Health, HIV/AIDS and Migrants
CARAM ASIA
Presented by Valentina Soe, at the IMA Founding Assembly,
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1.0 Introduction

Migration has become a key facet of today's world. Migrants living outside of their country of birth are 191 million persons (international migration 2006, UN department of Economic and Social Affairs, population division (www.unpopulation.org). Trans-border migration has always been a part of human history. What makes today's international migration different is both its unprecedented velocity of movement at so many different points around the globe and the complexity of attending factors such as states' sovereignty, universalities of human/labor rights, and vested interests of different groups involved in migration processes. There are two forms of migration; "forced migration" - fleeing from persecution and for security reasons (including internally displaced persons or refugees, victims of forced relocation for development projects, famine, natural disaster, and/or armed conflicts) and "voluntary migration" - seeking greater economic betterment. Difficulty in distinguishing between forced migrants and voluntary migrants is one of the intricacies in contemporary migration. [1] For far too many, particularly the ones from the developing world, migration becomes a survival necessity rather than a choice.

Migration is a by-product of rapid economic and political globalisation. It occurs under circumstances of poverty, unemployment, underemployment, economic and political instability, landlessness or the deterioration of the environment.[2] These circumstances are perpetuated in the countries of the global south by a persistent push from entities that are ardent advocates of globalisation and the continued adoption of neo-liberal policies. At the global level, the policy debate concentrates on the maximisation of the linkages between migration and economic development. Increasingly, governments are using remittances stemmed from migration as an instrument to generate foreign exchange and to alleviate poverty. Attempts to juxtapose the benefits of remittances against the losses that the poor countries suffer from large-scale skill emigration have added to the intensity of the debate.[3]

However, the health right and well-being of migrants and the overall social cost of migration are overlooked by policies and programme that are related to the processes of migration. Health status of migrants being one of the tangible indicators of migrants' wellbeing, CARAM Asia ensures to use the lens of health in analysing the international labour migration. Regrettably a discussion on health of migrants does not gain worthwhile attention in the present discourse on globalisation and labour migration. Further, the existing key stakeholders concerning health issues of migrants restrict themselves to look the health issue through a conventional medial paradigm. The failure to integrate the greater social, cultural, political and economic factors impacting on the health of migrants leads to a popular, yet distorted, belief that migrant populations are vectors of grave diseases. Such a

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[1] P.Wickramasekera, 2001, "Asian Labour Migration: Issues and Challenges in an Era Globalization," ILO, p.2.
[2] Nova Nelson, CARAM Asia's presentation at the Consultation with the UNSR on VAW 2007
[3] IOM, 2006, Remittance myth and reality.

misguided notion gives rise to the establishment of policies and programmes that use health as one of the criteria for immigration decisions.

The overall structure of cyclical short-term migration and its recruitment system view migrants as commodities, not as human beings with social needs. The labour recruitment system is only concerned about the profits reaped from migrants. These recruitment agencies are given a mandate to conduct pre-entry and on-arrival health testing with private clinics. Without an efficient government monitoring system in place, the link between granting a work visa and the compulsory health testing of migrant workers has become a money making tool for recruitment agents and testing facilities.

1.1 Overview of the state of health of migrants

For migrants, health is their wealth as they cannot afford to be ill or injured as well as do not have financial resources for required treatment. Being a migrant in and of itself does not make him/her to be more prone to sickness. However there are a myriad of tangible and intangible factors that jeopardise the health and well-being of migrants. These are: living, working, and psycho-social conditions.

1.2 Living Conditions

Living conditions of migrants in many destination countries often reflect an existence of relative poverty, as the migrant worker earns depressed wages lower than that of most locals. Poorly ventilated, overcrowded housing and a lack of nutritious food quickly result in the rapid deterioration of a migrant worker's health. Most migrants are on the mission of saving the last penny to send home. For instance, in Malaysia, some companies required migrants to buy food from the company canteen which is relatively more expensive than outside. Migrants ended up skipping the meal at work.[4] When food is being provided, there is a deficit in the amount and quality of food, which is a most reported complain of many domestic workers. Especially for women domestic workers (DWs) who live in the house of their employer, they encounter substandard living conditions. Series of studies on the living conditions of DWs have shown that generally speaking, with the expectation of lucky ones, who are permitted to share the room with the children of their employers, DWs do not have a private room, are made to sleep in kitchen areas, or common living room areas. In extreme cases, DWs sleep in a room build near the roof of the house without fan or proper air circulation resulting in chronic respiratory related illness. [5]

