

A REVIEW

OF HIV POLICY PROGRESSION
AND MIGRANTS' HEALTH RIGHTS IN

FIVE
ORIGIN
COUNTRIES



CARAM ASIA
TASK FORCE ON MIGRATION, HEALTH AND HIV



A REVIEW OF HIV POLICY PROGRESSION AND MIGRANTS' HEALTH RIGHTS IN FIVE ORIGIN COUNTRIES

CARAM ASIA

Task Force on Migration, Health and HIV





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A REVIEW OF HIV POLICY PROGRESSION AND MIGRANTS'
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01

INTRODUCTION

ASIA

Many countries in South and Southeast Asia are migrant-sending countries. These countries have growing populations of work-aged people entering the workforce with few or limited opportunities in the local job market. Labour exporting countries rely on policies which promote out-migration to relieve the pressure of under-employment. Simultaneously, the export of the surplus workforce provides considerable income to the countries' coffers through foreign exchange generated by migrants' remittances. The impetus of securing macro-benefits tends to drive migration policies, while considerations of migrants' rights are overlooked. In the rush of competing for market position, many countries are willing to compromise their nationals' rights by allowing or even facilitating their placement in countries which lack proper migrants' rights protections. While incidents of labour exploitation, physical abuse and trafficking are the most dramatic incidents, migrants' health rights are quietly being violated on a regular basis.

When a migrant is denied employment opportunities overseas because of a health condition, not only is it a great indignation, it is a great hardship. As job opportunities are difficult to find at home, many migrants take out loans beyond their means in order to work abroad. All their hopes ride on this opportunity. If it is taken away, it is not just them, but also their families that suffer. Yet, health is a right which should be provided in order to obtain opportunity, rather than used as a screening device to limit opportunity. While origin countries want to send as many migrants abroad as possible, they still abide by the demands of the destination countries, which translates to discriminatory health screening policies. In effect, a small number of people are sacrificed, usually those who come from a poor or rural background, have low education and limited skills beyond their manual labour.

While it is destination countries which impose migrant health policies that are considered insensitive or outright discriminatory, origin countries also bear a certain portion of the burden. As migration is a continuum, the health rights of migrants need to be considered and upheld at all stages of migration. This means health information and services need to be provided at the pre-departure stage (which includes the "contemplation" period before even deciding to migrate), in transit, upon arrival, on-site, upon return, and as part of reintegration. In many cases, this may require specialized services or policies. The difficulty is that when a migrant is in his or her home country, they are simply considered as any other civilian, even though they may have special needs as a pre-departure migrant, or having already gone abroad and returned. Countries of origin are also unwilling to negotiate too much with destination countries, such as the health testing issue, out of fear they will reduce quotas of migrants.

This study intends to provide a brief context of the current situation of migrants' health rights, primarily by looking at the progression of HIV and AIDS related policies and practices over time. HIV is considered an indicator because it is one of the most sensitive health conditions. As a treatable disease, considerations surrounding HIV extend beyond health and encompass social issues of stigma and discrimination. The aim of this study was to compile information to assess whether there had been any positive changes at the policy level in the protection of migrants' health rights, as well as to identify remaining obstacles in the protection of migrant's health rights, specifically as it concerns HIV.

METHODOLOGY

Member organizations from CARAM Asia in five origin countries, namely, Bangladesh, Cambodia, Pakistan, Philippines and Sri Lanka, undertook this brief research. The majority of the research was desk review of policies and statistics which were readily available, looking at: policies on migration, data on numbers of migrants abroad, National Health and HIV / AIDS Laws,

National HIV Strategy Plans, and data on HIV trends. This information was aimed at assessing whether policy changes had provided increased health rights protections for migrants over time or not, specifically with a focus on HIV prevention and care.

This was then followed up with interviews with policy makers and health service providers, as available, and focus group discussions (FGDs) with HIV positive migrants and HIV positive networks, to reflect on the reality of how these policies were being implemented and impacting migrants. It was not a rigorous research exercise.

Much of the evidence was self-evident, partly from previous research done by the partners and CARAM Asia, and there were limitations on time and availability of partners.

This was not an attempt to prove or repudiate the effectiveness of policies, but rather a cursory research aimed more or less at reviving advocacy on the issue of mandatory health and HIV testing of migrants. There is an analysis provided and recommendations which were primarily generated by migrants and HIV positive representatives, as well as reports from the five countries.

OBJECTIVES OF THE STUDY:

- To review HIV and AIDS related policies in 5 origin countries to identify new changes or remaining obstacles in protecting migrant's health rights;
- Explore impediments in access to HIV services for migrants.

THE COUNTRIES & PARTNER MEMBER ORGANIZATIONS WHICH UNDERTOOK THIS RESEARCH:

BANGLADESH :-
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CARAM Cambodia

PAKISTAN :-
SPEAK TRUST

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SRI LANKA :-
Community Development Services (CDS)

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REGIONAL ANALYSIS

ASIA

A BRIEF HISTORY OF HIV AND MIGRATION

HIV has shadowed migration since the late 80s. As people started migrating more for work, HIV started appearing in the countries of origin along with returned migrants. Although the act of migrating itself is not a risk factor contributing to HIV infection, the conditions surrounding migration contribute to an increased risk of transmission among those who do engage in risky behaviors. As a result, the first cases of HIV in Asian countries where there is significant out-migration were registered with returned migrants. Philippines, Bangladesh, Pakistan and Sri Lanka are notable in this respect. It is generally assumed that the primary route of transmission among migrants while abroad has been through sexual transmission. While in Cambodia, although HIV was not originally traced to migrants, a number of migrants' source communities were ravaged by AIDS during the peak of the epidemic.

It is notable that four of the five countries included in this study have had low-prevalence since the beginning of the global AIDS epidemic. Cambodia was the exception with one of the highest HIV prevalence in Asia, but has successfully reduced its rate of infection to the point where it is characterized as a "concentrated epidemic." Although some countries have had an aggressive stance on tackling HIV from the outset, such as Sri Lanka, other countries have had a mixed response, hindered by poor infrastructure and traditional values. While most of these countries have had low-prevalence for such a long time, complacency has set in. Now, some of the low-prevalence countries are seeing significant increases in HIV infections, including among migrants.

All five countries in the study have advanced their approach to HIV and AIDS at both a medical and policy level. Laws and programs have been introduced to promote HIV prevention, decrease stigma and discrimination, and to increase the general population's access to HIV related services, including testing and treatment. Notably, there are efforts to expand into rural communities where many migrants come from. Policies and laws are in place to protect confidentiality, protect from disclosure of HIV status, and prevent discrimination in employment or travel. There are still practical limitations though, and implementation of policies and enforcement of laws is inconsistent.

While migration has been one of the largest contributors to HIV prevalence in each country, to varying but significant degrees, the HIV response to migration has been mixed in each of these countries. Public awareness campaigns and the addition of HIV components to pre-departure programs have been limited in scope and success. HIV prevention messages are commonly over-simplified for convenience, rendering efforts ineffective. In other cases, the medium may not be adequate to give comprehensive information, for example, billboards in airports, or an hour long session in a pre-departure training for migrants.

One thing none of these countries have been able to conquer is the stigma surrounding HIV generally, and especially among those who migrated and returned with HIV. In some cases, migrants who have returned HIV positive have been shunned by their families, in other cases, they have been afraid or unable to face their families.

Especially in low-prevalence countries, historically, HIV has been associated as the “migrants’ disease.” Previously, migrant women who returned infected with HIV were especially stigmatized, as it was assumed that had been doing sex work. Now, many MSM migrants are returning home infected with HIV, forcing them to face not just HIV related stigma and discrimination, but also homophobia and possibly punishment under religious edicts. (CARAM Asia, 2015)

While migration has contributed to the HIV epidemics of the five countries studied here, the two policy areas of HIV and migration are disconnected. Although over time there have been increased initiatives on migration and on HIV, there seems to be little interaction between HIV and migration policies. When there are inter-disciplinary initiatives on migration - HIV is rarely identified as a key thematic; and, conversely, HIV initiatives rarely identify migrants as a key target group. In fact, migrants are generally relinquished to the second tier of the National HIV Response regardless of the percentage of the population infected with HIV that are migrants.



NATIONAL AIDS PLANS AND MIGRANTS

Migrants are often left out of National AIDS plans or are only identified as “vulnerable populations” or “bridging populations” rather than as a “Most at Risk Population.” While this follows suit with international delineations by UNAIDS, and is partly aimed at reducing stigmatization of labor migrants, the problem is that it translates to reduced funding for HIV programming targeting migrants and their communities, and dilutes related interventions and strategies. It also reduces migrants’ role in related HIV initiatives such as representation on national oversight or guidance bodies for HIV programs. While it is clear that the act of migration in and of itself does not increase the risk of HIV infection, there are behaviors which migrants engage in that puts them at risk of HIV. The determination of being a “vulnerable population” therefore limits the scope of the response reaching migrants and their communities who engage in these behaviors. This raises the question if there are other reasons beyond AIDS politics that governments have selected the “vulnerable population” classification and therefore muted the HIV response for migrants. In most of these countries, migrants are a significant percentage of total number of people infected with HIV, such as in Bangladesh (33 percent), Pakistan (41 percent in some localities), Philippines (12 percent) and Sri Lanka (53 percent). In some cases they are a sub-population of the largest group of new infections. The Philippines is an example, where MSM make up the significant majority of new infections nationally, and migrants are a portion of those reporting new infections among MSM (i.e. migrants who are MSM). In fact, of the migrants who were infected with HIV in 2016, approximately 68 percent identified having unprotected sex with other males as the route of transmission. It may be that there is political motivation for these countries to not draw attention to HIV infection among their migrant populations.

Migrants are commoditized by their governments, meaning that they are marketed as a valuable export which brings in considerable amounts of foreign exchange through remittances. Bangladesh, Pakistan and Philippines were ranked 5, 6 and 7 top countries with stock of emigrants abroad - with 7.6, 6.2 and 6.0 million migrants, respectively, abroad as of 2013. (KNOMAD 2016) In 2015, the top remittance receiving countries in Asia were as follows: Philippines - \$29.7 billion, Pakistan - \$20.1 billion, and Bangladesh - \$15.8 billion. ¹ Hundreds of thousands of migrants go overseas each year, easing the strains on the job market at home by decreasing the excess number of job seekers in a limited pool of job opportunity while contributing essential foreign reserves to the home country’s economy. In fact, globally, remittances, through foreign exchange earnings, now contribute three times as much to the national economy as compared to Official Development Aid (ODA) in most developing countries. In 2014, remittance flows contributed 431 billion USD globally, as compared to 135 billion USD in ODA. (KNOMAD 2016). Considering the numbers of migrants going abroad and the fact that migrants engage in risky behaviors which can lead to HIV infection while they are abroad, by ignoring migrants’ vulnerability, migrants become more vulnerable to HIV infection when they do engage in those behaviors.

¹ “Migration and remittances Factbook 2016 - Third Edition”, World Bank Group: KNOMAD, as accessed at www.knomad.org.

Most of those migrants will eventually return to their country of origin, and will require services, which will add to the burden of the response. So, the question is what response do these countries have in place to protect migrants from HIV in the first place? Many countries have integrated HIV awareness components into pre-departure trainings, the Philippines and Bangladesh are examples. However, the content and consistency of these programs varies greatly between countries, and sometimes even by providers within the country. Some countries, not necessarily the ones in this study, have encouraged migrants to trust in their religion or have urged their young women to be virtuous and resist temptations. Of course, the realities migrants face while abroad are not so straightforward or simple. There are complex human emotions and relations that many migrants are not prepared for, as it may be their first time out of the country, or even their community.

Dealing with loneliness or other emotions makes people vulnerable and impulsive. Some migrants leave home to be able to express their sexuality and sexual orientation more freely. Once abroad, they may experience new social settings they are unprepared for, such as the ability to more freely engage in relationships or have sex, especially men who may be gay but are unable to express their identity at home. At the same time, many migrants lack a basic understanding of diseases, the way they are transmitted or prevented, or the consequence of some diseases, such as HIV. Some countries have focused on the benefit of condoms in birth control, leaving those who migrate unaware of their ability to prevent HIV and STIs. (CARAM Asia, 2015) When they find themselves in these circumstances, migrants will be unprepared to protect themselves from HIV.



HIV TESTING OF MIGRANTS AND DEPORTATION

Part of the problem is that migrants are considered primarily as labourers; and the agencies that deal with them are mainly focused on the labour aspect. Thus, preparations to go abroad are mainly geared towards their role as workers. Commonly, other aspects of being a migrant are overlooked or simply given cursory coverage (rights, health care, grievances). Consistent with this, there is also an absence of comprehensive HIV information in pre-departure interventions. Again, there are a couple of possible reasons for this, such as the limitations of labour-focused agencies which may be responsible for providing pre-departure preparations, the limited amount of time available for pre-departure trainings, and how much is really absorbed by migrants in these trainings. (CARAM Asia, 2007)

Yet, before migrants have a chance to travel, they must undergo a health examination. Health testing is required by the destination countries in the Gulf Countries Council (GCC), which is where the vast majority of migrants from Pakistan, Philippines, Sri Lanka, and Bangladesh go, and in ASEAN, which is also a major destination for some migrants from these countries and Cambodia. However, the nature of the testing is a major point of contention. Mandatory testing of diseases such as HIV, STI and Tuberculosis, are done with the results of the test used as a screening device. A migrant found to be “unfit” ends up simply being refused entry to any GCC country permanently, and their information is entered into a shared database. Moreover, the testing must only be done by clinics accredited by Gulf Approved Medical Centers Association (GAMCA). Test results from clinics which are not GAMCA accredited, including state facilities, are not accepted. (See APPENDIX I: GAMCA Policy) GAMCA clinics’ regulations then supersede national laws on HIV testing, and the results are used to discriminate against PLHIV. (CARAM Asia, 2007)

This is highly problematic as all the positive legislation developed by origin countries is completely disregarded, including laws and policies concerning rights around HIV, promoting best practices of VCCT, and decreasing stigma and discrimination. In fact, it is reported that migrants going through the health testing system are not provided consent, with few aware of what conditions are even being tested. There is no counseling, and if they are HIV positive, they are not even informed of their status by GAMCA. They are simply declared “unfit” and referred to HIV related services to be retested and receive proper counseling. (CARAM Asia, 2007).

Part of the reason for requiring GAMCA-only clinics to do testing is to avoid inaccurate or falsified results. Migrants are tested again upon arrival in the destination country and again to renew documents every six months or annually. If found to be HIV positive or infected with any of the exclusionary conditions, they will be summarily deported. This initial diligence may be because the employers pay for the air ticket. The deportation process from a GCC country can be quite abrupt and disruptive. Some migrants have reported being deported within 24 hours. They are commonly detained at the testing center, told they have a condition that renders them “unfit”, but are unable to collect their belongings as they would be considered a flight risk.

Then, once the employer has processed their exit documents, they are sent on the earliest possible flight home without any negotiation. (The conditions of detention have reportedly improved over the years, but people are also being deported more rapidly.)

The migrants' foreign mission should be the first line response when a migrant is being deported for health reasons, especially HIV. However, deportation is commonly done without notifying the foreign mission - supposedly, to protect confidentiality. In fact, the Health Ministry or Immigration Office in the destination countries are not obliged to inform the Embassy that they are deporting one of their migrant workers for HIV or any other health problem. Reportedly, migrants who experienced deportation for HIV from GCC countries were also not given the option to contact their Embassy after they were quarantined. So, when the migrant is returned home, he or she must find service providers on their own as there is no referral service being provided.

Even if their foreign missions are contacted, Labour Attaches and staff of foreign missions are generally unprepared to provide emotional support, counseling or referral as necessary to comfort a shell-shocked and confused migrant. They are not trained on HIV or the sensitivities surrounding handling migrants who have been diagnosed with HIV. This is also true of migrants who have been sexually abused or suffered other forms of mental or physical abuse, although this is starting to change. Commonly, the migrant may or may not be aware of what health condition they are even being deported for unless they understand the forms which are in the destination country language as they receive no counseling; or if they are aware, the migrant may not understand what HIV is, whether it is treatable, or anything other than he or she is infected with it and therefore must return home. Some who have suspected their status have not received their results to avoid expulsion, and have gone underground instead in order to remain and continue working and making money. (CARAM Asia, 2015).

