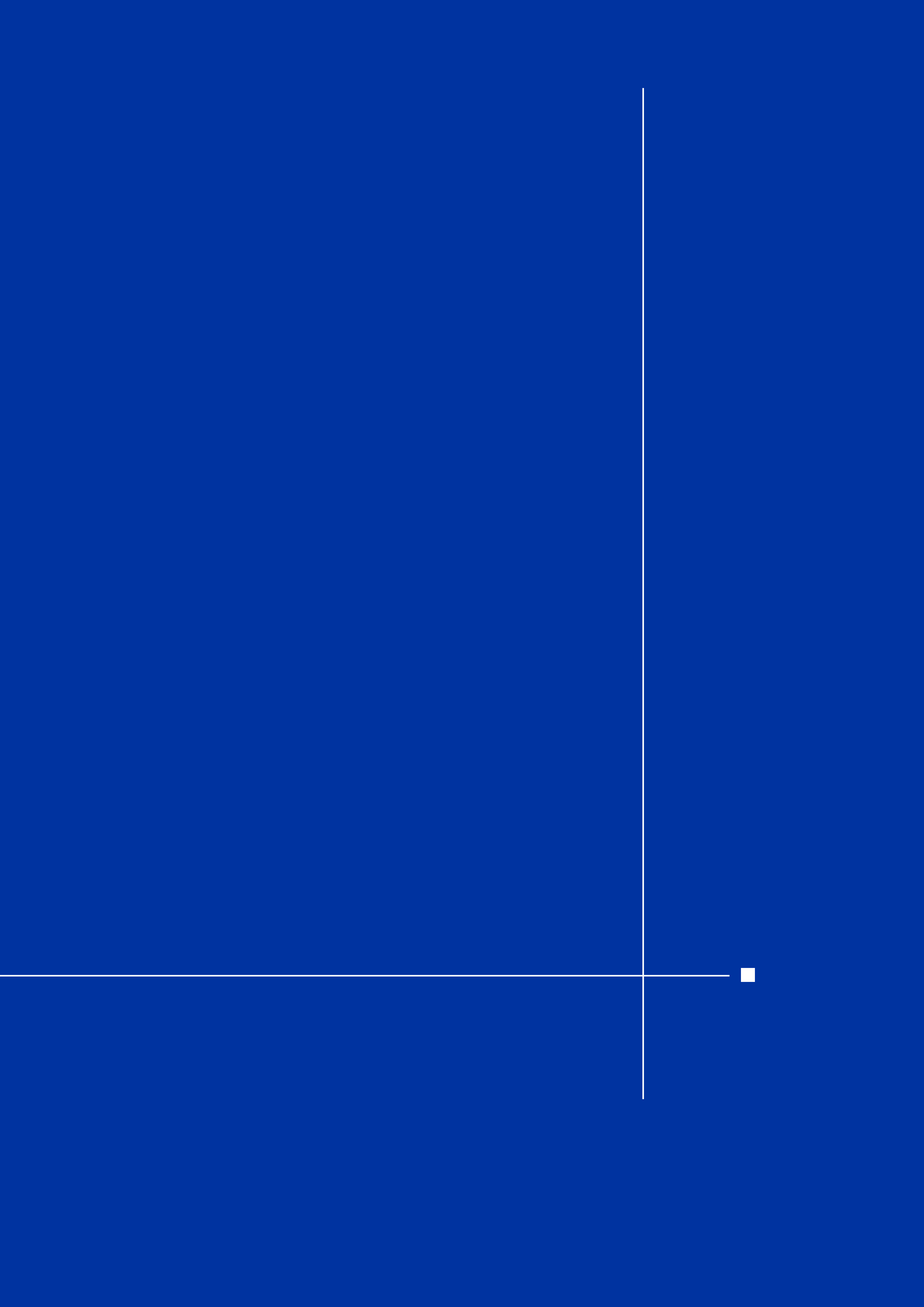
Table 13. Social protection for general migrant population

Country	Right to social security	Right to social protection	Right to work	Protect pregnant women		Migrants benefit from cash transfers	NSSF	Injury benefits/ sick leave	Working conditions	Annual leave	Pension	Equal pay for equal work	Equal opportunities
				Work place	Generally								
Burundi	Yes	Yes	Yes	Yes	Not clear	Yes	Yes	Not clear	Not clear	Not clear	Not clear	Not clear	Not clear
Kenya	Yes	Yes	Not clear	Yes	Not clear	Not clear	Yes	Yes	Not clear	Not clear	Not clear	Not clear	Not clear
Rwanda	Yes	Yes	Yes	Yes	Not clear	No	Not clear	Yes	Yes	Yes	Yes	Yes	Yes
Uganda	Yes	Yes	Yes	Yes	Not clear	Not clear	Yes	Yes	Not clear	Not clear	Not clear	Not clear	Not clear

Key

(teal)	Yes
(yellow)	No
(orange)	Not clear

Source: Authors own elaboration.