1.3 Working Conditions

Migrants the majority of them are employed in high risk, low pay, and labour intensive sectors of countries' economies (mining, plantation, sea food processing zones, agriculture, and domestic work). These occupations are not only characterised by their precariousness and substandard working conditions, but also they are usually excluded from labour protection laws and policies. The risky workplaces compounded with a lack of labour rights protections render migrants more vulnerable to occupational injury. The risk of occupational injury is also increased by lack of proper training, language barriers, and lack of familiarity with modern machineries. [6] Further, the emerging problem of sub-contracting short-termed

[4] CARAM Asia, SOH Report 2005, Chp:1, p.21
[5] Iibd, p.22
[6] CARAM Asia , SOH Report 2005, Chp: 1, p 22.

labour make more difficult for migrants to claim compensation when they are injured at work place. The employer's responsibility for workplace injury compensation is being transferred to the broker who sub-contracted the worker.

Work related stress takes the toll onto migrant's health both physically and mentally. The uncertainties posed by being a migrant workers- fear of being deported, sexual abuses for women migrants, being away from home and support system, financial insecurities, and becoming sick- are source of extreme anxiety. For example, the studies done by Human Rights Watch suggested that the following extreme cases are a manifestation of the desperate situation of FDWs.

> *Between 1999 and 2005, at least 147 migrant domestic workers died from workplace accidents or suicide, most by jumping or falling from residential buildings.*
> http://hrw.org/reports/2005/singapore1205/1.htm

1.4 Psycho-social conditions

Migration process is difficult and risky. By and large, migrants are healthy as they are required to mandatorily test all possible type of illness at the pre-departure stage. However, adjusting into a new country and being expose to new environment-- weather and food, without having a support from family and friends, migrants find it harder to maintain a healthy life. With regards to sexual health of migrants, their sexual needs do not disappear as they enter into a new country. It is unreasonable of the States to impose single-sex entry policy and restriction on marriage as part of their immigration regulations. The single sex policy requires migrants to come in without their partners and spouses. Again, such policy looks at migrants as commodity rather than see them as human beings with basic human needs and drives. Migrants, ones that are required to be single in the countries of destination may form new sexual relationship out of loneliness and need for intimacy, and may visit sex workers. Unless accesses to health information and protection methods (condoms, contraceptives) are properly given, health problem can occur. Those who come from rural areas are most likely to be unaware about safe sex practices; therefore it is necessary to understand the state of health of migrants by including both tangible and intangible factors. The current model adopted in many destination countries regarding the health of migrants is a surveillance, which strengthens to the belief of migrants are vector of diseases and they are the ones to blame for all social ill in destination countries.

Media is another institution that perpetuates such a distorted notion. In the case of Malaysia, when the statistics of the number of migrants deported for communicable diseases was published in 2001, it was portrayed in an alarming manner. Instead of giving the percentage of migrants who were sent back for their illnesses, the media released the actual number of migrants (around 10,000), making it sounds far too concerning. In fact, only 2% of the 500,000 migrants tested were infected. [7]

1.5 Vulnerability to HIV-AIDS

Migrating from one country to another can be physically, mentally and emotionally exhausting. Migrant workers must cope with and adapt to a different sociocultural context. Migrant workers quickly observe and possibly absorb new patterns of behaviour and belief