The fact that stigma and discrimination surrounding HIV has not been properly tackled in their home countries leaves deported migrants fearful of what comes next. While concerns of health eventually arise, their immediate fear is being ostracized by their family or community. In fact, migrants have inadvertently transmitted HIV to spouses and partners because they were afraid to reveal their HIV status upon return home. (CARAM Asia, 2007) This situation has led some countries to institute intrusive and regressive policies with the intention to protect spouses from such incidents by allowing spouses or family members or medical personnel to demand HIV test results of a person in question, usually a returning migrant. In other cases, due to the lack of confidentiality in the deportation process, there has been disclosure of returned migrants' status through news from other migrants from the same home community. In these cases, the worst possible outcomes materialize with families ostracizing returned migrants. On top of all this, migrants have lost the opportunity to legally work abroad again, especially in countries which have mandatory HIV testing, including the GCC, Malaysia and Singapore, among others.

HIV PROGRAMS FOR MIGRANTS

Unfortunately, there are few existing policies or programs which aim to address the health needs of migrants abroad (on-site) provided by the origin country. The ones that do exist face daunting limitations, starting from a lack of clear mandate among concerned government agencies, to limited personnel and funds. All of this constrains the ability to reach spread out populations of migrants in work sites around the destination countries. However, there are more migrant health policies increasingly being developed in the home countries.

For example, the Philippines has designated a Migration Health Unit in the Department of Health. There is now also the Philippine Migrant Health Network (PMHN), a multi-stakeholder network for migrant health. The creation of these bodies resulted in the enactment of the Joint Memorandum Circular on Medical Repatriation in 2017.

In 2012, Sri Lanka's Ministry of Health developed a migration health policy, which adopts an inter-agency approach and is supported by the IOM. While international migrants are identified as a key focus population, HIV is not a key disease being addressed. Much more attention is paid to highly contagious or communicable diseases, including MeRS. Internal migrants are another main focus, especially regarding, Malaria as national efforts have virtually eradicated the disease. For emigrants, most activities address the family members left behind, while activities preparing migrants for being abroad are less evident. (National Migration Health Policy, Sri Lanka, 2013).

For migrants who have been deported with HIV, once they are home they are considered as any other PLHIV. Similarly, there are a couple of main obstacles PLHIV migrants and all PLHIV in the home countries face. First, stigma and discrimination are still prevalent. PLHIV still report experiencing stigmatization from health providers and the community. Many PLHIV self-stigmatize and end up avoiding facilities if it is obvious they provide HIV related services. (CARAM Asia, 2007) Generally, not enough social support mechanisms and programs are in place to combat stigma and discrimination against PLHIV or provide support, especially for PLHIV migrants. Those who have identities which increase their vulnerability, such as being MSM, transgender or a person who injects drugs, find themselves ostracized from the general public and reliant on groups or organizations which focus on these populations.

HIV policies and programs have improved drastically over the years though, significantly increasing availability of prevention and treatment services. Rapid HIV testing is more widely available, and basic HIV services including dispensing ARV have been integrated to local level health facilities. However, a common shortcoming is that HIV related services, such as testing for CD4 and viral load, do not reach widely enough. Thus, there are still limitations in treatment services, especially in rural areas where many migrants' source communities are located. There are a few HIV initiatives which have been implemented that benefit internal migrants specifically, such as in Cambodia, where it is easy to change locations to receive ART.

Returned migrants need more than just health care though. Many return to conditions of poverty and a lack of financial means. In other words, social protections programs need to be in place and able to provide the support returned migrants need. This includes psycho-social and financial support need to be provided, as well as health services. Again, the Philippines has a number of these programs, but there have been gaps. With the recent upsurge in HIV cases, and a considerable number being deported migrants, the country has been amending migration, HIV and welfare laws and creating more comprehensive services through multi-agency coordination. How effective the services provided are is another question, but the fact that intent is being expressed is significant.

Overall, migrants have received the least attention in the AIDS response, but are the largest population affected in some countries in this study. While there have been advances in the fight to get to zero, some key areas are still lagging, namely combating stigma and discrimination, and protecting migrants' health rights while abroad, especially in relation to policies and practices of mandatory HIV testing. Migrants' contribution to these countries' development should be recognized. They should not be discriminated against for a health condition and if they are not given the opportunity to continue to act as a productive member of society, they should be entitled to comprehensive social welfare support.

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03






RECOMMENDATIONS

ASIA

TO DESTINATION COUNTRIES

-  Destination countries should remove HIV status and other treatable conditions as exclusionary conditions for recruitment and placement, and revise all health related entry and stay restrictions for non-contagious diseases.
-  Labour receiving countries should make voluntary and confidential counselling and testing available to migrant workers, and allow migrant workers who become infected with HIV while onsite to be able to continue working abroad and access affordable treatment and care services.
-  Ensure that authorised testing centres (GAMCA and other similar accredited testing centres) do not override national laws and conform to and respect internationally recognized universal testing guideline standards from UNAIDS and WHO including: informed consent to test, pre- and post-test counselling provided by qualified personnel (in language understandable to the migrant worker), test results are kept confidential, and the person is provided referral to appropriate treatment and care services
-  Governments of destination countries should ensure migrants get proper days off, and as possible, provide affordable, accessible, and healthy recreational activities to migrant workers as alternatives to risky behaviours for relaxation and holidays.

TO ORIGIN COUNTRIES

-  HIV Policies and Service Delivery
 -  National level research should be conducted and disaggregated data collected on HIV and migration to provide evidence-based policy guidance in countries with high rates of out migration.
 -  National AIDS Strategies, National Strategic Frameworks and Programmes need to include “migrants,” “migrant workers” and “families and partners of migrants” more prominently and address their specific needs with clearly elaborated strategies and comprehensive services, supported by appropriate levels of funding and inter-agency coordination.
 -  Migrant representatives from civil society, including those with other identities such as MSM or other most-at-risk groups, should be consulted and integral to the drafting of national and local HIV and AIDS strategies and programs.
 -  Combat stigma and discrimination, especially among health providers in all public and private hospitals and clinics.

- ✔ Make all HIV services and facilities, including ARV distribution and CD4 testing and other necessary services, as widely available as possible without stigmatization in rural areas where migrants come from by integrating HIV services into primary health service provision including the use of community dispensaries, and incorporate civil society such as PLHIV networks in the running of such facilities.
- ✔ Ensure that health rights are protected in bi-lateral agreements with labour receiving countries.

Prevention Measures

- ✔ HIV education should reach migrants' source communities and be comprehensive including information about sexual orientation, gender identities and expression (SOGIE) in interventions and media, especially social media targeting migrant workers, potential migrant workers and their communities, and the MSM community.
- ✔ Pre-departure training for both men and women must include a comprehensive session on HIV prevention, treatment and care, with contextual and factual information on risky behaviors which migrant workers may engage in while abroad (including homosexuality), with testimonies by previous migrants (as possible).
- ✔ Electronic multi-media (such as apps and facebook) should be utilized to provide migrants access to country specific information on health services, policies and laws of destination countries, as well as practical advice on safer sexual behaviours.
- ✔ Properly monitor recruitment and placement agencies to ensure that they are providing correct and accurate information to potential migrants about destination countries, migration and health related policies, and ensure that travel agents and their associations do not act in lieu of proper recruitment agencies.

On Site, Return and Reintegration

- ✔ Labour Attaches and consular staff of embassies and all foreign missions should be better prepared and sensitized to be able to provide appropriate emotional support, counselling and referral, as necessary, to distressed migrants, especially those who find out they are HIV positive and may be deported.
- ✔ Establish health referral mechanisms between countries of destination and origin to assist migrants with HIV or other conditions to return home safely and access appropriate services and treatment.

- ✔ Provide voluntary and confidential counseling and testing (VCCT) to returnees, their spouses and partners, and promote HIV positive persons to join PLHIV support groups and networks.
- ✔ Develop voluntary and consensual reintegration programmes which integrate returned HIV positive migrant workers into mainstream employment opportunities without stigmatization, including provision of vocational skills training and training on self-employment / businesses start-up and management.
- ✔ Ensure comprehensive social protections packages are provided and accessible to PLHIV and other deported migrants, ranging from health services, to social-psycho support, to financial and livelihood support.
- ✔ Support migrants' networks and associations in both origin and destination countries to promote advocacy on migrants' rights and health.
- ✔ Promote broader networking among civil society, bringing together migrant networks with PLHIV and MSM groups, as well as other groups that may have overlapping issues which are not immediately obvious in order to build a stronger social movement.

Higher Political and Multi-lateral Platforms

- ✔ International and regional platforms like the Abu Dhabi Dialogue, Colombo Process, ASEAN and SAARC, can be utilized as potential venues for increasing bi-lateral and multi-lateral cooperation and collaboration on HIV / AIDS and migration.
- ✔ Explicitly recognize and protect migrants' health rights in the Global Compact on Migration.
- ✔ In order to achieve the Sustainable Development Goals, with Universal Health Coverage as one of the identified mechanisms, the governments of sending countries need to accelerate policies, programs and services in order to ensure that their migrant workers receive their full health rights wherever they are, and governments of destination countries need to ensure access to health for everyone within their borders, including migrant workers.

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**ALL PEOPLE HAVE THE
RIGHT TO STAY OR MOVE
AND LIVE AND WORK IN
DIGNITY WITH EQUAL
RIGHTS IN A SOCIETY,
WHERE THEIR QUALITY
OF LIFE IS ENSURED.**

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05

COUNTRY REPORTS

ASIA

MIGRATION

Over the years, labour migration has become a major livelihood strategy for many Bangladeshis. This is mainly because of huge labour surplus and underemployment in the country, estimated between 20-40 percent (Ulandssekretariatet, 2014). Around two million job seekers enter into the labour market every year in Bangladesh. Labour migration accounts for around one-fourth [around 500,000] of those job seekers every year. Apart from official channels, it is assumed that the same number head for overseas employment through irregular channels. Economic hardship due to lower socio-demographic profile, patriarchal societal practices including family violence and pervasive gender disparity also push Bangladeshi women for overseas migration to find work. (OKUP, 2014)

Labour migration plays a significant role in the country's economic development through remittances. Bangladesh is one of the top ten largest remittance earning countries in the world. Remittances sent by Bangladeshi migrant workers contributed on average 10.64 percent to the GDP of fiscal years between 2010 and 2015. Migrants' remittances constitute 77 percent of the country's foreign currency reserve in 2012-13 and 61 percent in 2014-15, and is seven times more than the foreign aid received by the country. (Finance Division, 2015) Apart from the macro level economy, remittances have a huge impact on the socio-economic well-being of migrants' households.

According to the Bureau of Manpower Employment and Training (BMET), some 11 million Bangladeshi nationals have left the country through government channels over the past four decades between 1976 and 2016. Labour migration from Bangladesh seems to increase every decade. During the 1980s, some 672,724 Bangladeshis were deployed abroad, increasing to 2,154,983 in the 1990s. During the first decade of 2000's, a total of 4,149,326 people migrated while 3,324,409 have already migrated during 2011-2016. (BMET, Overseas Employment and Remittance, 2016)

After lifting a ban on women migrating for work in 2003, the official number of women migrants from Bangladesh suddenly jumped by 378.50 percent from the previous year. The average annual flow of women migrant workers stood at around 42,680 between 2004 and 2016. During the period between 2011-2016, women migrant workers constituted around 13 percent of all migrants. (BMET, Overseas Employment of Female Workers, 2016)

There is no national level mechanism yet in Bangladesh to know the number of migrant workers who get infected with different types of diseases while abroad, or to know how many are deported due to the results of mandatory health tests in the destination country, especially for HIV/AIDS.

| HIV SITUATION

Bangladesh is still considered a low prevalence [<0.01 percent] country for HIV and AIDS. The Epidemic Snapshot of the Country Profile in the AIDS Data Hub estimates that the current number of new HIV infections annually in Bangladesh is 1,500, while the number of people living with HIV is currently 12,000. Amongst the identified as HIV positive, only 16 percent are receiving ART treatment. Numbers of AIDS related deaths are around 1,000. (UNAIDS DataHub, Country Profile Bangladesh)

The first HIV infected person in Bangladesh was a returned migrant worker. Returning migrant workers have always contributed to the numbers of people newly infected with HIV in Bangladesh. However, little solid data about the numbers of HIV infected migrant workers is available. The National AIDS/STD Programme of the Ministry of Health and Family Welfare (MoHFW) first showed that 57 of 102 newly reported HIV cases in 2004 were among returned migrants (Samuels and Wagle, 2011). Similarly, the 2006 National AIDS/STD Programme (NASP) estimated 67 percent of identified HIV positive cases in the country were returnee migrant workers and their spouses. The National AIDS/STD Programme (NASP) Report 2014 also identified that out of 645 adults who were HIV positive and had been employed, 64.3 percent had previously worked abroad. According to the NASP, out of 469 newly infected HIV people in 2015 the number of HIV positive migrant workers and their spouses is 140 (30 percent), and this number was 189 (32.96 percent) out of 578 total in 2016. (NASP, 2014-16).

| MIGRATION POLICY

The government of Bangladesh has considered overseas employment as a significant part of the country's economy. Bangladesh ratified the UN Convention on the "Rights of Migrant workers and the Members of Their Families" in 2011, and adopted a law in 2013 entitled "Overseas Employment and Migrants' Act". The law has focused on regulating recruitment, and stipulates penalties against recruitment related offences. It entitles migrant workers to access information, legal aid, right to file civil suit against any perpetrator and also right to return home. The law omits issues of health rights of migrant workers though.

Notably, the first mention of migrants' health rights in migration policy was in clause (f) of section 7 of the Code of Conduct of Recruiting Agencies and License Rules 2002 [still in place], which states that the recruitment agents must "arrange the medical examination properly". There is no clause or section to guide the procedures of medical testing though. The "Bangladesh Overseas Employment Policy 2006" first spelled out the necessity of creating awareness among migrant workers about health related issues, especially HIV and AIDS. Under the policy, the "Health Service" for migrant workers was incorporated in the work contract between the employer and the worker. However, HIV and AIDS and other infectious diseases are not included in Health Service provision. The Government of Bangladesh has passed a comprehensive Migration Policy in 2016 entitled the "Expatriate Welfare and Overseas Employment Policy" (EWOEP).

In line with the Constitutional provisions of the country (Article 19, 20 and 40), the core goal of the policy is to encourage and ensure voluntary overseas employment through safe and dignified migration. One of the major objectives of this policy is to establish a “rights-based” protection system for migrant workers and their families. The EWOEP states that a “Standard Contract Agreement” will be prepared [clause 2.2.2], and under the section “Welfare for Migrant Workers” it is clearly stated that “the state shall undertake necessary steps for the migrant workers before departure and upon return to provide low cost health treatment and other facilities especially for HIV and AIDS and other infectious diseases with due importance and confidentiality” [Clause 2.3.8]. The policy has also given special attention to women migrant workers’ protection through the appointment of more female staffs in the labour wings of foreign missions who are prepared with training and capacity building on the provision of assistance with legal, psychological, health and financial issues [Clause 2.4.8]. Most importantly, the health of migrant workers has been incorporated in the country’s “7th Five Year Plan 2016-2020.”

Under Section 3.5 on Migration and Development and sub-section 3.5.4 on Human Development and Migration, the health of migrant workers has been identified as a significant issue for the first time despite the fact that health is closely interlinked with sustainable development. The document clearly stated seven intervention points to address the health rights of the migrant workers. These are: (i) review existing policies to promote migrant-sensitive health policies and public health strategies, (ii) consider migrants’ health in the national health information system, (iii) collect, standardize and analyze qualitative information in relation to migrants’ health for policymaking, (iv) gather, document and share information and best practices for meeting migrants’ health needs in countries of origin or return, transit and destination, (v) ensure equitable access to health, disease prevention and care for migrants and their families without discrimination, (vi) build capacity, guidance, and set standards for service providers and professionals promoting cultural and gender sensitivity to deal with migrants’ health issue, and (vii) promote bilateral and multilateral cooperation on migrants’ health among countries involved in the whole process of migration. (General Economics Division, 2015).

| HIV POLICY & TESTING

National Policy on HIV/AIDS and STD related Issues was first adopted in 1996. The policy provided comprehensive guidelines to prevent HIV/AIDS infection and reduce the impact of HIV on the individual and community. The policy did not identify migrant workers as a core group affected by HIV and AIDS, but Guideline No. 12 of the policy addressed the issue of HIV and AIDS and mobility and recognized migrant workers as an especially vulnerable group due to lack of knowledge and information. The policy further recognized that migrants are also vulnerable due to legal restrictions on family reunification, and that migrants often fall in the gaps of prevention programs on HIV/AIDS. At the same time, the policy condemns work-place discrimination and provision of forced repatriation of migrant workers on the ground of HIV/AIDS.