Uganda MHD H1 TB lab demonstration.
@IOM 2019/Richard M KAVUMA

PART V

Discussion

This review is summarized in three main thematic areas: health law, regulation and policies; migration law regulation and policy; social protection and labour laws, regulation and policies.

A. Health laws, regulations and policies

It is noted from the onset that not all health-related laws in the East African region referred to the general right to health care as should have been according to the right to health and social security enshrined in the Universal Declaration on Human Rights (United Nations General Assembly, 1948) at Articles 22 and 25. An example at hand was the Public Health Code, (1982) of Burundi. The Malaria Prevention Act (1983), Public Health Act (1986) and Prohibition of FGM Act (2011) in Kenya equally made no mention of the right to health care in general for both Kenyans and non-Kenyans. Most of the health-related laws had more references directed to health risks rather than rights. In the context of migration, the emphasis, therefore, seemed more on the implementation of certain international human rights provisions focusing on health security and cross border risk of imported diseases. Cross-border movements, inbound migration, and rural-urban migration were described in this context as a public health risk without offering measures to improve access to health care particularly when no specific health interventions were described.

Some health-related laws in the East African countries fell short of international standards in relation to provisions for specific groups, or specific measures as the Constitutions of the four East African countries seemed not to take into consideration the reference to the "right to the highest attainable standard of health." The Offer of Health Care and Services Code (2018) in Burundi for example considers specific groups but is not as extensive in its proscription for specific measures and has limited reference to specific health rights. The Health Policy (2016–2025) of Burundi reportedly draws on international instruments relevant to health subscribed to by Burundi but does not reflect in its text, for example, matters pertaining to migrant health. In the case of Kenya despite the domestication of international instruments into largely national laws with migrant-inclusive language, numerous

IOM health-care worker conducting health assessment to a beneficiary for travel assistance at an IOM Resettlement Clinic. © IOM 2015

health-related policies employ less-comprehensive interpretations and do not address the application of the right to health to particular groups as extensively or inclusively. In Kenya still, while other health-related policies adopted a broad definition of health and considered specific groups, they were still not as extensive in their proscription for specific measures.

Inconsistent use of language was another issue that stands out in our assessment. This made it unclear whether laws and policies on health were inclusive of migrants. This was an issue at the level of the national laws in the region with exception of Kenya. In Kenya, most of the related laws were nominally inclusive of regular migrants because they used inclusive language (such as "all persons" or "every person") or were specific about their scope of application; however, language was more mixed up in policies. The terms "Kenyans", "citizens", and "all people" were sometimes used interchangeably, in addition to broad and ill-defined terms such as "vulnerable", "marginalized", "hard-to-reach" or "at risk" populations. Because these terms are broad and vague, they could be interpreted in different ways and could potentially lead to the exclusion of migrants. This presented missed opportunity to interpret laws' inclusive language in a way that could be operationalized through policies, strategies, and plans in ways beneficial to migrants. It was also unclear whether non-citizens had equal rights and were included in health-related policies because terms such as "different social minorities" and "those who are most vulnerable or marginalized" were not defined in some countries (see Burundi Health Policy, 2016–2025). There was incongruence too in the language employed as was the case in Burundi with reference to the Offer of Health Care and Services Code, (2018). The incongruence was glaring between the principle of non-discrimination and the implied universality of the right to health care of "sick persons", and the stated right of "every citizen" – not every person – to access basic health-care services.

In Burundi, the inconsistent use of language and lack of standard definitions is evident as is seen in the use of the terms "*sinistré*", "indigent", and "marginalized" that are used differently depending on the instruments (especially in policies). Regarding *sinistrés*, the term designates all displaced, regrouped and dispersed persons and returnees (according to Protocol IV of the Arusha Accords), while subsequent legislation expands this term to include "the repatriated, the displaced, the regrouped, or dispersed, the widow, the orphan" affected by conflict in

East African Technical Working Group to discuss Risk Communication and Community Engagement Activities in IOM Regional Office in Nairobi. © IOM 2020