[7] Excerpted from a presentation given at National Consultation on Foreign Domestic Workers in Malaysia 2002, organised by Tenaganita

systems – a process that can occur rapidly given that previous community controls no longer exist in their new environment. Away from home, migrant workers are able to 'try on' new cultural and sexual identities. While exciting, this too can be overwhelming and can potentially comprise migrant workers health if they are unable to access preventative health information on HIV/AIDS and STIs and health care services in the event they become ill. It is also normal to desire to have sexual needs met. Individuals who previously met these human needs are no longer available. As a consequence, migrant workers seek out and establish new social relationships with others, which sometimes become sexually intimate. The majority of migrant workers are between the ages of 25 and 45 and in the prime of their reproductive health. Many are single and encountering an environment where they are relatively free from the normative social constraints in place at home. National governments unfortunately tend to ignore the fact that migrant workers are humans with needs for intimacy; instead they strictly regard them from an economic vantage point, as a cheap source of labour to be sent back home once their contracts are finished. Stakeholders involved in developing and implementing national laws, policies and programmes on migration rarely tackle issues of gender equality and empowerment, lack of access to reproductive and sexual information and services, limited access to condoms, and the motivations behind risk taking behaviours.[8]

HIV is a communicable disease; but it is only transmitted through direct contact via particular behaviours, such as sexual intercourse, sharing of intravenous needles, and transferring of bodily fluid. It is not transmitted through causal or indirect contact. The spread of its virus can easily be prevented through ensuring certain measures. Even people living with HIV can live healthy and productive lives. [9]

To encapsulate, the governments and stakeholders involved in the migration processes do not address the lack of conditions important to sustaining a healthy life, like access to HIV prevention and care programmes, protection measures, and counselling services. These deficits unnecessarily jeopardise migrants' health and wellbeing.

2.0 Health is a right not an instrument for border control

Using health as criteria instruments of determining fitness for the acceptance of new immigrants is nothing new. By the 19th Century it could find evidence of the use of medical fitness in deciding the intake of new immigrants in the Americas.[10] Even in the dawn of 21th century, despite the gains made for the advancement of human rights for all globally, many States still use mandatory health testing practice as part and parcel of their immigration policies.

The compulsory health examination procedures are discriminatory and come into existence due to the xenophobia of destination countries. Even from the public health perspective, such policy does not serve the purpose of protecting the public health as in some destination countries, like in Malaysia, this policy only applies to "low- and semi-skilled" workers. In the case of HIV there is the additional blow to the individual of finding out about the disease in an environment where the immigration process rather than health is the primary concern. In any context, compulsory health screening poses a danger of creating an environment in which individuals seek to escape immigration controls, rather than

[8] CARAM Asia, SOH Report, 2005
[9] CARAM Asia, SOH 2007, p.6
[10] MacPherson, Douglas W., 2004, *Irregular migration and health.*

present themselves and remain within the system. Fearful of being refused entry (in the case of pre-entry controls) or deported (if tested on entry), those with infectious diseases are consequently forced underground without treatment. [11]

Although mobile populations are considered a high risk group, health testing and deportation of migrants does not guarantee in any way a reduction to public health risks. To their detriment, in the event of migrants are sick, they would not seek for medical attention. The way in which such examination are conducted violate migrants rights and are in violation of the international standards set out by UNAIDS and WHO. Moreover, this contravenes international guidelines and national laws on HIV testing, becoming totally disregarding for the established best practices of consent, confidentiality, and counselling.[12]

3.0 Women, migration, and health

The feminization of labour migration in Asia has taken on a more predominant turn in the beginning of the 90's. In 1976, women migrants from Asia accounted for 15% of the migrant labour force; in 1987, 27%; and in 2000, 47.5% (CARAM-Asia, 2004). In Sri Lanka alone, 80-90% of migrant workers are women; in the Philippines, 64% of new hires are women, while in Indonesia, female migrants comprise over 70% of total migrants. Why do women migrate?[13] There are various push and pull factors that facilitate the movement of women:

3.1 Political and economical factors

Push factors include landlessness, domestic or community conflicts, labour "export" policies adopted by many developing countries, low and variable agriculture productivity, and natural calamities, among others. Women in these economies are often the hardest hit because of their low status, illiteracy and political disempowerment. With decreasing opportunities and choices for women, migration has become a means of survival rather than an option. With a shift in demographic, women's economic participation have increased worldwide. In destination countries more and more women partake in professional careers but the domestic activities remain to be a feminine responsibility.[14]

The traditional ways of taking care of the elderly and the children by family networks are disappearing especially in many middle income countries in Asia (Malaysia and Singapore). The hiring of female migrant domestic workers has become a cheap solution for this private and public problem. As some social scientists now even consider 'domestic and care work' as the contemporary raw material extracted from less developed countries, as resources such as gold, silver and rubber used to be in the past [15].