The problem is that the policy fails to mention a strategy on prevention and care of HIV/AIDS for migrant workers. The “Strategic Plan on the National AIDS Programme of Bangladesh (1997-2002),” addressed groups with high-risk behaviors, but migrant workers and their spouses were not included as a group in this category, although migrant workers were identified as a “bridging population.”

The 2nd National Strategic Plan for HIV/AIDS was adopted for 2004-2010. Similar to the first national strategic plan, the 2nd one did not address migrant workers with much importance. Bangladesh developed its first Antiretroviral Therapy (ART) treatment guidelines in 2006, with PLHIV able to buy subsidized antiretroviral drugs from specified pharmacies. Unfortunately, most HIV diagnostic facilities were provided by NGOs based in Dhaka, meaning that most rural and cross-border migrants missed out on ART, HIV testing and other care and support services. If they sought out private care, the cost was beyond their means.

In the 3rd National Strategic Plan 2011-2015, there was a slight improvement in regards to the inclusion of migrant workers. This Strategic Plan included migrant workers as a highly vulnerable group for HIV/AIDS but did not include them under the Most at Risk People (MARF) group, which consists of PWID, sex workers and their clients, MSM and Hijras. However, this strategy did identify strategies to combat HIV/AIDS among migrant workers. The strategies identified included pre-departure preparation of migrant workers with information regarding HIV/AIDS prevention and care through distribution of IEC materials such as CDs, procuring airport advertisements, distributing media components such as in-flight magazines and announcements on flights leaving Bangladesh with migrant workers, interventions for departing and returning migrants through communities, establishing Voluntary Counseling and Testing (VCT) centers for returnee migrants and further research. It is unclear to what level this strategy has been implemented.

The Bangladesh HIV testing policy was embedded in the National Policy on HIV/AIDS and STD Related Issues in 1996. The key principle of the HIV testing policy is that it should be voluntary, based on informed consent, provide pre-test and post-test counselling, and confidentiality of the test result.

The policy guideline has clearly stated that,

“ Screening for HIV infection or other STDs will not be mandatory for travelers or migrants into or out of the country. As an HIV infected person does not necessarily affect the state of health or performance of an individual, it is not by itself grounds for refusal of employment. HIV screening will not be mandatory for those seeking employment in any public or private organisation or enterprise. ”

The Bangladesh policy referred to the WHO resolution which states that a mandatory health test demanded by the third party using undue coercion is not ethically acceptable without consent by the person to be tested.

(Forth-fifty World Health Assembly Resolution 45. 35. 14 May 1992 “there is no public health rationale for any measures that limit the rights of the individual, notably measures establishing mandatory screening”) The policy also added that HIV testing should not be included as part of a normal medical examination without the knowledge and consent of the person undergoing medical examination. Once consent has been obtained, the procedure is to follow the same as voluntary HIV testing.

Under the Ministry of Expatriates’ Welfare and Overseas Employment (MoWEOE) a “Health Check-up Policy for the Outbound Bangladeshi Migrant Workers” was established in 2008. Clause 8(j) of the policy stated that the “quality of medical testing should be in line with international standard (WHO)”. However, the policy mandates that HIV/AIDS is tested along with eight other diseases, contradicting the international HIV/AIDS policy and also the Bangladesh National Policy on HIV/AIDS and STDs 1996. For those who wish to migrate to GCC countries, migrant workers are subject to mandatory health screening in GAMCA accredited facilities only for 16 infectious and non-infectious diseases including HIV in order to gain permission for entry, and are subject to regulations surrounding testing once in the country, which includes deportation if found to have any of the exclusionary conditions.

Bangladesh revised the National Health Policy in 2011, identifying infectious diseases as one of the major challenges for public health in Bangladesh. Policy Strategy No. 32 aimed at combatting infectious diseases such as diarrhea, dengue, tuberculosis, leprosy, malaria, filariasis... But the strategy did not include HIV/AIDS and STDs. Policy Strategy No. 39 aimed to have health screening facilities in all land, sea and air ports to screen the health of returning migrant workers, especially those who returned from countries which have epidemics of certain critical infectious diseases. It is unclear the extent this strategy has been implemented.

| NATIONAL RESPONSES TO HIV/AIDS IN BANGLADESH

The Global Fund to fight AIDS, Tuberculosis and Malaria has been supporting the national response to fight HIV and AIDS in Bangladesh since 2004. Bangladesh has received three rounds of funding: Round 2 from 2004 to 2009, Round 6 from 2007 to 2012 and the Rolling Continuation Channel (RCC) from 2009 to 2015. The Round 2 grant focused mainly on prevention of HIV among young people with strategies including (i) HIV/AIDS prevention messages dissemination through information campaign in mass and print media, (ii) HIV/AIDS orientation, training and services via Life skills education, Youth Friendly Health services and accessing condom, (iii) Integration of HIV/AIDS in school and college curriculum, (iv) Advocacy and sensitization of religious leaders, parents and policy makers, and (v) Generating information for policies and programs. The main focus of the Round 6 grant was on Most at Risk Populations (MARPs) and scaled up the Round 2 project, including interventions with vulnerable youth. The main objectives of the RCC Program were to (i) Increase the scale of prevention services for key populations at higher risk: Injecting Drug Users (IDUs), Sex Workers (FSWs), hijras (transgender people) & Men who have Sex with Men (MSM);

(ii) Increase the scale of the most effective HIV/AIDS activities conducted through Round 2, including provision of treatment, care and support for PLHIV; and (iii) Build capacity of partners to increase scale of national response to the HIV/AIDS epidemic. National level capacity building, strengthening district co-ordination, support to networks and self-help groups were also among the strategies.

However, migrants were not identified as a key population in any of the GFATM programs. It was only in the UNICEF project entitled “HIV/AIDS Prevention Project (HAPP)” from 2004 to 2007 that this occurred. The HAPP procured services by NGOs with the aim of implementing HIV prevention activities among the most at-risk populations - injecting drug users, sex workers, men who have sex with men, and clients of sex workers. (HAPP) included providing information through peer outreach activities to mobile populations, in particular, labour migrant workers. In 2009, UNICEF handed over the project to the government, but it no longer included mobile populations and migrant workers.

During 2013-2015, NASP and IOM with the support of UNAIDS, developed a program for Migrant Workers in Bangladesh. The World Bank allocated around 2 million USD. However, the program was not rolled out. The NASP prepared another proposal for 2016-2020 which was approved by the Prime Minister’s Office. It was expected that the NASP would call open tender on this program. The government has been working to adopt a new National Strategic Plan for HIV and AIDS Response 2018-2022. Fortunately, migrant workers have been considered as one of the key groups in the National Strategic Planning process and have been included in the Strategic Plan.

| POLICY MAKERS’ PERSPECTIVES

According to policy makers, migrant workers’ health is practically missing in the whole migration discourse. Although health insurance is mandatory for work visa and residence permit in the destination countries, the employers usually provide the lowest premium of health insurance in order to meet the government rule. In terms of migrant workers and HIV/AIDS, sexual and reproductive health, and infectious diseases, these are completely absent in the guidance on health insurance and occupational safety. Migrant workers are completely excluded under the HIV/AIDS programs in most destination countries, especially in the Middle East and Malaysia. There is no data or source of information to the Ministry of Expatriate about the migrants who are being deported or being returned due to HIV, STIs or any other health complication, including those who experienced an accident.

The government organizes 3-day pre-departure trainings for men migrant workers and 30 days pre-departure training for women migrant workers. There is hardly any discussion on health or HIV/AIDS in these pre-departure trainings though. The participants of the pre-departure training are given booklets which contain very little information on HIV/AIDS and nothing very relevant to their specific situation.

HEALTH SERVICE PROVIDERS' PERSPECTIVE

The government of Bangladesh has taken initiatives to integrate HIV testing and counselling centres into the government's health system. The transition of HIV testing and service centres has been in progress since 2015. At present, the government has set 20 HIV testing, counselling and service centres in 20 different hospitals around the country. In this transition period, the CBOs with the support of different donor organizations have been working with the government health personnel in the government-run counselling and testing centres. One of the counsellors of such a centre mentioned that they provide counselling and testing to around 25-30 people every month. Majority of the people are referred by different hospitals, private doctors and clinics. Many of them come through different health service provider NGOs. The centres usually maintain a database of HIV positive people. The database has categorizations including migrant workers, their spouses and children, but all personal data is kept confidential.

The National AIDS/STD Control (NASC) has been working to roll out a National Program for the Migrant Workers in coming years. The "Expatriate Welfare and Overseas Employment Policy 2016" and the country's 7th Five Year Plan address migrant workers' access to affordable health services and treatment including HIV/AIDS, and will include pre-departure interventions

PLHIV PERSPECTIVES

At present, there are 20 Health Testing Centres in Bangladesh. The government has established these centres in different government hospitals in different parts of the country considering the concentration of HIV/AIDS. Since 2006, the government distributed ART to HIV positive people through three CBOs. These CBOs received support under various projects including Global Fund, and implemented other HIV related activities including counselling, nutrition support, and care, as well as providing ART.

In destination countries, migrant workers try to get information about their health test results through different channels before they collect the report from the testing centres. Many migrant workers said that they had not received the reports once they came to know the result is 'unfit' for fear that they would lose their job and would be forced to return back home. In fact, many of those who knew they were unfit fled their work place and employer and became undocumented. This is because those who were identified as HIV positive in the destination countries and were caught, were instantly put in detention and reported having to face severe mistreatment until they were sent back. These migrant workers also reported returning empty handed without any of their belongings. Undocumented and without health insurance, migrants with HIV or other health conditions would return back home only once they had encountered various diseases in the destination countries and felt that they were unable to continue receiving treatment through private means any longer. They would exit by managing their own out passes.

“ I went to a Middle East country in 2008. I got a job in a catering company as labour, but over the years I got promotion as ‘Cook’. Then in 2011, I returned back home on leave for two months and got married. In 2015, I did medical test for renew my “Akama” [work permit]. Having done all through process, the company told me that they could not renew my Akama. They told me to return back home. I asked “why”? But they didn’t tell me anything. I had to return back in late 2015. After return, I checked my blood in a diagnosis centre in my district. They found nothing. Then I decided to migrate again. I have been diagnosed HIV positive when I went under the health test before second migration. ”

“ I requested a nurse of the testing centre about my result. She told that I had been unfit. Having heard that I instantly left the centre and became undocumented. I worked several years until I got seriously sick. Then I returned back home ”

“ “S” returned back from Dubai after 11 years. Her husband received all her monies but not her. So, they got divorced. Then, she decided to go abroad again. Under a recruitment agency, she travelled to Lebanon in 2011 for domestic work. She couldn’t continue with her employer since she was not happy with the salary. She fled away from the employer’s house and managed part time work in different houses. In the middle of 2014 she got seriously sick and was admitted to a hospital. The doctor found she had liver cancer. She got released from the hospital and applied to the Bangladesh Embassy for repatriation. Since she was undocumented it was long official process to get returned. So, some Bangladeshi migrant workers called the police and got her caught for being undocumented in order to speed up her repatriation since her condition was deteriorating fast. Finally she got repatriated in the end of August 2015. ”




There is still stigma and discrimination towards people living with HIV/AIDS in Bangladesh. They are discriminated in the family and by society. The majority of PLHIV still maintain secrecy of their status, not even disclosing to family members. Many of them left their families and live alone. There are incidents where spouses have left once they found out the person was infected with HIV. There are even cases where family members have tried to deprive HIV positive family members of their family property.

PLHIV NETWORKS' PERSPECTIVES

There are several networks of PLHIV in Bangladesh. These networks have come forward and made a national platform - the Network of PLHIV (NoP+). Majority of the members of this network are either returned migrant workers or their spouses and children.

In June 2016, the government published a report of the results of a “Mapping Study and Size Estimation of Key Populations in Bangladesh for HIV programs 2015-2016”. Although returning migrant workers and their spouses represent the majority of member in HIV positive networks, they are surprisingly excluded in the study. There are still gaps in provision of basic services for PLHIV. For instance, the government only provides ART, but not other key services such as CD4 testing. The cost of these tests are a significant amount to pay out of pocket, and which most of PLHIV cannot afford. Other medicines for OI and proper nutrition are also unavailable. Meanwhile, the majority of PLHIV in Bangladesh are impoverished and lack employment, yet the government has no program to assist. Even access to ART is limited to specific hospitals, particularly at the divisional level. Therefore, many HIV positive people who are from remote areas or poor financial status face difficulties in accessing treatment.

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MIGRATION

Over the past decades Cambodia has experienced momentous internal and external human migration. According to the National Institute of Statistics (NIS) of the Ministry of Planning (MoP), about 35 percent of the total population moved internally from one province to another (NIS, 2005). At the same time, Cambodia is primarily a country of origin for men, women, and children going to work as laborers in other countries in the region, and increasingly outside the region. Push factors include a combination of poverty, limited employment opportunities, the conversion of agricultural land into economic land, lack of access to markets, landlessness due to land grabbing, debt bondage, and natural disasters such as flooding and drought.

A report from the Ministry of Labor and Vocational Training in 2017 said that over one million Cambodians had migrated to work in different countries. However, the picture is not totally clear as undocumented migrants are not included, and records of cumulative migrants with current migrants are mixed. The majority of migrants go to Thailand (approx. 700,000 were registered at any one time with various official status); followed by 46,000 in cumulative total to Malaysia with 8,548 registered migrants in Oct 2015; and 43,571 had gone through formal channels to the Republic of South Korea over eight years; while Japan had 2,383 formal migrants as of 2016, and Singapore had 400 on record. (ILO, 2017) There were a few people who were reported to be laborers in other part of the globe such as in Africa and Middle East, but not yet in significant numbers.

It is estimated that in Thailand there are considerably more than 800,000 Cambodian laborers working in different sectors, with at least 100,000 working as undocumented migrants or with a cross-border daily worker status. Cambodian men, in particular, do long-term work in different sectors in Thailand including agriculture, fishing and construction. In a port city of Rayong Province alone, 40,000 Cambodians, most of whom were undocumented, were reportedly working on fishing boats for long periods; some were on boats for years, and many were considered to be forced labor. There was a report saying that in 2015 there were 55,626 undocumented migrants deported from Thailand at a single border checkpoint of Poipet in Banteay Meanchey Province over that year. (Cambodia Daily, 2015) This figure included about 8.5 percent children workers and 59 percent men, and was recognized as accurate by the Cambodian National Police.

Cambodian women are increasingly being sent to work in Malaysia as domestic workers, mainly through formal channels under the Association of Cambodian Recruiting Agencies (ACRA) and labor companies registered with the Ministry of Labor and Vocational Training (MoLVT). Those Cambodians working in Korea were recruited and sent through a system of Employment Permit System (EPS) which was a government to government agreement between Cambodia's MoLVT and the Ministry of Human Resource Development of Korea. Under this agreement, the Korean government provides pre-departure orientation and training.



Conflict Resolution Mechanism for Overseas Migrant Workers

The Ministry of Labor and Vocational Training, has set forth a mandatory obligation for all labor recruitment agents to establish permanent coordination in the countries where they send migrants. This aims to ensure that a system is in place to assist migrants when there are conflicts between the employer and migrant workers and to provide assistance for preparation of returned migrants. In the Prakas No 252 dated 23 September 2013, all labor recruitment agents are obligated to follow the Prakas by deploying a coordinator or two in the destination countries based on the size of the number of migrants being sent. The coordinators have the responsibilities of monitoring and observing whether the work and living conditions are appropriate and if basic human rights are being respected.

Coordinators must also assist each and individual migrant to have their own bank account, regularly provide counseling and mentoring on working conditions to different occupations, and report all cases of violations to the Ministry on an annual basis. There are also complaint points in the Provinces in Cambodia, related to recruitment agencies. In one report it was found that although the complaint mechanism is new, most complaints in the Province were about paying fees to recruitment agents but not being placed, and that 90 percent of respondents were satisfied with the service, even though none received their promised wages. (Mekong Migration Network, 2017).

| HIV SITUATION

According to the National Center for HIV/AIDS, Dermatology and STD (NCHADS), by the end of 2015, it was estimated that there were 72,607 people infected with HIV (PLHIV) in the whole country, out of which there were about 57,651 who had already been diagnosed and confirmed as HIV positive, of which 54,769 were on Anti-Retroviral Treatment (ART). There are still approximately 15,000 people who are infected with HIV who are not aware of their HIV status (NCHADS, 2016). There was no reliable source for the estimate of PLHIV who were migrants, and no figures on migrants deported for HIV or other health conditions available.