Burundi since independence. Vision Burundi 2025 meanwhile refers to the protection and reintegration of *sinistrés*, comprising street children, demobilized persons, retired persons and other older persons. Regarding "indigent", "vulnerable" and "marginalized" persons, no systematic classification of Burundi's population based on its socioeconomic situation and purchasing powers has been undertaken, which has resulted in a variety of entities and programmes targeting different categories of the population with no coherence or coordination. This inconsistency is also reflected in the absence of reliable data on different populations and their coverage by health or social protection schemes. Consequently, non-Burundian migrants are likely excluded from several free health services and national health programmes. Even though the vulnerability of migrants is recognized in several policies, there are no national health schemes in place catering to their needs, and it is unclear whether migrants are included in general health-related laws and policies. The absence of a targeted scheme makes it even more likely that migrants will fall through the cracks in terms of access to health care. This is especially the case for irregular migrants.

The sustainability of financing the health system is a central problem in the region as external funding is decreasing faster than domestic resources are increasing. Limited resources lead to making choices in terms of cost-efficient interventions and target populations for maximum impact on the health status of the population, but this situation represents a threat to maintaining the desired availability and quality of health services. Closely connected is the insufficient involvement of the private sector, and the need for strengthening health insurance schemes to ensure financial self-reliance on health services and reduce out-of-pocket health expenditure. This should help enhance regulations on the operational level for the management of maternity and child welfare, control of communicable diseases, and rural imbalances for example.

B. Migration laws, regulations and policies

The achievement of the free movement protocol embedded by all EAC State Partners allow citizens of EAC countries to move free among the EAC geographic area. While this is a paramount progress, the current migration governance framework in the East African region privileges security lens and efforts are underway to improve migration governance in general. In this regard, Kenya and Uganda have taken positive steps to develop migration governance framework by establishing the National Coordination Mechanism (NCM) on Migration and by developing national migration policies, labour migration policies, and labour migration bills. The NCM in Kenya, however, primarily focuses on outbound low-skilled labour migration to the Middle East and Gulf countries, and these draft policies and bills are yet to be adopted. While laws and policies that have a peripheral bearing on migrants' rights are more explicitly inclusive (social security and labour laws being more explicit about equality of treatment of regular migrant workers) or can be interpreted as such, existing migration laws tend to privilege a focus on security over rights and the existing policy framework for migration is relevant to outbound migrants only. The Burundi system exhibits a lack of legal and regulatory framework addressing *sinistrés* in particular

(even though there is, for example, a law pertaining to refugees and asylum-seekers). The existing legal and policy framework for *sinistrés* privileges resettlement and socioeconomic reintegration without mentioning health concerns specifically. Migration policies however are under development (the National Migration Policy and the Labour Migration Policy).

Whereas reference is made to migrants' rights, migration-related laws tend to be inconsistent in the extent to which they define the right to health care. The Prevention, Protection and Assistance to Internally Displaced Persons and Affected Communities Act (2012) in Kenya for example, does specifically refer to access to health care for IDPs, but the Kenya Citizenship and Immigration Act (2011), for example, refers only to the right to "social services and facilities" of permanent residents (excluding many other categories of migrants). The Kenya Citizens and Foreign Nationals Management Service Act (2011) does not mention migrants' rights at all. Burundi on its part has not ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, (United Nations General Assembly, 1990). Burundi has signed, but not ratified, the African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (African Union, 2009). The current migration governance framework privileges governing access to Burundi and the employment of foreign workers rather than addressing migrant workers' rights. Uganda has not yet ratified the United Nations Convention on the Reduction of Statelessness, (United Nations General Assembly, 1954). Rwanda and Uganda laws and policies relating to migrant groups other than refugees or asylum-seekers are rather fragmented. There is no comprehensive framework, law or migration policy that clearly establishes or defines the rights of such migrants in relation to access to all public social services, including health care, treatment and education.

Some laws are not aligned with the Constitution, which may have implications for migrants' access to health care. The Kenya Citizenship and Immigration Act (2011) for example provides that, a person born outside Kenya shall be a citizen by birth if on the date of birth that person's mother or father was or is a citizen by birth (not a citizen by registration). This is contrary to the Constitution, which does not distinguish between the parent(s) being a citizen by birth or registration. The consequences of this for the eligibility of certain migrants (such as stateless persons and the descendants of migrants) to apply for citizenship or permanent residence is unclear. It may also have implications for their ability to access health care (particularly through social assistance schemes, for which only citizens are eligible).