3.2 Social and cultural factors

Women's ascribed traditional role in society is reproduced even in the migration sphere. Women migrants are largely concentrated in reproductive work such as domestic work, child rearing and care giving, which are part of the informal sector of many receiving countries.

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[11] MacPherson, Douglas W., 2004, *Irregular migration and health.*
[12] CARAM Asia, SOH, Policy Paper on Mandatory Testing
[13] Marin and Quesada, 2002
[14] CARAM-Asia, Campaign Toolkit, 2007.
[15] Hochschild, 2002

Because this work is not recognized as paid and productive work, women migrants are predisposed to abuses, exploitation and health vulnerabilities[16].

3.3 Occupational health

Female migrant workers face intersectional discrimination of class, race, religion, and gender due to statelessness or their irregular status. As majority of women migrants are employed in informal sectors as domestic workers, sex workers, vendors, and sweat shop workers. Working in such sector predisposes women migrants to various occupational health hazards. Migrant workers take up long hours and heavy workloads leading to poor health outcome. The workloads of average domestic workers serve as evidence for migrant's working conditions. FDWs do not have a proper job description, they are on call for 24 hrs; even at nights, and domestic workers are required to care for infants, the elderly, and the sick. There have been cases reported that a domestic worker is shared by two different families requiring her to work for both houses with a single payment. [17]

Extensive studies done by various migrant support groups have shown that FDWs are not given sufficient amounts of food, hygienic living and working conditions, privacy, or security. Some are only allowed to eat dry noodles for every meal, and made to work 10-14 hours a day, 7 days a week (except in HK) without any time off or overtime pay. [18] Diet is essential for health, just as mental well-being and a sense of security are critical for overall mental health. It is conventional knowledge that the staple meal of a FDW is left-overs from the employer and his/her family. In such situation, the improper intake of nutrition on a regular basis leads FDWs to be predisposed to a weakened condition and their immunity is bound to be decreased. It is far too common to find FDWs who have chronic anaemia resulted from lack of sufficient foods and overloaded working hours. Substandard nutritional intake and inconsistent eating patterns are contributors to a common sickness of indigestion among the FDWs that interviewed by GAATW. [19]

Women migrants that are employed in factories are not given a sufficient amount of time to use the rest room leading to a prevalence of UTIs among women migrant factory workers. It was reported that the worst things about factory work were the long hours, low pay, and substandard working conditions (poor air circulation). Those who work in the entertainment industry are prone to many forms of violence, perpetrated by clients as well as their employers. Fearful of being arrested by the police, sex workers do not report cases of mistreatment and violence against them. As they work in a sector that has no protection mechanism due to their undocumented status and legally unprotected occupation, it is almost impossible for them to make claims for justice. [20]

Thus, for women migrants who work in unprotected sectors, the likelihood of them getting sick is higher; with overwork and a lack of rest becoming contributing factors. Also, the mental stress of losing a job, not being able to contact their families back home, and fear of abuse from employers, FDWs are prone to psychosomatic diseases such as insomnia, anxiety, and depression. [21]

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[16] Marin and Quesada, 2002
[17] CARAM Asia, *Foreign Domestic Workers Campaign Paper*, 2007.
[18] Ehrenreich & Hochschild, *Global Women*: Nannies, maids, sex workers in New Economy, 2003
[19] GAATW, 2007, Women Mobility and Reproductive Health Report
[20] Ibid