Over the past five years, the HIV epidemic has been characterized as a concentrated epidemic in Cambodia because it remains concentrated and spreading specifically among particular groups with high-risk behaviors and who are most marginalized, such as MSM, Transgender, entertainment workers (EW), and People who inject drugs. The country has streamlined its HIV prevention programs by focusing on these most-at-risk groups.

UNIVERSAL HEALTH COVERAGE AND MIGRATION

Like a few other countries in the region, Cambodia has also adopted the UN's universal health coverage (UHC) policy aimed at improving access to healthcare for all citizens, particularly poor and vulnerable groups. These groups, however, need other kinds of support, including financial, transportation, social support and other material assistance in order to access healthcare in their own communities and maintain their health. HIV/AIDS was included as one of the key interventions in achieving UHC, with a focus on the universal coverage of Anti-Retroviral Treatment (ART). The policy itself did not specify any special groups, but emphasized access to all those who are eligible according to the ART treatment and care guidelines. That means regardless of an individual's status, including migrants, those who are in need of treatment and meet the criteria are eligible for the service.

In order to ensure greater access by all people in need, the MoH's NCHADS has repeatedly changed the ART care and treatment guidelines based on CD4 counts. For example, starting in 2002 the minimum level of CD4 count was determined at the 250 cell/mm³ of blood, and was then increased to 350 cell/mm³ in 2010 and then again to 500 cell/mm³ in recent years, and finally to unconditional treatment guideline which is a "Test and Treat for all" policy as of 2016 (NCHADS, 2016).

GOVERNMENT POLITICAL COMMITMENTS ON MIGRATION AND HIV

The Royal Government of Cambodia (RGC) issued a "National Guidelines on the Management of Labor Force and the Flow of Migration" to ensure that all relevant government ministries have access to necessary legal tools in order to protect migrant workers from exploitation. This eight-fold guideline urges key government ministries including Ministry of Interior, Ministry of Labor, Ministry of Foreign Affairs and International Corporation, and other national level institutions and authorities to facilitate and cooperate with other government agents and partner countries with the aim of reducing human trafficking or smuggling, or exploitation associated with the migration and labor force moving to other countries. In cases where an incident happens outside the country, the Ministry of Foreign Affairs has a critical role to ensure that Cambodian migrants in need of assistance are reached and to prevent further harm to the migrants.



National Plan of Action of National Committee for Counter Trafficking (NCCT) 2014-2018

The aims of the plan were to prevent all forms of trafficking by developing effective strategies that engage the participation of communities and civil society organizations, and by integrating other aspects such as gender-based and right-based approaches. In addition, the plan also encouraged the enhanced co-operation of all law enforcement agencies with other agencies for effective prevention and care for all victims of trafficking. The plan did not address any health specific issues such as HIV.



National AIDS Authority's 7-point Policy Directives

The Royal Government of Cambodia (RGC) issued a Sor Chor Nor (a government's executive order) on 17 December 2013 as an approved policy direction to guide the National AIDS Authority (NAA) to reinforce its coordination role in addressing the issues of HIV/AIDS from a multi-sectoral perspective. This encouraged the agency to work with different government ministries and institutions and encourage the participation and engagement of community-based organizations and CSOs. Even though migration was not specifically mentioned in the policy directive, the policy itself supports the NAA to work with authorities ranging from national to local levels (for example commune and village) to map the localities of PLHIV and most at risk population (MARP), which include local migrants such as entertainment workers (EW), and to ensure that they are supported to access needed HIV services.

| NATIONAL COMPREHENSIVE AND MULTI-SECTORAL RESPONSE TO HIV

The National AIDS Authority developed a comprehensive response to cover both health and non-health components of the national response to HIV/AIDS in the country. This fourth National Strategic Plan (NSP4) emphasizes HIV prevention interventions and improving the quality and expansion of coverage to ensure access by "MARP" (Most at Risk Populations) groups including Entertainment workers (EW), Men who have sex with men (MSM), Transgender (TG), and People who inject Drugs (PWID). Entertainment workers are considered internal migrants, as they move from the rural and remote communities, but that is the only point covering migrants.

Most importantly, one of the six components of the NSP4 was the strategy 5.0 which focuses on the enabling environment through promoting better understanding and implementation of laws and policies aimed at protecting the human rights of PLHIV and MARPs, and by encouraging the engagement of all stakeholders, including employers and other key partners such as law enforcement officers. In other words, the strategy engages parties considered as social enablers to create demand for services by the communities by easing law enforcement, and to support PLHIV and MARPs' access to necessary HIV and non-HIV related services.

| HIV SERVICES AND MIGRATION

Cambodia is one of the countries in the world which has been successful in the fight against HIV and AIDS. The country has reduced the prevalence of HIV infection from the peak of a generalized epidemic of 1.7 percent in 1998 to as low as 0.6 percent in 2010, and is expected to see a continued low prevalence into the future.

In 2013, to achieve the Cambodia 3.0 initiative the National Center for HIV and AIDS, Dermatology and STD (NCHADS), under the MoH, adopted the “Test and treat all” policy aimed at the elimination of HIV by setting the 90-90-90 targets of 2020, based on global targets, which means identifying 90 percent of new HIV cases, enrolling the 90 percent of newly detected cases on ART, and retaining up to 90 percent of those enrolled cases on ART.

NCHADS has also adopted a Boosted Integrated Active Case Management (B-IACM) Approach to support all interventions and services of the HIV prevention, care and support and treatment. Most recently, under the Cambodia 3.0 Initiative by NCHADS, a new HIV elimination target has been established as 95-95-95 by 2025, which will see Cambodia with as few as 300 cases of HIV incidence each year, which means less than one person infected per day in the whole country (NCHADS, 2016).

| LOCATION OF HIV SERVICES AND ACCESSIBILITY

These aggressive eradication policies are linked to the UHC policy by promoting all segments of the population to be able to access HIV prevention, care/support and treatment services free of charge, or paid by the public funding through the Health Equity Fund. To increase accessibility, the HIV prevention interventions are employing a Community Action Approach which mobilizes community resources to identify, reach and detect new and old PLHIV. The services are available almost everywhere in the country, with community health workers and public health facility-based staff who can provide counseling and HIV testing at a localized level in almost all of the country’s primary healthcare system.

This means there are more than 1,100 health centers and health posts (out of total 1,209 HC and HP), plus 73 sites offering HIV testing and counseling at Referral Hospitals in the country (NCHADS, 2017). Once the community-based and primary healthcare-based centers detect an HIV reactive case, they can send the person to a nearby VCCT center for a confirmatory test. There is a total number of 65 VCCT Centers in the country, and the number of sites/clinics providing ART treatment for adult PLHIV is 52, with 37 pediatric PLHIV centers. In addition, there are 37 Family Health Clinics which provide STD and HIV services.

People in need of HIV services, including migrants or former migrants, are able to access and use them mostly free of charge. Any PLHIV is able to change his or her location to receive ART for a center where they feel comfortable going without concern of stigma, or which may be closer to their place of residence or workplace. PLHIV on ART are supported in switching locations with assistance provided from both NGOs and government health care staff. In addition, NCHADS has just recently adopted a new ART loss-to-follow-up definition based on the new WHO guideline. The guidelines allow for spacing of appointments for receiving ART and testing in intervals of up to a year in order to minimize the risk of loss-to-follow up with ART clinicians. This allows patients to remain in their workplace if they work far from the ART clinics or health facility usually linked to their home registration - a situation that specifically accommodates internal migrant workers.

HIV TESTING LAWS AND POLICIES

The 2002 law on the Prevention and Control of HIV/AIDS adopted by the national assembly is the highest guide for all national policy and guidelines on HIV/AIDS interventions. In this law, compulsory HIV testing is strictly prohibited by any individuals, public and private institutions and agents. Article 20 reads that:

“ It is strictly prohibited for any compulsory HIV testing undertaken to indicate pre or post conditions for employment, admission to educational institutions, as well as for the exercise of freedom of abode, traveling, and the provision of medical services or other services ”

If a person requests HIV testing, it must be done anonymously as stated in Article 22. All NCHADS's guidelines and standard operating procedures (SOP) have highlighted the key aspect of HIV confidentiality and reducing discrimination against PLHIV, which protects the right from disclosure of a person's HIV status, including requiring the person to show the HIV result before or after job deployment.

POLICY MAKERS' PERSPECTIVE

Regardless of the receiving country, pre-departure programs for Cambodian migrant workers do not receive training on basic human rights, health, or policies of labor laws/regulations of destination countries, and are provided very little detailed information about work conditions. These programs are mainly designed to teach basic working skills and working procedures required to achieve the predefined outcomes of employment placement, plus some basic skill level of self-adjustment in the different cultural environments of foreign countries.

How to seek legal assistance in case of abuse by the employer or other support from the embassy is not addressed during the pre-departure training. Health screening is done, and if a migrant is found to be HIV positive, have a sexually transmitted infection or is pregnant, that person will be disqualified as a potential migrant worker and dismissed from the departure list. Another critical concern of potential workers is debt. The majority of workers recruited to go abroad for work are mostly from poor families. In order to be able to pay for pre-departure training and to support themselves during the training, pay for passport and visa fees, health testing, and other related costs, a potential migrant has to take out a loan.

Being recruited for a job in Japan, a migrant has to pay about \$5,000 (five thousand US dollars) of which \$2,000 is paid for a pre-departure training and health checking fees, while another \$3,000 is paid off through monthly installments deducted from their salary over the period of employment. Because there is no other alternative, they have to loan cash from local Micro Finance Institutions (MFI), informal lenders or non-registered private creditors, which demand high interest rates.

An average rate for MFIs who are registered (formal) is about three percent per month, which is around 36 percent per annum, whereas for other non-registered or informal lenders, the rate is double or triple higher. If a potential migrant worker is found to have an exclusionary health problem, as mentioned above, that person can be fired immediately, deported and return to a serious debt, unemployed.

HIV POSITIVE MIGRANTS' PERSPECTIVE

“ The life of migrant workers is not easy during the time working abroad,.. said migrants ”

There are many rules and regulations to follow, which include regular health checks on an annual basis, including HIV and sexual health. All costs associated with required regular health checks comes from the pocket of the migrants, in most of the cases they paid direct cash by themselves; but in other circumstances, the employers paid upfront and then deducted from their salary later. In Thailand, for example, all registered migrants are required to undergo health testing where they are then supposed to be able to receive health insurance coverage; while undocumented migrants do not receive healthcare coverage.

“ In case that we are found having serious health issues particularly HIV Hepatitis B or C and STD, we are apparently fired and finally are forced to be deported. Imagine if we are in debt back at home, this fact leads us to a worse situation of debt doubled with unemployment”,... said the majority of the FGD participants. ”

(Note: Thai government health testing, supposedly does not test for HIV, and is not linked to deportation. This could be reference to employers' independent testing or decision to terminate the migrant's employment).

HEALTH SERVICE PROVIDERS' PERSPECTIVE

“ Our family health clinics provide HIV Counseling and Testing, STI and other sexual and reproductive health services such as family planning to anyone who comes to the service center regardless their status as an EW, or MSM or Transgender or migrant... In most of the cases the services are free. The exception is with some medicines which are not on the essential drug lists of the MoH, and clients are required to buy it themselves; there are also certain lab services that clients have to pay for at a basic cost,... government referral hospital staff. (Interview 5 December 2016, in Kampong Cham province) ”

According to the interview, it became clear that labor recruitment companies are practicing mandatory HIV and STI testing of potential migrants, most notably those who were sent abroad, particularly to Thailand. The same interview reported that in November 2016 there was at least one labor recruitment company in the province which was known to send workers to this clinic to have a health check and testing for HIV, syphilis and other STIs.

| HIV POSITIVE NETWORKS' PERSPECTIVES

The Cambodian People Living with HIV Network (CPN+) is also part of the regional Asian People Living with HIV Network (APN+). These networks advocate for respect of basic human rights of PLHIV, including the right to decent employment. However, the issues of PLHIV and migration are beyond the capacity of CPN+ or APN+, as they fall under the realm of economic and political relations between countries. CPN+ also has capacity limitations on its ability to assist PLHIV migrants in other countries.

According to the CPN+ National Coordinator, there has been “No” or “little” effort in integrating information on HIV or ARV drug literacy into the training package of the pre-departure for the majority of the labor companies who are responsible for recruiting potential migrants. This, therefore, leads to the lack of awareness on how to access to ARV drugs if a migrant, later on, finds him or herself HIV positive and in need of accessing ART in the destination country.

Cambodia does not have a government level Memorandum of Understanding (MoU) with Thailand on assisting migrants with HIV. There have been a few exchange visits to some of the provinces in Thailand such as Trat, Samuthsakhon, and ChonBuri conducted by groups of government and civil society organizations working on HIV and AIDS. These trips have been primarily to learn about the ART services available and explore possible short term solutions.

Cambodian PLHIV migrants face many issues in accessing ART in Thailand. Their migrant status is the primary issue, but there is also a lack of support networks, and incompatible drug regimens for those already on ART. To be eligible for ART in Thailand, a PLHIV has to be enrolled with health insurance, which costs around 1,900 THB (60 USD) per year.

A recommendation by CPN+ is that even though PLHIV generally benefit from the expanded ART service coverage and “Treatment for all” policy, NCHADS and MoH should expand the ART services as far as possible. This could include making ARV drug distribution localized, by allowing community-based health workers to receive rigorous training and technical back up by the health facility physicians. The CPN+ network could play this role as they have expanded their network to most of the provinces in the country. The Cambodian government should also invest more on establishing a MoU with Thailand to be able to assist all Cambodian PLHIV migrants to access ART and other healthcare services



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MIGRATION

According to estimates of Pakistan's Bureau of Emigration and Overseas Employment, around 9,610,920 people in total have migrated abroad from Pakistan since records were first taken in 1971 (BEOE, 2017). According to estimates, the migration rate from Pakistan is 3.3 people per 1000 inhabitants. A major portion of migrant workers from Pakistan are hosted by the Gulf States including Qatar, Oman, Kuwait, Bahrain, United Arab Emirates and Saudi Arabia. In fact, 94 percent of Pakistanis have gone to Gulf Cooperative Council (GCC) Countries for work, and 80 percent of Pakistani migrant workers are located in just two countries, Saudi Arabia and UAE. The total number of Pakistani workers registered for overseas employment in 2012 was 628,452, while in 2015 it was 946,571, and in 2016 it was 839,353 (Bureau of Emigration & Overseas Employment). It is estimated that a large number of migrants also go abroad through undocumented channels. During the 2008-13 period, more than 50 percent of total emigrants from Pakistan originated from the Province of Punjab, followed by Khyber Pakhtunkhwa (28 percent), and Sindh at (8 percent) (Bureau of Emigration & Overseas Employment). Many people migrating abroad come from these rural areas of Pakistan, and most of them go to Gulf countries.

In Pakistan, the legal framework that safeguards the rights of overseas workers and regulates the activities of overseas recruitment agents is contained in the Emigration Ordinance (1979) and the Emigration Rules (1979), which were both updated in 2012. Overseas employment is regulated under Section 8 of the Emigration Ordinance. It grants vast powers to the Director General of the Bureau of Emigration and Overseas Employment (BEOE), the Protector of Emigrants, and the Community Welfare Attaché/Labor Attaché, who, between them, deal with all matters pertaining to overseas employment of Pakistani workers. The BEOE functions through its seven regional offices, called Protector of Emigrants, located in Karachi, Lahore, Rawalpindi, Peshawar, Quetta, Malakand and Multan.

HIV/AIDS SITUATION

Pakistan had an estimated 102,000 people living with HIV by the end of 2016 and up to 133,000 in 2017, with only 17,224 PLHIV registered with the National AIDS Control Program in 2016 and then up to 22,333 in 2017. Out of these, 8,133 are receiving ART through government provided service centers in 2016 and then 12,046 in 2017 (NACP). On average, in 2012-2013 there were 33-45 PLHIV initiated on ART per month.

The 2011 IBBS conducted in 19 cities by the Government of Pakistan's HIV and AIDS Surveillance Project (HASP) among key populations confirmed that HIV prevalence among IDU rose from 20.8 percent in 2008 to 27.2 percent in 2011; among MSW 1.6 percent in 2011 compared to 0.9 percent in 2008; and among FSW 0.6 percent in 2011 compared to 0.2 percent in 2007. Estimates also show that by the end of 2014, over 51,000 migrants had been deported cumulatively from the Gulf States for being found to be HIV positive (Durrani, 2016).