The case of Uganda demonstrates a lack of information on monitoring the labour market's demand for immigration, as Uganda does not publish occupational-shortage lists. Foreign students too are not permitted to undertake employment in Uganda during their studies and there are no clear procedures to obtain a work permit after graduation. Investment in skills and vocational training are essential to improving the employability of refugees and nationals and this will require a concerted effort in the region. Focused attention is also needed to address gender-based discrimination in accessing land, credit, input and output markets, and employment opportunities for all including migrants.

C. Social protection and labour laws, regulations and policies

The provision of social protection in East Africa exhibits fragmentation. Many different public and private entities are involved in social protection, which may lead to duplication and inconsistencies in the implementation of social protection interventions. In Kenya, employers are individually liable for sickness, maternity, medical, and occupational injury, and disease benefits (in addition to contributing to one or more retirement schemes (Employment Act, 2007), which raises concerns about negative hiring practices (e.g. discrimination against women likely to request maternity leave or candidates with adverse medical histories). Social security and health insurance schemes are not currently harmonized (i.e. medical and dependants' benefits are separate, and there is not one unified registry or database of contributors, beneficiaries, and employers). This lack of coordination likely makes it more difficult to ensure coverage and maintain the social security rights of migrants. The National Social Protection Policy (2011) noted that there is indeed insufficient provision for non-citizens in terms of social security and health insurance, falling short of international and regional (EAC) standards. Burundi too is characterised by a fragmented provision of social protection with a weak institutional framework, since the powers of the various ministries overlap and the social protection activities are run in parallel with state activities, development partners, and civil society organizations. This lack of coordination translates into the fragmentation of funding leading to both duplication and coverage gaps resulting in either partial coverage or prohibitively high co-payments.

Although laws regarding social security are generally more explicit about the right to equality of treatment for regular migrant workers, often it is not clear to what extent the export of benefits is possible. Kenya for example lacks bilateral, regional, or multilateral agreements in place to facilitate the transferability and portability of social security benefits. In addition, national legislation is often silent on this matter. The Work Injury Benefits Act (2007) in Kenya, does not mention export of benefits. Even though a regular migrant worker would be covered in Kenya, they may not be entitled to continue receiving benefits if they return to their country of origin. It is also unclear whether a former migrant worker who is diagnosed with a disease they contracted while they were employed in Kenya could apply for compensation from abroad (considering also that claims need to be lodged within 12 months of injury or diagnosis). For Burundi, the law situation regarding social security is dire. Burundi has not ratified ILO conventions pertaining to social security (ILO, 1952) (C102, C118, C121, C128, C130, C157, C183) and others which are particularly relevant to migrants (C97, C143 and C189), which consequently make it more difficult to harmonize social security systems with other countries hence potentially impacts outbound and inbound migrant workers negatively. Most workers in Burundi serve in the informal economy (World Bank, 2020), a sector experiencing low social protection coverage and workers are generally less protected in labour legislation, particularly migrant workers. The Labour Code does not contain specific provisions protecting informal and daily workers, and there do not seem to be other laws that cover this underserved population. Equally, Burundi has not ratified the Occupational Safety and Health Convention (ILO,

1981) number 155 while its provision for migrant workers in the Social Security Code and the Labour Code is ambiguous. It is indeed therefore not clear to what extent the export of benefits is possible under the former, and the conditions attached to sickness and maternity benefits (e.g. the minimum required length of service) under the latter. It must be pointed out that not all national laws in East Africa that are potentially relevant to social protection refer to it. For example, the Persons with Disabilities Act (2003) in Kenya makes no specific reference to the right of persons with disabilities to non-discrimination in social security (including health insurance), even though other laws do clearly refer to this right (such as the HIV and AIDS Prevention and Control Act (2006) and the Cancer Prevention and Control Act (2012)). The Merchant Shipping Act (2009) likewise makes no specific mention of social protection for seafarers.

There is low coverage of workers in the informal economy, and migrant workers are at a particular disadvantage. Contributory schemes like those proposed by the NSSF and NHIF in Kenya have traditionally favoured formal sector employees and salaried workers. Although both funds have taken steps to increase the enrolment of members in the informal economy, the effective coverage is still low because workers may have incomes that are too low or too irregular to keep up with consistent payments required by these schemes. Access among those in the informal economy to health insurance benefits can therefore only be achieved if the government subsidizes or pays the contributions of those on low incomes. Several schemes have been launched to this effect, but since they match health insurance with social assistance programmes, inbound migrants are automatically excluded because only citizens are eligible for such support (Social Assistance Act, 2013). Certain jobs in the informal sector may also fall outside the scope of occupational health and safety rules, including employer liability for injury, which may have a disproportionate impact on migrants if they are overrepresented among such occupations. The Social Security Code and Labour Code only apply to foreign workers who have a contract. Social security has little coverage, especially for retirement and professional risks schemes are a privilege for precisely those who have the privilege to access employment in the formal sector. With no sanctions or monitoring system in place, decisions relating to social security are left to private sector employers to either affiliate their employees to health insurance schemes or pay directly for health care and sickness/maternity benefits by themselves. This may result in coverage gaps if the employer ignores this legal obligation. Insufficient benefits for many, see these employees finding themselves pushed to subscribe to a self-sponsored health insurance, which they may afford to sustain.