[21] CARAM Asia, FDW Campaign Paper, 2007

3.4 Vulnerability to HIV/AIDS

Women migrants' sexual and reproductive health is often render vulnerable by their living and working condition abroad. Most of these migrants are from the reproductive ages of 15-35. The research done by one of the CARAM Asia members stated that the age of first time departing migrants as one of the factors of their HIV/AIDS vulnerability. [22] Being confined in a place where they work or being excluded from the formally protected occupations, women migrants are at the mercy of their male employers who may expect and force them to have sexual relations with them. Apart from vulnerability that women face in a state of isolation, and that also impedes them from accessing to crucial health and preventative information. In the case of Thailand, owing to the isolated working place, the awareness of FDWs on sexual and reproductive health is strikingly less than those who work in factories. [23] Even in a consensual relationship, they remain vulnerable to HIV and STIs as they tend to have minimum access to information on sexual and reproductive health. In addition, owing to the power differential, women migrants do not have negotiation power to demand protective sex. Women migrants who work in factories shared their experiences of drawing strength from their peers as they face health problems. That is the similar case for sex workers who work in brothels as opposed to individual streetwalkers. Similarly, FDWs are individualised in their workplace without any peers support.[24]

Although condoms play an important role in HIV prevention, migrant women may have less access to preventive messages, because – the methods used do not reach them-– there are language barriers, they may not have the resources to purchase appropriate contraception that protects them against STIs and HIV. STIs make women more vulnerable for contracting HIV, which is why it is even more important to quickly treat a suspected STI.[25]

4.0 Access to health care and treatment

Lack of access to health care is a perennial problem in migrant populations. Owing to a variety of situations ranging from lack of financial means to language barrier, migrants in general tend to endure the illness until it comes out of control. Coming from financially difficult circumstance, migrants generally have tendency for poor health seeking behaviour. For instance the Malaysian Double Fee policy (foreigners in Malaysia are required to pay twice as much as locals) further marginalise migrants' access to health care and treatment. Migrants as a group already earn depressed wages than the locals, the higher cost of health care increases their inability to seek medical attention.[26]

Often it is also the indifference of the employer and States' healthcare system to the specific vulnerability of migrants to better health. Migrants who do not have documents are worst off because in some hospitals in Thailand for them to access to healthcare, they have

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[22] CARAM ASIA REPORT 2002, Regional Summit on the Foreign Domestic Workers

[23] GAATW, 2007,Women Mobility and Reproductive Health Report
[24] CARAM Asia, SOH Report, 2005.
[25] lbid
[26] lbid

to produce appropriate documents. In principle, the health right is universal and not depending on legal status of a person, the sad reality tells otherwise.

Foreign domestic workers who are denied a day off from work are less likely to seek medical treatment even when they are sick, or they are entirely dependent on the mercy of their employers who may, or may not, allow them to go for medical treatment. [27]

4.1 Barriers to access to health and information

The culture of silent around the sexual and reproductive health has disastrous consequences particularly for migrants who are overseas and far away from regular sex partner. Many migrants are ignorant of modes of diseases transmission and preventive measures. In reality, as shown in one of the FGDs during the PAR in Pakistan, male migrants were defensive and claimed that it is responsibility of women to know such information. Such attitude poses a real barrier to prevention.[28]

4.2 Pre-departure briefing

Despite in some origin countries such as Pakistan and Nepal the law dictates that potential migrant workers must go through a pre-departure briefing, though there is no health component requirement. Any health information delivered is usually not comprehensive and adequate. In Nepal experience has been a 15 minutes of official briefing done by authorities on the "dos and donts" in the destination countries. In both Vietnam and Cambodia, potential migrant workers are required to partake in pre-departure training, but no health information is provided. Fortunately, in both of these countries, NGOs, such as CARAM Cambodia and Mobility Research and Support Centre (CARAM Vietnam), have worked with these governments to assist in delivering information on HIV/AIDS and STIs. [29](CARAM SOH 2005, p 161-5)

In a positive move, the governments of Indonesia, Sri Lanka and the Philippines have included a health component in their pre-departure training programmes for potential migrant workers, but the training is far from ideal.[30] (CARAM ASIA: SOH 2005, p. 168)

4.3 Health Insurance

Ideally, comprehensive, affordable health insurance should be readily available for all migrant workers regardless of their documentation status. On the contrary, the process of calming health insurance is not straight forward. Some Indonesian migrant workers, who were made to pay for their own health care abroad, shared that they suspected their employers of taking their insurance claim money. Migrant workers from other countries also suspected their employers of doing the same thing.[31] One other distressing fact that found during focus groups with migrants is that migrant workers are minimally informed on health insurance matter and are not aware that they can claim for insurance amount in case of injury, disability or death.