Since 1971, around 97 percent of the 9,313,111 Pakistanis registered with the Bureau of Overseas Employment (BEOE) migrated to the six GCC countries alone. Screening for HIV remains mandatory for getting or renewing a work visa to all GCC countries. As such, all registered migrant workers must undergo health testing from certified GAMCA medical centers. This testing, which includes HIV, is done without consent, confidentiality or pre and post-test counseling (Sönmez, et al., 2011). If someone is found to be HIV positive in one of the GCC states, that person will be immediately deported back to his or her home country.

The risk of onward HIV transmission to spouses and children upon the return of migrant workers from abroad has been documented. In Khyber Pakhtunkhwa (KP) for example, at the end of 2013, among the 1,257 PLHIV ever-registered (includes dead and missing), 41.8 percent (526) were migrants. At the end of 2013, among the 819 on ART, 28.9 percent were migrants (237). In the last quarter of 2013, a total of 27 returned migrant men were registered at the HIV Clinic in KP. All were married, and of 27 spouses, 6 were found to be HIV positive but none of the children (NACP, 2014).



The Federal Investigation Agency

Although a powerful agency that has a separate Immigration and Anti-Human Smuggling Wing, it lacks a mechanism to ascertain reasons for migrant workers deportation from Gulf Countries or other countries. FIA does not have specialized units at entry points either to seek reasons for migrants' arrival back home or to determine if they were deported in order to provide legal or medical support.

| HIV RELATED LEGISLATURE



HIV & AIDS Prevention and Treatment Act, 2007 (Bill)

The preamble reads:

“ An Act to prevent the HIV from becoming established amongst general population, particularly in most-at-risk and vulnerable populations, and to provide for the care, support and treatment of persons living with HIV and with AIDS.

Notable is a section under the heading “Protection against Discrimination,” where it is stated that: “The HIV Prevention and Treatment Bill prohibits the discrimination against any person on the basis of his HIV status in any form in relation to any activity in the private or public sector; and further declares it unlawful that a person be required and / or coerced to be screened for HIV for any of the following purposes...” Employment, training or benefit in the private sector is listed; as is Immigration to, emigration from, or citizenship of Pakistan; and lastly, Visiting another country for any purpose whatsoever including but not limited to tourism, studies or work.



HIV (Safety And Control) Act, 2010 (Bill)

This piece of legislature known as the HIV Safety Bill is a provincial bill and applies only to the Islamabad Capital Territory. Its primary purpose is to control the spread of HIV. However, it does so by compromising certain human rights associated with HIV. For example, Section 3.2 provides that HIV/AIDS tests can be required by court, public prosecutors or by a physician, primary health care giver, nurse, attendant, or paramedic involved in care of patients, even though no one else should have the right to ask any person for a HIV test. The results are supposed to be maintained under confidentiality. The person being tested shall also be informed of the tests. Although for medical personnel only, it opens the door to Section 4 which provides that the following persons shall be required to undergo mandatory testing:

(c) High risk groups including the following:

- (i) *All immigrant workers returning to Pakistan, at all entrance points, and the results shall be communicated to the person tested; and in case the results are positive than the tests of the family members shall also be conducted.*



The Sindh HIV And AIDS Control Treatment And Protection Act, 2013

This Act was meant to control the transmission and spread of HIV in the Province of Sindh and to provide measures for the treatment, care and support of People Living with HIV and AIDS. This act is also a comprehensive guide for an implementing body to tackle HIV issues in Pakistan. The act covers many HIV related issues, but the specific needs and potential risks of migrants, including social and legal protections, were not addressed, as migrants were identified under Key Populations rather than as a Most at Risk Population. Some key elements of the Act were to ensure representation from the Most at Risk Groups on basis of integrated behavioural and biological surveillance in the “implementing body,” which means that migrants were not represented as they were only considered as key populations. Chapter 3 of the Act protects the rights of PLHIV in the Province of Sindh from all forms of discrimination based on their positive status.

The Act also echoes the 2007 Bill, by making it unlawful to require or to coerce a person to be screened for HIV for purposes of employment, training or benefit in the private sector, or immigration to, emigration from, or citizenship of Pakistan. Moreover, the Health Department was tasked with ensuring that HIV and AIDS awareness and Voluntarily Confidential Counseling Testing were available at the basic health unit level. This meant that CD4 and viral load testing, Anti-Retroviral treatment (adult and children), psychological support, treatment for opportunistic infections and sexually transmitted infections, were also to be made available at the primary health care level. This was evidently aimed at reaching more rural areas.



Proposed HIV and AIDS Prevention And Treatment, Care And Support Act, 2013

Similar to the HIV Act of 2010, this act tries to emphasize testing as a means of preventing the spread of HIV. However, it once again exceeds personal right to confidentiality as it declares:

- (I) Migrant workers returning to Pakistan shall be subjected to HIV test at all entrance points (airport, seaport), and the results, whatever it may be, shall be communicated to the person tested. If the result is positive, the test of family members of such a person shall also be conducted.

Although it provides well-intentioned protections to spouses, by allowing an individual to approach the court if he/she suspects his or her spouse to be HIV positive, and as a consequence of his/her marital relations with him/her the person can prove that he/she is at significant risk of acquiring the disease.

Whether anyone will use this legal right is another question considering socio-cultural context. The act aims to improve HIV related counseling:

“ A person who undergoes the HIV test, shall be informed of the results, whatever it may be. If the result is positive the relevant hospital or clinic shall be responsible for their counseling and for preparing them to live with the disease and stop transmission of it to their relatives. ”

It also promotes consent, although the wording lacks a rights-based underpinning:

“ Before a person undergoes the test for HIV consent form, to be prescribed, shall be signed by him/ her. The personal details of the HIV infected individual are then entered into a National Data Bank. ”

| ESTABLISHMENT OF NATIONAL AIDS CONTROL PROGRAM

After the first AIDS case was detected in Pakistan, the government of Pakistan established the National AIDS Control Program (NACP) in 1986-87, with a focus on diagnosing cases that came to hospitals. The NACP has implemented several policies and frameworks aimed at combatting the spread of HIV and AIDS:

National Strategic Framework

The development of the first National Strategic Framework (NSF) in 2001 provided strategic vision to the government of Pakistan's national AIDS response. With support from the World Bank, the government launched the Enhanced HIV and AIDS Control Program (EHACP). So far there have been three National Strategic Frameworks implemented in 2001, 2007 and 2015. It was in the 2007-2012 National Strategic framework that migrant workers were first identified in the "Most at risk and bridge group" for HIV and AIDS transmission. However, actions identified were vague, such as "design specific interventions for bridging groups, including providing support groups." With a lackluster response, there have been significant numbers of HIV cases reported to the health care services, especially in Khyber Pakhtunkhwa, among migrants who were deported from the Gulf States for being found to be HIV positive.

Access to HIV Services

In Pakistan there are 21 treatment centers located in the federal capital and 4 provinces. These centers provide services to all groups infected and affected by HIV. A range of services are provided in these centers: ART services, Diagnostic services (HIV confirmation, Baseline investigations, CD4 testing, Viral Load testing), and Post-exposure prophylaxis after a potential exposure to HIV. All these treatment centers are situated in the major cities of Pakistan making it difficult for the migrant population, which largely hails from rural areas, to be aware of or access these centers.

| RETURNED MIGRANTS' PERSPECTIVES

Among those who participated in the FGDs, all of whom were men as very few women migrate from Pakistan through formal channels, few of the participants were aware of migration policies or laws in either their home or destination countries. They all had expected social acceptance and higher wages abroad. Potential migrants were hopeful of establishing businesses and improving their life upon return. Almost 90 percent of participants of focus group discussions were also unaware of HIV and AIDS related policies and laws of Pakistan and destination countries. The lack of awareness about HIV and AIDS was common among the majority of participants, but it was noted that potential migrants had higher awareness. Low literacy rates and social exclusion may contribute to a lack of awareness of policies. Research participants who were former migrants revealed that they often engaged in MSM sexual encounters abroad and had multiple sex partners; most of their partners were either buying or selling sex. Isolation, fatigue and financial needs were reasons for involvement in these sexual activities. Easy access to sexual networks was also a reason for having multiple sexual partners abroad. Drug use and having sex was considered to be a sole joy for most of the respondents, and situational sex had a greater frequency among participants while abroad.

Participants had poor access to the most essential HIV prevention tools. Structural barriers at the policy and cultural level played a central role in hindering access to condoms, lubricants, HIV testing, and HIV treatment in destination countries, particularly in GCC countries. Focus group participants described how criminalization and social stigma negatively affected health seeking behaviors and access to services. Discrimination on the part of health care providers was especially damaging, and caused men to delay or avoid treatment for HIV and other sexually transmitted infections. The impact of structural barriers trickled down to the interpersonal and individual level, leading to social alienation, poor mental health outcomes, and further declines in access to services and health-seeking behaviors.

The deported migrants had distinctive experiences as compared to other returned migrants. Their HIV positive status made it more difficult for them to face their families and communities due to stigmatization and discrimination they felt from society. A lack of awareness or understanding of HIV among the public worsened the situation for deported PLHIV. Services related to HIV and AIDS are available in Pakistan, but access to these services is complicated by the concentration of these services in capital cities and limited outreach by organizations working on HIV and AIDS. Lack of understanding of health services and their benefit is another reason for lower access to services. Effective outreach and peer education mechanisms through association with CSOs outreach workers and their peers were found to be helpful in engaging PLHIV migrants in health seeking behaviors. However, all of the participants indicated a lack of migration related services including rehabilitation services and employment opportunities from the government.

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MIGRATION

Based on the 2016 Survey on Overseas Filipinos conducted by the Philippine Statistics Authority (PSA), there were about 2.2 Million Overseas Foreign Workers (OFWs) working abroad at any given time between April to September 2016. Out of this figure, 97.5 percent were overseas contract workers (OCWs) or those OFWs with existing employment contracts (PSA, 2016). The rest it is estimated are Filipinos working abroad but do not have existing employment contracts, who are categorized as undocumented workers. The PSA survey showed that most of OFWs (21 percent) came from Region IV-A, which is the region of provinces immediately south and contiguous to the National Capital Region (NCR). Meanwhile, the NCR accounts for 12.9 percent of OFWs, followed closely by Central Luzon (12.7 percent).

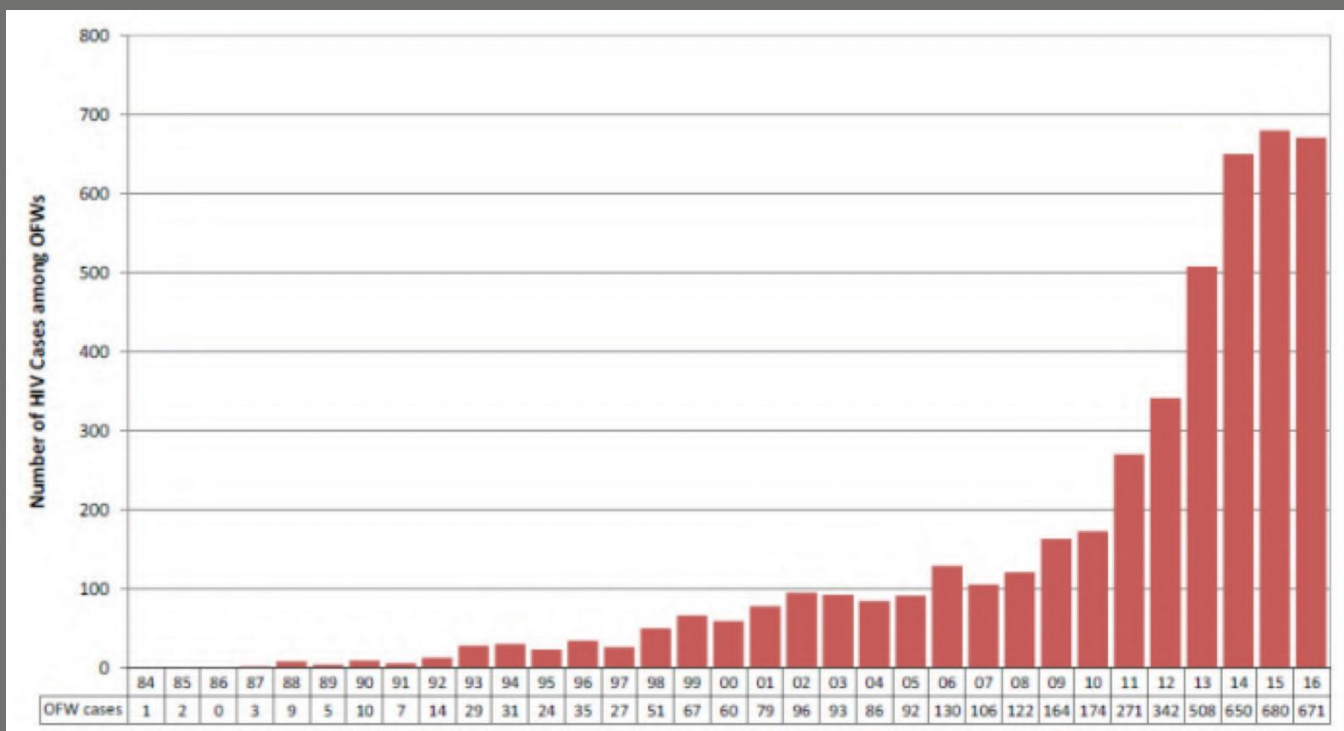
The PSA survey also showed that 34.5 percent of OFWs worked in ‘elementary occupations’. The International Standard Classification of Occupations defines “Elementary Occupations” as occupations that consist of simple and routine tasks which mainly require the use of hand-held tools and often some physical effort. More than half of the women OFWs deployed were in elementary occupations (mostly domestic work). More than half of the OFWs deployed in 2016 were female, comprising 53.6 percent. Among the female OFWs, 67.8 percent belong to the 25 to 39 years old age group. The PSA report also states that the largest group of male OFWs worked as plant and machine operators and assemblers. According to the Compendium of OFW Statistics of the Philippine Overseas Employment Administration (POEA), the number of Seafarers deployed from the Philippines increased annually, from 401,826 in 2014 to 406,531 in 2015, and 442,820 in 2016 (PSA, 2016). According to PSA, Middle East countries continue to be the major destination of the majority of OFWs. About twenty-three percent (23.8 percent) of OFWs worked in Saudi Arabia in 2016. Other preferred destinations were United Arab Emirates (16 percent), Kuwait and Qatar (6.4 percent each), Singapore and Hong Kong, SAR of China (5.6 percent each).

HIV SITUATION

The incidence of HIV in the Philippines continues to rise while most countries around the world have seen a decrease in yearly HIV infections. By the end of 2016, the Epidemiology Bureau (EB) of the Department of Health (DOH) recorded a total of 39,622 individuals confirmed to be infected with HIV since it started to monitor the HIV epidemic in 1984. In 2016 alone, there were a total of 9,264 individuals newly diagnosed with HIV. This figure can be translated to about 26 individuals diagnosed with HIV per day. (This number rose again to 31 new infections per day as of Aug. 2017) This dramatic increase in the number of individuals diagnosed with HIV is made even more alarming given that back in 2010, there were only four (4) individuals diagnosed with HIV per day (Bureau of Epidemiology, 2016). Out of the 39,622 ever reported to be infected with HIV, 93 percent or 36,801 were males. Ninety-four percent (94 percent) or 37,385 individuals contracted through sexual transmission. Eighty-two percent (82 percent) or 30,238 were infected from engaging in unprotected male-to-male sex.

Twelve percent (12 percent) or 4,577 were males who were infected with HIV from having unprotected sex with women; while six percent or 2,570 were women who contracted the virus from having unprotected sex with men (Bureau of Epidemiology, 2016). The profile of newly diagnosed individuals is getting younger. By the end of 2016, around 53 percent of those diagnosed with HIV (20,386) were between 25 to 39 years old. This is followed by those aged 15 to 24 years old who comprise 28 percent (10,720) of total number of people diagnosed with HIV in the country. In the early part of the last decade, 2001 to 2005, the majority of individuals diagnosed with HIV were aged 35 to 49. But from 2006 onwards, the trend shifted to the younger age groups (Bureau of Epidemiology, 2016).