Minimum time requirements may negatively impact migrants. For example, the Employment Act (2007) provides for sick leave only after two consecutive months of service. The same Act only allows for a casual worker's contract to be converted into a term contract if they have worked a certain number of days. This requirement could still negatively impact migrant seasonal workers and casual workers (including day labourers) who work less than the prescribed number of days, as well as workers in the informal economy. Non-contributory social security schemes have gaps, which may render them less effective. All in all, the existence of additional costs linked to transport and certain medications continue

to be obstacles to making free health care for pregnant women and children under five a reality, particularly among migrants who are often vulnerable. This is further aggravated by the lack of adequate social assistance programme, as well as the lack of key indicators on migration and development, migration and health, migration census, demography, and migration and labour surveys. Table 14 provides a summary of access to health-related services by migrants in the East African region.

Table 14. Access to health-care services for migrant populations in the East African Region

Country	Have access to universal health care (regular)	Have access to universal health care (irregular)	Government financial health science	Receive help through IOM (regular)	Receive help through IOM (irregular)	Receive help through IOM (general)	Access to emergency health care	Access to maternal health care	Access to HIV treatment
Burundi	No	No	Not clear	No	No	Yes	Yes	No	No
Kenya	Yes	No	No	No	No	No	Yes	No	No
Rwanda	Yes	No	Yes	No	No	No	Yes	Yes	Yes
Uganda	Yes	No	Not clear	No	No	No	Yes	Yes	Yes

Key

Colour	Meaning
(teal)	Yes
(yellow)	No
(orange)	Not clear

Source: Authors own elaboration.

Community Engagement meeting at the IOM Resettlement Clinic in Kenya. @IOM Kenya

PART VI

Conclusion and recommendations

Although these countries have made significant progress in domesticating international and regional instruments aimed at protecting the rights of migrants, a careful consideration of opportunities and gaps in this review reveals major limitations with reference to migrants' access to health care. The domesticated laws and policies on health care, migration, social and labour in combination, do not effectively address the rights of migrants' access to health care and treatment. In the sustainability lenses of health system financing, considering that no one country had met the threshold of Abuja declaration to invest 15 per cent of GDP in health system and for a region highly dependent on external funding, that is decreasing faster than the commitment to increasing internal resources, the advancement of the migrant health-care access deserves international attention. This study does not include an analysis of practices in this area and more research is required to assess how laws are translated into practice. An identification of good practices could facilitate and guide the revision of laws and policies where necessary.

Recommendations

Based on findings from this review, key recommendations include:

- Revision and development of regulations of cross-cutting national laws and policies on health, migration and labour to reflect international and regional legal instruments that provide guidance on institutionalization of access to health care and treatment for migrants, including use of specific reference to "migrants" for all associated rights and obligations.
- Assess practices and identify case studies to advance the right to health for migrants to guide the policy revision.
- Continue and sustain advocacy dialogue for increased national resource allocation to health for sustained health system financing for affordable high-quality health care "for everyone" that shall also ensures migrants' access to health care.
- Facilitate a desk review of successful health financing scheme for migrants and provide a guidance for strengthening a regional mechanism for health financing across borders
- Make use of migration coordination forum such as RCPs and NCMs to expand health rights for all into migration initiatives. This implies strengthen national and inter-country coordination, networking and information-sharing toward a regionalization of migration health on policy development, governance, and data collection including a structured monitoring mechanism for the implementation of migration health policies.
- Enhance the engagement of continental institutions (e.g. AUC, WHO-AFRO), Regional Economic Commission (e.g. IGAD, EAC) to:
  - Develop a continental and/or regional framework on migration health to enhance policy coherence and regional consensus on priority actions related to migrant.
  - Foster reciprocal agreements and coordination with EAC and non-EAC countries and IGAD and non IGAD countries regarding social security across borders in support of regional integration and free movement of person in EAC countries.
  - Consider to identify a financing mechanism across-border and equitable cost-sharing mechanisms to address health coverage for migrants also in the respect of free movement protocol and regional integration.

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