[27] CARAM Asia, FDW Campaign Paper, 2007
[28] CARAM Asia, SOH Report, 2005
[29] lbid
[30] lbid
[31] ibid

4.4 Privatisation of health care system and private involvement

Privatisation of health fails to meet the needs of the marginalised and brings about negative health outcomes among migrant communities. Health systems both at sending and receiving countries are impacted by economic globalisation. Migrant communities trapped in resource poor settings at home and abroad are vulnerable to poor health outcomes. As the emphasis of health care shifts from public to that of profit centered private service migrant workers face serious lack of access to health care. [32]

4.5 Restriction on freedom of movement

There are certain laws in destination countries that are a serious detriment to migrant workers' access to health. Examples of this include laws that restrict migrant workers' freedom of movement. In the Republic of Korea 'running away' from a designated workplace is considered a criminal offence without 'justifiable reasons', and once found, migrant workers are subject to detention and deportation. In Bahrain, leaving an employer's residence is a criminal act for a domestic worker. The worker who runs away from abusive employer becomes undocumented migrant automatically. In the face of stringent immigration policies, it is very easy for workers to fall into undocumented category. In Saudi Arabia, a passport is not an acceptable form of identification; instead the government issued *iqama* is the identification document that all foreign workers in the kingdom are required to carry. Without this document, migrant workers have almost no freedom of movement, are subject to arrest at any time and cannot be admitted to hospitals for medical treatment. [33]

5.0 CARAM Asia's Responses

From its inception, CARAM Asia utilises Participatory Action Research (PAR) methodology to collect the issues of migrants and the outcomes from the researches are used for key regional for advocacy and capacity building activities aimed at creating a regional response to improving the health and wellbeing of migrants. PAR has been effective tool in developing information materials which empowers migrants to understand, provide solutions and gain control of their own situations. The real strength in PAR is that it is conducted *"by local communities for local communities"*.

Due to sustained advocacy efforts and community organising, a positive momentum at the policy level has begun. The push to remove HIV status as a barrier to get a travel visa and stay in a country has started. A comprehensive, multi-sector response, focusing on migrant workers' right to health, is called for. The agenda of CARAM Asia would involve: a challenge to the current paradigm of migrants' remittances as a tool for development; press on the social cost of migration; a move towards accessible, affordable and quality health care, counselling and legal services; confidentially of one's HIV status, including a challenge to mandatory HIV testing and deportation; protection against discrimination (including access to legal redress); the application of local labour laws to migrant workers and domestic workers; access to basic social security during employment; and the ratification of various

[32] Migration, Health and Globalisation Policy Paper, 2007
[33] CARAM Asia, SOH Report, 2005

international instruments that directly or indirectly address the protection of migrant workers.

Our on-going campaign, advocacy efforts, and work programmes are to ensure that the right to health of migrants is becoming an integral part of migration policies and programmes:

- Recognise Domestic Work as Work Campaign
- Participatory Action Research on the social cost of migration. This research is to examine the social cost and quality of life of migrant communities in countries with strong labour export policies, and provide alternatives to the current migration discourse which promotes remittances as a tool for development.
- Empowerment of migrants living with HIV-AIDS and spouses
- Removal of mandatory testing advocacy efforts
- Networking with groups that have shared goals and alliance building
- Supporting and fostering the spirit of solidarity among migrants' groups worldwide
- Engaging with other anti-globalisation, social movements on issues related to globalisation, trade, migration and health
- Joining the rights to redress campaign as well as cooperating with legal reform groups; in the absence of national law to protect domestic workers, their right to health cannot be guaranteed
- Policy advocacy including high level dialogues, sensitisation of health professionals on migrants issues, and targeting regional blocs such as ASEAN to include health protection elements for migrants in their protection frameworks
- Engagement with the media

The situation for migrants remains harsh. However, the level of resistance of migrants and their communities, and their commitment to fight for their rights, continues to increase. As we witness today at the founding assembly of IMA, migrants are speaking for themselves. The voices of migrants are no longer being represented by others; from now on they are representing their own voices and concerns. We shall continue to struggle with our sisters, domestic workers from other countries, so they too will to be able to speak up for themselves.

END.