OFWs are among the sub-populations monitored by the DOH for HIV infection. The first Filipino diagnosed with HIV in 1984 was a migrant returnee from the United States. Medical clinics which process pre-employment medical examinations for OFWs are required to submit their results to the DOH, providing a “passive surveillance” on OFWs for the Epidemiology Bureau. Overseas Filipino workers comprise 12 percent (4,639) of the total number of individuals diagnosed with HIV. Eighty-five percent (85 percent) or 3,934 of the OFW who were HIV positive were male; and 68 percent (2,670) of that group had engaged in unprotected sex with other males. The median age among male OFWs diagnosed with HIV is 32 years old, while for women, it is 34 years old (Bureau of Epidemiology, 2016). In 2016 alone, 671 OFWs were diagnosed with HIV. This accounted for 7 percent of the total number of individuals diagnosed with HIV for that year. This means about one to two OFWs were diagnosed with HIV per day in 2016 (Bureau of Epidemiology, 2016).



Source: HIV/AIDS and ART Registry of the Philippines, Department of Health. December 2016

Back in 2007, the Department of Labor and Employment (DOLE) asked the DOH to stop including this information because they feared it might affect the competitiveness of OFWs, particularly, seafarers, in the international labor market. This has made it quite difficult to access HIV data on OFW from the DOH.

The last decade has seen progress in the recognition of health as a crucial issue faced by OFWs. This is evidenced by the inclusion of health issues of migrant workers in various national plans, the enactment of various policies, and the establishment of programs specifically addressing health concerns of OFWs.

| SOCIAL PROTECTIONS

Prior to updating health and migration-related policies and programs, the Philippine's social protection mechanisms were already in place. Ideally, these mechanisms should cover every Filipino, including those who go abroad for employment. In practice, however, membership and collection of premiums for these mechanisms has been less than efficient among OFWs, in part because they have to remit their contributions voluntarily. In the Philippines, the social protection system has three components: 1) the Social Security System (SSS) for employees in the private sector and the Government Social Insurance System (GSIS); 2) the PhilHealth; and 3) the Home Development Mutual Fund (HDMF). All OFWs are required to pay their contributions to the SSS, the PhilHealth and the HDMF. In most cases, these are paid for by the OFW prior to departure for overseas work. For instance, they could pay their PhilHealth contributions for a whole year before they leave the country. There are field offices in Philippine Embassies and Consulates where OFWs can continue to remit their contributions regularly. Beyond that, their families in the Philippines can make the regular payments to ensure that the OFWs and their dependents continue to enjoy the benefits of these social protection mechanisms. Among other benefits, OFWs who have been infected with HIV are able to access disability benefits from the SSS when they are afflicted with Tuberculosis or other illnesses covered under the SSS rules.

PhilHealth is the only one of the social protection mechanisms that has specific coverage for HIV. On top of the regular PhilHealth benefits, there is an additional coverage for HIV treatment called the Outpatient HIV and AIDS Treatment (OHAT) Package. The package covers laboratory tests, anti-retroviral treatment and professional fees. If the OFW has a child who also is infected with HIV, as a dependent of a PhilHealth member, the child will also receive coverage, including the OHAT Package. It only requires the member to be up-to-date with his/her PhilHealth contributions. One scheme designed for additional welfare coverage for OFWs is the Overseas Workers Welfare Administration (OWWA). All OFWs are required to pay 25 USD to the fund prior to deployment. This contribution to OWWA is for the duration of the OFW's contract. Benefits under this scheme include loans, both to the OFW and their families left behind, scholarships, and livelihood support. The biggest gap in this scheme is that when an OFW's employment contract ends, it becomes harder to access the benefits because OWWA prioritizes those who have active contracts.



Republic Act 8504: The Philippine AIDS Prevention and Control Act of 1998

Although the AIDS Law was enacted in 1998 and is currently undergoing amendment, it is the only national legislation that specifically mentions HIV prevention among OFWs. Article 1, Section 7 of the AIDS Law states:

“ All Overseas Filipino Workers, diplomatic, military, trade and labor officials and personnel to be assigned overseas shall undergo or attend a seminar on the cause, prevention and consequences of HIV/AIDS before certification for overseas assignment. ”

OVERSEAS AGENCIES AND IMPLEMENTATION OF THE AIDS LAW

The Overseas Workers Welfare Administration (OWWA), an attached agency of the DOLE, is the government agency tasked to ensure that this provision in the AIDS Law is implemented. The OWWA is then responsible for certifying organizations which conduct pre-departure orientation seminars (PDOS) for OFWs. However, monitoring the compliance of PDOS providers on including HIV orientation has been poor. It should be noted that the structure of the PDOS, which allots only about 30 minutes of HIV education, is an ineffective venue to educate OFWs properly about HIV.

To try to supplement the PDOS, the Philippine Overseas Employment Administration (POEA) included a module on HIV education in its online, pre-employment orientation seminar (PEOS), which is offered to prospective migrants who have not yet initiated the recruitment process. In fact, POEA made it a requirement for applying for work abroad to have a PEOS certificate that can only be acquired after going through the whole PEOS module online.

The AIDS Law is also presently undergoing amendment in Congress to make it more responsive to the current HIV epidemic that is facing the country. The bill that seeks to amend the AIDS Law also includes a similar provision on HIV education for OFWs. But unlike the present law, the bill includes a provision on programs and services for OFWs who have been infected with HIV and have lost the opportunity to work overseas. At the time of this review, the bill to amend the AIDS Law had not passed yet.

The 6th AIDS Medium Term Plan for 2017-2022 includes OFWs among ‘vulnerable populations’. However, the Plan does not have a specific key result area for OFWs. It is crucial, therefore, to ensure that when this Plan is operationalized and costed, there are specific targets, activities and budgetary allocation for HIV programs for OFWs.

HIV AND AIDS SERVICES FOR RETURNED OFW

Overseas Filipino workers who are diagnosed with HIV in destination countries and are subsequently deported need to undergo HIV testing again in the Philippines in order to be enrolled in the treatment program. All PLHIV need to be members of the Philippine Health Insurance (PhilHealth) to avail the so-called Outpatient HIV/AIDS Treatment (OHAT) Package which was rolled out by (PhilHealth) in 2010. This package provides an additional PhP30,000 (575 USD) annual benefit package for PLHIV on top of the usual benefits.

The OHAT package covers ARV treatment, treatment-related laboratory monitoring such as CD4 count and viral load tests, and professional fees. However, feedback from the community indicated that there is no standard guiding the coverage of the OHAT Package. The only consistent service across all treatment hubs is the provision of free ARV treatment. Laboratory and other services vary from one treatment hub to the next. For instance, there are treatment hubs that provide free medicines for opportunistic infections, such as pneumonia, and prophylaxis for Tuberculosis. But it is not clear whether these services are under the OHAT Package or are provided by the Global Fund or the Department of Health (DOH). Thus, advocates continue to engage PhilHealth and the DOH to improve the coverage of this package, as well as ensure its proper and consistent implementation, while ensuring that other health needs of PLHIV are addressed.

The welfare of OFWs has been under the mandate of the Department of Labor and Employment, primarily the OWWA, and to some extent the Department of Foreign Affairs, through its Assistance to Nationals (ATN) units in Embassies and Consulates abroad. But health services have been greatly lacking among the social services that OFWs can avail. In May 2013, the Department of Foreign Affairs signed Department Order (DO) No. 09-2013 or the “Guidelines on the Formulation and Implementation of the HIV and AIDS Prevention and Control Policy and Program in the Department of Foreign Affairs and its Attached Agencies.” This DO provides for HIV education and services, not only to those employed by the Department and its attached agencies, but also enumerates specific HIV prevention and care programs for OFWs. Below are the specific provisions that relate to OFWs:

- **Section 5 - 5.1.4:** “The Office of Personnel and Administrative Services (OPAS) and Foreign Service Institute (FSI), in consultation with DOH and the Philippine National AIDS Council (PNAC) shall be responsible for providing jointly funded, specialized training on STI, HIV and AIDS... [including] information on a referral mechanism... to assist overseas Filipinos living with HIV and AIDS.”
- **Sec. 6 - 6.2.1:** “DFA personnel are required to take an active role in educating overseas Filipinos on STI, HIV and AIDS, including its prevention and control.”
- **Section 7 - 7.1.3:** “The Department and the Foreign Service Institute shall integrate specialized information on providing assistance to overseas Filipinos living with HIV and AIDS into the PDOS of diplomatic, military, trade, labour and other government officials and staff, including gender focal points who will be assigned overseas.”

Even before this DO was signed, the FSI had included an HIV and Migration module in the curriculum for the Cadetship Program of Foreign Service Officers and the PDOS of foreign service personnel. A few years after the DO was signed, the HIV part of the curricula was cut short when the education and training programs were revised and shortened. These revisions were made either to make way for other topics deemed more important, or because the Officials decided to shorten the whole training program. For its part, the Department of Labour and Employment (DOLE) also established their own reintegration program for repatriated OFWs through the Department Order No. 189-14 or the so-called Assist WELL Program.

This reintegration package has four (4) components: welfare, employment, legal and livelihood. The welfare component provides airport assistance, temporary shelter, transportation to residence, emergency medical assistance and stress debriefing. The employment component offers job placement or referral for local employment and skills competency assessment. The livelihood component provides entrepreneurial development training, hands-on business mentoring and support, and business loan assistance. The legal component offers legal advice, conciliation proceedings, assistance in preparing complaints for illegal recruitment, recruitment violations and disciplinary proceedings for erring recruitment agencies, counselling during preliminary investigation, and hearing of criminal cases of illegal recruitment.

Faced with the deportation of OFWs for various reasons, especially health conditions including HIV, the Department of Social Welfare and Development (DSWD) issued Administrative Order (AO) No. 3 in 2008, also known as the “Guidelines on the Comprehensive Delivery of Reintegration Services for Deportees, Repatriates and Returned Irregular Overseas Filipino Workers.” Under the AO No. 3, OFWs who have been deported, repatriated or returned, including OFWs who have been diagnosed with HIV, can access psycho-social services. Also, DSWD has included PLHIV among those eligible to receive a Person with Disability (PWD) card that avails the holder 20 percent discount on medicines, and certain services, among other benefits. Additionally, the DSWD also provides financial assistance to indigent PLHIV, allocating about 1,000 USD per quarter. PLHIV are classified under the category of ‘psycho-social disability’ so that their HIV status is not visible on the PWD card.

Advocates and the PLHIV community are divided on the issue of providing this PWD card to PLHIV for two main reasons:

01

classifying HIV status as a disability may contradict advocacy for acceptance of PLHIV, and

02

the PWD card is vulnerable to abuses by PLHIV. For instance, there have been PLHIV who have used their PWD card to access parking spaces and other spaces that are designated for people with physical limitations and disabilities, while they are still physically fit.



Amendment of the Migrant Workers Act of 1995 (Republic Act 8042)

When the Republic Act 8042 or the Migrant Workers Act of 1995 was amended in 2010, the Law strengthened the protection of OFWs from illegal recruitment and labour-related abuses. Health-related provisions enhanced or introduced in the new Migrant Workers Law were in relation to stricter regulation of the pre-employment medical examinations and in the mandatory provision of insurance coverage for OFWs.

Section 16 provides for the following:

- ✔ (c) The Department of Health shall regulate the activities and operations of all clinics which conduct medical, physical, optical, dental, psychological and other similar examinations, hereinafter referred to as health examinations, on Filipino migrant workers as requirement for their overseas employment. Pursuant to this, the DOH shall ensure that:
 - ✔ (c.1) The fees for the health examinations are regulated, regularly monitored and duly published to ensure that the said fees are reasonable and not exorbitant;
 - ✔ (c.2) The Filipino migrant worker shall only be required to undergo health examinations when there is reasonable certainty that he or she will be hired and deployed to the jobsite and only those health examinations which are absolutely necessary for the type of job applied for or those specifically required by the foreign employer shall be conducted;
 - ✔ (c.3) No group or groups of medical clinics shall have monopoly of exclusively conducting health examinations on migrant workers for certain receiving countries;
 - ✔ (c.4) Every Filipino migrant worker shall have the freedom to choose any of the DOH-accredited or DOH-operated clinics that will conduct his/her health examinations and that his or her rights as a patient are respected. The decking practice, which requires an overseas Filipino worker to go first to an office for registration and then farmed out to a medical clinic located elsewhere, shall not be allowed;
 - ✔ (c.5) Within a period of three (3) months from the effectivity of this Act, all DOH regional and/or provincial hospitals shall establish and operate clinics that can serve the health examination requirements of Filipino migrant workers to provide them easy access to such clinics all over the country and lessen their transportation and lodging expenses, and;
 - ✔ (c.6) All DOH-accredited medical clinics, including DOH-operated clinics, conducting health examinations for Filipino migrant workers shall observe the same standard operating procedures and shall comply with internationally accepted standards in their operations to conform with the requirement of receiving countries or of foreign employers/principals.

- ✔ “All Foreign employers who do not honour the results of valid health examinations conducted by a DOH-accredited or DOH-operated clinic shall be temporarily disqualified from participating in the overseas employment program, pursuant to POEA rules and regulations.
- ✔ “In case an overseas Filipino worker is found to be not medically fit upon his/her immediate arrival in the country of destination, the medical clinic that conducted her health examination/s of such overseas Filipino worker shall pay for his or her repatriation back to the Philippines and the cost of deployment of such worker.”

The glaring issue here is the fact that the Philippine government still caters to the requirements of the foreign employers of destination countries. It does not address, for instance, the fact that HIV testing is required in most destination countries, and although a migrant worker with HIV is still able to work, they are considered unfit to work. Still, an improvement to the process is the involvement of CSOs like the Positive Action Foundation Philippines, Inc. (PAFPI) in providing post-test counselling to OFWs who are tested positive for HIV during the PEME. With the intervention of PAFPI, the newly diagnosed OFW can easily be referred to appropriate service providers, especially for enrolment in ARV treatment and PLHIV support groups.

Section 23 is a new provision that was introduced to RA 10022. It requires recruitment agencies to provide insurance coverage to all agency-hired OFWs. The specific provisions related to health and well-being of OFWs are as follows:

“ **Compulsory Insurance Coverage for Agency-Hired Workers.... each migrant worker deployed by the recruitment / manning agency shall be covered by a compulsory insurance policy which shall be secured at no cost to the said worker. Such insurance policy shall be effective for the duration of the migrant worker’s employment. (Coverage is mostly for accidents but does not stipulate anything about HIV or disease treatment...)** ”

NATIONAL POLICY ON THE HEALTH OF MIGRANTS AND OVERSEAS FILIPINOS

In 2013-14, the Department of Health (DOH) worked with the International Organization for Migration (IOM) in a commissioned study on the health concerns of OFWs. The study was mainly a review of existing researches on the issue. But there was a very limited knowledge base on health and migration. In fact, most of the literature used in this study came from ACHIEVE’s published studies on HIV and Migration. The study also found that there were existing policies that aim to address the health needs of OFWs but there was no clear institutional mandate among concerned government agencies.

Two years later the DOH issued a policy directive to create a network to focus on migrant health, along with guidelines and structures to operationalize the provision of health-related services for OFWs. In March 7, 2016, the DOH issued Administrative Order No. 2016-0007 or the National Policy on the Health of Migrants and Overseas Filipinos. The AO aims to set the overall policy directions and the national policy framework for addressing the health of migrants and overseas Filipinos.

The AO has three specific objectives:



The AO established three main structures within the purview of the DOH to oversee migrant health concerns. These structures are the Migrant Health Unit, DOH Intra-Agency Task Force on Migrant Health, and the Philippine Migrant Health Network.

The Migrant Health Unit (MHU) is lodged within the Bureau of International Health Cooperation (BHIC) of the DOH and is tasked to be the focal point in the DOH for all migrant health-related issues. As the focal point for migrant health concerns, the MHU’s roles and functions include the following:



The DOH Intra-Agency Task Force, on the other hand, was formed to review policies and programs relevant to migrant health; to monitor the health status of migrants; to identify gaps and challenges; to develop collective policy and implement programmatic responses to pressing health issues; and recommend action on migrant health-related issues to the Secretary of Health.

The Task Force is composed of five divisions within the DOH, namely:



The Philippine Migrant Health Network (PMHN) is a multi-stakeholder network for migrant health. It is composed of government agencies, civil society organizations, academe, private sector and international organizations. The PMHN was established to discuss and provide recommendations on migrant health concerns; advocate and lobby for migrant health programs; develop and review proposals of migrant health related projects for resource mobilization; and establish migrant health research agenda and review research proposals. The Network is coordinated and convened by the Bureau of International Health Cooperation (BIHC). Since the creation of PMHN, the network has held three (3) annual network meetings and migration conferences. The members have also come together to develop a plan of action, which is currently being finalized.



Other Joint Initiatives to Assist OFWs

The Department of Foreign Affairs led the development of a Joint Manual of Operations in Providing Assistance to Migrant Workers and other Filipinos Overseas. Several government agencies are involved with DFA in this initiative, namely, the Department of Labour and Employment, the Department of Social Welfare and Development, the Department of Health, the Philippine Overseas Employment Administration, and the Overseas Workers Welfare Administration. According to the Office of the Undersecretary for Migrant Workers Affairs of the DFA, the Joint Manual of Operations will be able to establish greater transparency and accountability in providing services and assistance to OFWs. It will also strengthen the institutional framework of collaboration and coordination among the concerned government agencies, in the Philippines and in the posts abroad.

When this Joint Manual of Operations was developed, it was envisaged to respond primarily to OFWs, mainly women, who are victims of trafficking. It did not have a fully developed framework in the aspect of health service delivery within the Manual. According to the OUMWA, all repatriation cases, including medical repatriation, are lumped together, meaning there is no differentiation of specific needs by case type. Meanwhile, with the creation of the Philippine Migrant Health Network, the Migrant Health Unit of the DOH has come to seriously consider how they can respond to the needs of OFWs undergoing medical repatriation. Thus, the Bureau of International Health Cooperation (BIHC) actively pushed for the enactment of the Joint Memorandum Circular on Medical Repatriation, which was signed in 2017.

The intent of the Circular is to provide free services to OFWs who are being repatriated due to medical reasons. The network of service providers includes DOH, DFA, DOLE, the POEA, OWWA, the Manila International Airport Authority (MIAA) and the Philippine Charity Sweepstakes (PCSO). The scope of the services is from airport to the hospital or home, depending on the needs of the repatriated OFW. This Circular will also pave the way for a database on the medical needs of OFWs, including HIV, reproductive health conditions, pregnancy, Tuberculosis, mental health problems and others.

| MIGRANTS' PERSPECTIVE

The establishment of these programs and the creation of new policies are welcome developments in migration work in the Philippines, especially those that have integrated health and HIV. However, the test of any policy or program is in its implementation and how well it serves the communities it hopes to impact. One of the most immediate requisites to ensure effective implementation of these programs is for the frontline service providers to be trained on HIV and migration issues, as well as be capacitated on handling issues faced by OFWs who are diagnosed with HIV.






Onsite interventions remain to be the most challenging. There remains a big gap in accessing the Embassies, Consulates and POLO when an OFW is diagnosed with HIV. According to the OFWs living with HIV who were deported back to the Philippines between 2012 and 2016, they shared their experience of not being allowed to contact the Embassy after they were quarantined. The Health Ministry or Immigration Office in the destination countries are not obliged to inform the Embassy that they are deporting an OFW because of HIV or any other health problem. So when the OFW is not connected to the Embassy, s/he will not be able to avail of the whole range of services related to repatriation and reintegration. It will then depend on the OFWs capacity to find service providers on their own. In effect, this renders the joint repatriation and reintegration programs irrelevant.

To remedy this, the Philippine posts need to be more pro-active in reaching out to the OFW communities abroad, particularly those in the health sector. OFWs working in the health sector can then be tapped to act as a linkage between those who are admitted in hospitals or those quarantined, and the Embassies and Consulates. It would also be beneficial to be more proactive by providing information on these services through recruitment agencies and manning agencies prior to departure.

Generally, the HIV-related services for Filipinos living with HIV has improved over the years, even though there are still gaps, particularly in terms of increasing service coverage and sustainability. With more and more institutions taking up the issue of HIV, health and migration, there is more hope that OFWs will not fall between the cracks. But informing the migrant community about these programs and services remains key.

Although there are local employment and livelihood programs for deported or repatriated OFWs, the main recommendation is for OFWs living with HIV to be able to continue working abroad. Positibong Marino is an organization of seafarers living with HIV advocating for manning agencies and the maritime industry to allow seafarers living with HIV to continue working on their ships. More initiatives like this need to come forward to advocate on the issue, bringing forward the voice of migrant workers affected by HIV.

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MIGRATION

Sri Lanka is predominantly a labour sending country averaging between 250,000-300,000 migrant workers departing each year to mostly the Gulf States. In total, there are between 1.7 - 1.9 million migrant workers abroad from Sri Lanka, with the majority (at least 80 percent) working in the Gulf region (Sri Lanka Bureau of Foreign Employment, 2016). Most are considered low skilled migrants. Sri Lanka has been known as a country which sends female domestic workers to the Gulf States. The number of domestic workers is falling rapidly, However, mainly due to a self-imposed regulation introduced by the government of Sri Lanka.

EMPLOYMENT DESTINATION BY SRI LANKAN MIGRANTS 2015-16

Country	2015		2016	
	Number	%	Number	%
Saudi Arabia	74894	28.4	63389	26.1
Qatar	65139	24.7	59527	24.5
Kuwait	38473	14.6	32415	13.3
UAE	43666	16.6	40124	16.5
Other	41135	15.7	47475	19.5

DETAILS OF SRI LANKAN MIGRANTS DEPARTING FOR FOREIGN EMPLOYMENT

	2012	2013	2014	2015	2016*
Male	144,135	175,185	190,217	172,630	160,302
Female	138,312	118,033	110,486	90,677	82,628
Total	282,447	293,218	300,703	263,307	242,930
Manpower categories					
Professional	4,448	5,151	5,372	6,257	6,574
Middle	9,280	16,510	20,778	6,921	8,235
Clerical	16,184	26,561	29,267	12,472	10,864
Skilled	67,150	73,707	73,162	82,098	76,559
Semiskilled	3,467	3,412	3,977	4,837	3,930
Unskilled	62,907	70,977	79,519	77,444	71,641
Domestic Worker	119,011	96,900	88,628	73,278	65,127

Source: Sri Lanka Bureau of Foreign Employment

HIV SITUATION

The separation from family, spouse and partner for two years (standard contract period) or longer while in the destination country can lead to behaviour changes which may increase risk of contracting HIV. Lacking knowledge on HIV and prevention methods, in combination with a lack of access to condoms and sexual and reproductive health services while in the host country are all factors which contribute to the vulnerability of both male and female migrants. Being a victim of sexual abuse or trafficking increases migrants' vulnerability to HIV infection considerably, regardless of their sex.

There were 249 newly reported HIV cases in 2016, the highest since the first case was reported in 1987 (NSACP, 2016). This, however, is only an incidental figure and not a full representation of the actual total number of people infected. Stigma and discrimination and the fact that people are unaware of their HIV status are contributing factors to not having an accurate number of HIV infected persons in Sri Lanka. According to the National STD/AIDS Control Programme (NSACP) Annual Report in 2016:

- It is estimated that there are about 4,200 people infected with HIV in the country and that there are about 550 new infections every year.
- In 2015, a total of 1,020,000 HIV tests were carried out in the country of which 235 were confirmed as HIV positive, equating a sero-positive prevalence of 0.03 percent.
- The male to female ratio is about 1.8 to 1 with the highest age bracket of those infected being 25-49 with a steady increase in the 15-24 age bracket.
- The HIV prevalence among FSWs is 0.8 percent and among MSM is 0.9 percent.

HIV awareness is high but knowledge levels are mixed, as results from the Demographic and Health Survey 2016 (DHS) show. For example, almost all women who have ever been married (93 percent) have heard about HIV/AIDS but only one out of three (33 percent) have comprehensive knowledge of AIDS (prevention and misconceptions); only 24 percent of young adults age 15-24 had this knowledge. Moreover, only 10 percent of all women who had ever been married were tested for HIV during the last 12 months, and of those tested, only 73 percent received the results from the test (Dept. of Census and Statistics, 2016).

HIV CASES REPORTED AS OF DECEMBER 2016 BY SEX

Year	Men	Women	Total	Cumulative Total
2010	77	44	121	1317
2011	82	64	146	1463
2012	120	66	186	1649
2013	129	67	196	1845
2014	167	61	228	2073
2015	174	61	235	2308
2016	188	61	249	2502

REPORTED NUMBERS OF HIV POSITIVE AMONG SPECIFIC POPULATIONS (NSACP)

Year	FSW	MSM/Bisexual	DU/IVDU	Migrants
2010	2	9	3	42
2011	4	26	3	43
2012	2	40	3	71
2013	1	53	5	75
2014	0	63	3	43
2015	3	88	2	85
2016, 2 nd Q	3	42	0	50

National STD/AIDS Control Programme (NSACP), Ministry of Health

Sri Lanka recognizes sex workers, MSMs and injecting drug users as the main Most-at-Risk-Population (MARP) groups. Data showing extremely high incidence of new infections among migrant workers highlights this group as a vulnerable population. It was only recently that beach boys and migrant workers were added as “vulnerable populations” under the National AIDS Strategy.



History of the HIV Response in Sri Lanka

The Health Ministry of the government of Sri Lanka has been working on the prevention of HIV since the mid 1980's. The then minister and the administration of the health ministry had the foresight to recognize HIV and AIDS as a growing concern in communicable diseases. Sri Lanka recorded its very first HIV case in 1987. Since then, robust awareness and prevention strategies were put in place, keeping the epidemic at bay, with a national prevalence of under 0.1 percent.

As the epidemic was rapidly growing globally, Sri Lanka recognized the disease not only as a public health concern but also as a social and development challenge. As a country that embraced the modern global economy, Sri Lanka had all the factors for a rapid spread of the disease. However, due to visionary strategic interventions and scaling up of the response, Sri Lanka has been able to maintain its low prevalence status even today.

In the first stages, sexual transmission was recorded through primarily unprotected heterosexual behaviour. It was much later that infections from men having sex with men (MSM) and injecting drug use (IDU) were recorded, in part because Sri Lanka has never had a history of high use of injecting drugs. The promotion of condoms in Sri Lanka goes back to the early 1970's period as a form of contraception, along with birth spacing and limiting family size. Condoms were introduced as an HIV prevention strategy in the early 1990's. The blood screening that was initiated way back in the 1980's and the subsequent introduction of screening and testing of pregnant mothers at the antenatal stage were two other strategies which contributed to success in controlling the epidemic at the outset.

Some other factors identified as contributing to the control of the epidemic, include: education and literacy among both men and women and consequent high levels of health knowledge; a strong health infrastructure throughout the country with state health care facilities which offer services to the population at no cost; and provision of the necessary health infrastructure and training for the health care sector to combat HIV and AIDS, with HIV facilities available in provincial and district level hospitals. The establishment of the National STD/AIDS Control Programme (NSACP) was a very important step in ensuring there was a coherent HIV response. Lastly, but essentially, Sri Lanka's civil society organizations also played a key role in supporting the national programme on family planning services, sexual and reproductive health education, and with HIV awareness and prevention strategies.

As of the end of 2016, NSACP has been providing both preventive and curative services through 31 full-time STI clinics and 23 branch clinics distributed island wide. The expansion of antiretroviral treatment (ART) services to 21 centers is an important achievement made during the recent year. Additionally, the government of Sri Lanka, as of 2016, is funding the National ART programme completely using domestic resources.



National AIDS Policy

It was not until just after the millennium (2000) had passed that the health ministry put forth a National AIDS Policy which was ratified by parliament. It is here that rights protections were finally addressed.

National AIDS Policy Objectives:

- To prevent HIV and other sexually transmitted infections in Sri Lanka through effective strategies aimed at reducing:
 - ✓ Sexual transmission
 - ✓ Mother to child transmission
 - ✓ Transmission through blood & blood products
- To improve the quality of life of people infected and or affected by HIV/AIDS through minimizing stigma and discrimination and providing quality care and support.

The HIV policy does not target any key population groups. It is a policy for the general public. The role and responsibility of the health ministry, the National AIDS Committee and the National AIDS Council is to address issues of awareness, prevention, treatment, and care.

The National AIDS Policy states the following regarding the human rights of persons infected with HIV:

“ **The Government of Sri Lanka will ensure that the human rights of people living with HIV/AIDS are promoted, protected and respected and measures taken to eliminate discrimination and combat stigma which will provide an enabling environment to seek relevant services. These include the rights of everyone to life, liberty and security of person, freedom from inhuman or degrading treatment or punishment, equality before law, absence of discrimination, freedom from arbitrary interference with privacy or family life, freedom of movement, the right to work (rights of the people living with HIV in the work places) and to a standard of living adequate for health and wellbeing including housing, food and clothing, the right to the highest attainable standard of physical and mental health, the right to education, the right to information which includes the right to knowledge about HIV/AIDS/STI related issues and safer sexual practices, the right to capacity building of the individual in dealing with this condition, the right to participate in the cultural life of the community and to share in scientific advancement and it's benefit (National HIV/AIDS Policy Sri Lanka, 2011).** ”

Despite 30 years since the first HIV case was detected, and even with the availability of advanced antiretroviral therapy, People Living with HIV (PLHIV) in Sri Lanka continue to face stigma and discrimination. Those who are most affected are the key affected populations (also known as MARP), namely MSM. In part, this stems from structural discrimination in the form of Article 377, a remnant of Common law from the days of British Colonization which criminalizes homosexual acts and is still in place. In January 2017, a motion to decriminalize homosexuality was brought before parliament, but the measure failed to pass.

| NATIONAL HIV & AIDS STRATEGIC PLAN 2013-2017

The second National HIV & AIDS Strategic Plan was developed in relation to Sri Lanka being a low prevalence country. The primary mode of transmission has been through unprotected heterosexual sexual behaviour, followed by men having sex with men. In the National AIDS Strategy, Sri Lanka does not identify migrant workers as a most-at-risk-population (MARP) but as a vulnerable population. Here is how migrants fit under the plan.



Strategic Direction 1 - Prevention

In the strategic plan, migrant workers are recognized as a vulnerable population group, not as a MARP. Even though returned migrants and their spouses account for over half of all new infections registered in the country, this tier designation means limited resources are devoted to prevention as compared to if they had been designated as a key affected population. Even though internationally migrants are considered a vulnerable population, nationally, the burden of new infections is among this group.



Strategic Direction 2 - Diagnosis, Treatment, and Care

Voluntary, confidential, counselling and testing is scaled up and promoted among key affected population groups and vulnerable population groups, resulting in increased access to HIV testing. Guidelines are updated and in place to test with consent those who visit government STI clinics, and linkages between services are in place to promote continuum of care. Sri Lanka's Ministry of Health has committed to provide free ARVs to those who are infected with HIV and register them with the authorities for treatment. This includes all population groups and migrant workers. Previously, treatment began when a person's CD4 count was below 400.

Today, treatment is given upon detection according to universal standards. Migrant workers do not have their own HIV positive person's network. Most belong to one of the three existing PLHIV network, and there are a few PLHIV migrant workers who are part of an MSM group.

Strategic Direction 3 - Strategic Information Management Systems

In the strategic information management strategy, a key aim is to increase Surveillance of HIV and monitor provision of HIV services. This is backed up by research. The intent is to gain pertinent information in order to understand the trends in HIV infection and respond appropriately. There is provision for data disaggregation by population group even though the data is predominately collected on the most at risk population groups. The data on labour migrants can be obtained on request.

Regarding migrants, a gap in the current data is that it does not analyze when or where infection occurred or where the testing was done, whether during the period of service abroad or during testing for re-migration. The data indicates simply whether the infected person has had a migration history.

Strategic Direction 4 - Health Systems Strengthening

The aim is to strengthen institutional and human resource capacities among health workers and NGOs to ensure quality and reach of HIV services. Part of this is to build the capacity of existing health infrastructure to accommodate all counseling, testing and treatment service needs.

Strategic Direction 5 - Supportive Environment

People Living with HIV continued to report suffering stigma and discrimination from the community level to health providers. This strategic direction aims to promote principles of non-discrimination through HIV/AIDS Laws and policies, increase acceptance of PLHIV, and reduce deaths by refusal of treatment.

One of the strategies includes advocacy and capacity building to enhance access of services for PLHIV and marginalized groups, including migrant workers and their families. There are also points on reviewing and revising policies, and strengthening collaboration and capacity with NGOs. The question is whether these strategies will be able to really impact stigma and discrimination, especially among groups with multiple identities, such as male migrants who belong to the MSM community.

In other words, protecting from HIV discrimination needs to be addressed irrespective of sexual orientation.

NATIONAL MIGRATION HEALTH POLICY

The National Migration Health Policy (NMHP) was developed in 2012 by the Ministry of Health with support by the IOM. With an emphasis on labour migrants, it was developed on the premise that migration is a significant contributor to the national economy and that access to health is a fundamental right of all migrants and their families throughout the migration cycle. The National Migration Health Policy stems from Sri Lanka's overall vision for the protection of rights of all migrant populations, as part of the country's vision for development, and as a reflection of the World Health Assembly Resolution on "Health of Migrants" adopted in 2008.

The policy covers three categories of migration: out-bound migrants, internal migrants, and in-bound migrants. A fourth dimension to these migrant categories is the families left behind by out-bound migrants. There is no reference made of undocumented migrant workers.

The Migration Health Policy, whilst complimenting the National Labour Migration Policy of 2009, states that the latter deals with only HIV and reproductive health of migrant workers. The Migration Health Policy is more comprehensive as it includes communicable diseases and non-communicable diseases and occupational health of migrant workers at pre-departure, onsite (in-service), and at reintegration stages of the migration continuum. Some of the measures include, bi-lateral agreements which include health protections, increased access to pre-departure health related information, voluntary health assessments upon return with referral, and coordinated services at the local level to assist migrants and their families left behind to address physical and mental health issues as well as provide social welfare.

As this is a welcome policy that addresses the health of migrant workers and their families, we would like to observe the following that requires the attention of the health sector authorities.

- ✔ It is mandatory that migrant workers must undergo a comprehensive medical examination conducted and recognised only by the Gulf Approved Medical Centers Association (GAMCA).
- ✔ Migrant workers selected for employment to the Gulf countries do not recognise tests carried out by government hospitals or other private testing centers.
- ✔ The HIV test is mandatory for all migrant workers going to the Gulf states. As such the HIV status of a worker is a determinant factor in the employment selection process. If a worker is found to be HIV positive, deportation or cancellation of the employment contract happens immediately.
- ✔ The policy states that the government will enter in to bilateral agreements and or MoUs with labour receiving countries, it must however be noted that all Gulf states deport migrant workers if found to be HIV positive.

NATIONAL LABOUR MIGRATION POLICY

The National Labour Migration Policy was promulgated in the latter half of 2008. It received technical guidance from the ILO and was developed by adopting the ILO tripartite framework. The key objectives were:

- ✔ To develop a long-term vision for the role of labour migration in the economy;
- ✔ To enhance the benefits of labour migration on the economy, society, and the migrant workers and their families, and to minimize its negative impacts;
- ✔ To work towards the fulfillment and protection of all human and labour rights of migrant workers.

Among other promises, the policy states that return and reintegration will take place with full rights protections, and that HIV information will be provided by the SLBFE in pre-departure trainings. Even prior to this policy coming into effect, the Sri Lanka Bureau of Foreign Employment (SLBFE) carried out an HIV education program in its 14-day pre-departure training for migrant domestic workers. When the Labour Migration Policy came into effect, the training program was extended to 21 days, with HIV education provided to migrant domestic workers including their spouses.

Later, the SLBFE modified its training curriculum even further to make it a 40 day program for migrant domestic workers and five days for male migrant workers. In this curriculum, the HIV and SRH knowledge component is given over one and a half days for females and a half a day session for males. The HIV and SRH (sexual and reproductive health) training curriculum has been developed for SLBFE trainers in conjunction with the health ministry.

MANDATORY MEDICAL TESTING FOR MIGRANT WORKERS UNDER GAMCA

All migrant workers seeking employment in Gulf States must undergo a mandatory medical test as a prequalification for employment. It is on the fulfillment of the medical test that one is granted a visa to travel to any one of the GCC countries. This is done under the auspices of GAMCA (Gulf Approved Medical Centers Association) approved centers in origin countries which carry out the medical tests and adhere to a specific set of policies and guidelines.

As 90 percent of Sri Lanka's migrants go primarily to the GCC states, they must succumb to the GAMCA policy. This includes a comprehensive medical examination conducted and recognized only by the Gulf Approved Medical Centers Association (GAMCA), and mandatory HIV testing, where an HIV positive results in cancellation of the employment contract.

In Sri Lanka, GAMCA certified centers are obliged to follow the GAMCA rule book (See Appendix I), which in some cases over-rides local policies on health testing. Furthermore, GAMCA is not obligated to share medical data of migrant workers with the origin country health administration system. GAMCA clinics also have their own rates for the testing procedure, which far exceeds what other private clinics would charge for the medical tests. The current price ranges from LKR 8,500 to 10,750. It should be noted that the employer bears the cost for all migrant domestic workers including the health test, while male migrants of other job categories must pay for the test out of their own pockets, which adds to the high migration cost.

HIV testing is included as part of the mandatory medical test which migrant workers are required to undergo. However, the only data GAMCA has shared with the Ministry of Health and the NSACP is when there is an HIV positive case sent for the confirmatory test. This raises the question of whether other STIs are not being reported to the national system. When one looks at the national clinic numbers, it is highly possible that there is a significantly higher than reported number of people infected with STIs.

HIV CASES REPORTED AS OF DECEMBER 2016 BY SEX

Types of blood samples screened for HIV	Number tested	Number positive
Blood donor screening (NBTS and private blood banks)	417,428	23
Antenatal mothers	323,518	11
Private hospitals, laboratories and Sri Jayewardenepura GH	225,047	40
STI clinic samples*	90,271	160
Tri-forces	29,236	4
Survey sample	23,615	1
Prison HIV testing programme	12,776	6
TB screening	7,896	4
Total	1,129,787	249

*(STI clinic samples include: clinic attendees, symptomatic patients, outreach samples and testing of contacts). Source: NSACP Annual Report, 2016

PLHIV MIGRANTS' PERSPECTIVE

Migrant workers going to GCC destinations must undergo mandatory HIV testing as part of pre-departure and as post arrival in the host country. Pre-departure mandatory HIV tests are carried out by private GAMCA clinics and not by state STI clinics. However, confirmatory tests are carried out by the state facility. GAMCA centers and testing facilities in the host countries do not offer any kind of pre or post-test counselling to migrant workers. GAMCA centers do not obtain consent to test migrants. If the migrant is found to be HIV positive, he or she is immediately deported and blacklisted from migrating for employment to any Gulf country through a shared database.

Even though the Ministry of Health has been working closely with the Sri Lanka Bureau of Foreign Employment (SLBFE) since 2006 in developing a training and knowledge pre-departure program for migrant workers, it has gaps on HIV information. This program continues today, and of note, wherever possible, the migrant worker's spouse/partner is included in the training. Though low skilled women migrant workers receive knowledge about HIV awareness during their pre-departure training to go abroad as domestic workers, there is no information provided on counselling, testing or treatment, and they are not made aware of what health conditions are being tested by the GAMCA centers, and are not made aware of the ramifications of being identified as having HIV. Migrant workers do not receive any referral service when diagnosed in the host country. The nature in which they are deported and the lack of information provided to them upon retesting leaves them susceptible to infecting their spouses or partners as they would not know or understand their HIV status.






At present, there is no strategy for migrant workers to receive VCCT upon return even though VCCT is a strategy promoted with other population groups. Almost all migrant workers must undergo a compulsory HIV test at re-migration; and therefore, many would only come to know of his or her HIV status at this stage. Though health systems are in place, VCCT strategies must address the immediate shock of learning of their HIV infection, and have follow up counselling and care strategies to address stigma, shame and discrimination that may arise within the family and community. This is especially important for female migrant workers who are immediately labeled as having prostituted themselves whilst working overseas. They are often abused, beaten, marginalized, and discarded from family and community upon revelation of their HIV status, making their survival more difficult. An unknown number of migrants from Sri Lanka have been deported home for HIV from GCC countries. Unfortunately, Labour Attaches for Sri Lanka are not properly trained in handling HIV positive migrant workers, and are unable to offer counselling or referral options upon arriving home. The conditions migrants find themselves being deported are also challenging.

“ I worked in Saudi Arabia for over 20 years in different jobs. It was like my second home. When I was diagnosed with HIV I was working in the hotel sector. I was deported in 24 hours. ”

For those deported home, having their HIV status disclosed by work colleagues to family members and friends is disastrous. Some have even lost their family status at home due to the stigma and discrimination associated with HIV. Whilst the service standards have improved considerably at government STD clinics and Infectious Disease Hospitals in Sri Lanka, including overcoming stigma and discrimination towards HIV positive persons, this is not the case at other government clinics and hospitals. MSM who are hospitalised for treatment reportedly regularly experience severe stigma and discrimination.

However, women migrants living with HIV are stigmatized and discriminated more severely than men. This is borne out by the HIV positive migrant women's group, which is comprised primarily of women who have worked as domestic workers and garment factory workers. A few in this group had been migrant workers since the early 90's and have re-migrated many times to either the same country or another Gulf country. Some of them were diagnosed with HIV during child birth at home; some have lost their children to AIDS and some have children living with HIV. Those who were detected in the 90s had a difficult time as they had to deal with death of their children, their spouse, and manage their HIV without treatment. Some have been called prostitutes even by their own families, and they face stigma and discrimination when they have to undergo medical treatment in hospitals.

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A REVIEW OF HIV POLICY PROGRESSION
AND MIGRANTS' HEALTH RIGHTS IN
FIVE ORIGIN COUNTRIES

CARAM

06

APPENDIX 1

ASIA

GAMCA POLICY

All migrant workers seeking employment in Gulf States must undergo a mandatory medical test as a prequalification for employment. It is on the fulfillment of the medical test that one is granted a visa to travel to any one of the GCC countries. Seven GCC states namely, Saudi Arabia, Kuwait, Qatar, UAE, Oman, Bahrain, and Yemen subscribe to GAMCA (Gulf Approved Medical Centers Association). GAMCA is the agency responsible for certifying centers in origin and destination countries to carry out the required medical tests. GAMCA has its own specific set of policies and guidelines, however, which are apart from National policies and guidelines of host countries. GAMCA certification is required as a way of preventing fraudulent health results which could previously be procured through kickbacks, as is stated on the GAMCA Bangladesh website.

For migrants wishing to go to the GCC for employment:

- ✔ It is mandatory for migrant workers to undergo a comprehensive medical examination conducted and recognized only by the Gulf Approved Medical Centers Association (GAMCA). Tests carried out by government hospitals or other private testing centers are not recognized.
- ✔ The HIV test is mandatory for all migrant workers going to the Gulf States. As such the HIV status of a worker is a determining factor in the employment approval process. If a worker is found to be HIV positive, deportation or cancellation of the employment contract happens immediately.

The GAMCA administrative office is authorized by the Executive Board of the Health Minister's Council for Gulf Cooperation Council States (GCC) to issue allocations to Medical Centres which have been approved by the Executive Board to perform pre-departure medical certification under the GCC Expatriate Workers Check-Up Program. The GAMCA policy has very stringent regulation for the testing centres, and if in the event a test result is not up to standard, meaning inaccurate, that clinic is penalised with very heavy fines, and in some instances, the GAMCA licence is even cancelled.

The rules and regulations of the fourth edition (2016) of the Executive Board of the Health Ministers Council for GCC countries in Article 2 states that:






- ✔ Medical examination of expatriates aims at taking appropriate health measures to make sure that expatriates are free from any contagious disease which can be transmitted through contact to others in such a way that threatens the security and safety of the Gulf community & to affirm the health fitness for the purpose of recruitment.

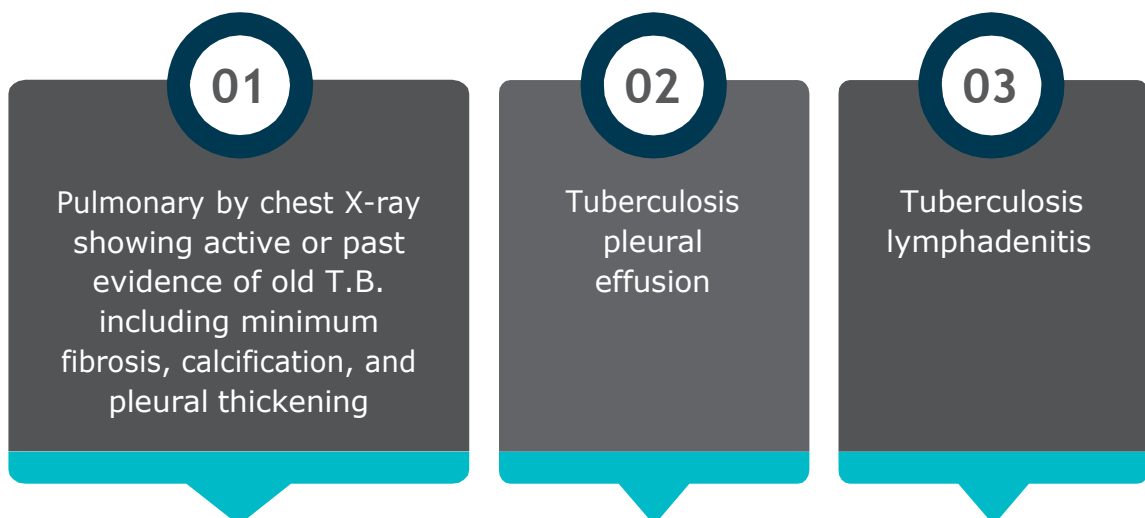
Article 13 (1) states that the medical centres at the origin country must be licensed by the local / national health authorities. Article 14 (3) states that “Conduction of all required medical examinations according to the approved form issued by the Gulf Health Council,” which means that the GAMCA rules override local policies.

Rejections are permanent for test results from diagnosis of certain health conditions, and results are entered in an electronic database shared by all GCC countries. The test for Tuberculosis is highly contentious. The only test GAMCA uses is a chest X-ray, which is only a screening tool. Without conducting a confirmatory test using the sputum test, which is known to give a more accurate result, the x-ray may show previous scars and the person may not be reactive any longer, but is still rejected. Thus, a migrant may be denied a work visa for previously having had Tuberculosis (Migrant-Rights.org, 2011).

As per the 4th edition of the “Rules & Regulations for Medical Examination of Expatriates Coming to GCC States for Residence,” a person undergoing medical certification will be found ‘UNFIT’ to work / reside in GCC Countries if any of the following diseases (or conditions) are found:

Infectious diseases

-  HIV AIDS reactive
-  Hepatitis B surface antigen positive and Anti HCV
-  Microfilaria positive and malaria blood film positive
-  Known leprosy patient
-  Tuberculosis any type:-



Non-Infectious diseases

- Chronic renal failure
- Chronic hepatic failure
- Congestive heart failure
- Uncontrolled hypertension
- Uncontrolled diabetes mellitus
- Known case of cancer
- Psychiatric diseases and neurological disorders
- Physical disability
- Any major operation
- Hemoglobin below 10mg/100ml

Others



- Pregnancy

If already in a destination country in the GCC when diagnosed with HIV, deportation is immediate for migrant workers. Even though comprehensive mandatory health tests are conducted in the country of origin to GCC standards, which include the HIV test, upon arrival, almost all categories of workers must undergo a further test which includes HIV. Migrant workers serving in the hospitality industry, food service, cooks, must also undergo a compulsory health check including HIV every six months.

The medical staff of the clinics doing the tests make sure that positive cases are immediately reported to the authorities for further action. As language is an issue, clinics are uninterested in giving any form of post-test counselling. The obligation on the part of the testing clinics is to inform the migrants' respective workplaces and have their personal data given to the immigration authorities, thus ensuring that those migrants were barred from entering the country again.

All HIV positive migrants identified through testing are reported to every GCC country consulate office and a record is maintained at the GAMCA headquarters in Saudi Arabia. While more recently the destination countries have relaxed the way in which they treat migrants who are detected with HIV, no longer threatening them or detaining them under inhumane conditions. The policy of deportation more or less within 48 hours remains in practice though.

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CARAM ASIA

TASK FORCE ON MIGRATION, HEALTH AND HIV

CARAM Asia (Coordination of Action Research on AIDS and Mobility in Asia) is a Regional Network/ NGO in Special Consultative Status with the Economic and Social Council of the United Nations. The Network comprised of 42 member organizations in 21 countries across Asia was set up in response to the growing phenomenon of migration and emphasizes a regional approach in addressing migrant workers' health issues. Since its inception in 1997, CARAM Asia Network has moved actively to do special interventions for migrant population at all stages of migration in order to reduce vulnerabilities including HIV and advance their health rights.

CARAM Asia has been working to promote and protect the health and labor rights of migrant workers in Asia through research, advocacy and capacity building. CARAM Asia has undertaken evidence-based research and produced a number of reports on migrant workers' health rights including: "The Forgotten Spaces," "State of Health: Access to Health," "State of Health: Mandatory HIV Testing," and "HIV Vulnerabilities of Migrant Women: from Asia to the Arab States."

CARAM Asia partner's key thrust is to develop continuous information through participatory action research with migrants and their communities at all stages of migration to strengthen the migrant perspective. CARAM Asia has used the results of its research to pursue advocacy to protect migrant workers' health rights at national, regional and international levels.